

GUIDANCE NOTE | 2011

HIV and Social Protection Guidance Note

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HIV and Social Protection Guidance Note

Social protection can help mitigate the significant social and economic impacts of HIV on households and individuals, provided that programmes are responsive to the particular needs of people living with and affected by HIV.

Social protection can help address the multiple social determinants of the epidemic – income inequalities, gender inequalities, social exclusion – and thus contribute to a reduction in new infections.

Social protection can help address demand side barriers to access HIV services with potential to improve prevention, treatment and care and support outcomes.

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Background

UNAIDS has identified social protection as a strategic priority in the global HIV response because of its importance in addressing the drivers of the epidemic as well as helping to mitigate its impacts on communities, households and individuals. Moreover, according to the UNAIDS Investment Framework, investments in social protection are necessary to achieving the vision of zero new HIV infections, zero discrimination and zero AIDS-related deaths. There is growing global and national commitment to social protection in low- and middle-income countries, in part in response to HIV. It is now time for HIV experts to work more closely with social protection experts to ensure that national social protection strategies are responsive to individuals and families living with and affected by HIV – in short, that it is ‘HIV-sensitive social protection’.

This guidance note summarises information on HIV-sensitive social protection, sets out key principles to provide a strong foundation for programming, and describes the potential of social protection to advance HIV prevention, treatment, care and support outcomes. This brief also presents case studies illustrating how HIV-sensitive social protection is working on the ground. The audience is HIV policy-makers and programmers at global, regional, and country levels. It builds on the UNAIDS Business Case on Enhancing Social Protection,¹ a UNAIDS/UNICEF/IDS report of the evidence on HIV-sensitive social protection,² and regional consultations with HIV and social protection specialists.³

1. What is Social Protection and how is it Relevant to HIV?

Social protection has been defined as “*all public and private initiatives that provide income or consumption transfers to the poor, protect the vulnerable against livelihood risks, and enhance the social status and rights of the marginalised; with the overall objective of reducing the economic and social vulnerability of poor, vulnerable and marginalized groups.*”⁴ Social protection can help reduce disadvantages and inequalities that make people susceptible to HIV infection, help overcome barriers to access to treatment, and mitigate the impact of HIV on household poverty and social exclusion.

Much is known about the factors that make households and communities more or less resilient to the impacts of the epidemic. Poverty can make households less able to cope with growing health costs and declining incomes caused by a chronic illness; children without parental care – including many children orphaned by AIDS – have worse developmental outcomes than those with parental care. AIDS reduces household incomes^{5,6} agricultural

¹ UNAIDS. 2010. Expanded Business Case: Enhancing Social Protection.

² Temin, M. 2010. HIV-Sensitive Social Protection: What Does the Evidence Say? UNAIDS, UNICEF, IDS.

³ Regional meetings were organized by UNAIDS co-sponsors in 2011 in Cambodia and South Africa which have informed this paper.

⁴ Devereux & Sabates-Wheeler, 2004, Transformative Social Protection, IDS.

⁵ Bachmann, M. and Booysen, F. 2003. Health and economic impact of HIV/AIDS on South African households: a cohort study. *BMC Public Health* 2003, 3:14. Fox, M. et al. 2004. The Impact of HIV/AIDS on Labour Productivity in Kenya. *Trop Med and International Health*, 9:3, 318–24.

⁶ A recent HIV impact study in Cambodia details the ways that HIV affects household economies: an HIV-affected household in Cambodia is 23% more likely to be poor than a non-affected one, even when controlling for household head education level, urban/rural residence, and other variables. National AIDS Authority and UN. 2010. The Socioeconomic Impact of HIV at the Household Level in Cambodia.

output,⁷ and educational opportunity,⁸ increases absenteeism from work, and perpetuates inter-generational poverty.

Social protection can significantly reduce HIV-related vulnerability and is a critical enabler for successful HIV prevention and treatment outcomes. Although much of the interest in social protection has been as a result of the success of cash and other social transfers (food, vouchers, etc.), comprehensive social protection in the context of HIV encompasses both economic assistance and approaches to tackle inequality and social exclusion. Social protection is particularly relevant to HIV because of its ability to address issues such as gender inequality, HIV-related stigma, and discrimination that exacerbate the marginalisation and vulnerability faced by key populations at high risk of infection. The evidence also suggests another important potential of social protection: to interrupt the cycle from being AIDS-affected to becoming HIV-infected.

Social protection is HIV sensitive when it is inclusive of people who are either at risk of HIV infection or susceptible to the consequences of HIV. HIV-sensitive social protection can be grouped into three broad categories of interventions:

- ▶ *financial protection* through predictable transfers of cash, food, or other transfers for those affected by HIV and those who are most vulnerable;
- ▶ *programmes that support access to affordable quality services*, including treatment, health, and education services through for example social health insurance and school fees exemption;
- ▶ *policies, legislation and regulation* to meet the needs and uphold the rights of the most vulnerable and excluded.

2. Key Principles of HIV-Sensitive Social Protection

A set of guiding principles has emerged from country experience with social protection. Adhering to these will help maximise social protection's potential for Universal Access.

- ▶ *Rights-based approaches*: HIV sensitive social protection plans and programmes must be rooted in the principles of rights-based programming, which include being **equitable, inclusive, non-stigmatising** and **non-discriminatory**. It also means ensuring that they promote the **best interests** of the target population, are **age and gender-sensitive**, and include the **right to participation** by people living with HIV, HIV-affected children, and excluded and other affected populations in programme design, implementation, and monitoring. In the world of work, there should be no discrimination or stigmatisation of workers based on real or perceived HIV status.⁹
- ▶ *HIV-sensitive rather than HIV-exclusive approaches*: HIV-sensitive social protection means **not exclusively targeting people affected by HIV**. With an HIV-sensitive approach, people living with HIV and other vulnerable populations are served together so as to not exclude equally needy groups. For example there is evidence on targeting vulnerable children in the context of HIV which has led to a shift away from focusing

⁷ Gillespie, S. and Kadiyala, S. 2005. HIV/AIDS and Food and Nutrition Security: From Evidence to Action, IFPRI.

⁸ Steinberg, M. et al. 2002. Hitting Home: How households cope with the impact of the HIV/AIDS epidemic, a survey of households affected by HIV/AIDS in South Africa. Henry J. Kaiser Family Foundation, Health Systems Trust. Birdsall, N. and Hamoudi, A. 2004. AIDS and the Accumulation and Utilization of Human Capital in Africa in the Macroeconomics of AIDS, IMF.

⁹ ILO. 2010. Recommendation concerning HIV in the World of Work, Section III. General Principles, paragraph 3.

on orphans exclusively, to looking at broader dimensions of vulnerability including poverty levels and children in households without parental care.¹⁰ The Malawi case study below demonstrates how HIV-sensitive inclusion criteria helped to ensure the targeting of cash transfers to reach households most in need, including those affected by HIV.

- ▶ *Comprehensive social protection:* HIV-sensitive social protection is not just focused on transfers but addresses wider issues of **social exclusion**. A comprehensive approach to social protection includes a range of measures for both programming and policy, including broad legal reforms to protect the rights of people living with HIV and vulnerable groups and complementary economic empowerment initiatives (e.g., savings, asset building, income generation, employment creation). It also includes building **linkages and referrals** to maximise the impact of investments in different sectors, for example, linking care and support with health facilities to improve health outcomes. The India case study below highlights the successes in extending national social protection programming to exclude groups affected by HIV, while the Botswana case study provides an example of social protection for HIV-affected children that goes beyond cash.
- ▶ *Beneficiary context and vulnerabilities, capacities, and behaviours:* HIV sensitive social protection needs to respond to barriers to accessing services or achieving HIV-related outcomes. **Vulnerabilities** describe how exposure to certain socio-economic or environmental risks increases the probability of negative outcomes. **Capacities** relate to the resources that households can mobilise to meet current and future needs. In the absence of treatment, HIV can substantially reduce the availability of labour and assets within a household, making participation in productive activities challenging. For the most severely labour constrained households social transfers may be appropriate responses. However as the Uganda case study shows, where labour is less constrained many poor PLHIV can and are successfully engaging in productive livelihood activities.
- ▶ *Aid effectiveness:* Many HIV-sensitive social protection programmes have been developed as pilots and are small scale and fragmented. Scaling up social protection requires adhering to agreed principles of aid effectiveness. These include **national ownership** and working within existing social protection frameworks; building in measures to promote **sustainability**, including long-term financing; and expanding **coverage** as countries move from pilots to national programmes within coordinated government-owned plans.
- ▶ *Systems strengthening:* Nationally-led social protection programmes rely on **systems strengthening** (health, social welfare, and community systems) in countries where capacity, delivery systems, and commitment by government and civil society are weak. Improving the effectiveness and coverage of social protection relies on attention to improving legislation and policy frameworks to ensure that programmes include vulnerable HIV affected populations, investing human resources, effective institutional arrangements to ensure co-ordination among sectors, monitoring and information systems for assessing performance and coverage.

¹⁰ Though it also recognises that there are scenarios where HIV-specific approaches make sense, for example food by prescription approaches for malnourished people living with HIV.

3. Social Protection and Universal Access Outcomes

In 2011 at the General Assembly High Level Meeting on AIDS countries emphatically pledged to work towards UNAIDS vision of zero new HIV infections, zero discrimination and zero AIDS-related deaths. The *Political Declaration on AIDS* not only recommits the global community to achieve universal access to HIV prevention, treatment, care and support by 2015, it also establishes a set of global targets, transforming the principle of universal access from an aspirational goal into concrete and measurable objectives. HIV-sensitive social protection is needed to help meet these targets. In order to do this most effectively, HIV-sensitive social protection strategies and programming should be fully integrated within national and international policies. Prominent amongst international policy initiatives is the UN's Social Protection Floor Initiative.¹¹ At national level, it is essential to build on the many government-led broad-based anti-poverty initiatives, including supporting a significant role for civil society organisations in programme development and implementation.

Linking social protection & Universal Access: Indicative instruments & populations¹²

	HIV Prevention for those most vulnerable to HIV infection	Treatment for people living with HIV	Care & Support for people living with and affected by HIV
Financial protection <i>Social assistance</i> protection for very poor	Cash and food transfers for the very poor to increase household resilience and reduce risky coping mechanisms	Transfers to poor PLHIV for better HIV treatment access & adherence	Transfers to mitigate the impact of AIDS on individuals & households
<i>Livelihoods support</i> for poor and vulnerable	Income generation or micro-credit to reduce HIV risk for poor key population groups	Economic empowerment for PLHA to prolong & improve life	Income generating activities, livelihoods strengthening, micro-finance for affected
Access to affordable quality services <i>E.g., Social Health Protection</i> for vulnerable	Social insurance to prevent HIV risk (social security, public finance of RH, MH & HIV prevention services etc.)	Social health protection to ensure access to health care & to prevent erosion of savings	Preventive insurance measures appropriate for those affected (pension schemes, funeral clubs etc.)
Laws, policy, regulation <i>Social justice</i> for the marginalised	Legal reform, policy process, and protection regulation to reduce HIV risk (decriminalisation)	Protection of rights to health, treatment and work to improve life for people living with HIV (anti-discrimination)	Legal protection for affected (widow's and orphans' property rights, birth registration etc.)

Social protection and HIV prevention: Sexual transmission

Inequality fuels susceptibility to HIV infection; poverty also plays a role although the links between HIV, poverty, and inequality are complex and multi-directional.¹³ Of particular concern is how gender inequality disproportionately places adolescent girls and young women at risk, especially in the highest prevalence contexts. Social protection can reduce HIV risk borne out of economic and gender inequality by reducing income disparities and

¹¹ Adopted in 2009 and reinforced at the 2010 UN MDG Summit.

¹² Adapted from Temin, M. 2010. HIV-Sensitive Social Protection: What Does the Evidence Say? UNAIDS, UNICEF, IDS.

¹³ Piot, P. et al. 2007. Squaring the Circle: AIDS, Poverty, and Human Development. PLoS Med 4(10): e314.

providing girls and women with more equitable access to economic assets and resources. For example, a study in Zomba, Malawi, described below, shows the potential of cash transfers in particular for reducing HIV risk in adolescent girls as part of a range of benefits including delayed marriage and sexual debut.

The Zomba Cash Transfer Experiment for Adolescent Girls

One of the few experiments to assess the benefits of cash transfers for adolescent girls substantially increased school attendance among beneficiaries, who were currently enrolled in school or had dropped out at baseline. The intervention also led to a significant decline in early marriage, pregnancy, and self-reported sexual activity among beneficiaries in both the conditional and non-conditional arms. Critically, preliminary findings indicate that HIV prevalence among “baseline schoolgirls” (beneficiaries who were enrolled in school at baseline) was 60% lower than HIV prevalence amongst the control group following the intervention, although there was no HIV effect among the “baseline dropouts” (girls who returned to school as a result of receiving cash transfers). Researchers found that the sexually active beneficiaries reduced their risky behaviour; they did not cease having sex, but rather with the cash in hand from the transfer, moved away from older partners to peer partners, who were less likely to be HIV-positive. The authors are currently investigating the relative roles of additional income and increased schooling leading to the large HIV effect.

Baird S., et al. ‘Cash or Condition? Evidence from a randomized cash transfer program’, World Bank Policy Research Working Paper No. 5259, Washington D.C., 2010. Ozler, B. presentation, IDS, UNICEF and UNAIDS Meeting on the Evidence for HIV-Sensitive Social Protection. June, 2010, Brighton, UK.

Other types of structural factors make people vulnerable to sexual transmission. Exclusion, harassment, and stigma due to social standing (e.g., sex workers, men who have sex with men, people who use drugs), minority ethnic background, or migrant status can increase risk by keeping people away from services such as VCT, STI treatment, and condom distribution.¹⁴ Social protection in the form of policies, legislation, and regulation can address the factors that keep people at high risk of infection away from essential protective services. It can facilitate the realisation of their social and legal rights and reduce stigma and discrimination, as well as protecting inheritance rights—all of which contribute directly or indirectly to prevention. For example, the comprehensive public health programme in Sonagachi India illustrates the power of sex worker collectives, public health and livelihoods programmes increasing condom use and reducing STI prevalence.¹⁵

The impacts of HIV on households can influence behaviours that may make people susceptible to infection. Some members of HIV-affected households are vulnerable because of the loss of a breadwinner or withdrawal from school, which deprives children of the protective benefits of schooling and the potential to acquire life skills that can protect them from HIV in later years. Social protection in the form of financial assistance, including social transfers and free schooling, can help mitigate the household level impact of HIV by reducing poverty. This in turn can support prevention efforts by keeping children in school and keeping individuals from resorting to coping strategies that may make them susceptible to infection. This is especially important for adolescent girls, whose underlying vulnerability is exacerbated by being orphaned. Combining financial assistance with employment and livelihood assistance can improve programme sustainability.

¹⁴ E.g., UNICEF. 2010. Blame and Banishment: The underground HIV epidemic affecting children in Eastern Europe and Central Asia.

¹⁵ Jana, S. et al. 2004. The Sonagachi Project: A Sustainable Community Intervention Program. AIDS Education and Prevention: Vol. 16, No. 5, pp. 405-414.

Ongoing studies are further exploring the possible intersection between social protection and HIV prevention by studying the role of cash incentives in encouraging VCT and protected sex. If proven, this could become another way for social protection approaches to boost prevention efforts.

Social protection and stopping new HIV infections among children

Poverty plays a role in hindering access to and use of PMTCT services, hampering the drive towards virtual elimination of new HIV infections among children. Strengthening the links between social protection and PMTCT with joint planning and better referrals can help address this challenge.

Evidence from the maternal health field: Cash transfers and care

Mexico: *Oportunidades*, a national conditional cash transfer (CCT) programme, included free healthcare in the package of benefits including prenatal care and care at delivery. Evaluations show the programme improved the quality of prenatal care for rural women, though not birth attendance. The impact on the quality of care may be due to the fact that women became more active and informed health consumers through their participation in *Oportunidades*. (Urquieta-Salomon et al. 2009, Barber and Gertler 2009)

India: The *Janani Suraksha Yojana* (JSY) programme gave a cash incentive to encourage women to deliver in facilities. JSY had a positive impact on prenatal care, in-facility births or out-of-facility births with a skilled attendant, and in some models, a reduction of neonatal and perinatal deaths. (Lin et al. 2010)

Lessons on using social protection to increase equity in the maternal health field are applicable to PMTCT where services are integrated into maternal, neonatal and child health services, as well as for stand-alone PMTCT services and treatment. For example, conditional cash transfers (CCT) have been shown to increase antenatal care visits, which is critically important for accelerating PMTCT coverage. Non-conditional cash transfers specifically targeting women can also play a role by having an income effect, releasing household income for health care while women-controlled transfers are available for other expenses. Other approaches proven to reduce financial barriers to access, such as maternity care vouchers and user fee abolition, also have the potential to increase equity in PMTCT delivery. Combining these different social protection measures can be even more powerful than implementing each individually.

Social protection and treatment

Poverty also hinders access and adherence to AIDS treatment. In a Cameroon study, patients who reported financial difficulties in purchasing ART were significantly less likely to have good adherence than those who did not, resulting in significantly lower CD4 counts.¹⁶ Costs associated with treatment can also impoverish households.¹⁷ The cost of drugs is only part of the affordability challenge; costs of medical care, transport, and the opportunity costs of seeking care prevent many from continuous, quality treatment. Even in the face of subsidy schemes and exemption mechanisms targeted at the poorest, health care-related fees persist

¹⁶ Financial barriers to HIV treatment in Yaoundé, Cameroon: first results of a national cross-sectional survey Sylvie Boyer, et al. *Bull World Health Organ* 2009;87:279–287

¹⁷ Russell, S. 2004. The Economic Burden of Illness for Households in Developing Countries: A Review of studies focusing on malaria, TB and HIV/AIDS. *Am J Trop Med Hyg*, 71:2 suppl 147–155

undermining access.¹⁸ Legal barriers also keep some groups of people living with HIV from treatment, such as people with illegal status. Social protection can play a critical role in reducing the financial burden associated with treatment as well as legal barriers, thereby increasing equity.

Food insecurity is an important dimension of poverty that is also linked to sub-optimal ART access, acceptance and adherence in many contexts.^{19, 20} By reducing the economic burden of illness and improving ART tolerance, food interventions (provided as food or cash transfers or vouchers) can increase treatment access, acceptance, and adherence, thereby enhancing outcomes. The provision of energy- and nutrient-dense foods, in particular, enhances the nutritional recovery of people living with HIV on treatment and supports improved treatment outcomes. In a Zambia study, food supplementation was associated with better adherence to therapy among food-insecure adults initiating ART.²¹ Addressing food insecurity as a structural barrier to accessing and adhering to ART will help policymakers and clinicians to increase the number of eligible people on treatment.

HIV-sensitive social protection in the form of pro-poor financing mechanisms can improve access and adherence to AIDS treatment. Indeed, WHO emphasises the role of reforming health financing systems in reducing financial barriers and achieving universal health care coverage.²² Specifically, it emphasises the importance of replacing or reducing out-of-pocket payments with more efficient and equitable financing mechanisms. These include vouchers such as those for transport, exemptions, and socialised health protection mechanisms that facilitate pre-payment for services and risk pooling. Here, tax financing and compulsory social health insurance mechanisms have greater potential to raise funds and cross-subsidise the poor than private health insurance mechanisms including community-based insurance. In countries with large informal sectors, it is unlikely that payroll taxes or collecting contributory insurance contributions alone will generate sufficient revenues and therefore substantial financing from general taxation sources (e.g. consumption taxes) will also be required. Increasing public financing and reducing financial barriers, including the elimination of direct fees, is likely to be one of the most effective routes to increasing access for those in need of treatment. In particular, WHO's approach to scaling up treatment access in developing countries endorses the provision of "free-of-charge ART at the point of delivery" as a key component for achieving universal access to HIV care and treatment.²³

¹⁸ Souteyrand Y, et al. Free care at the point of service delivery: a key component for reaching universal access to HIV/AIDS treatment in developing countries. *AIDS* 2008; 22: 161-8.

¹⁹ Weiser SD, et al.. 2010. Food Insecurity as a Barrier to Sustained ART Adherence in Uganda. *PLoS ONE* 5(4): e10340.

²⁰ Unge C et al. 2008. Reasons for unsatisfactory acceptance of antiretroviral treatment in the urban Kibera slum, Kenya. *AIDS Care* 20(2): 146-149.

²¹ Cantrell RA et al. 2008. A Pilot Study of Food Supplementation to Improve Adherence to Antiretroviral Therapy Among Food-Insecure Adults in Lusaka, Zambia. *J Acquir Immune Defic Syndr* 49(2): 190-195.

²² WHO, 2010. The world health report - Health systems financing: the path to universal coverage.

²³ Gilks CF, et al. The WHO public-health approach to ART against HIV in resource-limited settings. *Lancet* 2006; 368: 505-10.

Social protection and care and support

Comprehensive care and support includes clinical, psychosocial, social and economic, nutritional, legal, and human rights services, as well as family and community support that people and households affected by HIV require.²⁴ The main targets for such efforts are those most in need of impact mitigation: the ultra-poor, such as members of labour constrained households and especially children. Comprehensive care and support is imperative for individuals and households receiving HIV treatment to ensure access and adherence to treatment; it is also critical to mitigate the impacts of HIV on those affected, particularly caregivers and affected children.

The ways that social protection contributes to care and support are well-documented:

- ▶ Financial protection, including predictable social transfers such as food, cash, or equipment, can enable carers and households to provide adequate and comprehensive care and support and protect minimum levels of household income for food and other essentials. Combining transfer schemes with social work and child protective services is critical to reduce exclusion errors and expand coverage to those typically excluded
- ▶ Promoting household productivity – Livelihood programmes when made HIV-sensitive – can increase household ability to withstand shocks and reduce poverty. These may include public works, income generating activities, ensuring employment rights of people living with HIV, and micro-credit.
- ▶ Legislative, regulation, and policy changes to reduce stigma and protect the rights of people living with HIV and affected children, including inheritance protection for widows, are other important components of care and support.

For many years, civil society organisations have provided the majority of care and support in resource poor areas. Over the last decade, governments – with significant civil society contributions – have increasingly used social protection programmes to mitigate the effects of HIV on households, focusing on the poorest. Some, such as Malawi, Kenya, and, Zimbabwe have scaled up social protection in response to the large numbers of orphans and vulnerable children. In others such as Thailand, where there is already a range of social protection programmes in place, there are plans to make these more HIV-sensitive, for example, by ensuring inclusion of vulnerable HIV-affected populations who face difficulties accessing services.

A key constraint common across care and support programmes is the limited capacity in ministries of social welfare and in communities. Both lead ministries and communities require systems strengthening and human resource capacity building. This can help to improve collaboration to increase service access and enhance the reach, quality, and affordability of care and support.

²⁴ UNAIDS 2011-2015 Strategy: 'Getting to Zero', 2010.

Annex: Case Studies

1. Mchinji, Malawi: HIV-Sensitive Cash Transfers

The Mchinji Social Cash Transfer (CT) Programme is an exemplary case of an HIV-sensitive social protection programme – a programme that addresses the structural causes of poverty, marginalisation, and associated harms while protecting vulnerable children in the face of challenges posed by HIV by linking to other sectoral or issue-focused programmes.²⁵ This CT scheme, which began in 2006, targets households that are both ultra-poor (belonging to the lowest income quintile) and labour-constrained. The latter eligibility requirement entails that households have no adult aged 19 to 64 fit for productive work or more than three dependents per fit adult. It is estimated that about 10% of all households in Malawi (250,000) belong to this category and that over 60% of the members of these households are children, of which 85% are orphans. By integrating both economic (low income) and social (high dependency ratio) eligibility requirements, the programme was able to go beyond simply targeting poor households to honing in on children who were vulnerable and, in the majority of cases, orphaned or affected by HIV. Indeed, in 53% of recipient households, one or more adult household members died due to AIDS.²⁶

The positive effects of the programme have been noticeable.²⁷ In contrast to the comparison group, the households receiving CTs experienced dramatic improvements in food security. Children gained in height and weight, were less likely to work outside the home and more likely to attend school. Also significant is the fact that recipient households increased their demand for health care and education as well as increasing productive assets (farming equipment, livestock, etc.). Additionally, it was found that households receiving the transfer used their cash in ways that benefited the community at large, by hiring labour, giving loans, sharing food, spending in local markets, or pooling money for larger income-generating activities.

The programme has an integrative component that is especially useful to households affected by HIV: 800 Community Child Protection workers link orphans and vulnerable children from beneficiary households to Community-Based Child Care Centres, thereby helping to ensure adequate early childhood development. Efforts are also being made to link the cash transfers to a case management system to ensure that children's economic and child protection needs are met in a more systematic and integrated way and appropriate referrals are made for children requiring specific child protection, education, or health needs.

By February 2009, 23,650 households in seven of Malawi's 28 districts received transfers monthly. The government plans to bring the CT programme to national scale by 2012.

UNICEF. Contact: Rachel Yates, ryates@unicef.org and Jennifer Yablonski, jyablonski@unicef.org

²⁵ Roelen, K. et al. "Child and HIV sensitive social protection in Eastern and Southern Africa. Lessons from the Children and AIDS Regional Initiative (CARI)" IDS and Centre Social Protection. 2011.

²⁶ Schubert, B. "The Impact of Social Cash Transfers on Children Affected by HIV: Evidence from Zambia, Malawi and South Africa." UNICEF Eastern and Southern Africa Regional Office. Lilongwe, 2007.

²⁷ Miller, C. "Economic Impact Report of the Mchinji Social Cash Transfer Pilot." Draft. Center for International Health and Development Boston University School of Public Health and Centre for Social Research University of Malawi. 2009.

2. Uganda: National Community of Women Living with HIV/AIDS (NACWOLA) Supporting Treatment Adherence

NACWOLA is an indigenous, membership-based organisation started in 1992 and run by and for women living with HIV. NACWOLA ensures that decisions are made *by* people living with HIV *for* people living with HIV. The vast majority of NACWOLA's members are women, but have increasingly involved men for broader impact and to support a gender-transformative approach. NACWOLA uses a community-based approach in its work. They provide a range of services to vulnerable and marginalised populations including orphans and vulnerable children, people with disabilities, children, other family members and peers with HIV through a rights-based approach. The comprehensive care and support services include sexual and reproductive health and rights awareness and services, PMTCT, drug adherence, fighting stigma and discrimination, economic, social and legal support, and provision of peer psychosocial support and referrals. Importantly, all the work is used for evidence and grass-roots-based advocacy at regional and national levels.

NACWOLA has had a critical role in supporting HIV treatment adherence. Members join adherence clubs of people living with HIV within a community, who meet regularly to support each other. If health centres are far from the community, one member of the club travels to the health centre to collect the drugs for the whole group. In this way, the members save travel costs and do not miss a dose due to financial constraints. Members also join income generating activities to find their own source of income to support their families, pay medical bills, and consume a healthy diet. This is crucial for successful treatment with ARVs since the majority of members are single mothers who carry the burden of looking after their families, a role complicated by their lack of formal education.

NACWOLA provides these services mainly through Community Support Agents (CSAs), who provide support for mobilisation, follow up, and bridging the gap between health centres and communities. CSAs are living with HIV themselves and working within their own communities. NACWOLA provides specific training by assisting CSAs with practical aspects of home-based care including how to care for people living with HIV, AIDS and TB; supporting them with Home-Based Care Kits; and providing basic psychosocial support and promote positive living.

NACWOLA has grown into a national network with over 60,000 members in 30 branches, and has supported around 35,000 people living with and affected by HIV all around Uganda. This has led to increased positive living, drug adherence, positive prevention, and increased access to HIV and TB services. This model of work responds to the needs of people in a way that inspires ownership, which is key to transformative action. A further example of this transformational approach is that the caregivers themselves are at the centre of the organisation. NACWOLA's home-based caregivers are actively involved in decision making, benefit from NACWOLA's activities and receive regular small remunerations.

To ensure sustainability, substantial investments have gone into individual, community, and institutional capacity building and cooperation with government ministries and other civil society organisations. Advocacy for new or improved policies and home-based care-related social protection is also a priority.

Caregivers Action Network. Contact: Mike Podmore, mpodmore@aidsalliance.org

3. Zambia: Using Innovation to Reduce Stigma

In Zambia, a country that continues to face daunting challenges related to high rates of malnutrition, poverty, food insecurity, gender inequality, HIV, and malaria, the World Food Programme (WFP) has embraced innovative technology to support government social protection programmes that target the most vulnerable. Social transfers are designed to ensure access to a basket of nutritious foods, and increasingly, where markets are functioning, WFP is providing electronic vouchers to beneficiaries that empower them to collect food rations at the local shop of their choice. Households are targeted on the basis of food insecurity and one member receiving ART or tuberculosis treatment or attending mother and child health and nutrition centres for pregnant women, lactating mothers, and children under 24 months.

Such an approach has eliminated the stigma attached with collecting food commodities, especially at local health clinics, and allows recipients to collect rations at a convenient time based on their work and other priorities. The mobile delivery technology also allows for more effective monitoring of ration collection by programme staff, and has helped to boost local businesses who benefit from increased customer demand and a safe and secure electronic payment system.

During the period November 2009 through February 2011 an estimated 275,000 e-vouchers were distributed in various centres around Zambia.

WFP. Contact: Maureen Forsythe, maureen.forsythe@wfp.org

4. Botswana: Psychosocial Support for Children Affected by HIV

Botswana has a long-standing scheme of social welfare, with the government taking a strong role in design and implementation. While many countries in Eastern and Southern Africa struggle to move social protection beyond interventions for short-term and material needs, Botswana, as a middle-income country, is less prone to resource constraints and more able to extend its response for children affected by HIV to include, for example, psychosocial support (PSS). Existing programmes include benefit schemes providing cash transfers, food vouchers and other material support. In order to respond to children's broader needs, NGOs step in and provide a range of services from legal advice and support to counselling to PSS. NGOs can be considered the main implementing partners of such services offered with the Department of Social Services (DSS) as its coordinating and monitoring body. While this arrangement ensures consistency between services offered by different providers, it also poses constraints to the range and types of services offered by NGOs as government approval is required.

One such NGO is Ark 'n Mark, which organises wilderness retreats for orphaned children (single or double orphans, regardless of cause) between primary and secondary school, providing PSS using a combination of counselling methods including group therapy, individual counselling, and rites of passage. In combination, these methods enable orphans to process grief and loss, build social skills and friendships, as well as practical life-skills and relationship skills for growing up. After returning from retreats, volunteer mothers support follow-up. Interviews show that retreats have an impact on children's lives, with many indicating that they have a more positive outlook on life as a result of participation. Other outcomes include improved self-esteem and efficacy, awareness of HIV prevention and living with HIV, and stronger resilience.

This illustrates the important role for social protection interventions that go beyond transfers within a holistic social welfare response for children affected by HIV, as well as the potential benefits of such interventions beyond short-term and material needs. At this point, coverage of these types of interventions is low, and considerable efforts are required to reach more children. Scaling-up HIV-sensitive social protection interventions for children should take account of the important role of programmes such as these in reaching broader outcomes beyond material ones. Given the capacity and resource constraints in many countries, the role of NGOs is crucial in providing such support, especially in light of the potential for ‘scale-ability’ and extending coverage.

Importantly, challenges with respect to comprehensive social protection approaches are plentiful even when resources are available. These include programme specific issues, such as the degree of follow-up and engagement of parents and carers, as well as structural challenges around roles and responsibilities. While government coordination is important to provide a coherent national response, there is also a risk that strong control may impede NGO work. In addition, strong reliance on volunteers and uncertain NGO resources may endanger sustainability.

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5. India: Making National Social Protection Schemes HIV-Sensitive

A UNDP study on the socio-economic impact of HIV in India (2006) indicates that the financial burden on families of people living with HIV is the most visible impact of HIV at the household level. The study further finds that there is a steady decline in employment of people living with HIV in all occupation groups. The income loss due to health-related leave or unemployment is high. This leads families to borrow, even for basic consumption needs. All of the HIV-affected households surveyed in the study, irrespective of their income level, resorted to borrowing and liquidation of assets in order to cover hospitalisation expenses, with liquidation being inversely proportional to income. Data from this study also point to higher drop-out rates for school children from HIV-affected households.

There is a clear need to safeguard these vulnerable individuals and households from falling into extreme poverty because of illness and ill health. UNDP India focuses on securing social protection programmes, primarily from state run sources, for people living with HIV, especially women and girls.

UNDP provides technical support to the Government of India to sensitise State AIDS Control Offices staff on HIV-sensitive social protection and to review existing schemes to ensure that they are inclusive of the needs of people living with HIV. UNDP supports the National AIDS Control Organisation (NACO) and its state offices in ensuring that social protection programmes reach key populations, such as sex workers, injecting drug users, men who have sex with men, transgender populations, and migrants. UNDP India has undertaken evidence-based advocacy together with networks of people living with HIV, NACO, and its state offices for inclusive policies and programmes.

As a result, 35 government schemes have been amended to respond to the needs of people living with HIV, including:

- ▶ Removal of an HIV exclusion clause from the special health insurance scheme of the Ministry of Labour for informal sector workers;
- ▶ Removal of age criterion so that HIV positive widows can access the widow pension scheme provided by the Department of Women and Child Development;
- ▶ Supporting legal aid clinics for people living with HIV to help ensure access to HIV and other services;
- ▶ Provision of transport allowances for people living with HIV who are unable to afford their travel costs to support access to HIV treatment and improve adherence to HIV treatment.

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6. Thailand: Ensuring Universal Access to Health Care

In 2001, Thailand introduced the Universal Coverage Scheme (UCS) to provide health care to all citizens not covered under other social protection schemes such as the Compulsory Contributory Social Security Scheme (SSS) and the Non-contributory Civil Servants Medical Benefit Scheme (CSMBS). The UCS is financed from tax revenues and includes a comprehensive set of health provisions such as preventative services, ambulatory care, and in-patient care. In 2006, it added HIV services such as HIV testing and ART provision.

All citizens with national identification are eligible under the UCS. Limited health care provisions are available to some non-Thai citizens, classified as registered migrant and new immigrant workers, unregistered migrant workers, and stateless people residing in Thailand. Migrant and new immigrant workers are entitled to health care under the SSS, which includes provision of HIV services, although not all employers register their workers. Unregistered migrant workers are covered by a special health insurance system which offers limited protection up to a ceiling of 1,900 Baths²⁸ but HIV services are not included. Stateless populations are not eligible for any health care schemes.

According to UNAIDS, over 530,000 people are living with HIV in Thailand and the epidemic is concentrated among key populations at high risk of infection, including injecting drug users, men who have sex with men, migrant workers, and sex workers. In 2007, an estimated 22.5% of sex workers had no health insurance coverage. Even where ARV treatment is available under the UCS, studies have shown that people living with HIV are often reluctant to consult primary health care for fear of stigma.

The Government and UN partners in Thailand recognise that the UCS and other social protection schemes provide impressive health coverage but are not accessed by some groups, usually the most excluded, many of whom may also be HIV-affected or infected. They are exploring ways of reducing access inequities and providing for populations not covered under national schemes.

²⁸ / 1900 THB = 65 US dollars

Previously, a Global Fund to Fight AIDS, TB and Malaria grant covered ART provision for 2000 people, mostly from vulnerable populations such as ethnic minorities and undocumented people. The current Round 10 grant also includes improving access to HIV treatment and health care for people living with HIV and other excluded populations and addressing stigma.

Many poor HIV-affected households lack resources to cover HIV-related costs. To overcome this, a cash transfer of 500 Thai Bhat per month is available for all citizens who are guardians of children living with HIV. To avoid the stigmatising impact of this targeted approach, the government is now considering moving towards a cash transfer for all vulnerable children.

The UN also is supporting an assessment of all welfare provisions in Thailand with a view towards achieving a Social Protection Floor that will ensure a series of universal benefits, including for those living with and affected by HIV.

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