FINAL COPY | **SYNTHESIS REPORT**

The Joint Learning Initiative on Children and HIV/AIDS **Learning Group 4**

Social and Economic Policies

Compiled by Learning Group 4 Co-Chairs **Alex de Waal** (Social Science Research Council) and **Masuma Mamdani** (Research on Poverty Alleviation)

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The Joint Learning Initiative on Children and HIV/AIDS

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JLICA JOINT LEARNING INITIATIVE ON CHILDREN AND HIV/AIDS

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Acronyms

CSO	civil society organization
CABA	children affected by HIV/AIDS
CSG	child support grant
FCG	foster care grant
JLICA	Joint Learning Initiative on Children and AIDS
LG	learning group
MVC	most vulnerable children
NGO	non-governmental organization
ODA	Official Development Assistance
PEPFAR	US President's Emergency Plan for AIDS Relief
PMTCT	prevention of mother-to-child-transmission
NSP-II	Second National AIDS Strategy
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNICEF	United Nations Children's Fund

Introduction

The Joint Learning Initiative on Children and HIV/AIDS (JLICA) is an independent, time-limited network of researchers, practitioners, policymakers, community leaders and people affected by HIV and AIDS. Its goal is to improve the well-being of children, families and communities affected by HIV and AIDS by mobilizing the scientific evidence and producing actionable recommendations for policy and practice.

Launched in October 2006, JLICA brings together experts from more than a dozen countries. To date, the initiative has produced more than 50 original review and research papers and reports. These outputs mobilize knowledge from a broad spectrum of disciplines with the aim of enabling evidence-informed policy decisions to improve children's lives. JLICA addresses itself in the first instance to national policymakers in heavily-burdened countries and those who advise them. Many of its findings apply to low-prevalence and highly concentrated epidemics. JLICA also speaks to donors; international agencies concerned with children and AIDS; international and national non-governmental organizations; and local civil society organizations and movements.

JLICA's research activities are conducted by four thematic Learning Groups, organized according to the main recommendations of the widely endorsed *Framework for the Protection, Care, and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS* (UNICEF/UNAIDS, 2004). Learning Groups have undertaken a programme of work involving reviews of existing research; the commissioning of strategic studies in under-researched areas; disseminating results among stakeholders; fostering public debate on key policy issues; and providing information to decision-makers and national, regional and global policy forums. Each Learning Group is bringing together its key findings and recommendations in an integrated synthesis paper. Learning Group synthesis papers serve as key inputs to the JLICA final report. As they are completed, all JLICA research products will be freely available on the initiative's website at **http://www.jlica.org**.

JLICA's four Learning Groups are structured and led as follows:

- **Learning Group 1: Strengthening Families,** chaired by Linda Richter (Human Sciences Research Council, South Africa) and Lorraine Sherr (University College London, United Kingdom)
- **Learning Group 2: Community Action,** chaired by Geoff Foster (Family AIDS Caring Trust, Zimbabwe) and Madhu Deshmukh (CARE USA, United States of America)
- **Learning Group 3: Expanding Access to Services and Protecting Human Rights,** chaired by Jim Yong Kim (François-Xavier Bagnoud Center for Health and Human Rights, Harvard University, United States of America) and Lydia Mungherera (Mama's Club and The AIDS Support Organization, Uganda)
- **Learning Group 4: Social and Economic Policies,** chaired by Alex de Waal (Social Science Research Council, United States of America) and Masuma Mamdani (Research on Poverty Alleviation, Tanzania)

JLICA was created in response to the enduring neglect of children in the context of HIV and AIDS. Many factors have contributed to this marginalization. In part, it has been perpetuated because children lack power, organization and voice to defend their interests politically. In part, it is because the responsibility of caring for affected children in the context of HIV and AIDS has been unobtrusively absorbed by families and communities on the front lines of the epidemic. A guiding aim of JLICA's analysis is to identify the specific ways in which national governments and other actors can most effectively support families and communities, as the latter must remain at the heart of any sustainable response to children's needs in the context of HIV and AIDS.

Shared values underpin JLICA's work. Most importantly, JLICA is committed to a human rights-based approach to issues of children and AIDS. This includes the right of children, young people and families to participate in key decisions that affect their lives.

A number of methodological and definitional principles are also shared across all Learning Groups. JLICA uses the Convention on the Rights of the Child to define a "child" as a person under 18 years of age. JLICA's research has highlighted the confusions caused by the definition of "orphan" adopted by United Nations agencies and used to generate international statistics. JLICA has called for the official UN definition to be reviewed and applauds recent indications that such a review may be imminent (Richter, 2008; Sherr et al., 2008).[1] Because of the associated definitional ambiguities, JLICA discourages reliance on the term "orphans and vulnerable children" and, in particular, the reifying acronym "OVC." The preferred inclusive term within JLICA is "children affected by HIV and AIDS."

The inclusive quality of this term has both practical value and ethical significance. Indeed, JLICA argues that, in addition to the categories specified under the UNAIDS and UNICEF definition, the term "children affected by HIV and AIDS" must be understood more expansively. In settings characterized by high HIV prevalence and widespread poverty, the meaning of this term extends to include:

- Children indirectly affected by HIV and AIDS because they are living in communities heavily burdened by HIV and AIDS, and
- Children especially vulnerable to exposure to HIV due to their circumstances.

JLICA is committed to the disaggregation of child-related data by gender, age, household economic level and other relevant stratifiers. Equally important, JLICA emphasizes that the information derived from disaggregated data should be, not merely reported, but also *used* to better understand the specific needs and risks faced by vulnerable groups, including girls and young women, and to develop appropriate responses.

1 See UNICEF's recent call for a reevaluation of the UN definition of 'orphan': UNICEF (2008). 'Orphans'. Press statement published online, available at: http://www.unicef.org/media/media_44928.html (accessed 13 September 2008).

Overview

This paper consists of a *synthesis* of Learning Group 4's findings (based upon the work commissioned for the JLICA exercise) and what LG4 understands to be the key findings of LGs 1–3, followed by a *synopsis* of the LG's work in each of its four main areas, concluding with the main *findings and considerations*.

Learning Group 4 focused on four major questions. The first was; *How best to prevent HIV infections among children and adolescents?* The key finding was the importance of "structural" rather than traditional behavioural interventions. Adolescent girls find themselves in social and economic contexts in which they are extremely vulnerable to sexual harassment and abuse and it follows that prevention measures must focus on these contexts, including the predicament of men. It follows that prevention and protection (including both physical and social protection) should be closely linked. We found that prevention policies are still driven by behaviour-change paradigms and, despite increasing concern with structural prevention, are not well-integrated into protection policies.

The second question was: W*hat is necessary for good policy?* Not content with exhortations to "political will" or "leadership," LG4 explored the craft of policymaking and identified considerations that can assist policymakers to identify, design and implement policies that have the best chance of success. The best policies are those that have been prioritized by a nationally-led process supported by civil society, an informed populace and (in the case of countries substantially dependent on official development assistance [ODA]) an understanding donor. Those policies should be institutionally simple to implement, and readily monitored by the public. Policies that fail to get effectively implemented include those adopted by governments in order to please foreign donors or acquire funds, which involve complex institutional procedures and do not latch on to existing priorities.

The third question was: *What are the costs of interventions and how can they be borne?* There is no straightforward answer to this and LG4 does not put forward a headline figure for the total bill. Apart from the sheer complexity of measuring programme costs there are fundamental questions about whether costing is an exercise in assessing the cost to all stakeholders, or only the budgetary requirement demanded from government or aid donor. Does it include the costs of inaction, the importance of targeting all poor and vulnerable children, and the wider economic implications of spending significant money on these activities? A major conclusion of LG1's work in this area is that money spent on basic social protection measures (including cash transfers to the poor) is cost effective and a good way of disbursing aid resources. The findings of LG4 imply that cash-based social protection programmes have relatively minor distorting impacts, and therefore should be considered a priority candidate for receiving assistance. However, the logic of LG4's findings is that comprehensive social protection should be provided to all poor and vulnerable children in sub-Saharan Africa, and that the ultimate objective of meeting the needs of these children cannot be realized without ending child poverty. This is an ambitious and expensive goal.

A final question was: *How is the issue of children and AIDS located within wider debates and trends on AIDS and development?* The key findings were that AIDS exceptionalism is in retreat while efforts to integrate or mainstream HIV/AIDS programmes within sectoral initiatives, notably health systems but also school-based programmes, are gaining ground. Meanwhile, critiques of aid as an instrument for promoting economic growth are also gaining acceptance. A focus on poor and vulnerable children, including especially those affected by AIDS, requires an emphasis on social protection measures that alleviate the poverty and increase the life chances of children, including those who are likely to be left behind by policies which emphasize economic growth. While aid can be an instrument for social protection, the key to success is national policy.

The methods adopted by the LG4 researchers varied across the topics considered. They ranged from detailed case studies, through comparative reviews to statistical analyses of datasets. On one topic we chose to sponsor a debate among individuals with divergent views.

Synthesis

The findings of all the JLICA Learning Groups indicate that the HIV/AIDS epidemic in the hardest-hit countries of sub-Saharan Africa is causing immense distress and impoverishment to children and impairing their life chances, and that governmental and donor responses to date are grossly insufficient. This is neither new nor surprising. But the next steps of the analysis are less obvious. The implications for national and international response are more radical and far-reaching than we might imagine.

The key analytical finding is that *the specific impacts of the HIV/AIDS epidemic on outcomes for children are hard to distinguish from the broader impacts of poverty, deprivation and associated social crisis*. These other factors are so important in delimiting children's lives and life chances and the HIV/AIDS epidemic has now been around so long and is so deeply embedded

in social functioning that the specific impacts of AIDS are difficult to discern except at the individual level. It takes the sharpest statistical scalpel to slice the socio-economic factors at play so as to isolate how HIV/AIDS impacts children distinct from these other adversities. It makes no sense at a national or community level to insist on privileging this increment of distress caused by the disease. Singling out the victims of the disease from others has so many undesirable (stigmatizing) side effects that it has long been abandoned by practitioners in the field. This is a pivotal finding from LG1 that is strongly echoed in LG4's work: we must look beyond orphans and children affected by HIV and AIDS and respond to the entire category of poor and vulnerable children in the social and economic contexts in which they find themselves.

Slender the impacts of AIDS may be when averaged across a whole population—but at an individual level, they can be striking. For most Europeans and Americans, the message of Madonna's advocacy for Malawian children affected by AIDS is that these innocent victims should be saved one-by-one—by adoption, for instance. What of the distress of the lonely child caring for a mother dying of AIDS, out of school and shunned by her former friends, or the over-burdened grandmother caring for her orphaned grandchildren, or the orphaned adolescent girl who runs away from a foster home and falls onto the less-than-tender mercies of a city pimp? Acts of compassion organized by communities reach many—but not all—of these people. Kinship networks—Africa's famous "extended families"—carry by far the greater part of the burden, putting to shame the meagre efforts of government and international agencies. Demographic data indicate that family sizes are expanding rather than contracting under the impact of HIV/AIDS, and that family structures are changing to become more centered on women and female kinship relations. But families, however extended, cannot reach every individual. A powerful argument is: should we not exert extra efforts to reach children affected by AIDS and target them with assistance? Many people are moved by the plight of children orphaned by AIDS and this is the starting point for their engagement with the issue.

Two key relevant points arise from the research findings of the LGs. One is that *interventions need to reach families*. It is a mistake to frame policies with the intent of "reaching" children outside of the

context of their families and communities. Children can only be reached—assisted and protected—in a context, and for the overwhelming majority of those children, that context is the family. (There is a need for state action for the small but very vulnerable minority of children who need institutional care and those adolescents who have left home and are vulnerable.) As indicated by LG1, it is important to define "family" for our purposes: families are social groups connected by kinship, marriage or adoption that have clearly defined hierarchical relationships, mutual obligations and responsibilities, and share a sense of togetherness. Families are changing due to numerous social and economic factors including the HIV/AIDS epidemic and while it is important not to idealize families and their values, it must be recognized that no other mechanisms exist which possess comparable efficacy for assisting and protecting children.

The second key point is that social policies for the most vulnerable children can only succeed against a backdrop of *universal* service provision. *We are not in favour of targeting children affected by AIDS* for social protection. There is always space for individual charitable acts targeting individual children in special need and medical interventions must by definition be targeted. But efforts at scale to design the most sophisticated programmes to target social protection and assistance to children affected by AIDS simply cannot work. The governmental, non-governmental and community institutions in poor countries cannot do it with any measure of efficacy. In many cases they simply won't do it because it would mean spending vast financial, human and political resources in an inequitable targeting exercise—making sure that children equally needy but not on account of AIDS don't get a commensurate amount of help. It's not enough to say to the rest of the population, "your turn will come at some indefinite future point and in the meantime foreign donors have decided that AIDS is the priority." In less poor countries, where targeting is an option, then it should be undertaken on the basis of specific medical, psychosocial, educational or socioeconomic need, rather than on the basis of HIV.

Targeting can be done where universal social protection, education, water and sanitation and health services are already provided. Indeed, such targeting would be welcome because children affected by AIDS have specific medical and psychosocial needs that others don't have.

It is important to underline that these two findings apply equally to the most-affected southern African countries and countries with lower prevalence. The specific needs of children vary but the basic formula does not. The distinction between the poorest and less poor or middle-income countries entails different immediate priorities, reflecting different capacities for what is possible immediately.

In this context, why a Joint Learning Initiative on Children *and AIDS*—rather than one simply on poor and vulnerable children? There are three reasons: AIDS is an entry point; HIV/AIDS has its gravest social impacts at precisely the point where social policy finds it hardest to operate (the family); and there are big challenges for HIV prevention among children and adolescents.

The first is an instrumental reason. The international response to HIV/AIDS has generated immense and ambitious treatment programmes and, to a lesser extent, prevention and impact mitigation efforts. The international financial architecture for HIV/AIDS continues to grow, notably with the renewal and expansion of PEPFAR. Those tasked with implementing AIDS programmes at scale increasingly find that they cannot succeed unless resources are also ploughed in to health systems and social protection. Is it legitimate to use some AIDS-earmarked funds to attend to these needs? It is certainly *necessary* to do so, because the needed funds simply aren't available elsewhere, and a key principle of emergency response is whatever is necessary, is legitimate. Moreover, a significant part of those needs are generated by the impacts of HIV/AIDS and the additional challenges of responding to them. The JLICA's research demonstrates that those impacts and challenges are sufficiently great

to warrant major additional resources, though at the same time so deeply enmeshed in other social and economic problems that an AIDS-targeted response is rarely possible. The criterion we seek to highlight is "*AIDS sensitivity,*" so the response in question should have a significant impact of lessening the impacts of HIV/AIDS and/or should facilitate responses to HIV/AIDS. We do not support AIDS-exclusive social protection measures.

A second reason for focusing on children and AIDS is that the impacts of HIV/AIDS are felt first and hardest by families and it is families and communities that take up by far the greater share of the responsibility for responding. According to general consensus within the JLICA, the early estimate made by Geoff Foster (2005) that families and communities provide 90 percent of the response is if anything an underestimate. The societal costs of AIDS's impacts are vast and in the long run may be unsustainable. Strong (if as yet inconclusive) arguments can be made that failing to support families will have long term adverse impacts on national economies and societies. (This was the case presented by Devarajan and Goldstein, 2007). As a matter of epidemiological fact and social reality, HIV/AIDS and its impacts cluster in families. Describing AIDS as a "family disease" is a salutary reminder that it is not simply an individual medical condition. Beyond that, what is the significance of AIDS being a "family disease"?

The most important policy insight that follows from the family disease label is that family problems are normally left off the public policy agenda and remain in the private domain. The impacts of HIV/AIDS become a constellation of family misfortunes rather than a political scandal—in contrast to, say, the price of bread. Politicians prefer it this way. As long as these impacts are felt within the unmeasured and unremunerated economy of (almost entirely female) caregivers, and society as a whole holds that this is fair and correct, there is no political demand for leaders to do anything much about it. Private, invisible, long-term—these characteristics push AIDS's impacts to the end of a long queue of demands on social policy.

It follows that AIDS and children is not just an arbitrary entry-point chosen because it is backed by international dollars. The disease is a significant augmentation to the poverty and deprivation of children. Children and AIDS is a lens that brings into focus the burdens which are borne by families and communities. These burdens are certainly inequitable and are the cause of deep human suffering. These burdens will not necessarily be lifted by growth-led poverty alleviation measures. While economic growth is necessary for widespread poverty alleviation it is not sufficient for equitable poverty reduction. There are no guarantees that the poorest and most vulnerable children will benefit from growth unless there are also commensurate efforts at social protection.

It follows that *any national policies and any global responses determined to meet the needs of children affected by AIDS must be designed to ensure that social protection and assistance reaches the very poorest and most vulnerable, irrespective of the cause of that poverty and vulnerability*. National governments and international donors need to mount large-scale efforts aimed at social protection. The primary rationale for this is humanitarian—these children have an inalienable right to equitable life chances. The research of JLICA's LG1 indicates that in most circumstances the best instrument for social protection is cash transfer to the poor. LG2's findings show that communities—defined broadly to include networks as well as spatially-defined communities—play a vital role in providing assistance but are overstretched and under-resourced. Community-based organizations receive very little external funding. They deserve more funds but are intrinsically ill-suited to responding at the scale required. The policy research of LG4 indicates that national ownership of social protection strategies is essential to their success (Mamdani et al., 2008). National ownership of the goals and strategies of social protection dictates sensitivity to local circumstance and provides a cautionary note against imposing standardized blueprints.

A third reason for a special interest in children and AIDS is that *HIV prevention among children is not succeeding*. This has distinct elements: sexual transmission from adult men to adolescent girls, the under-reported and under-explained infections among children aged two-to-fourteen, and vertical mother-to-child transmission. National and international health systems are doing a deeply disappointing job of preventing these HIV infections.

There is a shocking epidemic of HIV infection among children and adolescents. In some populations a fifth of girls—*girls* who have not reached their eighteenth birthday—are infected with HIV. Both literature reviews and case studies point to the importance of structural rather than solely behavioural interventions. Adolescent girls find themselves in social and economic contexts in which they are extremely vulnerable to sexual harassment and abuse. In this context, messages about behaviour change have limited relevance—behaviour change is an outcome not an intervention. What is needed is to change the circumstances in which girls are relentlessly vulnerable at school, on the way to school, at work and in marriage. Structural prevention measures are complex and location-specific and therefore intrinsically difficult to design, implement, monitor and evaluate. They demand tackling a range of fundamentally different issues including gender inequity, social mores, poverty and vulnerability. They involve engaging with men and boys as well as girls, addressing the reasons why males behave in ways that leave girls and young women vulnerable. Despite these difficulties, we conclude that *structural prevention is the way ahead* for turning the tide of HIV infection.

The links between social protection and adolescent prevention are not simple. Strengthening families and communities (the latter including networks such as unions and voluntary associations) should result in fewer young women being placed in situations of extreme vulnerability. But some people will always fall between the cracks; in some cases, economic empowerment may actually increase the vulnerability to HIV of some young women; and communities can also discriminate and stigmatize. The links between physical safety and HIV prevention are also more complex than they might appear. Safety is an outcome, not an intervention. The institutions and programmes responsible for physical safety, such as the police

or community organizations, can themselves be a source of danger and vulnerability. These observations underline the importance of designing prevention, social protection and safety measures with local participation and ownership, while also recognizing that some of those most at risk of HIV are precisely those who are socially excluded and cannot easily be reached by family and community-based efforts.

A focus on social protection runs the danger of missing an important aspect to the challenge of structural prevention. Economic policies that emphasize rapid growth, which is usually associated with urbanization, reliance on the informal sector to employ young people, labour migration, increased transport infrastructure and mobility, tend to contribute to the social conditions which sustain high levels of HIV transmission. Social policies that entrench gender inequity do the same. We need to consider "AIDS testing" development policies to make them compatible with the HIV prevention and protection needs for children and young people.

Unpublished evidence compiled by Geoff Foster points to an under-reported epidemic of HIV infection in children aged between two and fourteen. Research by the Human Sciences Research Council (Brookes et al., 2004) also provides compelling data on this. This epidemic has been missed for the simple reason that researchers have not looked for it. Possible reasons for the infections include child sex abuse and contaminated injections in health facilities. Addressing either of these causes highlights the huge problems of denial that confront effective HIV prevention policies.

Some of the challenges of responding to these scandals are specific to health systems (better PMTCT, better anti-retrovirals for children, preventing needle-stick infections) and other challenges are embedded in the social and physical protection policies required to tackle impoverishment, vulnerability and social exclusion.

LG3 has worked on the challenge of increasing coverage and uptake of PMTCT, which remains disappointingly low. LG3 identifies the "implementation gap" as the key challenge in service delivery, and a combination of a Learning Collaborative and value chain analysis as the key methods for bridging this gap in the context of improving overall health system performance. This is a practical application of "joint learning" that boldly takes operational research to the very front line of health service delivery. It is axiomatic to the Learning Collaborative approach that there are significant efficiencies to be made through lateral sharing of experience and innovation among practitioners.

The findings of LG4's research would anticipate that the ultimate success of the Learning Collaborative will be constrained by the contexts of poverty, stigma and limited availability of other essential services. Thus, LG1 has already reported, in line with the experience of Partners in Health elsewhere, that cash transfers to poor households enable those households to improve their situations, which often include increasing uptake of health services. A common experience across Africa is that stigma is a major impediment to a mother-to-be coming forward for PMTCT, because of the prior step of HIV testing and the associated problems of partner disclosure and stigma. Perhaps most important, we would expect that the uptake of any AIDS-specific service is constrained by the extent of general health service provision. The general point is that the science of implementation works within the limitations established by the craft of policymaking—if a policy is the focus of popular support and civil society mobilization and monitoring, then implementation improvements will be identified and adopted more quickly than if is not.

Synopsis of: Preventing HIV Infection Among Children and Adolescents

Poverty

The debate on whether and how poverty contributes to risks of HIV infection and the outcomes for children affected by AIDS has sometimes generated more heat than light. The question is more sensibly disaggregated into a series of sub-issues which warrant their own specific investigations. LG4 addressed this issue through a critical literature review by Stuart Gillespie (2008).

Key findings are:

1. The links between poverty and HIV vulnerability are complex, situational and gendered, and cannot be reduced to simple associations between poverty and HIV. The associations are different at national, district, community, household and individual levels. As a general rule, poverty is *not* associated with vulnerability to HIV and men and women who are less poor and more mobile and relatively affluent are more likely to contract HIV.

2. Inequality is key. The most unequal societies are those with the highest HIV prevalence. Gender inequality is the single most important determinant of HIV vulnerability.

3. What this means is that we cannot expect that most current poverty reduction or growth strategies will reduce HIV in and of themselves—they will merely change its pattern. Some measures, such as education, are likely to help reduce HIV vulnerability. Other measures to promote livelihoods and increase income may in fact increase vulnerability to HIV among certain groups. Prominent among these are economic growth policies that result in rapid urbanization, labour migration, and reliance on informal sector activities.

4. The adverse economic impacts of HIV/AIDS on children living in affected families are substantial. Children who are already poor are further impoverished by the impacts of HIV/AIDS at the household level. Many of these families are likely to be left behind in poverty reduction driven primarily by economic growth.

One lesson from this is that measures to mitigate the impact of HIV/AIDS on families and children should be undertaken for their own sake, rather than because they may contribute to other developmental or public health goals (including, especially, growth). Another lesson is that development policies and programmes can vary greatly in their implications for HIV/AIDS and should be designed with these impacts in mind.

Socioeconomic Context

Richard Mabala and Brian Cooksey (2008) was commissioned to undertake an exploratory study of adolescent vulnerability to HIV in Dar es Salaam, Tanzania, as a means to grasp a fuller understanding of the range of factors that leave young people—especially girls—vulnerable to HIV infection. Using a range of participatory techniques, researchers probed some of the above and other potential causes of vulnerability with groups of teenagers of both sexes in two research sites in the city. Their research identified a number of factors that increase the vulnerability of the young, adolescent girls in particular, including orphanhood, migration, forced sexual initiation, the effects of residence and of membership in sexual networks. The research also outlined the deeper causes of these vulnerabilities, including patriarchal systems that devalue women and girls and the absence of accessible meaningful masculine roles for boys and young men.

One key finding is that living arrangements for children in sub-Saharan Africa are both variable and changing. Many non-orphans are brought up in households with an absent parent. Family structures are in considerable flux; with household sizes tending towards a slight increase overall, with contacts among maternal kin proving significantly stronger than among paternal kin. The plight of children orphaned by AIDS needs to be seen in this context. There is a widespread perception that the mistreatment of orphans by relatives and guardians sometimes forces them to find their way on the street, often ending up as sex workers, but there are many instances of foster families selflessly supporting orphaned children.

Migrants may be seeking education or work, or escaping from abusive or oppressive family relationships and forced marriage. Young migrant women who live in areas where they know few people are at greater risk of sexual harassment and abuse.

Forced sexual initiation through marriage is still common in some parts of Tanzania, and there is evidence that young married women have higher rates of HIV than those who are sexually active but unmarried. During *unyago* (initiation) 12–13 year old girls are told that now they should be self-reliant, while poor parents may tell their daughters to go out and "find the evening meal" for the family. Girls who become pregnant are additionally vulnerable, through having to drop out of school, through the expenses and dangers of a backstreet abortion, or through the impoverishment associated with having to look after a baby.

Mabala's research in Dar es Salaam finds that at least a fifth of girls report that their first sexual encounter is forced. Sexual abuse is so prevalent that it is hardly even noticed, or is treated as normal. Girls were aware of the possibility of sexual violence against them, which determined even their reactions to the continual propositions being made to them. There are few sanctions against male perpetrators of rape—it is considered something marginally shameful and hardly a crime. Gang rape is practiced as a means of punishing and removing young sex workers.

There is a strong correlation between residence and HIV prevalence. Tanzanian data shows HIV infection rates of 12.0 and 9.6 percent for females and males in urban areas, compared to 5.8 and 4.8 percent in rural areas. Aspects of locality increase the risks of HIV. For example, young women and girls who have to travel considerable distances to study or find work are vulnerable to sexual harassment and abuse on account of the journey and the way that the public transport system works against students.

Lastly, involvement in sexual networks helps shape levels of vulnerability to HIV infection. Poor young women are pushed into transactional sexual relationships with better-off men. The nature of sexual networks may help explain why the wealthy and educated are apparently more vulnerable to HIV infection than the poor and why the income-HIV risk association is so strongly gendered.

Tara Sinha (2007) was commissioned to analyze the role of the Self Employed Women's Association, a trade union of women workers in India's informal sector, as a lens for understanding the vulnerability of young women to HIV. The paper's framework lays out multiple layers

of vulnerabilities at the individual, social and programmatic levels. Within the home, early age at marriage combined with limited negotiating power places women at risk within marriage. Women have little say in early marriage and are subject to gender-based violence within marriage. Outside the home, women workers face sexual exploitation and gender-based discrimination which negatively impact on their vulnerability to HIV. Programmatically, the health care system does not target information and services to young women effectively. Overall, young women are poorly equipped to prevent HIV infection.

The study finds that women's empowerment, including their ability to mobilize and create social movements, is key to reducing vulnerability to HIV. Both social security and physical security are essential, the latter to create safe spaces in which women can live, travel and work.

Sinha's key finding is that young women and girls are at risk for a host of social, cultural and economic reasons. Adolescent girls form an especially vulnerable sub-group due to the combination of gender inequality and poverty. Their vulnerability stems from the fact that they are sexually mature. This vulnerability is different from the vulnerability of young children who lose care-givers. Adolescent girls warrant special measures to address their vulnerability in the home, school, and workplace. Gender inequality is pervasive and is manifest in a number of specific ways that lead to heightened risks of HIV. Women's mobilization and empowerment are central components of the prevention agenda.

Intergenerational Factors

LG4 sponsored research into the question: *Do children affected by HIV and AIDS have greater risks of HIV infection as they grow into adolescence and adulthood?* LG4 commissioned Lucie Cluver and Don Operario (2008) to review the evidence. One important consideration influencing researchers is the need to be evidence-based while also alert to the danger of self-fulfilling stigmatization—simply posing questions around the unique vulnerabilities of children orphaned by or affected by AIDS poses risks for those children.

There are few studies that explicitly explore the links between AIDS orphanhood and later life HIV vulnerability and fewer that demonstrate links between the two. Most studies are cross-sectional, which makes it difficult to demonstrate intergenerational linkages. A small number of studies suggest correlations between orphanhood and HIV infection and sexual behaviour among orphans. These are too few and non-specific to AIDS orphans for firm conclusions to be drawn. But studies on adolescents in Zimbabwe, Kenya, South Africa and Russia suggest links between orphanhood and HIV infection, and orphanhood and earlier sexual debut.

Possible links identified include: (i) direct transmission of HIV to a child through sexual abuse or caregiving accident (e.g. needlestick injury); (ii) poverty and malnutrition consequent on the impoverishing effects of HIV/AIDS at the household level; (iii) withdrawal from school because of poverty, stigma or the need to act as caregiver; (iv) reduced access to healthcare for the above reasons; (v) greater likelihood of alcohol and/or substance abuse associated with psychosocial problems; (vi) mental health problems; (vii) stresses associated with caregiving itself; (viii) intra-family violence and associated stresses; (ix) sexual abuse and rape, both within the home and outside it; and (x) being placed in situations of higher risk sex including seeking out older sexual partners and engaging in sex work or transactional sex. In all cases, the evidence is mixed or thin; some anecdote, some studies which indicate areas

needing attention. It is a thin layer of evidence but sufficient to indicate that children affected by AIDS warrant special concern and attention, especially in the field of psychosocial support.

The key finding is that there is enough evidence to indicate that children affected by AIDS suffer long-term adverse impacts that render them more vulnerable to HIV infection later in life. The increment of vulnerability may be small and specific to certain contexts and categories but it is real.

II. Synopsis of: What Makes Good Policy on Children and AIDS?

There is a craft to making workable policy. A combination of comparative and statistical analysis allows us to draw conclusions.

Case Study of South Africa

LG4 commissioned Debbie Budlender, Paula Proudlock and Lucy Jamieson (2008) to study how policies relating to children and AIDS were developed and implemented in South Africa. They chose three policies: the child support grant, the Children's Act and the foster care grant. South Africa is a unique and fascinating case because (1) it has the world's worst HIV/AIDS epidemic; (2) the government's approach to HIV/AIDS has been marked by ambivalence; (3) it has no national poverty reduction programme beyond specific social protection policies; and (4) it has unique policy-making processes deriving from its history. Two of the policies under consideration—the Child Support Grant and the Children's Act—derived from the post-Apartheid constitution with its strong emphasis on human rights. Despite the constitutional commitment to universal human rights, progress on child-related policies is related to the fact that children are seen as the "deserving poor." Against this, it should be noted that children lack "voice"—that is, they do not represent themselves in the political arena and rely on others to make that representation.

The State Maintenance Grant (SMG) was an Apartheid-era programme that favoured white, Indian and coloured children, which was replaced by the Child Support Grant (CSG) in 1995. This was the outcome of the Lund Committee on Child and Family Support, which worked expeditiously to dramatically reshape the SMG into the CSG. Taking the fiscal constraints seriously, the Committee made relatively modest proposals which could be rapidly implemented. Public pressure from child and gender advocates subsequently led to an increased grant.

The CSG differs from its predecessor (the SMG) in important respects. The SMG assumed a nuclear family with two parents as the norm. The CSG

"follows the child" and is more appropriate for the kind of fractured society that South Africa has become, with many children born outside stable relationships, many absent fathers, a widening ambit of caregivers and a decline in the role of paternal kin. The follow the child approach could however be improved in certain respects, as the grant is difficult to transfer from one caregiver to another and requires birth certificates and identity documents. Subsequent changes to the CSG have expanded the upper limit of the age group eligible from 9 to 14 years and changed and relaxed the means test.

The CSG is simple, cheap to administer and has a high uptake rate (almost 90 percent). Research indicates that it has had measurable positive impacts on outcomes on child nutrition and health, the ability of caregivers to provide essentials to children, and school enrolment.

The Children's Act aimed to realize children's constitutional rights to family care, parental care or appropriate alternative care; to social services; and to protection from abuse, neglect, maltreatment and discrimination. The Children's Amendment Bill goes into detail concerning the provision and regulation of a range of social services for children. The Children's Act is the product of a lengthy and complicated process of consultation and legislation (six years up to the first draft of the bill and a further three years until it was passed by Parliament plus a further two for the Amendment Bill). It reflects a developmental philosophy of welfare in contrast to the residual approach taken by the Apartheid government. The participation of a range of civil society organizations has ensured that popular pressure always existed to make sure the process ultimately reached a successful conclusion. One of the innovations in the participatory process was the involvement of children themselves as advocates. The disability advocates were successful in ensuring that the Act contained a number of clauses, for example concerning non-discrimination, which are very relevant to children infected or affected by AIDS. Advocacy groups were successful in changing the language of the Bill from "may provide" to "must provide" in reference to as wide a range of services as possible, thus laying the basis for insisting that government ensure that the necessary funds are available. This human rights-based advocacy has significant implications for the scale of services mandated by the Act.

Implementing the provisions of the Children's Act will be expensive. Current provincial government spending on related activities covers only 10 percent – 34 percent of the activities required by the existing Act, which are substantially less than those envisaged by the new Act. In the "full cost high scenario," services to children orphaned by AIDS take up as much as two-thirds of the projected expenditures. The civil society advocacy groups focused much effort on making sure that the government finds the resources necessary to finance the activities required. Finding the necessary funds and also the human resources will be an immense challenge to fulfilling the demands of the Act. There is a shortage of social workers and government continues to use NGOs as a cheap option, failing to provide sufficient funds for NGOs to pay competitive salaries.

The foster care grant (FCG) is an old provision that was originally designed as a child protection measure, but has increasingly become a poverty alleviation measure. It is a more targeted and larger grant than the CSG. The number of beneficiaries increased more than six-fold between 2000 and 2007, in large part reflecting the impact of AIDS on orphan numbers. There has been a vigorous debate over whether most or all cases of children eligible for the FCG should in fact be transferred to the CSG. The FCG was said to discriminate against non-orphans living in poverty and also against orphans living with close relatives, who had not been placed there by a court order. On the other hand, the more substantial resources provided by the FCG were held to be necessary for fostered children. The Children's Amendment Bill has taken a compromise position on some of these issues, for example allowing close relatives to count as foster parents without a court order. However, the FCG remains bedeviled by problems of perverse incentives (in favour of fostering away from the family), complicated and lengthy procedures, and the problem of inequity. It is questionable whether it is the best policy option for orphans.

The South African study brings to the fore the importance of a number of key issues. One is constitutional obligations, which have driven an ambitious (and as yet unrealized) policy. Related to this is the occasional use of litigation as an activist tool. Perceived fiscal constraints are another issue, leading policymakers towards caution

and advocates towards activism on government budgets while making claims on human rights grounds. Human resources are another issue: there is a huge gap between policy and availability of trained personnel to make it a reality. Public participation has been essential to the success in passing essential legislation with the ambition to make a real difference to children. The impact of the HIV/AIDS lobby has been mitigated by its lack of unity and some important victories for children affected by AIDS have been won by others, such as the disability advocates. Lack of cross-sectoral planning and dialogue has been a problem. The experience of policymaking shows that there is no single clear locus of decision making, and successful policymaking has consisted in getting buy-in across a range of institutions and stakeholders in government and adjacent to it.

Importantly for the JLICA, the examples of policy-making analyzed all demonstrate the importance of good empirical evidence (mostly statistical) produced in a relevant and timely manner. Evidence has genuinely had an impact on policymaking. But vigilance is needed to ensure that the gains made during policymaking are sustained during implementation.

The South African experience also illustrates that it is possible to develop policies based on universal provision or income-based targeting that bring real benefits to children affected by AIDS. This is an exemplar of AIDS-sensitivity. The authors mention that this may be specific to the South African case because of the scale of the epidemic in the country and its relative wealth.

Case Study of Tanzania

LG4 commissioned Masuma Mamdani, Rakesh Rajani, Valerie Leach, Zubeida Tumbo Masabo and Francis Omondi (2008) to examine aspects of socioeconomic policymaking relevant to children and AIDS in Tanzania. The three studies that comprise this paper analyze primary education reforms, the children's statute, and social protection for the most vulnerable children.

Assistance to education is perhaps the single most important public policy measure that assists children affected by AIDS in Tanzania and universal primary education is the biggest social transfer to children. Tanzania's education system suffered from decades of neglect and repeated attempts to reform it ran into insurmountable obstacles chiefly because technocratic solutions failed to take account of the politics of institutional change. This began to turn around due to a combination of popular pressure from the electorate and donor concern. Under the Primary Education Development Plan (2002–2006) mandatory primary school fees and contributions were abolished, the number of teachers was increased by 50 percent and over 41,000 new classrooms were built. The overall education budget doubled and resources disbursed at school level increased at least five-fold. This allowed an additional two million children to be enrolled in primary school by 2006, with net enrollment reaching 96 percent. It can be counted a signal success. However, significant problems exist including inequities in schooling provision across the country, overcrowding in classrooms, teaching geared specifically to the primary school-leaving exam, and uneven budgetary disbursements.

One lesson to be learned from this experience is that research evidence and lobbying, on their own, were insufficient to create change. The empirics were well known for many years before any change occurred. Evidence did prove crucial in undergirding an effective strategy, but only after the strategy itself became feasible when political pressure resulted in politically-accountable promises. Technical solutions need political opportunities, which often means getting the incentives right. Pressures to disburse funds quickly and to act in a technical manner encourage avoidance of the most important challenges of implementation and sustainability. Another lesson is that the influence of donors, while large, tends to be exaggerated. Even though donors provide 40 percent of Tanzania's budget they cannot determine policy. However, a well-placed donor with a good understanding of local politics can help move things forward at the right moment. Leadership is key—and there are no shortcuts around it. Education was fortunate in that there was a combination of public pressure and donor readiness. A citizen-centered political dynamic was crucial to effecting change. This underlines the importance of a social mobilization approach as opposed to apolitical technical development programmes.

Like South Africa, Tanzania has a long-held intention of developing a children's statute to provide specific effect to the relevant provisions in the Constitution and align policy with the Convention on the Rights of the Child. The process began in 1984 and has yet to come to fruition. The delay is not attributable to technical reasons involved in drafting a statute. Rather, the social sensitivity of legislating on children, marriage and inheritance along with the absence of an effective coordinated voice for children's rights are more likely causes. The children's statute involves many thorny questions (e.g. marriage and inheritance rights) that cannot be resolved without controversy, and children lack strong champions who can draw other constituencies into supporting them. In addition, people may be sceptical that the legislation will make a real difference and hesitate to get deeply involved in campaigning for it. One implication of this is that even if a statute is enacted, implementation is likely to be haphazard and uncertain unless there is strong and consistent public pressure.

Another possible reason for the dilatoriness of efforts is that governments agree to international codes because this is perceived as desirable in the eyes of an international community on which the country is dependent for funding, with little intention to implement the changes in practice. The norms remain aspirations rather than genuine commitments. A lesson here is that international instruments in themselves have limited power to affect wellbeing in practice, and we are reminded of the large gap between policy and practice. There is a striking contrast between the slow progress of the children's statute and the speed with which legislation on child sex abuse was adopted, in response to public outcry. Poor and vulnerable children remain a constituency that can safely be ignored.

Tanzania is one of the poorest countries in the world. Orphanhood is one factor among many in poverty and vulnerability, but researchers note that the level of relative disadvantage of orphans and foster children is slight compared to the level of need of virtually all children.

The government is committed to a coordinated, systemic response, and aims to mount such a response in a manner that recognizes the rights and entitlements of all children. In developing this response it faces the issues of donor coordination and harmonization and the tendency of donors to create parallel plans and systems. The multiplicity of efforts is not only wasteful but also creates distortions and undermines local capacity. Local government authorities are the most important implementing stakeholders, but are constrained by insufficient resources, personnel and information and are overwhelmed by the multiple demands made on them. Long-term investment in institutions is needed rather than yet another short-term programme.

The government faces a key policy question of targeting versus universalism. Centralised means testing has its theoretical attractions but is beyond the capacity of Tanzania's weak administrative systems. Community-based targeting is an alternative that is being tried, but it has problems of inexactness and divisiveness. Targeting the very poorest among the (merely) very poor is unsatisfactory. It is preferable to focus on expanding support to local government to deliver core services such as health, education and water to all children. This may reach more children at risk in a manner that is cost-effective, simpler and enjoy broader support, as well as strengthen existing public capacities. Embedding specific criteria and mechanisms to safeguard the interests of vulnerable children within these broad services, such as inclusion of the most vulnerable

children in schooling, provision of accessible water and free or affordable health services may reach more children over a longer period at lower cost than targeting outside these mainstream service delivery channels. However, a national universal child benefit programme would entail a vast fiscal allocation far beyond existing budgetary limits.

Another key policy question is exceptionalism—how different is HIV/AIDS from the government's other priorities in the health and social arenas and to what extent does it need an explicit focus? Among donors and international bodies HIV and AIDS hold an exceptionally important place, which is reflected in high levels of aid and the multiplicity of programmes and institutional arrangements. However, there is little evidence to suggest that Tanzanians place as high a priority on this issue as do the donors. This implies that programmes that are integrated rather than AIDS-exceptional will enjoy greater public support and be more sustainable.

Tanzania has operationalized its National Plan of Action for most vulnerable children (MVCs), which was developed by the Government of Tanzania Department of Social Welfare but has been largely driven by external actors with a low level of national financial commitment. Currently about 160,000 MVCs are receiving support through programmes which use community-based targeting for the most vulnerable, destitute children. Children are provided support in kind— clothing, school uniforms, contributions for community health insurance schemes, materials for shelter improvements. Funding is channeled through international NGOs and community-based organizations. This MVC response is reliant on a few external donors, notably PEPFAR, leaving it vulnerable to donor policy shifts. Dependence on HIV/AIDS-specific funding is a particular concern.

It is instructive to compare the success of the Universal Primary Education policy with the shortcomings of the MVC programme and the children's statute. The difference is likely to lie in two areas: the way in which the primary education crisis was a broad and explicit public concern, such that is was a popular issue and not a "donor issue," and the manner in which the primary education reform was structured to strengthen government systems and open them up to greater public engagement and scrutiny.

The key concern of the Tanzania case study is the best way to enable support for children, and especially the most vulnerable children, given limited resources and often weak administrative structures. While the issues remain complex, an examination of the three different cases indicates a core common lesson: initiatives that resonate with and respond to broad public concern are more likely to gain traction, exercise accountability, and be sustainable. Efforts that are technically driven and overemphasize the provision of funds are unlikely to be effective because they may fail to engage with the political drivers of change in the country. This lesson is particularly relevant for international actors seeking to do well, for it suggests the need for a nuanced engagement with politics, culture and social forces that shape priorities, implementation and accountabilities that lay at the heart of effective support for children.

Case Study of Cambodia

LG4 commissioned Jerker Edström, Jenne Roberts and Andy Summer (2008) to recount and analyze the process of three sets of policies in Cambodia, seeking to identify the major drivers of change and drawing out key lessons. Three policy developments are examined, (1) the Policy for Alternative Care for Children, (2) policies on paediatric AIDS treatment under the Continuum of Care, and (3) the Impact Mitigation chapter of the Second National AIDS Strategy (NSP-II). The study focused on the roles played by discourse and evidence, by actors and networks, and by institutions and interests. This directly addresses a core concern of the JLICA, namely developing policy that is based on evidence, rather than supposition, and which is participatory and sustainable rather than based on unsupported supposition or political interest.

The study findings indicate different and contrasting configurations of factors determining how policies are adopted and implemented. The three Cambodian policies were not shaped in the same way. Evidence and discourses from international best practice played a major role in some instances and less so in others, and institutions and participatory processes facilitated some policies and not others.

This is illustrated by the case studies. The Policy for Alternative Care for Children was driven by discourses and impeded by the lack of participatory institutions. The impulse to develop alternatives to institutional care arose from Cambodian participation in an international conference on the topic in 2003, which prompted dialogue between government and civil society. Child rights activists influenced this initiative and the direction it took. Policy formulation drew upon evidence in the form of data from a census of children in residential care, albeit with some significant gaps. Special attention was given to the needs of children affected by HIV and AIDS. A network of the key actors including NGOs, UNICEF and government institutions shaped the policy including specifying the goals, guided by a clear statement of intent from the Ministry of Social Affairs, Veterans and Youth Rehabilitation. There was, however, no mechanism to allow the participation of youth and children in the policy process, a significant weakness. A new policy was formally authorized by the government in April 2006. The policy as implemented was unresponsive to some key demands, such as a means for verifying whether a child is in need of institutional care, and mechanisms specifically geared to children living with HIV and AIDS. The policy was not widely known or used to guide planning or operational policies. In many cases, the authorities cannot afford to implement it and lack implementation guidelines. Parents and children also lack a clear avenue to address their concerns and do not have their rights clearly specified.

The adoption of the policy on paediatric AIDS treatment presents a picture with important differences. Two major steps forward were taken: the provision of free ART for children and the provision of paediatric treatment guidelines. Formally guided by a rights-based commitment to meeting international targets and especially universal access, in practice the policy has also been influenced by a more flexible and less normative process including humanitarian appeals, the demands of physicians who represented individual cases and NGOs such as Maryknoll and Médecins Sans Frontières that were keen to demonstrate operational success. Cambodia's network of people living with HIV and AIDS also made its voice heard. Cambodia's Ministry of Health instituted its "Continuum of Care" policy in 2005, despite the risk of instituting a vertical policy when its priority was overall sustainability.

Thus, the policy adoption process was largely driven by actors and institutions via participatory structures bringing local evidence to bear. There was no formal policy statement in the form of a decree or Act, but rather an iterative process of setting targets and procedures among the different stakeholders, including government and civil society. The result has been an integrated policy framework, without parallel structures—straightforward for both government and donors to finance and monitor. The main criticisms of the policy are that it has been too slow to roll out in rural areas and that discrimination and exclusion remain a problem for groups such as drug users and their children.

Cambodia's national policy on mitigating the impact of HIV/AIDS on children arose from the development of its second multi-sectoral plan, the "National Strategic Plan for a Comprehensive Multi-sectoral response to HIV and AIDS, 2006–2010" (NSP-II). This is a rare example of an approach to this issue in Asia, where the impacts of HIV/AIDS on children have largely been off the policy radar screen. Notably, it marked the first time that the term "OVC" was introduced into government HIV/AIDS plans. A national plan of action for children affected by HIV/AIDS was the outcome, the first ever such plan, and as such an important step forward in clarifying what should be done and by whom. However, as yet there is neither

consensus nor clarity on the definition of the term "OVC" and whether it should apply solely to those affected by HIV/AIDS (in line with USAID stipulation) or should be broader. The process of obtaining an effective and implemented policy has been fraught by failures of coordination, participation, and representation of children and youth, and by mutual distrust among stakeholders.

The policy recommendations that arise focus on strengthening the effective drivers of good policy and reducing the impediments. The most productive strategies are to: focus on institutions; support the participation of children, youth and civil society in policy formation and implementation to mobilize a policy narrative; open access to spaces for formal policy making; provide financial resources and training to enable civic participation; and influence and provide support for participatory monitoring and evaluation of policy implementation.

Political Correlates of Good Policy

Per Strand and colleagues (2008) were commissioned to contribute a paper analyzing datasets that can provide insight into the political correlates of good policy. The presumption is that countries that are at a structural disadvantage can still beat AIDS with the right policies, institutions and public leadership. The study correlates data for 42 sub-Saharan African countries for governance variables grouped into "AIDS governance," "general governance," "democracy," "political competitiveness" and "political opinion on AIDS." Indicators for children and AIDS outcomes are (1) the percentage of HIV-positive pregnant women with access to ARVs (PMTCT coverage); (2) the percentage of HIV-positive children in need of ARVs with access to ARVs; (3) The percentage of HIV-positive adults in need of ART who receive such treatment; (4) the schooling ratio between double orphans and non-orphans, and; (5) the "policy score" resulting from the policy effort index on children affected by HIV and AIDS—which is a "policy score" rather than an outcome per se.

An important finding was that some of the elements of the AIDS governance variables (the AIDS Program Effort Index and the OVC index) that we would have expected to have an impact are poorly linked to the outcome variables. In particular, the API 2003 scores for political support, policy and planning, and prevention programmes were not linked to any outcomes. The most probable explanation for this, consistent with LG4's other research, is that outcomes such as PMTCT uptake are closely associated with health systems and gender issues rather than AIDS-focused efforts. Another result was that none of the governance variables was correlated with the schooling ratio. However, a range of other more general governance variables correlated with the other dependent variables. The World Bank governance indicators for government effectiveness, rule of law and voice and accountability appear to be the most relevant to the analysis.

Several strong results emerge from regression analyses. Governance variables are shown to matter a great deal, both in terms of the general quality of governance in the state as well as in the quality of the institutional response to AIDS, especially the care and treatment programmes and the national action plans pertaining to children affected by HIV and AIDS. The level of donor funding and the national commitment to fund health are also important for effective outcomes. These results raise the question why some countries spend more and have better care and treatment services. While the level of political leadership does not have a direct effect on policy outcomes, it has an indirect effect by strengthening monitoring and evaluation and the regulatory environment, which, in turn, lead to better care programmes and action plans.

The key finding of this study is that effective responses have occurred through resourceful and diligent planning through state institutions relatively free from patrimonialism. Participatory processes have an impact, but the electoral process itself has tended not to generate AIDS-focused policies.

III. Synopsis of: How Can the Cost be Borne?

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

LG4 commissioned five papers as part of a debate on the question: *"Can a developing country support the welfare needs of children affected by AIDS?"* The rationale for the debate format was that if we had commissioned a single paper, the answer would have been determined in large part by the choice of author. By soliciting a range of contributors with differing opinions — including the unpopular viewpoint that a poor country *cannot* afford to assist children affected by AIDS — the debate was intended to sharpen thinking and make the outcome of the JLICA process more relevant to the policy world.

Valerie Leach (2008) presented a paper based on the Tanzania country experience of a programme for assisting MVCs (see the Tanzania policy case study, above). Leach argues that it is difficult to make the case for targeting children affected by AIDS, distinct from other children in need. More than 40 percent of Tanzanian children live below the poverty line. She summarized data from Tanzanian studies which show the adverse impacts of orphaning and HIV/AIDS at household level, and which note the sad reality that households fostering children are on average poorer than those that are not. The total number of children estimated to be most vulnerable — orphaned or disabled and living in extremely poor conditions — is estimated at almost one million, 5 percent of the child population. More of these MVCs are in the older age categories than the younger.

Current programmes for MVCs are reaching a small proportion of these children and at high unit cost, providing support to individual children at levels far in excess of the normal expenditures of children in their communities. For similar levels of funding, household expenditures for one million children who are now living at levels which are 30 percent below the poverty line could be raised to the poverty line. The financial cost was estimated to be US $36 million in 2006, 1 percent of the national budget then, and 11 percent of HIV/AIDS financing. For relatively meagre expenditures, extremes of destitution can be avoided. A key point from this presentation is that the current Tanzanian MVC programme is small in scale and modest in impacts.

Malcolm McPherson (2008) portrayed himself as "the Grinch" in the debate — he argued that a poor country (his example was Zambia) cannot support the needs of children affected by AIDS. He argued that such an effort would be inefficient, inequitable, and unaffordable. Better, he argued, to focus on economic growth which will benefit all. Any measures which targeted children affected by AIDS would neglect others in equal need. And the sheer scale of the resources required to bring all children up to the poverty line of US $2 per day would surpass the existing national and foreign aid budgets for developing countries. In the case of Zambia, the cost would be $1,000 per child per year, or US $3 billion total annually, 43 percent of the country's GNP. Even were such resources available, McPherson argued that this would not be an appropriate way of spending the money. If aid had worked, countries such as Zambia would be wealthy by now. The reason it hasn't worked is that the institutional capacity is not there to make good use of the resources and the political incentives for effective expenditure do not exist.

Chris Desmond (2008) criticized McPherson's numbers, arguing that they needed to be substantially reduced to take account of what was already being provided by families, communities, NGOs and the government itself. He argued that there is a strong case for a fairer distribution of wealth from those who have too much to those who lack the basics.

Desmond quoted the figures developed by John Stover and the Policy Project which are much lower, a total of US $1.1–$4.4 billion per year by 2010 for a range of services for children affected by HIV/AIDS globally (mostly in sub-Saharan Africa). Although the method for calculating this figure is open to question it provides at least a benchmark, closer to the experience of countries such as Tanzania in providing essential minimum packages. For middle income countries, cash transfers are affordable and effective. For poor countries, they are effective but need external support in the form of aid. Desmond cited the ILO modeling exercise for social protection

packages in low income African countries, which resulted in a figure for child benefit of between 1.5 percent–4.5 percent of GDP. The total package, with more than half of the costs represented by health care, was 5 percent–15 percent of GDP. This, he said, is a figure that should be affordable.

Desmond also questioned whether aid would have the distorting effects on the macro-economy asserted by McPherson. He cited evidence that "Dutch disease" (the negative economic consequences resulting from large increases in income) is not the problem to be feared. To the contrary, he argued that well-targeted aid could increase productivity and competitiveness, especially if it increases human capital. He concluded by arguing that countries do in fact support the response to HIV/AIDS, but that the costs are borne chiefly by families and communities, and that the policy priority should be to support this response of proven efficacy, which will in turn have positive social and economic outcomes.

McPherson responded to these points on the JLICA blog. He rejected the wider argument about global fairness as not relevant, questioned the basis for the Policy Project estimates, and asserted that "Dutch disease" is a verified reality. His central point was that the levels of support that exist today (through families and communities) and those suggested in the Tanzanian paper and the Policy Project scenarios, are grossly insufficient to be regarded as a truly effective response.

Shantayanan Devarajan and Marcus Goldstein (2007) took the same premises as McPherson to come to the opposite conclusion, namely that a developing country cannot afford *not* to act to mitigate the deprivation experienced by children affected by AIDS. He presented a model developed jointly with colleagues Clive Bell and Hans Gersbach which demonstrated that neglecting the educational and welfare needs of children affected by AIDS in a country affected by a high-prevalence HIV/AIDS epidemic would lead to a catastrophic decline in human capital over three generations. He drew attention to the societal costs of responding and the implications of failing to support those societal mechanisms. If "we" decide we cannot "afford" to finance a program, we are implicitly asking families and communities to bear this cost, without attending to whether they can afford to or not.

Devarajan's model and conclusions were criticized for the case of South Africa (his example) on several grounds. One was that he had failed to differentiate among subcategories of the population (the richer segments have lower HIV prevalence and will sustain their human capital over generations regardless of HIV/AIDS). Another criticism was that he may have underestimated the "coping" capacity of African family systems. Writing on the JLICA blog, Devarajan rejected this criticism, making the point that reducing provider costs entails increasing societal costs—families cope, but at a cost which may be invisible to outsiders. A third critique was that the declines predicted by the model were not actually happening—to which Devarajan responded that we shouldn't be complacent because the declines haven't happened yet. It will take generations for the full impacts to be seen, he argued.

Amy Nunn and Francisco Bastos (2008) presented a paper outlining Brazil's response. This emphasized that the early and significant investment by the national government—an action taken against the advice of multilateral financial agencies—had ultimately saved the country both a social crisis and an economic burden. This is a positive example of Devarajan's injunction to consider the costs saved by timely action. Brazil's nationally-led universal access programme provides a model and inspiration for others. While Brazil's experience may be difficult to replicate in African countries with fewer resources and larger

epidemics, it does highlight the importance of a country's own political and social choices and interests in its ability to support children affected by HIV and AIDS.

The key lessons from the debate are the following. (1) A developing country can certainly afford a minimum package of responses. But as the response is taken to scale, issues of affordability and distortions may arise. These are manageable with good policy. (2) It is important to take a broad approach to considering the costs of responding, including the costs of *not* responding. (3) Any response involves important policy choices. There are trade-offs to a response at scale, in terms of the financial, human and institutional resources that will be allocated to the needs of children affected by AIDS, which cannot be allocated to other national priorities.

Approaches to Costing the Response

LG4 commissioned Gerard Boyce (2007) to review costing studies for responses to the needs of children affected by AIDS. Boyce posed several questions, notably whether costing exercises had taken the perspective of provider costs or societal costs, and the related issue of evaluating the extent to which the burden of care on different stakeholders had been taken into account. (Few studies took the societal cost perspective.) The studies reviewed were diverse with respect to their definition of the population of concern (orphans, children affected by HIV and AIDS, etc). Some costed existing interventions and others estimated costs for national or global responses. Most costing exercises take unit costs (average costs for service provision), rather than marginal costs, which make it difficult to estimate the true costs of scaling up and the costs of programmatic interventions at different stages. These divergent definitions and approaches make for problems of comparability.

Some general conclusions can be drawn from the review. First, costings do not account for the support given by families and communities, which are the greater part of the interventions. Provider costs for governments or external agencies dominate the approaches. Related to this, most costing exercises are undertaken for aid budgeting purposes and hence focus on financial costing not economic costing. In many cases the cost estimates are viewed as the end goals of fundraising estimates rather than as tools for meeting needs. Second, the question of "affordability" is often raised, without adequate attention to the tradeoffs between different societal goals. The worthiness of the object of the spending is accepted, so that demonstrating affordability serves to place the onus for financing interventions on national governments and donor agencies. And the converse point, that labeling an intervention as "unaffordable" merely shifts the burden to families and communities, is also easily lost.

The logic of JLICA's approach and recommendation has important costing implications. The core messages of all the Learning Groups (which are also consonant with the studies undertaken by the Inter-Agency Task Team) are that universal social protection is necessary and that programmes and policies should be AIDS-sensitive rather than AIDS-exclusive or AIDS-targeted. Social protection should be provided to all children living in poverty, which will then have the greatest effect in mitigating the impacts of HIV/AIDS. In short, the challenge is to overcome child poverty. While this recommendation applies to high- and low-prevalence contexts alike, the greatest burden is in sub-Saharan Africa.

LG4 is not able to produce a figure for the cost (under any definition) of overcoming child poverty in sub-Saharan Africa. While the considerations noted by Leach (2008) and Desmond (2008) mean that the cost per child may be considerably lower than the figure of $1,000 proffered by McPherson (2008), the number of children affected is much higher than the orphan estimates used by the Policy Project. In many sub-Saharan countries most children live below internationally-recognized poverty lines. The total cost of such social protection measures will therefore be very large. New mechanisms for raising and disbursing these funds will be needed.

IV. Synopsis of: The Changing Context

The JLICA report will be released into a changing political context. Alex de Waal (2008) contributed a paper which examines that context and raises questions about how best to promote our common concerns. This paper is based upon observation of, and participation in, some of the key debates around HIV/AIDS and international policy.

One important domain of change is "AIDS revisionism." This is the critique of the UNAIDS-led AIDS-exceptionalist approach that has dominated for the last decade. The revisionists argue that AIDS is not so different from other diseases and that we should be less worried about the social, economic and security implications of the pandemic. One of the main aspects to this revisionism is an emphasis on the diversity of epidemics, distinguishing the generalized epidemics of sub-Saharan Africa from those in Asia, Europe and the Americas, and also distinguishing the exceptional hyper-endemic situation in South Africa and its immediate neighbours from elsewhere in Africa.

A second challenge is a push-back against the aid-dominated approach to reducing poverty with a greater emphasis on promoting growth, especially through trade and investment. Aid levels are likely to remain at historic highs, which makes it very tempting to advocate an aid-based response to the challenge of children and AIDS. However the downsides of aid reliance must be appreciated. Official aid is likely to be oriented toward activities that have demonstrable positive impacts on economic growth.

These debates reflect a lack of convergence among the approaches to development cooperation taken in Europe, the U.S. and Asia. It may be that there will be no consensus among major aid donors on the key issues of concern to the JLICA. Such a diversity of approaches will create both problems and opportunities for UN agencies and the World Bank.

The issue of children and HIV/AIDS is trying to find a niche in a crowded field. It faces competition for funds and attention. Alex de Waal's paper assesses

each challenge and the politics behind it. It concludes with thoughts on how to frame children and HIV/AIDS as a "hybrid" issue, which combines both the appeal of a single-issue campaign and the complexities of making workable policy, and bridges different sectors and perspectives. While identifying specific agendas for action today, a focus on children and AIDS also allows us to catalyze deeper thinking about the wider challenges of effective policies for development and tackling HIV/AIDS.

The greatest strength of the case for children and AIDS is either humanitarian or human rights. Providing assistance and protection to children affected by HIV and AIDS will save lives and enhance their life chances, and is a means for those children to realize their rights. These children cannot expect economic growth to deliver these benefits. Assisting these children will have beneficial side effects but its central aim is exactly what it claims, helping children who need that help and who are entitled to the outcomes. The costs of inaction are to be located less in the monetary impacts of failing to care for the poorest and most vulnerable members of our societies, than in the failure of humanity that is indicated by an indifference to the plight and rights of these individuals.

One key message from the "political context" study is that we need to attend to constituencies outside the AIDS constituency.

Findings and Considerations

Learning Group 4 seeks to derive both specific and general conclusions from the research activities we have commissioned and from the findings of the other Learning Groups. The findings and considerations in this section must be seen in this light.

Some general considerations include the following:

- poverty is the backdrop;
- inequity by age, gender, geographical origin and economic status marks vulnerabilities;
- it is important to define "family" carefully to avoid misunderstandings;
- the majority of children of concern are aged eleven and older;
- our fundamental rationale is that children have rights;
- migrants fall between the cracks; and
- diversity of circumstances must be acknowledged: different epidemics and different levels of income and government service provision determine different responses.

HIV Prevention

"Break up the boxes" for children. Our research indicates that the various labels and boxes that have been in common usage are useful neither for analytical nor programmatic purposes. Our research confirms the widely-held view that labels such as orphan, OVC, MVC, and even CABA can lead to stigma and discrimination and are not useful for understanding the conditions in which children find themselves. "Just call them children," is a useful admonition—with the reminder that the needs of boys and girls, infants and young children, school-age children and adolescents are very different.

Orphanhood matters for HIV vulnerability. There are data—limited but persuasive—in support of HIV and AIDS having inter-generational impacts. Children orphaned by AIDS are statistically more likely to become infected with HIV in adolescence. However, the explanatory power of orphanhood is low compared to more immediate determinants of vulnerability such as household poverty, low school attendance, early pregnancy, and abuse within the family. The recommendation arising from this is in line with existing best practice, namely that interventions should not be targeted at children by virtue of their having been orphaned by AIDS but on those indicated to be vulnerable on account of poverty, school dropout, family crises, etc.

Prevention among teenage girls must focus on the social and economic context of vulnerability. Our case studies indicate that the preoccupation of the prevention debate on A, B and C is missing the more important point that young people, especially girls, are vulnerable to HIV infection in social, economic and cultural contexts in which they lack power. The powerlessness and vulnerabilities of adolescent girls vary according to the specific contexts in which they find themselves. Structural prevention is the way ahead. The focus of LG4 analysis was on safe livelihoods, safe schools, safe transport to school, safe employment and safe marriage. Migrants who are cut off from networks of family and community support are especially vulnerable.

Measures to strengthen families and communities of residence and networks of membership can all reduce the vulnerabilities of adolescent girls. Institutions such as trade unions, respectful police forces and women's associations also hold out important potential. It is important to work with young men and boys to improve self-image, promote constructive masculinities, increase employment and livelihoods and reduce abusive vigilantism. However it is also essential to be cognizant of the limits of what family and community responses can achieve: they can reduce vulnerabilities but not eliminate them. By definition, the most vulnerable young people are those for whom family and community have failed. The physical protection of the most vulnerable girls is a responsibility of the state and the institution that serves in the front line of engagement with crimes committed against them; namely, police services.

Learning Group 4's research draws a strong link between HIV prevention and physical and social protection of girls. The associated recommendation is to appreciate the links, strengthen the overlaps

and associate the responses between prevention and protection. These measures range from providing safe transport to school to stronger enforcement of legislation against sexual abuse to educating girls that marriage does not necessarily provide protection from HIV and include better case identification, management and referrals between educational, health and other social services.

Learning Group 4's case studies also illustrated the possibility of older children organizing themselves to protect themselves against abuse. Adolescents are not just vulnerable victims—they often have remarkable energy, dedication and capacity to mobilize. Involvement of boys is crucial.

Policy

The combination of policy case studies and comparative quantitative political science analysis allows us to draw important conclusions about how to make policy work, from inception to implementation. Some of the considerations that arise from the empirical findings may appear obvious but it is remarkable how rarely they are followed in practice and in particular in the practice of international institutions.

Simplicity is the first consideration. The policies that are adopted most rapidly and implemented most efficiently and effectively are those which are simple—specifically those that are simple for existing national institutions. Such policies may grow more complicated over time but they should start simple. Simplicity also means that they are amenable to transparency and accountability to the public. Another corollary of simplicity is prioritization. In resource-constrained countries, governments have limited capacity for policy implementation and policymakers face real and repeated dilemmas of prioritizing actions—too often it really is a case of either/or.

Complicated policies include those that require intricate multi-sectoral legislation or coordination or the creation of new institutions or coordinating bodies.

Political sustainability is the second consideration. Policies that are popular are likely to be easier to adopt, implement and hold to high standards. This does not imply that popularity alone should be a determining criterion as some policies (on law and order, on discrimination) that are popular or populist may be undesirable. But policymakers should be attuned to the priorities expressed by the general public. For example, African public opinion surveys regularly find that employment, education and general health are major concerns and HIV/AIDS is low down the list. Case studies show that when governments have adopted policies on such issues, such as universal primary education, they have proved politically sustainable regardless of prior misgivings by international policymakers.
The support of national civil society organizations is also an important factor. A policy that allows space for popular engagement and monitoring—for example district-level scrutiny of budgets and spending—makes for stronger outcomes.

It is important that policies should not overlook invisible and stigmatized groups, including migrants. There is a role for human rights-based legislation that can be enforced through the courts (perhaps on the basis of public interest litigation by civil society organizations [CSOs]) and for designing policies in such a way that they are universal and acclaimed as such as a basis for inclusiveness.

Policies that are not politically sustainable include those that are seen as passing donor fashions demanded from national governments, those that are unduly complex and difficult to explain or scrutinize, and those that are widely regarded as inequitable or distorting national priorities. A policy that seeks a comprehensive multi-sectoral response to a complicated problem is likely to be politically unsustainable because citizens cannot understand much of it and because it is overly ambitious in trying to address social problems that many people do not think should fall within the realm of government activity. For this reason, national policies crafted on the basis of wide-ranging aspirational declarations adopted in multinational fora are unlikely to be politically sustainable. Donors can play a crucial role, not only in providing resources, but in pushing for the right policies at the right time, sensitive to the social and political context of policy initiatives.

AIDS sensitivity is a third consideration. Learning Group 4 took care to define this term precisely based on its analysis of workable and non-workable policies. It refers to a policy that has

a wider social goal (e.g. education, poverty alleviation) but which also addresses problems associated with HIV/AIDS. Social research can illuminate the specific vulnerabilities to and impacts of HIV/AIDS. Policymakers should be aware of these. But social protection and impact mitigation responses that are universal or targeted according to a broader criterion such as poverty are generally the most progressive and cost-effective. Related to this is the finding that AIDS-targeted or AIDS-specific interventions are best-designed and implemented against a backdrop of general service provision.

Policies that are AIDS-exceptionalist, or stove-piped for AIDS alone, are less effective. LG4 members considered the difficulties in rolling out AIDS treatment in the absence of universal health service provision, or providing assistance to children orphaned by AIDS in the absence of general social protection, as illustrations of this.

Process is the key. The process of arriving at a good policy is as important in determining its success as the technical content of the policy itself. The policies that LG4 found to be most successful were those that were initiated nationally, with the support and involvement of civil society and which resonated with popular priorities. LG4 members approved of an approach in which national governments insist on their own development priorities, namely "just saying no" to the dollars offered by those donors that seek to impose their own strategies and goals. Working through national systems is essential. These are the ingredients of that elusive formula, national ownership, at once essential and hard to achieve.

The policy process continues during implementation—monitoring, evaluation, redesign and reform are all part of achieving success. In this regard, LG4 considered that the concept of a learning collaborative as developed by LG3 was an important innovation in policy implementation and improvement—and indeed an idea that could have wider application outside the health sector.

Implicit in this finding is the critique of bad process—identified as that determined by international donors using their finance and political power to leverage the adoption of particular priorities, mechanisms and practices. Best donor policy included sensitivity to national context, needs and ownership.

Costing

The key finding of LG4's work on costing is that there is no simple or "correct" figure of what it costs to respond to the needs of children affected by AIDS. This reflects the multiple difficulties and choices involved in any costing exercise. The following paragraphs deal with each of the main difficulties and choices.

Targeting. The clear consensus across the JLICA is to target social protection policies on the basis of poverty rather than orphanhood. This has the immediate implication that the use of orphan numbers as a proxy for the number of children needing assistance cannot be continued. Targeting on the basis of poverty brings its own difficulties. Poverty-based targeting will be country-specific, with different poverty lines and estimates of resource needs depending on those levels. Different scenarios for the future also lead to different estimates.

Level of service is crucial for estimating costs. A full package of assistance to bring all children up to levels considered acceptable entails a much bigger outlay than a programme that aims simply to move children in the right direction or reach the very poorest. All poverty levels are ultimately

arbitrary and depend upon a range of assumptions and it is de facto normal practice to calibrate costs based upon what is considered feasible rather than objective needs in line with poverty minima.

Linked to this is the question of *provider costs or societal costs*. Most costing exercises are aimed at estimating the budgetary cost to government or aid donor rather than the overall cost borne by all concerned. In a provider costing exercise, services provided by family or community are taken as given and costed as zero. But the invisible costs of unremunerated care and the costs of the unremedied failings of that care should also be taken into account somewhere.

Recognizing what is there already is important. Most of the costs of service provision are already borne, especially when unremunerated care and support at the level of the family and community are taken into account. This dramatically reduces the cost that has to be borne by the service provider. Noting that most costs are already covered in this manner also puts the external assistance in context: it is a relatively minor assistance to an effort that is already underway.

National ownership of goals and strategies for social protection is a fundamental principle affirmed by the JLICA. It follows that external funding should be aligned with national programmes and not vice versa. This makes for lack of standardization across countries and consequently for additional difficulties in calculating costs.

Assessments of affordability comprised an important part of LG4's research and discussions. The preceding considerations all feed into assessments of affordability—there is no simple answer to the basic question of, "how much is enough?" A major factor in estimates of affordability is the question of economic distortions as spending increases. LG4 recognized this problem and also noted that the height of the ceiling depends on how the money is spent. The ceiling is lower for spending on expensive professional expertise and sophisticated equipment and higher for resources allocated directly to households for spending on locally-produced essentials. Tactical and strategic considerations help determine what is affordable, and distinctions need to be made between new and redirected funding.

Any headline figure will be high. While LG4 avoided adopting any headline figure for "the" cost of responding to children affected by AIDS, the considerations of universal AIDS-sensitive programming and social protection for all poor children point to an ambitious agenda of child poverty reduction. This will be expensive, and if policymakers and publics are serious about the goal of meeting the needs and realizing the rights of children and youth, then they must be prepared to face significant budgetary and policy consequences.

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Appendix: Learning Group 4 Reports

Author(s)	Title
Gerard Boyce, Human Sciences Research Council	A review of costing studies for children made vulnerable by HIV and AIDS
Debbie Budlender, Paula Proudlock and Lucy Jamieson, Community Agency for Social Enquiry and Children's Institute, University of Cape Town	Formulating and implementing socio-economic policies for children in the context of HIV/AIDS: South African case study
Lucie Cluver and Don Operario, Department of Social Policy and Social Work, Oxford University	The inter-generational link between the impacts of AIDS on children, and their subsequent vulnerability to HIV infection: A study of the evidence to inform policy on HIV prevention and child and adolescent protection
Alex de Waal, Social Science Research Council	Children and AIDS 2008-09: The political context and challenges
Jerker Edström, Institute of Development Studies, University of Sussex	Social and economic policy and thinking on the protection and support to vulnerable children in an era of HIV and AIDS
Jerker Edström and Andy Sumner, Institute of Development Studies, University of Sussex and Jenne Roberts, an independent consultant, with Choub Sok Chamreun, Khmer HIV/AIDS NGO Alliance	A study of the policy process for children and AIDS in Cambodia: Drivers and obstacles
Stuart Gillespie, International Food Policy Research Institute	Poverty, food insecurity, HIV vulnerability and the impacts of AIDS in sub-Saharan Africa: A brief overview
Kelly Hallman and Jerker Edström, Institute of Development Studies, University of Sussex	Researching the determinants of vulnerability to HIV among adolescents and reflecting on what it might mean for policy
Richard Mabala and Brian Cooksey, Tamasha Vijana and Tanzania Development Research Group	Mapping adolescent vulnerability to HIV in Dar es Salaam
Masuma Mamdani, Francis Omondi, Rakesh Rajani, Valerie Leach, and Zubeida Tumbo Masabo, Research on Poverty Alleviation	A "socio economic" policy case study in Tanzania
Babu Manya, research intern under supervision of Alex de Waal, Social Science Research Council	Current research on children and HIV/AIDS focusing on policy implications

Author(s)	Title
Alastair Roderick, Justice Africa	Preparatory study on the social and political predictors of good policy on children and AIDS
Tara Sinha, Self Employed Women's Association	Placing young women at the centre: Reducing young women's vulnerability to HIV in India
Per Strand, Robert Mattes, and Mary Kinney, Democracy in Africa Research Unit, University of Cape Town	Political determinates of effective interventions for children affected by HIV/AIDS
Chris Desmond, Human Sciences Research Council	Can a developing country support the welfare needs of children affected by AIDS?
Shantayanan Devarajan and Markus Goldstein, The World Bank	Can a developing country support the welfare needs of children affected by AIDS? The case for public action
Valerie Leach, Research on Poverty Alleviation	Can a developing country support the welfare needs of children affected by AIDS? A perspective from Tanzania
Malcolm F. McPherson, Harvard University Kennedy School of Government	Can a developing country support the welfare needs of children affected by AIDS?
Amy Nunn, Global Business Coalition on HIV/AIDS, TB, and Malaria and Francisco Bastos, Oswaldo Cruz Foundation	Can a developing country support the welfare needs of children affected by AIDS? The case of Brazil
Editors Jerker Edström, Masuma Mamdani, and Alex de Waal	IDS Bulletin: Children, AIDS, and Development Policy, Volume 39, Number 5, November 2008