

CHAPTER 4

SAFETY NETS FOR CHILDREN AFFECTED BY HIV/AIDS IN SOUTHERN AFRICA

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Introduction

The devastating consequences of HIV/AIDS on African societies, and its particular impact on children, is requiring every organisation involved in fighting the epidemic to find new strategies to address adequately both the scale of the problem and its duration. The crisis of children left behind by AIDS is a humanitarian, development and human rights challenge of unprecedented proportions.

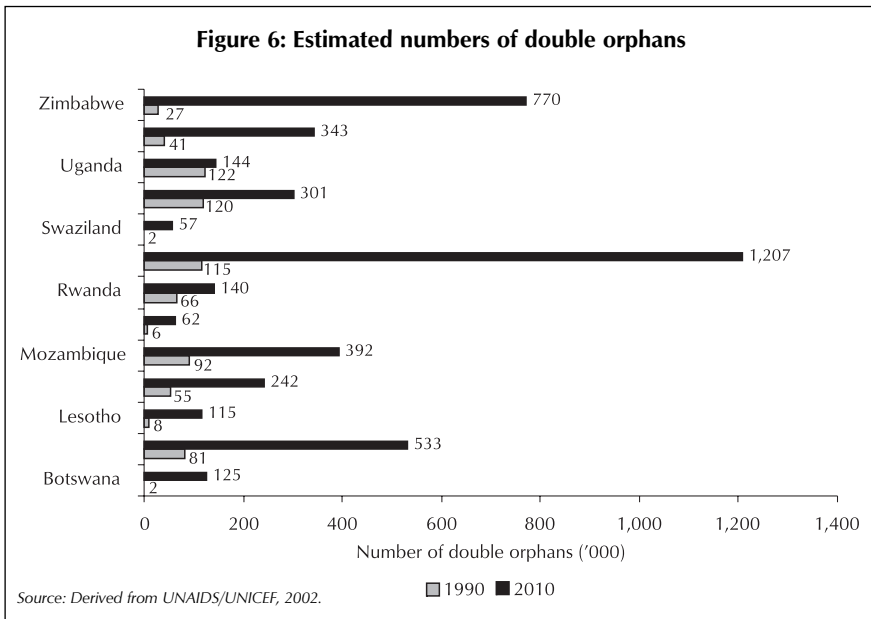
Although there have been substantial gains in improving overall child survival, these gains are being eroded in African countries hardest hit by the epidemic. The scale of the epidemic on this continent makes its repercussions qualitatively different from those in other parts of the world. The economic and social effects of HIV infection and AIDS on children include malnutrition, migration, homelessness and reduced access to education and health care. Psychological effects include depression, guilt and fear, possibly leading to long-term mental health problems. The combination of these effects on children increases their vulnerability to a range of consequences, including HIV infection, illiteracy, poverty, child labour, exploitation and the prospect of unemployment.

The first line of support for vulnerable children is their family, including the extended family and distant relatives, while households that struggle to meet the needs of vulnerable children may be assisted by members of their community. These informal safety net mechanisms are responsible for the care and support of the majority of vulnerable children in Southern Africa. Formal mechanisms, such as those provided by government and civil society, also provide services, especially for children living in situations of extreme vulnerability. This paper considers the interplay between informal mechanisms provided by the family and the community, and formal support mechanisms

provided by the state and NGO sectors. It concludes with a set of recommendations for ways in which statutory agencies can strengthen family and community safety nets to cope with orphans and other children made vulnerable by HIV/AIDS.

Children and AIDS: The scale of the problem

It is estimated that in 41 African countries, the number of children who are orphaned, for any reason, will nearly double between 1990 and 2010,¹ when almost three-quarters of double orphans in the world will be from Africa. In seven countries in Southern Africa, the most severely affected region, the number of orphaned children to have lost both parents is projected to increase by a staggering 1,100%, from 250,000 to 2.9 million (see Figure 6).



On their current trajectory, HIV and AIDS are set to leave millions of children orphaned and millions more in situations of vulnerability. Many children are first affected during the terminal illnesses of their parents, when they shoulder new responsibilities such as additional domestic chores, taking care of sick parents, income-generating activities and childcare duties for younger siblings. Indeed, it is now recognised that educational, social, economic and psychological

problems may be more severe before, as opposed to after, children become orphans.² In addition, AIDS increasingly affects almost everyone in severely affected communities, even households without HIV-infected members. Children may thus be affected when families provide money to support sick relatives and mothers leave home to provide care for AIDS-affected relatives, or when their children's standard of living deteriorates when cousins move in after the deaths of aunts and uncles.

Traditional extended family caring

The extended family safety net is still by far the most effective response to economic and social crises throughout sub-Saharan Africa. Members of extended families assist each other socially, economically, psychologically and emotionally. Financially, such assistance most often takes the form of regular urban-rural, inter-household income transfers. When crops fail, family members in town purchase food and bring cash to needy relatives in rural areas. When a relative in town loses a job, they are sent food from the rural areas or are received back into their rural homestead. Households experiencing income stress due to AIDS may send their children to live with relatives who become responsible for feeding the children in their care.

Coping mechanisms regarding orphans are, however, complex and vary according to social setting. In most African communities, the concept of 'adoption' does not exist in the Western sense. Even in the absence of parental death, children are often fostered; a practice whereby natal parents allow their children to be reared by adults other than themselves (see Table 3, *over page*). Child fostering is a reciprocal arrangement that contributes to mutually recognised benefits for both natal and fostering families and fostering by non-relatives remains uncommon. It has also been said that, traditionally, there is no such thing as an orphan in Africa,³ as relatives such as aunts and uncles have almost always taken on the parenting of orphaned children. The concept of a 'social orphan' is thus a new phenomenon in most African societies.

In the past, the sense of duty and responsibility of extended families towards other members was almost without limits. Even though a family did not have sufficient resources to care for existing members, orphans were taken in. Today, many families still cope with deaths by ensuring that relatives provide care for orphaned children. This may involve a member of the extended family moving

**Table 3: Percentage of children (5-14) fostered in the developing world
(Demographic Health Survey (DHS), 1990-96)**

Africa	%	Near East	%
Namibia	35.5	Morocco	5.9
Uganda	24.3	Turkey	1.5
Zimbabwe	22.0		
Côte d'Ivoire	21.6	Asia	
Cent. African. Rep.	21.5	Phillipines	7.5
Zambia	21.2	Indonesia	6.6
Ghana	20.1	Kazakhstan	3.2
Malawi	19.5	Pakistan	2.2
Tanzania	19.4		
Cameroon	18.6	Latin America	
Senegal	17.8	Haiti	23.7
Niger	17.1	Dominican Rep.	19.1
Nigeria	15.5	Paraguay	10.6
Burkina Faso	14.8	Colombia	10.3
Kenya	13.9	Brazil	8.8
		Guatemala	7.3

Source: M Ayad et al, cited in S Hunter, 2000.

into the orphan household to care for children, or orphans moving into the household of one or more relatives.

Weakening of the extended family

Cases of abuse, mistreatment or exploitation of fostered children have been reported. Girls in particular may be taken in by relatives because of their economic value in carrying out domestic chores or obtaining bride price. Judging by reports from child rape centres, cases of sexual abuse of orphans also appear to be increasing. However, though several studies have demonstrated that orphans are disadvantaged compared to non-orphans in other families, few studies have demonstrated significant differences in the ways relatives treat their own biological children compared to fostered children. Though such cases undoubtedly occur, for the most part, relatives go to considerable lengths to keep orphans in school, including borrowing money through informal networks and selling their own assets.⁴

Yet the extended family, which has proved so effective in the past, is becoming stressed as a result of both a dramatic increase in the number of maternal and double orphans and a reduction in the number of prime-age caregivers, such as aunts and uncles. If present rates of death among prime-age adults continue, it is projected that this will result in distortion of the population structure of affected countries. Although not entirely undisputed, it is argued that a new type of demographic structure, termed the 'population chimney', will replace the more familiar pyramid that characterises developing countries. Distortion of the pyramid will occur ten to 15 years after the age at which people become sexually active, when those infected with HIV early in their sexual lives begin to die. The population of women beyond their early 20s and men beyond their early 30s will shrink in heavily affected countries, leading to fewer middle-aged people—the so called 'chimney' effect. Due to the fact that more women become infected with HIV, do so at younger ages and die earlier, the epidemic is also expected to take a greater toll on women. The net product of both these trends will be a greater disparity between the number of children in need of care and the number of adults able to provide such care in the future.

Even prior to the HIV/AIDS epidemic, the role of extended families and communities in coping with orphans was in a state of flux. Table 4 outlines some of the changes that have taken place which have weakened kinship

<i>Change</i>	<i>How this has weakened extended families</i>
Labour migration, urbanisation and the cash economy	<ul style="list-style-type: none"> • Reduction in the frequency of contact with relatives. • Social and economic dependence; possessions are perceived as personal property and no longer belong to the extended family.
Increased life expectancy and family size	<ul style="list-style-type: none"> • Impossible for an extended family of three or four generations to reside together. • Diminishing availability of land makes it difficult for large families to be economically independent through subsistence agriculture.
Formal education	<ul style="list-style-type: none"> • Education about social values occurs through schools and interactions of children with their peers, rather than through traditional mechanisms, lessening the ability of older people to exert social control over children.

systems. The extent of such changes varies from place to place: where traditional values are maintained, such as in rural communities, the extended family safety net is better preserved. Where countries are more urbanised, extended family safety nets are weaker.

As the traditional practice of orphan inheritance by uncles and aunts has lessened, it has been replaced by alternative safety nets, with care provided by grandparents or other relatives. Grandparents are, however, often a last resort and agree to take in orphans because other relatives refuse. It goes without saying that although this provides short-term respite, the ability of many elderly grandparents to protect and provide for children in the long term is limited.

Children who live in situations of extreme vulnerability

The extended family is thus not a social sponge with infinite capacity to soak up orphans. Some children do slip through the extended family safety net and end up in a variety of extremely vulnerable situations. These include living and working on the streets, working for other people in low-paid domestic or agricultural settings, or living by themselves with their brothers and sisters in child-headed households.

It is difficult to obtain accurate estimates of the numbers of children living in extremely vulnerable situations. Estimates for children in these categories vary because of the lack of community-based surveys, standardised definitions (since not all children in these situations are equally vulnerable) and because some agencies inflate numbers for promotional purposes.⁵

Given these caveats, however, the total proportion of unsupported or exploited children living in extremely vulnerable situations probably represents less than 2% to 3% of all orphans, even in the most severely affected countries (see Table 5).⁶

Child-headed households

As a result of the impact of AIDS on communities, changes are taking place in care-giving arrangements for affected children. An increasing proportion of orphans are now in the care of either the elderly or teenage boys or girls. The increase in the number of double orphans has led to the establishment of

Table 5: Estimates of vulnerable children in selected countries

Country	No. of children 0–17, years, 2004 ⁷	No. of orphans 0–17, 2004 ⁸	Child-headed households	Street children	Economically active children 10–14
Burundi	4 million	660 000	20 500 ⁹		49% ¹⁰
Eritrea	2 million	230 000		3 002 ¹¹	
Rwanda	5 million	810 000	45 000 ¹²		
South Africa	17 million	2 200 000			
Swaziland	0.6 million	100 000	10% ¹³		
Tanzania	14 million	2 500 000	0.03% ¹⁴		
Uganda	18 million	2 000 000	2–3% ¹⁵		45% ¹⁶
Zambia	6 million	1 100 000		75 000 ¹⁷	
Zimbabwe	7 million	1 300 000	0.4% ¹⁸	1 000 ¹⁹	50 000 ²⁰

households headed by children, mostly in their teens, but with some headed by children as young as ten to 12 years old. This was previously unknown in sub-Saharan Africa.²¹

The number of child-headed households throughout Africa is, however, unknown. What we do know is that there are more child-headed households in urbanised countries such as Zimbabwe and Zambia than in predominantly rural societies like Tanzania, where safety nets are better preserved.²² In countries with severe HIV/AIDS epidemics, it may be anticipated that the number of child-headed households will increase significantly in the future.

Methods of establishment

In some cases grandparents, usually grandmothers, take in orphaned children. As these grandparents' age or experience deteriorating health, the situation in which the elderly provide childcare is reversed and grandchildren end up caring for increasingly frail grandparents.

When grandmothers die or move in with other relatives because of illness, children are sometimes left to live by themselves. Relatives may take in younger children, leaving older brothers and sisters living together. In other cases, child-headed households are formed when brothers and sisters insist on staying together and refuse to move away from their deceased parents' homestead.

Child-headed households are usually temporary arrangements. In many instances, it simply takes time for families to organise coping strategies in response to unaccompanied children, and it is accepted that such children will eventually become part of adult-headed households. In other cases, child-headed households disintegrate as a result of various catastrophes, following which children are taken into relatives' households. Often, it is only after crises that relatives who were previously equivocal about not providing care become amenable to taking in vulnerable children.

Problems faced by child-headed households

The situation of children living in child-headed households is often perilous. 'Child adults' often drop out of school for lack of school fees, money to buy books and uniforms and, sometimes, stigma. Many must work hard to feed and educate their younger siblings, while younger children may be forced to labour in domestic or agricultural chores once carried out by adults. Girls may feel their family's situation might improve if they were married, which may result in teenage motherhood and being forced to choose between their family and their husband if he rejects their younger siblings. Children living in child-headed households thus face problems that are common to other vulnerable children living in destitute households, such as:

- food insecurity;
- problems of access to education and skills training;
- the struggle to meet material needs;
- the absence of psychosocial support;
- poor life skills and knowledge;
- abuse and exploitation;
- absence of an extended family network;
- poor housing conditions and insecurity of tenure; and
- poor access to health care.

What is unique is that these problems are extreme and unrelenting and must be faced without adult assistance.

Child-headed households as a coping strategy

The appearance of child-headed households does not necessarily mean that

extended families have abandoned their responsibility to care for relatives' orphaned children. Not all child-headed households are equally vulnerable, and some child-headed households live in close proximity to nearby relatives who visit regularly and provide them with material support.²³ Indeed, some cases can be viewed as a new mechanism to cope with the impact of AIDS. The high prevalence of child-headed households in Swaziland, for example, is a consequence of traditional extended family living arrangements in that country, which enable child-headed households to live in supported situations. Many child-headed households are, however, left to fend for themselves and receive little support from their relatives who are already struggling to feed, clothe and educate their own children. Unsupported child-headed households are particularly vulnerable to exploitation as a result of destitution and a lack of adult supervision.

Street children

In Africa, it is thought that around one million children live and work on urban streets, with the highest rates in post-conflict countries where poverty and family disintegration as a result of war are common.²⁴ Most street children are engaged in trying to earn money, whether by begging, car guarding, buying and selling or crime. An important distinction to make, however, is between children *on* the street and children *of* the street.

Where children live *on* the street, the family support base has generally become weakened and so children share the responsibility for family survival by working on city streets. For these children, the home ceases to be the centre of play, culture and daily life. Nevertheless, while the street becomes their daytime location, the majority return home most nights. Despite potentially deteriorating family relationships, familial ties are still in place and the children continue to view life from the perspective of their families.

Children *of* the street constitute a smaller number of children who live, work and sleep on the street and struggle daily for survival, alone and without support. Though many people believe that street children have been abandoned by their relatives, in many cases it is more accurate to view such children as having abandoned their families—often as a result of insecurity, rejection and violence. Their ties with home have been broken and they are without families.

Many street children are orphans. In Zambia, for example, 65% of 'child prostitutes' and 56% of children living on the street were orphans.²⁵ Similarly, in a survey of 81 male and 15 female street children in Mutare, Zimbabwe, 67% were orphans, compared to an estimate of approximately 20% for the child population as a whole.²⁶ Two-thirds of these children were *on* the street, mostly staying with a relative; one-third were *of* the street and had no other dwelling place. It is impossible to say how many such children have been orphaned by AIDS, but given the growing contribution of AIDS to levels of orphaning in the region, it is likely that the epidemic is leading to increasing numbers of street children in Africa.

Problems identified by street children

Table 6 lists the main problems identified by the 96 street children in Zimbabwe.²⁷ Significantly, glue-sniffing—which is associated with social, medical and psychological consequences—was not mentioned, probably because it is viewed by street children as a solution to their predicament rather than a problem.

Table 6: Problems facing street children in Zimbabwe

<i>Problem</i>	<i>Number</i>
Bullying by older boys	52
No food/clothing	17
Fighting	9
Sexual harassment	7
No blankets	7
No shelter	7
No money	6
Harassment/humiliation by society	5
Lack of treatment for diseases	4
Harassment by police	4
Exploitation	2
Nowhere to bathe	1
No problems	13

Source: FACT, 2000.

Since the majority of street children live with or maintain ties with their families, strategies to respond to their situation should focus on strengthening the capacity of families to care for and protect their children.

Working children

In all societies, children are involved in work, whether for their own families or for money outside the home. Not all labour is necessarily damaging to children, and it is often difficult to draw a line between children's work that is a normal part of childhood development, such as assisting with family activities, and child labour that is exploitative and harmful. In families, parents or guardians assign work and responsibility compatible with a child's age, gender and developmental level. Families do not normally and intentionally exploit children.

Africa has a higher proportion of child labour than any other region, with 41% of children below the age of 14 in the labour force. This equates to over 80 million children, almost twice the Asian rate. This more often reflects the adverse economic situation facing families in Africa than regional approaches to child rearing. The most extensive market for child labour in sub-Saharan Africa is for domestic services, such as cleaning, washing, cooking and child minding for girls and gardening, farming, animal husbandry or herding for boys. Other common child labour practices include contract labour on commercial farms and estates, vending, hawking and selling, mining, touting customers for transport, brothels and shabeens and commercial sex work. In some West African countries, the demand for domestic services by children is so high that it may lead to child trafficking.²⁸

Children's work and the impact of HIV/AIDS

The economic consequences of the HIV/AIDS epidemic are impacting on children, both within and outside the family home.²⁹ Children affected by HIV/AIDS are increasingly taking on adult roles at a young age, including providing care for a sick parent and taking on extra household responsibilities. Some children, especially girls, also have to give up school in order to generate an income.

Orphanhood, in particular, is associated with increased child labour.³⁰ Most child heads of households engage in income generation to support their young

families. Adolescents may also leave orphan households to seek work, while some girls become involved in commercial sex or enter into marriage as girl brides to provide for the needs of the young or the elderly in their household. In Tanzania, for example, more than half of those children working full time in the country's mines were orphans.³¹ In Addis Ababa, Ethiopia, more than 75% of child domestic workers were orphans.³²

Orphans seem more likely to be child labourers as a result of their poorer living conditions, as opposed to discrimination against them by their caregivers. These inappropriate responsibilities can create long-term emotional problems, contribute to lost opportunities in education and development and lead to sexual exploitation. Child labour is illegal in many countries, but law-enforcement will have little effect unless families are supported in order to find adequate alternatives to child labour. The state and the community thus have a responsibility to ensure that children affected by HIV/AIDS are not denied their childhood.

Community safety nets

Seeking relief from family, friends and neighbours is a common response to economic crises. Even the poorest and most vulnerable people have set up resilient and ingenious coping mechanisms. Most communities throughout Africa have a tradition of voluntary associations or solidarity groups that provide essential support to households affected by misfortune. This type of community 'safety net'—the provision of short-term relief and assistance by individuals and organisations within the community—is a common response to an array of disasters, both natural and man-made.³³ In Tanzania, for example, there is a long tradition of social support groups. Members assist one another in routine ways by helping to cultivate one another's fields and by contributing labour, money or food to one another at times of special need such as sickness and funerals, or on occasions such as marriage ceremonies.³⁴ Voluntary associations provide a wide range of support that includes loans, food, funeral assistance, labour and cash through mechanisms such as:

- burial associations;
- grain loan schemes;
- self-help groups;
- labour-sharing schemes;

- savings clubs; and
- revolving credit-and-loan schemes.

Voluntary associations are poor people's insurance policies. Relatives, friends and neighbours provide both moral and material support to the sick and vulnerable on the assumption of future reciprocation, and supportive actions are part of a clearly understood system of solidarity, which ensures that all contributing individuals receive support in times of adversity. Culture reinforces such arrangements through oral tradition, as illustrated by the Shona proverb: "What has befallen me today will befall you tomorrow."

Weakened community safety nets

The amount of assistance that voluntary associations can provide is, however, generally limited and short-term in nature. In the case of death, for example, the duration of support is usually limited to the period of mourning. In addition, community safety nets are being weakened as a result of the steadily growing impact of the HIV/AIDS epidemic.

Better-off families, in particular, are increasingly finding their economic reserves depleted due to the continual demands placed on them by relatives affected by AIDS. Families in these circumstances become less able to contribute in cash, kind or by the provision of work to families in need. As AIDS causes the number of families falling from poverty into destitution to increase, the amount of relief that can be provided per destitute family is likely to decline.

Community initiatives in response to orphans

Without outside influence, community groups in Africa do not generally provide substitute parental care and few have established community foster homes or institutions in response to increasing numbers of orphans. However, starting in the 1990s, communities throughout Africa have begun to add additional layers to their community safety nets by providing material, educational, emotional and psychosocial support to children affected by HIV/AIDS. These community-based support initiatives have been established largely in the absence of significant external facilitation or financial support and are growing in scope and number. Recent research in East and Southern Africa has documented the high prevalence of community responses initiated by

churches, mosques, other religious groups, women's groups and community-based organisations (CBOs).³⁵ In this study, interviews conducted with 690 faith-based organisations found that over 9,000 volunteers were supporting in excess of 156,000 orphans and vulnerable children. Table 7 summarises different support activities carried out by community groups.

Table 7: Community-based support activities provided by 505 faith-based organisations (FBOs)		
<i>Type of response</i>	<i>FBOs</i>	<i>Description of response</i>
Religious education and spiritual support	90+%	Spiritual support to families and children through scripture reading, religious instruction, prayers, singing and encouragement to attend worship.
School assistance	73%	School fees, levies, uniforms, equipment, books, boarding fees, etc.
Material support	62%	Essential material support such as food and clothing to individual children from destitute households.
HIV prevention Visiting/home care	51% 39%	Increase awareness of HIV and moral guidance for children. Volunteers identify needy households in their neighbourhood, regularly visit and provide parenting, advice, household supervision, meal preparation, dwelling maintenance and assistance in household agriculture or income generation.
Psychosocial support	32%	Specifically provide counselling to children while others incorporate psychosocial support group activities.
Medical care	30%	Enable children to access essential medical support through the provision of medical fees or medicines.
Income generation/ vocational training	19%	Initiatives seek to raise money or provide experience in managing projects such as nutrition gardens, husbandry projects, manufacturing co-operatives and buying-and-selling initiatives or skills in carpentry, dressmaking, etc.
Day care centres	11%	Care during the day and food for pre-school children, often while caregivers are working.
Community schools Fostering promotion.	5% 3%	Non-formal education facilities for out-of-school children. Encourage fostering and adoption by non-relatives of orphans.
<i>Source: G Foster, 2003.</i>		

Such community initiatives support vulnerable children by enabling families to continue to provide care for orphans. Though most community responses to date are small scale and localised, the cumulative impact of large numbers of local initiatives is proving increasingly significant, and such community initiatives will be an essential element in caring for growing numbers of orphans and vulnerable children in coming years. Yet in order for them to continue to function and expand to address the multiple dimensions of care and protection required by vulnerable children, they require financial and technical support. The nature of the orphan crisis is such that small amounts of long-term funding will be needed to supplement community support mechanisms over the course of several decades. Unfortunately, most donors make large, short-term grants to a small number of contractors and few provide long-term, low-level support directly to community groups. Many grants also involve complicated and expensive application procedures and stringent reporting requirements that make them inaccessible to most CBOs.

This approach is generally incompatible with the situation in affected countries, where thousands of community groups are struggling to sustain social structures in the face of an epidemic with long-term and cumulative repercussions. There is thus an urgent need for the creation of innovative mechanisms to channel resources to community groups. This could be done through intermediary institutions, such as locally administered trust funds, local and regional networks, multi-layered committees and capacity-building NGOs.³⁶

State social security interventions

Where family and community networks fail, become overburdened or require supplementing, the state is often the final port of call. In this regard, there are many mechanisms by which governments can improve the situation of children made vulnerable by HIV/AIDS. These include employment creation, supporting families through the provision of access to basic services such as free basic education, good health care and community development programmes, as well as direct support initiatives such as feeding schemes and the provision of grants. With the exception of countries such as South Africa, Botswana and Namibia, however, state mechanisms in the region are relatively weak.

South Africa has one of the most well-developed statutory social support

schemes in Africa. Family and child benefits in South Africa currently include the following:

- Child Support Grant (CSG), which currently targets children under the age of 11, and will by the end of 2005 target children under the age of 14. The grant is means tested³⁷ and caregivers are eligible for a grant of R170 (approximately US\$28)³⁸ a month.
- Foster Child Grant (FCG) for children placed in foster care. This grant is for the sum of R530 (approximately US\$88) a month and only children placed in foster care by a court of law are eligible to receive it.
- The Care Dependency Grant (CDG) for children with severe mental or physical disabilities who require permanent home care. The grant is means tested and amounts to a sum of R740 a month (approximately US\$123). There is no specific provision for children with chronic illnesses such as HIV/AIDS and relatively few children in the terminal stages of the virus have managed to access this grant.³⁹

In addition to these grants, the South African government has put in place Social Relief of Distress measures, which take the form of temporary assistance—in cash or food—for people in need of immediate help to survive. The monetary amount or equivalent of such relief is less than the monthly value of the grants received by the household and will only be given to households for up to three months.

However, while such mechanisms are an important source of support for a range of children living in vulnerable circumstances, problems exist that cast doubt on the ability of the system to meet the needs of children affected by HIV/AIDS.

It is evident that, irrespective of the epidemic, only a minority of the poorest families receive child support grants from the state. It was estimated in 2003 that just over three-and-a-half million (3,622,479) children were registered to receive the CSG.⁴⁰ Take-up rates have increased in recent years but it is clear that many of the poorest children still do not have access to the grants, with a recent report suggesting that between 28% and 39% of poor children under the age of nine do not access the CSG (see Table 8).⁴¹

Table 8: Percentage of poor children aged seven and eight receiving the Child Support Grant per province (2003)

Province	Total 7–8 year olds	Provincial poverty shares	Approximate no. of children 7–8 in poverty	Children 7–8 receiving grants	Percentage of poor 7–8 year olds receiving grants by province
Eastern Cape	325 193	75.1%	244 220	74 214	30.4%
Free State	108 642	61.2%	66 489	43 686	65.7%
Gauteng	262 302	38.3%	100 462	73 795	73.5%
KwaZulu-Natal	444 452	63.8%	283 560	103 422	36.5%
Limpopo	289 615	68.4%	198 097	112 961	57.0%
Mpumalanga	146 232	59.4%	86 862	49 154	56.6%
Northern Cape	33 117	50.8%	16 823	8 357	49.7%
North West	149 796	60.4%	90 477	38 014	42.0%
Western Cape	162 308	25.3%	41 064	29 671	72.3%
Totals	1 921 657	Average: 59%	1 128 054	533 274	Average: 47.3%

Source: Leatt, 2003.

Many eligible children and households do not receive grants either because they are unaware of their entitlement or lack the documentation,⁴² time and resources necessary to access the social support system. Administrative delays in processing grant applications, as well as the poor attitude of some administrative personnel, also often deny families the grants to which they are entitled under South African law.⁴³ With the number of children to have lost one or both of their parents to AIDS alone expected to peak at 5.6 million by 2015,⁴⁴ it is unlikely that this situation will improve in the absence of fundamental change to the system.⁴⁵ Indeed, recent estimates produced by the Children's Institute in South Africa suggest that less than half of all children under 18 will receive support by 2017.⁴⁶

This is likely to be compounded by the orientation of the system towards children in adult care, which results in large numbers of the most vulnerable children being hidden from the state's view. These include street children, child labourers, children of illegal immigrants, children living in child-headed households and children over the qualifying age. Where such children are

minors, they are not entitled to receive child support grants on their own behalf and receive little, if any, assistance through current statutory child support systems.

Children affected by HIV/AIDS may also face particular problems in accessing state support. As already mentioned, movement is a survival strategy adopted by many poor households and often increases substantially in response to adult illness or death, as children are sent away to live with relatives who can better provide for them, household members leave in search of work or relatives join the household in order to provide care. Children affected by HIV/AIDS are particularly mobile, often moving several times both before and after their parents' death.

Given that it may take several months or even years for a grant application to be processed, and that children are required to remain resident with the guardian stipulated in the application, such movement is likely to hamper efforts to obtain grants on these children's behalf. The death of parents, and the subsequent movement of children, may also result in the loss of documents such as birth certificates, or complicate efforts to obtain such documentation.

Turning to problems associated with the specific structuring of the grants, the CSG is only payable in respect of a maximum of six children per household if they are not the biological children of the applicant. Given that single households often take in several children in addition to their own, the grant does not offer much assistance to the many families caring for large numbers of children.⁴⁷ This may act as a disincentive for relatives to take orphaned children into their families.

There are also a number of weaknesses associated with the FCG. Despite growing international recognition of the need to keep orphaned children in their families and communities, a disproportionate amount of the child welfare budget is being spent on supporting caregivers who are usually unrelated to the child.⁴⁸ Under the current system, foster care placements are also required by law to be reviewed every two years. This not only makes the grant expensive⁴⁹ and labour intensive to administer, it also adds enormously to the workload of already over-stretched and under-resourced social workers—resulting in administrative delays, non-adherence to legal reporting requirements⁵⁰ and, ultimately, the capacity to absorb only a limited number of children into the

system. The disparity between the CSG and the FCG also encourages caregivers, who would anyway be providing care, to have children formally placed in their care by the court.

As Meintjies et al argue, this ties orphaned children and caregivers 'in need of cash' to a labour intensive, surveillant and costly child protection system aimed at providing care and protection to children who are without support, or who suffer abuse or neglect.⁵¹ In so doing, such a system not only inappropriately targets scarce resources, it fails to address the predominantly material needs of families and children affected by HIV/AIDS.

Choice of care provision for orphans

When parents die there is no ideal placement for the children, just better or worse options. Enabling siblings to remain together in the care of family members they already know and are prepared to accept as new, permanent caregivers is the best option and maintaining orphans in families should be our highest priority.

Providing support to families under stress is the best way to achieve this and programmes such as those described earlier have the advantage of being less costly, both financially and in terms of the emotional cost to the child.

Adoption or fostering

If it is impossible for children to be maintained in their family of origin, the next best option is care within another family, through fostering or adoption by a non-relative. In Western societies, a clear distinction is usually made between adoption and fostering. The former is a type of family placement in which the rights and responsibilities of one set of parents are legally and permanently transferred to another set of caregivers.

Fostering is a less permanent form of substitute care which does not involve the transfer of parental rights and responsibilities. In practice, this distinction can become quite blurred, especially in African countries where legal adoption is often neither available nor accessible. In this context, new and innovative approaches to community foster care are being developed (see Box 1). These need to be assessed and, if found effective, replicated.

Box 1: Community family care

This model of care was pioneered by the Durban Child Welfare Society in South Africa. The aim is to provide relatively affordable, family-type care for up to six children in their communities of origin, or a similar social context. Under this model the community selects, assesses and trains an appropriate community member who becomes full-time 'mother' to the group of children. Sibling groups are accommodated and new 'families' are created for children who have no contactable relatives.

In contrast to regular foster care, where the house belongs to the foster family, either the state or an NGO provides the accommodation. Wherever possible, a small allowance is paid to the community-mother and she is assisted in accessing the available foster care grants. The created family is linked to all available community support systems and is monitored in the same way as a traditional foster care placement.

The model has proven appropriate in an urban context where abandonment of children is a serious concern.

Source: UNICEF/Child Protection Society, Zimbabwe, 1999.

Institutional care

Institutional responses to the crisis, such as orphanages, will never be able to address the scale of the orphan problem. They are also much more expensive to maintain than assisting families to care for children. Research by the World Bank in Tanzania, for example, found that institutional care was about six times more expensive than foster care, while cost comparisons in Uganda showed the ratio of operating costs for an orphanage to be 14 times higher than those for community care. Other studies have found a ratio of 1:20 or even 1:100.⁵² Orphanages also run counter to local traditions and fail to meet children's social, cultural and psychological needs.

Children need more than good physical care. They need the affection, attention, security and social connections that families and communities can provide. Countries with long-term experience with institutional care for children have seen a number of problems emerge as children raised in institutions grow into adulthood and have difficulty reintegrating into society. In Ethiopia, Rwanda and Uganda, for example, evaluation of the effects of long-term residence in orphanages have led these governments to adopt policies of de-institutionalisation and support for family-based care.

Should institutional care be deemed necessary, it should be short term and provided only when other levels of care are unavailable. Care in smaller, family-type community foster homes is preferable to larger institutions. Orphanages that provide dormitory-style accommodation for children of similar ages—for example, those with separate units for babies and pre-schoolers and dormitories for primary school-aged children and teenagers—are particularly damaging to children's self-esteem and development, since they fail to recreate the family-type environment children require. Efforts should also be made to improve the conditions of children already placed in residential institutions.

Overcoming problems with alternative care strategies⁵³

While community care strategies are the most appropriate means of strengthening the ability of extended families to cope with orphans, few states have yet established mechanisms to strengthen extended family and community safety nets through the provision of financial and technical support. Individual and community initiatives also receive little if any formal recognition by statutory bodies. Whereas children living in institutions or placed in formal fostering are recognised in law, and their situation is regulated and supervised by social welfare agencies, there seldom exist such statutory provisions for supervision and engagement with community care initiatives. However, both children and caregivers in informal foster situations need to be recognised and protected by law. Without such legal status, informal caregivers are often unable to access the government support that does exist, act as the child's guardian, grant permission for medical procedures, represent the child in judicial acts or administer his or her affairs.

In principle, informal foster care is encouraged by social welfare authorities. Yet in practice, the majority of financial and human resources within child welfare service provision for vulnerable children is spent on alternative care strategies for the minority who have slipped through extended family and community safety nets. Relatively small amounts of money are spent on strengthening informal support mechanisms, and most social service providers are involved in case-oriented approaches and have little experience in community mobilisation or strengthening safety nets. Individual child support and foster care grants do little to strengthen community support systems and may inadvertently undermine them by promoting concepts of paid foster care (see Table 9, *over page*).

Table 9: Interventions for foster families and children in vulnerable circumstances

<i>Intervention</i>	<i>Advantages</i>	<i>Disadvantages</i>
Fostering	<ul style="list-style-type: none"> • Family members are most likely to act in child's best interest. • Family integration promotes psychological and intellectual development of children. • Fostered children are integrated into society more readily than children in orphanages. 	<ul style="list-style-type: none"> • Discrimination in food allocation, workload, etc., may exist.
Subsidies distributed through the family	<ul style="list-style-type: none"> • Encourages even poor families to foster orphans with the additional costs of caring for orphans borne by the government. 	<ul style="list-style-type: none"> • Difficult to monitor. • Subsidies sometimes benefit head of household only. • Subsidies may be shared among too many family members, thus diluting the amount of support going to the orphan. • Subsidies exclusively for the orphan may stigmatise the orphan.
Subsidies distributed through community	<ul style="list-style-type: none"> • Communities will better know the needs of family. • If distributed by churches, stigma may be reduced. 	<ul style="list-style-type: none"> • May not work in urban areas where sense of community is weak. • May not work in communities where ethnic tension or discrimination exist.
School vouchers/ subsidies; health vouchers redeemed by clinics	<ul style="list-style-type: none"> • School subsidies are easy to monitor. • Most likely to prevent future loss of human capital. 	<ul style="list-style-type: none"> • May entail horizontal inequity, to the extent children with parents alive but in abject poverty do not receive any subsidy.
Income-generation schemes for fostering families	<ul style="list-style-type: none"> • Increase short-term incentives of households to adopt children. • If successful, improves the welfare of orphans. 	<ul style="list-style-type: none"> • Rarely succeed without tracing, follow up and leadership. • Provide no long-term incentive for caring for orphans.
Family tracing	<ul style="list-style-type: none"> • Being reunited with family members brings psychological benefits. 	<ul style="list-style-type: none"> • May not be viable in post-conflict situations, in areas where large percentage of the population has died or is missing, or in war-torn economies where family members are unable to care for orphans.
Orphanages	<ul style="list-style-type: none"> • Better than child-headed households or being a street child. • Orphanages run by religious groups may reduce stigma and attract donor and charitable funds. 	<ul style="list-style-type: none"> • Lack incentive to act on behalf of orphan. • May harm psychological development of orphans. • Not cost effective. • Can easily become commercial institutions rather than welfare institutions. • May not meet the emotional needs of children.
<p><i>Source: Subbarao et al, 2001.</i></p>		

Statutory approaches to child welfare

The rationale of statutory welfare structures is that the state has a responsibility to find the 'best possible' alternative care for children through placement by professional social workers. The system for children in need of care is designed to promote legal adoption or support fostering through maintenance grants and careful supervision by child welfare officers.

Vast differences, however, exist in social welfare provision for children in different parts of Africa. As already noted, while a few countries have fairly sophisticated systems of grants, procedures and supervisory practices backed by legal instruments and relatively well staffed social welfare departments, most countries' welfare systems are rudimentary. Most of the legislation and systems in place are also based on Western models of alternative care established during the colonial era. Legally endorsed child welfare models are thus designed to protect the child being taken into care through stringent assessment procedures for prospective foster or adoptive parents. Potential caregivers must meet eligibility criteria based on education level, marital status, employment, income, accommodation, age, medical information and motivation.

The reality, irrespective of AIDS, is somewhat different. Although children are placed in institutions with the notion that these are temporary places of safety, these institutions often become children's permanent home until they reach adulthood. Furthermore, while the supervision of childcare in institutions or foster homes is the responsibility of social welfare officers, high workloads often lead to foster care 'drift' where the child, home or institution is seldom visited or monitored.

While case-oriented systems involving placement of children by social workers in carefully selected family settings may have been feasible before the current orphan crisis, the strategy is inappropriate to support the increasing number of children in need of family homes. There is thus a need for statutory systems to recognise formally the role played by families and communities in supporting children. This may require that the criteria used to determine suitability of foster parents incorporate community norms. The minimum standards set for formal fostering and adoption are too high and the procedures too complicated for many poor but willing community members.⁵⁴ The concept of 'good enough' standards—appropriate to the norms of the community in which the child lived—is worthy of consideration in developing countries, especially where 10%

or more of the entire childhood population would have lost both parents in the decade to come.

Indigenising statutory care procedures

There is clearly a need for statutory agencies to strengthen extended family and community safety nets in order to reduce the number of children who need to be placed in care by the state. This type of undertaking would demand a significant commitment of resources by social welfare agencies and would involve retraining of staff and major reorientation of social welfare systems and procedures. The process of indigenising statutory care procedures might include measures such as:

- mapping community care programmes, to better understand their extent and nature;
- promoting an awareness of the concept of foster care and adoption by families not related to the child;
- promoting the establishment and development of community care programmes, especially in areas with limited access to social welfare departments;
- simplifying assessment procedures for potential foster parents to make them more 'client friendly';
- developing appropriate assessment forms and information materials for use among community child care volunteers and informal foster parents;
- training social workers in community care supervisory skills;
- training volunteers in community care programmes in family assessment and supervision;
- reviewing legal instruments so that they recognise the existence of informal foster parents and community care programmes;
- reviewing the appropriateness of existing foster grant systems, which provide

grants to formal adult foster parents, but make no provision for informal foster parents or child-headed households; and

- establishing multisectoral committees (such as the Child Welfare Forums in Zimbabwe) with statutory provision for them to monitor community care programmes.

Conclusion

Despite large increases in orphan numbers, surprisingly small numbers of children have, up to now, slipped through the safety net provided by the extended family. Provided that coping mechanisms are not undermined, all the evidence suggests that the traditional fostering systems in Africa, supported by community programmes, will continue to meet most of these children's basic needs. Indeed, families and local communities are the frontline of the HIV/AIDS epidemic's impact and have demonstrated remarkable resilience and creativity in addressing the myriad needs of affected children. Given the extent of the HIV/AIDS epidemic, however, families and communities cannot alone absorb and support the large numbers of children expected to be left orphaned and vulnerable by the epidemic. They need to be supported to avoid these mechanisms becoming overburdened.

The current systems, procedures and approaches of case-oriented social welfare provision are, however, inadequate for coping with the future impact of the epidemic and need to be simplified and adapted if they are to protect a significant number of the children left vulnerable by HIV/AIDS. State and NGO systems of support for vulnerable children also need to recognise the central role played by families and communities in the provision of care and need to ensure that their systems of support strengthen rather than undermine extended family and community support mechanisms.

Notes

- 1 UNAIDS/UNICEF, *Children on the brink 2002: A joint report on orphan estimates and program strategies*, 2002.
- 2 L Gilborn, R Nyonyintono, R Kabumbuli, G Jagwe-Wadda, *Making a difference for children affected by HIV/AIDS: Baseline findings from operations research in Uganda*, The Population Council, Washington, 2001.

- 3 G Foster, The capacity of the extended family for orphans in Africa, *Psychology, Health & Medicine*, 5, 2000, pp 55–62.
- 4 G Foster, Supporting community efforts to assist orphans in Africa, *New England Journal of Medicine*, 346, 24, 13 June 2002, pp 1907–1909.
- 5 G Foster, Understanding community responses to the situation of children affected by HIV/AIDS—Lessons for external agencies, in *One step further—Responses to HIV/AIDS, SIDA Studies*, 7, 2002, pp 91–115.
- 6 Ibid.
- 7 UNAIDS/UNICEF/USAID, *Children on the brink 2004: A joint report of new orphan estimates and a framework for action*, 2004.
- 8 Ibid. Orphans are defined as maternal and/or paternal orphans aged 0–17 years.
- 9 K Subbarao, A Mattimore & K Plangemann, *Social protection of Africa's orphans and other vulnerable children issues and good practice program options: Africa region*, World Bank, 2001. This is the number of unaccompanied children, 60% of whom are believed to be orphans.
- 10 World Vision 1998, cited in K Subbarao, 2002, *ibid*.
- 11 K Subbarao et al, *op cit*.
- 12 World Vision, 1998, *op cit*.
- 13 A Brody, *Combating HIV/AIDS: Intervention strategies, impact mitigation and policy issues*. Paper presented to international conference on Commitment to Combat HIV/AIDS, University of Swaziland, Kwaluseni Campus, 2–4 July 2002.
- 14 M Urassa, J Boerma, J Ng'weshemi, R Isingo, D Schapink & Y Kumugola, Orphanhood, child fostering and the AIDS epidemic in rural Tanzania, *Health Transition Review*, 7 (Suppl. 2), 1997, pp 141–154. This study showed that of 3,353 households surveyed, only one child-headed household was identified.
- 15 This figure is drawn from a range of sources. These include: UNICEF, *Action for children affected by HIV/AIDS—Programme profiles and lessons learned*, WHO/UNICEF, New York, 1994. This report showed that in the Rakai district of Uganda, an area with high HIV prevalence, 2% of orphans were living with a carer who was 18 years old or younger; F Nalugoda, M Weaver, J Konde-Lule, R Menon, R Gray, D Serwadda, N Sewankambo & C Li, HIV infection in rural households, Rakai District, Uganda, *Health Transition Review*, 7 (Suppl. 2), 1997, pp 127–140. This paper argued that 97% of orphan households had an adult of 17 years or older living in the household; L Gilborn, R Nyonyintono, R Kabumbuli & G Jagwe-Wadda, *Making a difference for children affected by HIV/AIDS: Baseline findings from operations research in Uganda*, Population Council, Washington DC, 2001. This report showed that in a community-based survey from two districts in Uganda, none of the 233 households where orphaned children had been taken in was headed by a child.
- 16 K Subbarao et al, *op cit*.
- 17 USAID/UNICEF/SIDA/Study Fund Project: Situation analysis of orphans in Zambia, 2, *Data Review: analysis and enumeration using existing data*, Government of Zambia, Lusaka, 1999. This study suggests that around 5,000 street children are homeless. The remainder live with relatives or friends
- 18 G Foster, C Makufa, R Drew & E Kralovec, Factors leading to the establishment of child-headed households: The case of Zimbabwe, *Health Transition Review*, 7, (Suppl 2), 1997, pp 155–168, <<http://nceph.anu.edu.au/htc/pdfs/Foster1.pdf>>. The estimated minimum prevalence was four per 1,000 households.
- 19 UNICEF, *Children in especially difficult circumstances in Zimbabwe*, UNICEF, Zimbabwe and Southern African Research and Documentation Centre, 1998. The report also

- estimated there were 200 abandoned children and 5,500 in institutions (1,819 in 39 children's homes, special schools, remand and probation hostels and prisons) in 1997.
- 20 S Mawoneke, A Sexton & K Moyo, *AIDS and street children in Zimbabwe*, SAT Programme, Harare, 2001. This study showed that 51% of the street children in Bulawayo and Mutare were orphans.
 - 21 G Foster et al, 1997, op cit.
 - 22 G Foster, 2000, op cit.
 - 23 G Foster et al, 1997, op cit; L Walker, *Orphan headed households on commercial farms in Zimbabwe*, oral presentation 636967, 13th International Conference on AIDS and STIs in Africa, Nairobi, 21–26 September 2003.
 - 24 K Subbarao et al, op cit.
 - 25 A Mushingeh et al, *A rapid assessment on the case of the Lusaka, Copperbelt and Eastern Provinces*, Paper No. 5, International Programme on the Elimination of Child Labour (IPEC), Geneva/Lusaka, August 2002, quoted in *Africa's Orphaned Generations*, UNICEF, 2003.
 - 26 FACT, *A report on the situation of the street children and youth in Mutare*, unpublished paper, Family AIDS Caring Trust/Scripture Union, 2000, p 31.
 - 27 Ibid.
 - 28 K Subbarao et al, op cit.
 - 29 G Rugalema, It is not only the loss of labour: HIV/AIDS, loss of household assets and household livelihood in Bukoba District, Tanzania, in G Mutangadura, H Jackson & D Mukurazita (eds), *AIDS and African smallholder agriculture*, Southern Africa AIDS Information Dissemination Service (SAFAIDS), Harare, 1999, pp 41–52; G Foster & J Williamson, Impact of HIV/AIDS on children in Africa: A review of current knowledge, *AIDS*, 14(suppl 3), 2000, pp S275–S284.
 - 30 V Makame, C Ani & S Grantham-McGregor, Psychological well-being of orphans in Dar El Salaam, Tanzania, *Acta Paediatrica*, 91, 2002, pp 459–65.
 - 31 J Mwami, J Sanga & J Nyoni, *Children labour in mining: A rapid assessment*, IPEC, Geneva/Tanzania, January 2002.
 - 32 A Kifle, *Child domestic workers in Addis Ababa: A rapid assessment*, IPEC, Geneva, July, 2002, quoted in *Africa's Orphaned Generations*, UNICEF, 2003.
 - 33 J Donahue, Community-based economic support for households affected by HIV/AIDS, *Discussion papers on HIV/AIDS care and support*, 6; V Arlington, Health Technical Services (HTS) Project, USAID, 1998.
 - 34 M Mukuyogo and G Williams, AIDS orphans, a community perspective from Tanzania, *Strategies for Hope*, 5, Action Aid/AMREF/World in Need, 1991.
 - 35 G Foster, *Preliminary report: Documentation study of the response by faith-based organizations to orphans and vulnerable children*, World Conference of Religions for Peace/United Nations Children's Fund, 2003.
 - 36 J Williamson, G Foster & M Lorey, *Mechanisms for channeling resources to grassroots groups supporting orphans and other vulnerable children*, unpublished paper, obtainable at <j.williamson@mindspring.com>.
 - 37 The means test is widely considered to be inadequate. The means test for the CSG varies according to the marital status and circumstances of the adult applying for the grant on behalf of the child. Eligibility is determined on the basis of the caregiver's own income if they are single and joint income if they are married. The cut-off level for the personal income of the caregiver and caregiver's spouse is R9,600 a year (R800 a month) for people in urban areas and R13,200 a year (R1,100 a month) for those living in a rural area or in informal housing in an urban area, irrespective of the number of children.

- Despite inflation, these thresholds have not increased since 1998, when the CSG was first introduced.
- 38 The amounts cited for the Care Dependency, Foster Care and Child Support grants are as of the 1 April 2004.
 - 39 D Ewing, Welfare, in J Gow & C Desmond (eds), *The HIV/AIDS epidemic and the children of South Africa*, University of Natal Press, 2002.
 - 40 A Leatt, using SOCPEN daily records as of 30 October 2003, in *Reaching Out*, working paper by the Children's Institute, University of Cape Town, 2003.
 - 41 A Leatt, op cit.
 - 42 Applicants must present the child's barcoded birth certificate and their own barcoded identification document to their provincial department of Social Development, together with proof of guardianship, and the child's clinic card. In a context where less than half of South African children have birth certificates, it is virtually impossible for many poor families to provide all the documentation necessary to apply for a grant (D Ewing, op cit).
 - 43 D Ewing, op cit.
 - 44 H Meintjies, D Budlender, S Giese & L Johnson, *Children 'in need of care' or in need of cash?* Joint working paper by the Children's Institute and the Centre for Actuarial Research, University of Cape Town, December 2003.
 - 45 The Child Care Act of 1983 is currently under review and its successor, the Children's Bill is due to be tabled in parliament shortly.
 - 46 H Meintjies et al, op cit. The authors calculate the reach of four different assistance options. They argue that the first option, consisting of two grants closely resembling those currently administered, would reach approximately 45% of all children under the age of 18 by 2017 (up from 29% of children in 2003). The second, which would involve placing children in the court-ordered care of relatives and later accessing a grant similar to the current FCG, would reach the same proportion. The third option, which involves a single grant similar to the CSG, would reach approximately 38% of all the children in need of the grant (up from 26% in 2003). The fourth option, a universal child support grant, would reach all children in need of assistance.
 - 47 D Ewing, op cit.
 - 48 Ibid.
 - 49 In addition to monetary grants, there are costs associated with children's court inquiries, statutory supervisory services and grant administration.
 - 50 See H Meintjies et al for a detailed discussion of these issues.
 - 51 H Meintjies et al, op cit.
 - 52 UNAIDS/UNICEF, 2002, op cit.
 - 53 This section draws heavily upon material developed by delegates from South Africa and Zimbabwe attending a series of workshops entitled, *Towards an African model of care for orphaned and children*, UNICEF/Child Protection Society, Zimbabwe, 1999.
 - 54 Ibid.