



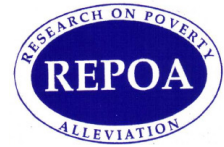
A Paper to Contribute to a Debate for the Joint Learning Initiative on Children and AIDS

**Can a Developing Country Support the Welfare Needs of Children Affected by  
AIDS? A perspective from Tanzania**

15 June 2007

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

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REPOA



Of course, the short answer to this question is yes it can. The real questions concern the extent of support which can and will be provided, including that from the Government budget, and whether “children affected by HIV/AIDS” warrant special support beyond that which would be available for children who are most vulnerable for whatever reason.<sup>1</sup> Moreover, support specifically targeted at children affected by AIDS runs the risk of being stigmatising and discriminatory, even if it were practically feasible.

### **Children affected by AIDS in Tanzania**

The overall rate of infection in adults in Tanzania is 7 per cent – 7.7 per cent among women and 6.3 per cent among men (Tanzania HIV Indicator Survey (THIS), 2003-04), thus overall HIV/AIDS is not as severe an epidemic as in neighbouring countries to the South. Some geographic areas have prevalence rates exceeding 10 per cent – Mbeya (15.2 %), Iringa (13.4 %), Dar es Salaam (12.2 %).<sup>2</sup> Orphanhood is highest in these regions too.

Eleven per cent of the population under 18 are orphaned (Population and Housing Census, 2002) – having lost one or both parents. In a population of 36 million, about 50 per cent of whom are under 18 years of age, this means that about 2 million children have been orphaned. Just over 1 per cent of children have lost both parents. UNAIDS/ WHO project that between 910,000 and 1,200,000 children living in 2005 had been orphaned as a result of HIV/AIDS – about half of the total number of orphaned children.<sup>3</sup>

The THIS also surveyed vulnerable children – children with one or both parents very sick for at least 3 months in the 12 months prior to the survey or children living in a household with no adult 18-59 years of age. Orphans and vulnerable children together were 16 per cent of the child population overall. By age, as with children who are orphaned, OVC are a smaller percentage of the youngest age group and a much larger percentage of older children. OVCs were 7 per cent of the under 5 year olds and 30 per cent of 15 to 17 year olds.

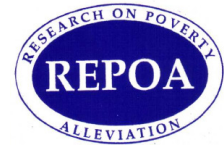
District disaggregation shows 14 districts where more than 14 per cent of children had lost either

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<sup>1</sup> This may be at odds with the JLICA, whose goal “is to protect and fulfill the rights of children affected by HIV/AIDS.” See Terms of Reference for this paper, attached.

<sup>2</sup> Dar es Salaam had the highest rate of refusal for testing among survey respondents, and it may be likely that the rate of infection there is underestimated.

<sup>3</sup> UNAIDS/WHO Epidemiological Fact Sheet on HIV/AIDS and Sexually Transmitted Infections, 2006 Update, for United Republic of Tanzania. This corresponds with other estimates, as discussed below, though UNAIDS/WHO



mother or father were in parts of Kagera and Mara, as well as Iringa and Mbeya<sup>4</sup>. In Makete district in Iringa Region almost one-quarter of all children had been orphaned. Generally the rate of paternal orphanhood is about double that of maternal orphanhood. Overall, the particular geographic areas with higher prevalence of HIV/AIDS are not those with the highest rates of child mortality, neither are they the areas with highest prevalence of poverty.

HIV prevalence is highest in urban areas – 10.9 per cent, compared with 5.3 per cent among rural adults – and among adults in the least poor quintile – infection rates vary from 3.4 per cent in the poorest quintile to 10.5 per cent in the least poor quintile.

People in urban areas have much easier access to services and support than those in rural areas. The THIS 2003-04 reported the percentage of orphans and vulnerable children in households having received support in the 12 months preceding the survey. Eight per cent of urban children and three to five per cent of rural children got medical, emotional, or material support from sources other than family or friends. The series of demographic and health surveys conducted in Tanzania over the 1990s and most recently in 2004, similarly, report higher access to health services among urban households than rural, lower rates of child mortality and malnutrition in urban and in least poor households. The most recent household budget survey, 2000-01 also shows a much lower rate of household income poverty in urban households, especially in Dar es Salaam, than in rural households, and that the reduction in income poverty over the 1990s was essentially confined to urban households, especially those in Dar es Salaam.

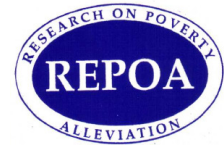
The case for general support for children affected by HIV from the national budget is therefore difficult to make – to the extent that orphanhood is a proxy for children affected by HIV, they are generally no worse off, may indeed be in households that are generally less poor than others. The majority of them are school-age and they are as well educated as other children.

More specific data are needed to identify particularly vulnerable children, to illustrate the particular toll of HIV/AIDS and orphanhood on individual children and the extent to which they need support.

In a study of orphanhood in Kagera, started in 1991-1994 at a time when Kagera was considered the epicentre of HIV/AIDS in Tanzania, children who were not orphaned at that time were followed up

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project more maternal orphans than paternal; orphans, which is contrary to census and survey data from Tanzania.



again in 2004. By then, 23 per cent of them had lost one or both parents before they reached the age of 15 years. Maternal orphans were more likely to be stunted and lose years of education. Paternal orphans, more common than maternal orphans, were less affected. Older children and those already in school were less likely to suffer from these adverse nutritional and educational outcomes than children who had been orphaned at a younger age and who had not yet started school.<sup>5</sup>

Research undertaken by the National Institute for Medical Research (NIMR), Mwanza Centre compared the circumstances of orphaned and other children and their care providers. The researchers found that across most indicators orphans appear to be more vulnerable than children in nuclear families, and that foster children are relatively less vulnerable to disadvantage than orphans but show evidence of reduced wellbeing across most indicators compared to children in nuclear families. Certain subgroups of orphans are more vulnerable than others, their sex and age, the sex of the deceased parent and the sex and age of the principal caregiver are determining factors. Nonetheless, the researchers note that the level of relative disadvantage of orphans and foster children is slight compared to the level of need of all children.<sup>6</sup>

A study of orphans in Bukoba, Kagera, and in Makete showed that their experience was quite different. In Bukoba Rural district, a wealth of community organisations provides various forms of social insurance that help to mitigate the adverse impacts of HIV/AIDS on households. Existing data from a large number of surveys undertaken in Kagera region from the 1980s onwards indicate that the epidemic initially affected better off (more mobile, more affluent, and larger) households, and that the measurement of the social and economic impacts of HIV/AIDS is complicated by the fact that some urban people 'go home' to die, so that their final illness and death are registered in their host household rather than their own household. Partly for these reasons, affected households in Bukoba Rural often have more assets and higher income and are larger than non-affected households.

In Makete, the socio-economic impacts of HIV/AIDS seemed to be found in both the least poor 20 per cent and the poorest 20 per cent of households. The household survey in Makete distinguished

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<sup>4</sup> The districts, with the percentage of children orphaned in brackets, are: Makete (24.2), Kyela (19.4), Iringa Urban (18.7), Bukoba Rural (18.2), Rungwe (17.4), Bukoba Urban (16.3), Mbeya Urban (16.2), Mufindi (15.8), Serengeti (15.5), Iringa Rural (15.0), Tarime (14.9), Njombe (14.3), Ludewa (14.2), Muleba (14.1)

<sup>5</sup> Beegle, K, J De Weerd and S. Dercon, "Orphanhood and the long-run impact on children," September 2005



between households affected by adult morbidity and mortality since 2000 (a proxy indicator for HIV/AIDS, n=124) and those not affected (n=162). There was an appreciable difference in livelihoods between affected and non-affected households. While both non-affected and affected households were highly reliant on farming, the affected households were also more reliant on gifts and food, selling of labour for food with the small number of child workers exclusively found among these affected households. In the more extreme cases they tended to re-locate household members. This would seem to imply that the rural affected households are adopting 'coping strategies' that leave them more vulnerable.

There were also differences between households fostering orphans and those not. Fostering households were poorer. Orphan fostering households were disproportionately represented in the poorest quintile of the population, few of them in the least poor quintile. They were eating fewer meals per day. Two thirds of all fostering homes were female headed. The combination of fostering an orphan and suffering adult morbidity or mortality showed starker differences. All the major responses to stress, including diversion of adult labour, loss of income, assets and food, were heightened in this group.

This study underscores the importance of understanding local and circumstantial factors which determine the extent to which communities, households, children will be affected by HIV. The findings from Tanzania are mirrored in the more general assessment provided by Maia Green.

Poverty limits the capacities of families and individuals to care for household members. Differentials between orphan children and other children are less significant than those between poor and non poor households (Ainsworth & Filmer 2002: 19). Where kinship bonds are strong and 'where families had adequate resources' orphan children do not necessarily fare worse than non-orphans (Madhavan 2004: 1445, my emphasis), nor are their development outcomes very different (Ainsworth & Filmer 2003: 19). The poverty of the household in which a child resides had greater impact on educational participation than orphan status (Ainsworth & Filmer 2002: 19), but double orphans fare worse than other children, across all households (Case 2004: 500).<sup>7</sup>

### **Most Vulnerable Children**

Poverty is pervasive in Tanzania, with over a third of households living below a basic needs poverty

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<sup>6</sup> "Operational Research to Compare the Circumstances of Orphan and Non-orphan Children and their Care Providers in Mwanza, Tanzania", The National Institute for Medical Research (NIMR), Mwanza Centre, for UNICEF Tanzania

<sup>7</sup> Green, M. "Strengthening National Responses to Children Affected by HIV/AIDS: What Is the Role of the State and Social Welfare in Africa?" background paper prepared for UNICEF for Wilton Park Conference Nov 14th - 16th 2005.



line, set in 2000/01 at TShs 259 per adult equivalent per day, even in purchasing power parity terms well below \$1 per day. Nearly 20 per cent live below the even lower food poverty line. This implies that such households do not command income sufficient even to provide enough food to satisfy their basic minimum nutritional requirements, with consequences for physical and mental development, economic and social wellbeing. Many children are therefore clearly affected by this generalised insecurity.

Estimates of the numbers of most vulnerable children – orphaned children living in poor living conditions – have been generated using population census data and projected to 2006.

### Estimated Number of Children by Different Vulnerability Criteria, 2006

Vulnerability criteria	0-6 years	7-14 years	15-17 years	Total
Number of poor children	3,126,362	2,645,657	841,304	6,613,324
Number of children in child headed household	39,910	62,282	72,008	174,201
Number of children in elderly headed household	69,445	163,671	59,765	292,882
Number of double orphaned children	24,820	110,085	70,579	205,484
Number of maternal orphaned children <sup>a</sup>	79,723	216,980	115,420	412,123
Number of paternal orphaned children <sup>a</sup>	257,779	591,556	291,920	1,141,255
<i>Total number of orphans</i>	<i>362,322</i>	<i>918,621</i>	<i>477,919</i>	<i>1,758,862</i>
Number of disabled children	56,977	99,277	37,729	193,982
Most vulnerable <sup>b</sup>	181,689	481,439	265,815	928,944

Source: Lindeboom, et al., 2007 using Tanzania National Projections, 2006 and PHDR, 2005

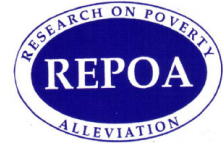
Notes: <sup>a</sup> Children with at least one parent alive

<sup>b</sup> Composite of the following vulnerability criteria:

- children living in child headed households
- children living in elderly headed households with no adult 20-59 years present
- children with both parents deceased
- in rural areas: children with one surviving parent living in a house with very poor quality roofing (grass and/or mud) and or children with a disability living in similarly poor conditions
- in urban areas: children with one surviving parent living in a house with very poor quality roofing (grass and/or mud) or with very poor wall materials or without toilet facility and children with a disability living in similar very poor conditions

The resulting estimate is 929,000 in total, 736,000 in rural areas and over 193,000 in urban areas. This is 5 percent of the child population. Note that this is not necessarily all AIDS orphans, since some of them will live in less poor households, nor is it even a majority of all the children who are very poor. It results from the combination of loss of close adult support and poverty.

There are geographic concentrations: of the 20 districts where the percentage of such children



exceeds 7 per cent of all children in the district, 4 districts are in Dodoma, all 4 districts in Singida, 2 in Iringa and 2 in Mbeya.

### **Estimating a Level of Support for Most Vulnerable Children**

The level of support which might be provided to the most vulnerable children has been estimated. The direct support costs per child are estimated to be the amount of money which would be needed to raise the average per child expenditure of the poorest children (those living in households with expenditures more than 30 per cent below the poverty line) to the average level of expenditures on children living at about the national poverty level. Since about 40 per cent of the child population live at or below this level, it is unlikely that a national programme could finance support for vulnerable children above this level, and to do so would imply support for the most vulnerable at levels above the norm for most children in their communities.

The analysis shows that the gap in expenditure for food is by far the largest element of cost. In 2006, the cost of bridging the expenditure gap for the 930,000 children considered to be most vulnerable would be TShs 37.8 billion (US \$31.5 million). Of this amount, TShs 30.7 billion is needed for food, TShs 7.1 billion for non-food items. With administrative costs at 15 per cent, the total annual cost would be TShs. 43.5 billion - \$36.2 million. The costs of establishing systems of identifying and providing support for most vulnerable children through local authorities and partner organisations are estimated to be an average of about TShs 50 million per district, a total for national coverage of about TShs 6 billion (US \$4.7 million).<sup>8</sup>

The total Government budget in 2006/07 was TShs 4,851 billion. These estimated annual costs for support of most vulnerable children are less than 1 per cent of this. The estimated budget for HIV/AIDS in 2006/07 was TShs 390.3 billion. The estimated annual cost for support of most vulnerable children is 11 per cent of this.

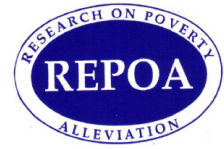
### **Integrating support for the most vulnerable children**

These costs are certainly affordable, and from the Government budget, though reallocations and changes in management practices will clearly be needed.

There are issues related to the high proportion of expenditures on HIV/AIDS programmes which are externally funded and the manner in which these programmes are managed. External financing

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<sup>8</sup> Lindeboom, W., R. Mhamba, B. Kilama and V. Leach, "Towards Revising the Costed National MVC



accounts for close to 90 per cent of total public expenditures on HIV/AIDS.<sup>9</sup> The US President's Emergency Plan for AIDS Relief (PEPFAR) alone accounts for 59 per cent of public spending on HIV/AIDS. It is "off-budget" and managed through non-governmental organisations.

Existing programmes of support for most vulnerable children are now co-ordinated through the Ministry of Health and Social Welfare and an implementing partners group. Most of the partners are non-governmental organisations, many of them with funds from PEPFAR and Global Funds against HIV/AIDS, tuberculosis and malaria. Most follow guidelines issued by the Department for Social Welfare for community-based programming. Though the largest gap in expenditures for most vulnerable children is for food, many of the programmes now in place are providing support to individual most vulnerable children for non-food items and at costs which far exceed the expenditures of households for other children. Where food stuffs are provided, they tend to be provided directly, incurring high transport costs. Moreover the number of children currently being provided support is in the tens of thousands, not close to the million who are most in need of support.

Funding through PEPFAR, the Global Fund, the World Bank's Multi-sectoral AIDS Project's Community HIV/AIDS Community Response Fund (CHRF) and Tanzania Social Action Fund's Village Funds which is available for support for most vulnerable children would cover most of the costs of a programme of support such as that costed above. If cash were to be made available for local purchase of locally produced food, the costs of providing food for vulnerable children might also be reduced compared to unit costing in the WFP programme. Modest assumptions may be made about contributions of communities to care for their most vulnerable children – examples of community farms in Makete are noteworthy, where produce is given to most vulnerable children. With these assumptions, the annual costs of modest support for close to one million children are within existing resourcing.

Questions of national government responsibilities, funding and local management still need to be addressed, and there are useful recommendations from the recent HIV/AIDS public expenditure review:

- i. Increase priority to prevention, and to the district and community response;
- ii. Make longer term and more predictable aid commitments;

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Programme," Report for the Ministry of Health and Social Welfare, Dar es Salaam, February 2007.

<sup>9</sup> Foster, M., and Smyth, R. "Tanzania Public Expenditure Review Multi-Sectoral Review: HIV/AIDS," Report prepared by on behalf of HIV/AIDS PER Working Group, TACAIDS, Ministry of Finance and Government of Tanzania, March 2007.



iii. Launch budget support for HIV/AIDS, including allocation of funds to local government authorities through the budget, based on objective criteria.

The analysis reported above provides the basis for such allocation.

### **Most Vulnerable Children in the Bigger Picture**

The calculations above do not cover some of the welfare needs of the most vulnerable children. In the particular cases of health care and education, the estimates incorporate the average expenditures of households living close to the poverty line. The additional costs of ensuring access to health care and full participation in education of the most vulnerable children have not been included. Compared to current government budgets for health and education, these additional costs are low.

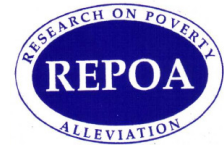
In education, while government policy is to have children enrolled in primary school at 7 years of age, most children are enrolled at an older age. Gross attendance rates in primary school of children in the poorest quintile of households are 82 percent, compared with 116 per cent of children in the least poor quintiles.<sup>10</sup> Enrolment rates of poor vulnerable children are slightly lower than those of other children, with greater differences among urban vulnerable children.<sup>11</sup> The marginal costs to the government budget of increasing school attendance of the poorest, most vulnerable children are modest. Reforms in funding primary education allow for capitation grants based on school-age population, not the numbers of children enrolled. With more equitable support for the most vulnerable children and locally-based structures of support for those most in need, their school attendance is more likely to be encouraged.

Access to basic preventive health services for young children is high – 75 per cent of children in the poorest quintile have been immunised with a third dose of DPT-Hb3 vaccine, as have 90 per cent of less poor children. These services are provided without charge. The costs of curative services, in spite of policies which provide for exemptions and waivers, distance to health facilities and costs of travel and waiting times are such that poorer and rural households are less likely to use health facilities. The difference shows up most starkly in births taking place in health facilities, where the DHS in 2004-05 report that 81 per cent of urban women delivered their babies in a health facility and only 39 per cent of rural women did so. Health financing, shortages, geographic allocations and

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<sup>10</sup> National Bureau of Statistics and ORC Macro, Tanzania Demographic and Health Survey 2004-2005, December 2005

<sup>11</sup> Calculations by W. Lindeboom for Lindeboom et. al. 2007



low productivity of health personnel are larger chronic issues confronting health services. HIV/AIDS exacerbates them.

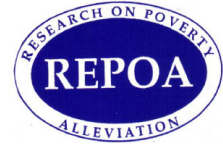
The children who are most directly affected by HIV/AIDS are those infected with the virus. In common with most other countries, Tanzania has been slow in rolling out universal access to prevention of mother-to-child transmission and to paediatric anti-retrovirals. UNAIDS/WHO estimates that there are between 21,000 and 64,000 children in need of anti-retroviral therapy, and between 100,000 and 320,000 in need of the inexpensive cotrimoxazole. In 2005, only 6 per cent of HIV-infected pregnant women received ARVs for the prevention of mother-to-child transmission.<sup>12</sup> More attention is being paid to these concerns and external financing increasingly available to address them. The larger issues of the health infrastructure and staffing remain of great concern. Here again, external financing is supporting improvements, including through a new World Bank programme of support for strengthening health systems.<sup>13</sup>

Within this larger picture, it is not the financing and affordability of the support which is needed by most vulnerable children which is the main concern. This concern is much more the marginalisation of children generally and poor children in particular in the political economy of Tanzania. Attention is being paid to specific sectoral developments in education and health. Beyond that, there is no strong coherent perspective of the rights of children and state obligations, nor firm direction towards their realisation. Tanzania will continue to need external support in discharging these obligations, and especially for HIV/AIDS, ensuring access to appropriate preventive and curative care. The effective management of such support and the equitable allocation of all public resources require strong national management and structures. And a stronger profile for children and role of social assistance/protection in development strategy is needed.

This is a tall order. There are many competing demands and the role of children as citizens is underplayed. But the consequences of not supporting the welfare needs of the most vulnerable children in Tanzania are continuing high rates of mortality and malnutrition, large numbers of children growing up in destitution, economic losses far in excess of the modest expenditures needed to provide support for the most vulnerable children now.

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<sup>12</sup> UNAIDS/WHO, Epidemiological Fact Sheet for United Republic of Tanzania, 2006 Update.



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<sup>13</sup> "Healthy Development ," The World Bank Strategy for HNP Results, April 24, 2007



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## **Annex A. Terms of Reference**

JLICA LG4 debate tor 160507

Joint Learning Initiative on Children and AIDS

Learning Group 4: Social and Economic Policies

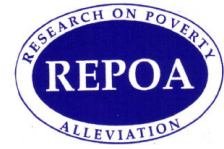
### **Debate:**

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

##### **Background and Justification**

The Joint Learning Initiative on Children and HIV/AIDS (JLICA) engages practitioners, policymakers, and scholars in collaborative problem-solving, research, and analysis to address the needs of children living in the context of HIV/AIDS. Its goal is to protect and fulfill the rights of children affected by HIV/AIDS by mobilizing the scientific evidence base and producing actionable recommendations for policy and practice. The substantive work of the JLICA is conducted through four learning groups, concerned with the family, community action, access to services and social and economic policies. Learning Group 4 will examine options at the level of social policy, including how universal access to AIDS treatment can be combined with integrated health and welfare programs to address other dimensions of children's well-being.

It is very likely that the major recommendations of the JLICA will include additional resources from national budgets and international aid funds to be targeted to meet the needs of children affected by AIDS, including welfare needs, health and education. Yet such resources cannot be mobilized or spent in a vacuum. The numbers of children affected by AIDS are sufficiently large, and their needs so far-ranging, that the resources required for low-income countries could represent a significant increase on existing social sector spending. This could entail a major reorientation of national budgets. Decades of experience of aid indicates that large inflows of resources can have adverse



side effects on both national economies and political systems. These issues need to be addressed by the JLICA's Learning Group 4.

Rather than commissioning a review of the evidence, members of Learning Group 4 decided that it would be more productive to ask eminent economists and policymakers with different and contrasting perspectives to contribute to a debate. This debate would be conducted initially online through an exchange of essays and commentaries, and could later be transferred to a live forum.

### **Question**

The central question of this debate is:

*“Can a developing country support the welfare needs of children affected by AIDS?”*

The definition of children affected by AIDS includes those who are living with HIV or AIDS, those in a family with a member who is living with HIV or AIDS, and also children affected by the strains that AIDS places on communities and services. In countries with high-prevalence generalized epidemics of HIV/AIDS, this is the majority of the nation's children.

The needs for these children include primary health care, education and social welfare. In populations with high-prevalence generalized epidemics of HIV/AIDS, this means establishing universal provision of services. Elsewhere the target group is smaller.

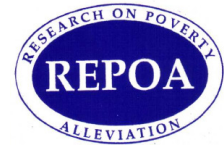
In turn, this question leads us to a series of critical secondary questions. These include, in what ways should a country severely impacted by HIV/AIDS, with a large additional welfare burden for affected children, adjust its macroeconomic policies to account for this new reality? What are the macroeconomic implications of failing to address the needs of children affected by HIV and AIDS—i.e. can a developing country afford not to support the welfare needs of these children?

The scope of the question is broad. However, it is not so broad as to encompass all forms of aid and expenditure on welfare and services. The debate should retain a focus on children affected by AIDS. Contributions to the debate should be based on rigorous review of the evidence including original research and analysis where necessary. For this reason the honorarium reflects a level of payment reflective of an original paper.

### **Contributors**

The debate will have four primary contributors.

Two of the opening essays will be contributed by eminent economists with contrasting views on the



central question. One view will be that developing countries can—indeed must—make the necessary investment in child welfare. Another view is that a significant increase in governmental spending on welfare will distort national economies, cause inflation and decrease investment in the productive sector, and therefore will undermine the prospects for medium- and long-term economic growth, which is the only engine for poverty reduction and an increase in welfare.

The additional two opening essays will provide a viewpoint from a developing country, especially taking into account the concerns of governmental policymakers who are struggling to reconcile the needs of the target population, the demands of national leaders and donors, and the constraints on resources. One of these will be the experience of Tanzania, which in recent years has tried to develop comprehensive national plans for poverty reduction, welfare, growth and tackling HIV/AIDS. It has done so in a manner that tries to be rounded without distorting national priorities. Another experience is that of Brazil, which has launched and implemented HIV/AIDS policies targeting children based on national resources and national priorities without deferring to international donors.

In stage two of the debate, other (unremunerated) contributions will be solicited and the debate will welcome unsolicited contributions as well.

### **Format**

The debate will begin with four essays of approximately 3,000 words each. These essays will be sent to the co-chairs of JLICA Learning Group 4, who may make minor editorial suggestions.

Contributors may also want to attach annexes or reference other papers.

When the first round of essays has been received, each of the contributors will be asked to provide a commentary of approximately 1,500 words on the views expressed by the others.

At this point the essays and commentaries will be posted on an online webforum. Additional commentaries and inputs will be solicited from academics, policymakers and practitioners, which will also be posted on the webforum. At a later stage in the debate, estimated to be four-to-six months after the discussion has gone online, the original four contributors will be asked to contribute an additional commentary.

In addition, the JLICA will try to organize a panel in which the contributors can debate the issues in front of an audience.