Social protection: a Fast-Track commitment to end AIDS

Guidance for policy-makers, and people living with, at risk of or affected by HIV

Contents

Why this document?

Although much has been written on HIV-sensitive social protection, there is insufficient guidance on how to bring to scale what works in the context of different HIV epidemics and for different populations. This document seeks to fill this gap. It provides guidance to governments, people living with, at risk of or affected by HIV, policy-makers, and other stakeholders on how to intensify the integration of HIV with social protection and other programmes for ending poverty and inequality towards ending AIDS.

It summarizes relevant evidence on social protection, including cash transfers, and on how social protection contributes to the AIDS response. It presents a brief account of the status of progress of Member States in meeting the HIV and social protection target of the 2016 Political Declaration on AIDS. It provides guidance for leveraging and scaling up social protection—in particular, social safety nets, financial incentives and social services—towards achieving the goal of ending AIDS. It does not focus on social security and labour market polices.

Executive summary

Strengthen national social and child protection systems to ensure that by 2020, 75% of people living with, at risk of or affected by HIV benefit from HIV-sensitive social protection

The UNAIDS Fast-Track approach seeks to frontload investments and reduce new HIV infections and AIDS-related deaths to fewer than 500 000 globally, and to achieve the 90–90–90 testing, treatment and viral suppression targets and the zero AIDS-related discrimination targets by 2020. Attaining these targets would put the world on course to ending the AIDS epidemic as a public health threat by 2030.

Paragraph 62(i) of the 2016 Political Declaration on HIV and AIDS contains a social protection target. The target encourages Member States to strengthen national social and child protection systems to ensure that by 2020, 75% of people living with, at risk of or affected by HIV benefit from HIV-sensitive social protection. This target is human rights-based. It feeds into and benefits from promoting, protecting and fulfilling all human rights and the dignity of all people living with, at risk of or affected by HIV *(1)*.

Evidence of how social protection programmes meet the multiple needs of people who are poor and excluded and benefit people living with, at risk of or affected by HIV is increasing. The question is not whether the AIDS response should increase attention to social protection, but how best to leverage resources and partnerships of movements working on ending poverty and inequality to work effectively towards ending AIDS.

To Fast-Track social protection to help end the AIDS epidemic, it is imperative that countries conduct assessments of their social protection responses, including their HIV sensitivity. This would help deepen and extend the coverage of social protection programmes to people living with, at risk of or affected by HIV. The assessments would also assist countries to generate strategic information to help understand how to sustainably finance social protection programmes. Relevant costs for increasing the HIV sensitivity of social protection programmes would be obtained from the assessments. Altogether, this information would inform effective planning and implementation of HIV and social protection programmes.

Working collaboratively with partners, as dictated by the country's HIV epidemic profile and social protection programmes, stakeholders should Fast-Track HIV and social protection programming by intensifying actions on the following four pillars:

- Pillar 1: scale up and progressively broaden sustainable social protection programmes. These programmes should enhance care, support and treatment outcomes for people living with HIV, key populations, adolescent girls and young women, vulnerable families and caregivers. Combination social protection approaches, including financial incentives, social assistance and social economic approaches, should be delivered in relevant geographical areas for appropriate populations, as required.
- Pillar 2: invest in expanding access to primary, secondary and tertiary schooling and pathways to employment as an effective HIV prevention strategy in countries with high HIV incidence. Predisposing factors that keep adolescents out of school or prevent them from remaining in school should be identified and addressed. Special

attention should be paid to adolescents out of school or on the verge of dropping out of school.

- Pillar 3: increase access to essential health services for people living with, at risk of or affected by HIV by addressing barriers that prevent them from accessing health services. Linkages to financial incentives and social economic approaches, social assistance and social services should be forged and strengthened. Stronger linkages would help address the multiple needs of people living with, at risk of or affected by HIV. This may encompass advocating for access to free health care at the point of use; birth registrations for children; providing identity cards for populations likely to be excluded from accessing health services, such as migrants and transgender people; providing transport support for health-care appointments; food security and nutrition programmes; housing and related subsidies; and reducing stigma and discrimination.
- Pillar 4: strengthen the active and meaningful engagement of civil society, in particular representatives of people living with, at risk of or affected by HIV, in the design and implementation of social protection to enable social protection programmes to meet the needs of such populations. Individuals and communities need to be empowered to address and respond to stigma and discrimination and advocate for strengthening the legal and policy environment to address stigma and discrimination. Civil society organizations may need to be supported in strengthening administrative and financial management capacities to manage their affairs effectively and have the necessary resources and social protection literacy to engage in national social protection coalitions and processes.

The HIV epidemic and its social determinants

The global HIV epidemic is defined not only by the virus and medical approaches to control it, but also by social, economic and political conditions and the systems put in place to deal with illness—"that is, by the social determinants of health" *(2)*. An analysis from 1992 unfortunately still reflects the reality on the ground: social determinants are driving the HIV epidemic, reducing HIV risk and vulnerability in some populations, but intensifying them in others, along "fault lines" of poverty and inequality *(3)*. Building on recent progress within and beyond the HIV response, much more can be done to address the social determinants of risk and vulnerability and to position the world to end the AIDS epidemic as a public threat by 2030 *(4)*.

The connection between poverty and HIV risk is often indirect *(5,6)*, but it is well established *(7,8)*. Earlier analyses that explored associations between income and HIV prevalence found high HIV prevalence among wealthier and more educated people. Recent studies show that HIV infections have declined more rapidly among wealthier and more educated people, and the pattern of high prevalence appears to be shifting towards less educated people *(9)*. Further studies show that relative wealth or income inequality is associated with HIV risk, as is gender inequality *(10)*.

Almost 70% of people living with HIV live in sub-Saharan Africa, one of the world's poorest regions. Between 2010 and 2016, HIV incidence remained high here, especially among adolescent girls and young women. New adult HIV infections are not declining fast enough in sub-Saharan Africa to reach the Political Declaration targets *(11)*. Incidence is estimated to be declining only slightly in high- and middle-income countries of the Middle East and North Africa region, while it is stable in Latin America, and rising in the Eastern Europe and Central Asia region *(12)*.

The expanding HIV epidemics in these regions could be attributed to discrimination and social exclusion of key populations, and insufficient investment in proven high-impact HIV services for key populations at risk of exposure to HIV *(13)*. The key populations are differentially vulnerable to and affected by HIV, and least able to withstand the economic and social shocks of HIV. Their active engagement in the AIDS response is critical to effective AIDS responses.

Mortality associated with HIV places a particular burden on older members of affected families *(14)*. In 2016, an estimated 16.5 million children aged 0–17 years had lost one or both parents to AIDS-related illnesses and were taken care of by family members or neighbours *(15)*. These households tend to be among the poorest, with potential for transmission of poverty from one family generation to the next. Increased caregiving demands and reduced income can lead families to take children out of school to fill in the gaps of household labour needs *(16)*. Family caregivers and informal support networks historically have been the backbone of the community-based response, providing care and support with meagre external assistance and even less financial support *(17)*.

People who need social protection, including poor people (daily income below the poverty line of US$ 1.25) and key populations, have multiple needs that vary over time, such as education, housing, health care and livelihood. For example, people recently released from prison are often in need of housing, access to medical care and credit, social support, and assistance in finding a job *(18)*. Orphans and vulnerable children may lack income and structure to access and make the most of social services, and critical positive parenting may be absent. For example, in Cambodia, households affected by HIV had multiple and markedly increased vulnerabilities compared with households not affected by HIV *(19)*:

- 53% of households affected by HIV owned their place of residence, compared with 80% of households not affected by HIV.
- Households affected by HIV owned significantly less compared with households not affected HIV (except for mobile phones, where the differences between households were not significant).
- Households affected by HIV reported an average lower annual per capita income (US$ 454) compared with households not affected by HIV (US$ 548).
- Accumulation of debt was more common among households affected by HIV (65%) compared with households not affected by HIV (53%).
- A child living in a household affected by HIV was 3 times more likely to have missed more than 10 days of school (41.8%) compared with a child from a household not affected by HIV (18.8%). Girls in households affected by HIV were impacted most, with a 50% increase in the percentage of girls living in households affected by HIV having been absent for 10 days or more (14%) compared with girls in households not affected by HIV (9%).

To combat poverty and enhance the resilience of people and communities, the economic objectives of social protection must be complemented by actions to transform the structures—institutions, hierarchies, laws and regulations, values and perceptions—that create inequalities. A study of community perceptions of social protection in Uganda found that participants viewed social transfers as "a gift" for which they should be grateful and uncomplaining, whereas in the occupied Palestinian territory people viewed social transfers as a right to be demanded *(20)*.

What is social protection?

Figure 1. Components of social protection systems

Source: State of social safety nets. Washington, DC: World Bank; 2015.

Social protection comprises public and private actions to reduce risk, vulnerability and poverty, such as social safety nets, social security, and labour market policies. It also comprises a set of policies and programmes that facilitate people's access to social services, such as education, nutrition, housing, health and other social services *(21)*. Figure 1 describes the main components of social protection and provides examples of social safety nets and social services.

Social safety nets, also known as social assistance or social transfers, are programmes that provide regular and predictable support to poor and vulnerable people. Social security, also known as social insurance, comprises contributory transfers from employee and employer payroll contributions based on age, and disability and unemployment payments.

Almost every country has a system of social protection, but the scope of benefits and delivery mechanisms provided by the various systems and schemes in each country varies widely. Social safety nets include cash transfers, which may be conditional or unconditional; in-kind transfers, which may be conditional or unconditional; and contributory insurance and public works programmes:

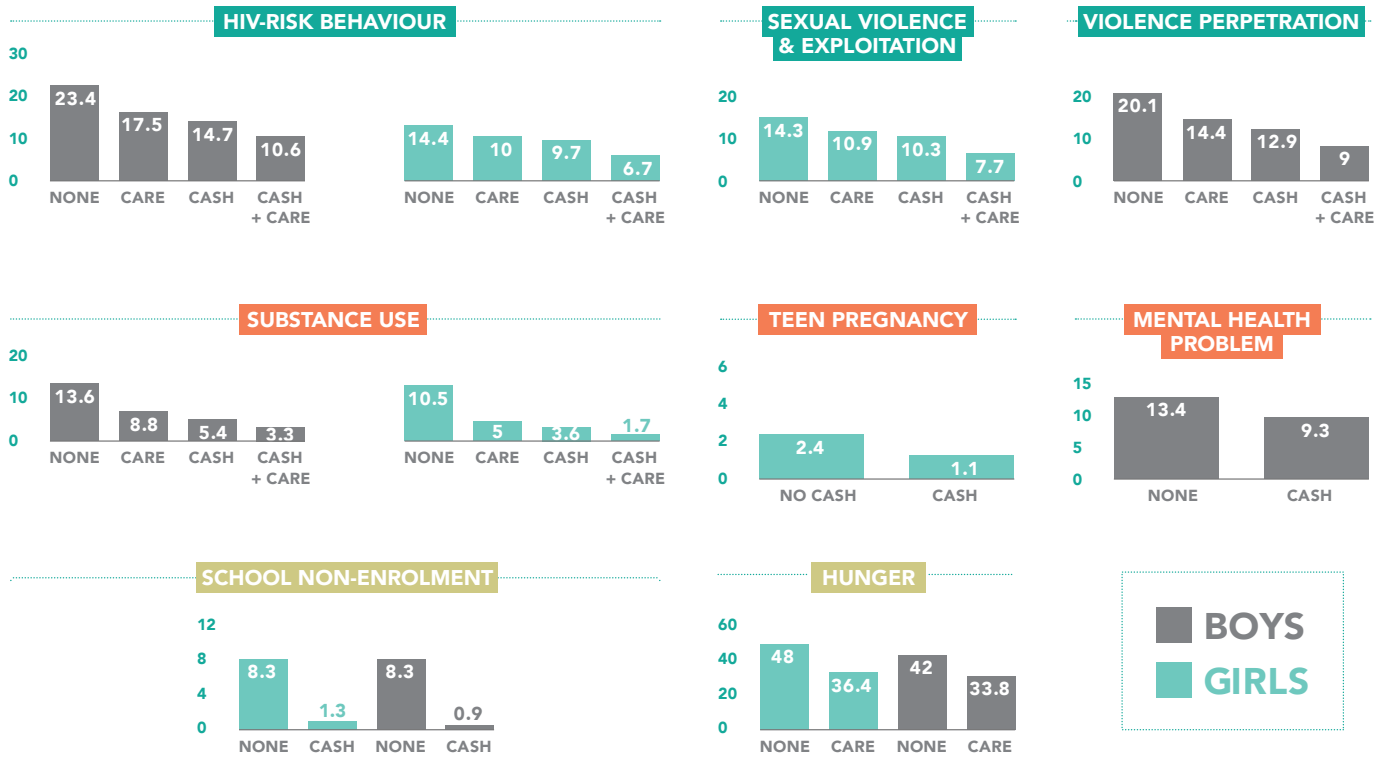
- With contributory instruments, people or households pay into the scheme. With non-contributory instruments, people or households do not pay into the scheme.
- Cash transfers involve transfer of money to recipients. In-kind modalities have a range of mechanisms, such as waivers to access goods and services, food, or vouchers to be redeemed for goods and services.
- Conditional transfers require responsibilities from recipients, such as school attendance, obtaining required vaccinations at a health facility, or remaining free of sexually transmitted infections, including HIV. Unconditional transfers do not place any obligations on recipients.
- Public works programmes typically engage recipients in manual labour-oriented activities such as building and restoring community assets and infrastructure *(21)*. Recipients are paid in kind or in wages.

Social protection and the Sustainable Development Goals

Social protection benefits people's health and well-being in numerous ways. HIV programmes and social protection schemes interact positively around the targets of Sustainable Development Goals (SDGs) 1, 2, 3, 4, 5, 6, 8, 10, 11, 16 and 17. These links highlight the many opportunities that exist for combining interventions aimed at improving HIV, social protection and broader development outcomes *(22)*. That impact can be especially strong in settings where people are at high risk for HIV infection and face multiple other threats to their health and well-being *(23)*. For example, a study in two South African provinces assessed the effects of cash-based or care-oriented social protection on the health and well-being of adolescents and found the interventions reduced the following (Figure 2) *(24)*:

- Hunger (SDG 2: food insecurity).
- HIV risk behaviours, mental health risks, and substance or alcohol misuse (SDG 3: health).
- School dropout rates (SDG 4: education).
- Sexual exploitation of and violence against girls, and improved access to sexual and reproductive health (SDG 5: gender equality).
- Perpetration of violence by boys (SDG 16: promote peaceful and inclusive societies).

Figure 2. Predictors of improvements in Sustainable Development Goals among adolescents receiving care and cash transfers in two provinces (urban and rural) of South Africa, 2012



Source: Cluver LD, Orkin M, Meinck F, Boyes ME, Yakubovich AR, Sherr L. Can social protection improve Sustainable Development Goals for adolescent health? PLoS One. 2016;11:e0164808.

SDG target 3.8 explicitly requires that countries "achieve universal health coverage, including financial risk protection, access to quality essential health care services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all" *(25)*. Universal health coverage aimed at population-wide access to comprehensive, good-quality essential health services, for which people do not suffer from financial hardship by paying *(26)*, is put forward as an overarching goal to attain the health-related SDG. It is estimated that 400 million people in 2013 did not have access to one or more essential health services *(27)*.

The International Labour Organization recommendation 202 states that universal health coverage requires effective access to essential health care as defined nationally. Legal health coverage is defined as "affiliation to a health system or scheme and access to healthcare as legally defined that meets specific criteria which are measured by proxy indicators". It is important to note that the scope of benefits provided by the various systems and schemes in each country varies widely *(28)*.

More than a third (38%) of the world's population are without any form of legal health coverage. Globally the largest coverage gaps are in rural areas, where 56% of the population lack health coverage, compared with 22% in urban areas. In Africa, particularly sub-Saharan Africa, the region with the largest HIV burden, 80% of the rural population is excluded from legal health coverage, compared with 60% of the urban population. In Asia, 56% of the rural population compared with 26% of the urban population remains without legal health coverage *(28)*.

Impact of social protection on livelihoods, education, and access to and use of health services

Cash transfers are a widely used form of social protection and are also among the most evaluated development interventions. They have been shown to have positive HIV-related outcomes. The evidence for social protection including cash transfers is strongest for livelihoods, education, and access to and use of health services. Approaches such as public works are less studied. Most countries have at least one cash transfer programme. Some are national programmes, while others serve narrow target populations or are small-scale pilot programmes *(29)*.

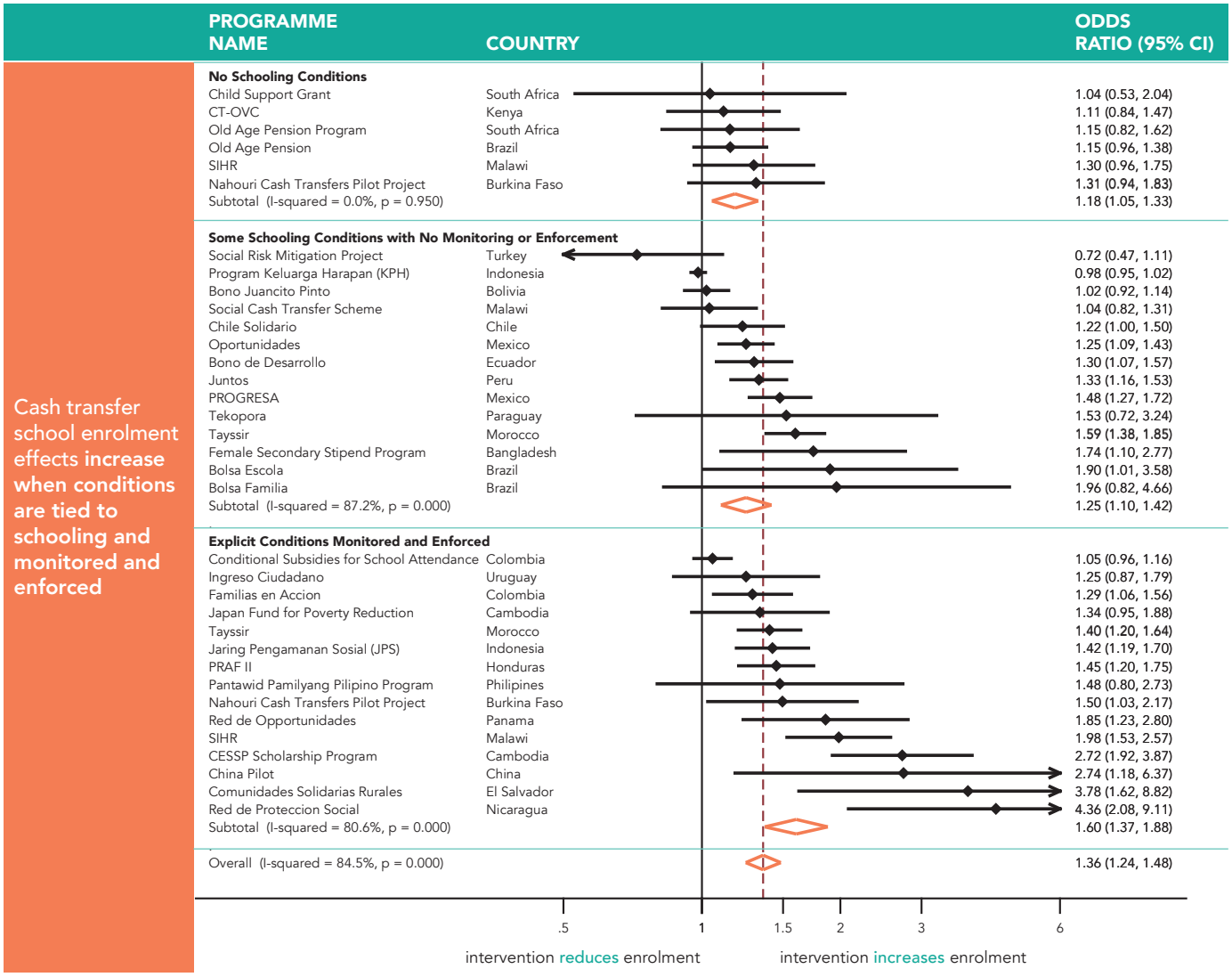
Sustaining livelihoods and improving living standards

Social protection generally promotes and sustains livelihoods and improves living standards by directly reducing poverty, hunger and inequality. Households receiving social protection including cash transfers accumulate assets, are assisted to prevent irreversible coping strategies such as selling of immovable assets, get cheaper credit, and enter labour and market economies more quickly compared with households not receiving social protection services. For example, Mexico's *Progresa/Oportunidades* cash transfer programme reduced the poverty gap by 30% after two years of operation, while Brazil's 28% reduction in the Gini coefficient (a measure of inequality) from 1995 to 2004 is attributed to a combination of cash transfer programmes *(30)*. Social protection also contributes to attaining gender equality by empowering women, especially adolescent girls and young women, to make their own decisions, and by reducing intimate partner violence *(31)*.

Increasing access to and retention in education

A 2013 global systematic review of 35 evaluations of social protection, particularly cash transfers, found 36% higher school enrolment in households that received cash transfers compared with households that did not receive the transfer *(32)*. The researchers found that associating conditions with cash transfers produced better results—41% more school enrolments with conditional cash transfers compared with 23% more school enrolments with unconditional cash transfers. The impact of cash transfers on school enrolment was greater at secondary school (31%) than primary school (4%). A similar pattern was reflected in the effect of cash transfers on school attendance—65% for the conditional group versus 41% for the unconditional group. Overall, the effects of cash transfers on school enrolment and attendance were higher in girls than boys. The effects were also larger when the conditions were tied to schooling and enforced, as shown in Figure 3, which is not specific for girls and boys.

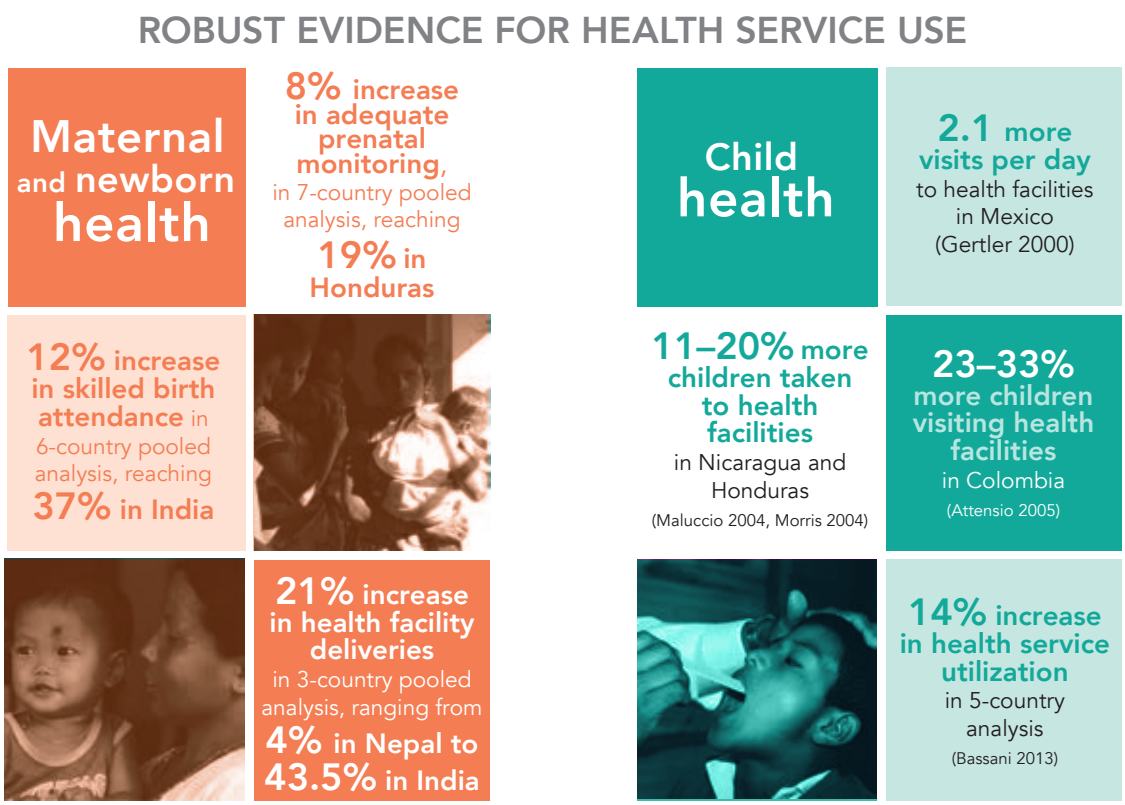
Figure 3. Conditions matter in school enrolment



Source: Baird S, Ferreira FHG, Özler B, Woolcock M. Relative effectiveness of conditional and unconditional cash transfers for schooling outcomes in developing countries: a systematic review. Campbell Syst Rev. 2013;8.

Cash transfers increase access to education and attendance of classes by mitigating demand-side barriers such as the cost of uniforms, books and tuition, but they do not address supply-side barriers such as quantity and quality of schools, competent and equipped teachers, mentoring, and reduction in violence for a more conducive learning environment. Complementary services to improve the quantity and quality of schools and learning outcomes are necessary. A 2016 literature review confirmed an increase in test scores and cognitive abilities among girls due to cash transfers *(33)*.

Figure 4. Impact of cash transfers on access to and use of health services



Sources: Lagarde M, Haines A, Palmer N. The impact of conditional cash transfers on health outcomes and use of health services in low and middle income countries. Cochrane Database Syst Rev. 2009;(4):CD008137. Adato M, Bassett L. Social protection to support vulnerable children and families: the potential of cash transfers to protect education, health and nutrition. AIDS Care. 2009;21(Suppl. 1):60–75. Cash transfers evidence paper: policy division. London: Department for International Development; 2011. Jones N, Samuels F, Gisby L, Presler-Marshall E. Rethinking cash transfers to promote maternal health: good practice from developing countries—background note. London: Overseas Development Institute; 2011. Glassman A, Duran D, Koblinsky M. Impact of conditional cash transfers on maternal and newborn health. Policy paper 019. Washington, DC: Center for Global Development; 2013 (www.cgdev.org/publication/impact-conditional-cash).

Increasing access to and use of health services

A 2011 Department for International Development evidence review found that cash transfers increase access to and use of health services by mitigating demand-side barriers such as the direct and indirect costs of using health services, regardless of whether or not the services are free at the point of use *(30,31)*. Figure 4 shows examples of the impact of cash transfers on access to and use of different health services.

Cash transfers are less effective, however, at increasing health outcomes, with the exception of food security and nutritional results. Households receiving transfers consume more food, resulting in increased weight, height and lifelong earnings decades later. In order to increase the impact of the use of services on health outcomes, cash transfers need to be paired with complementary approaches such as results-based financing; training, equipping and incentivizing health workers; collaboration with community care providers; and effective referrals *(30)*.

HIV-sensitive social protection

Social protection helps to address the multiple social determinants of HIV, including poverty, income inequality, gender inequalities, stigma and discrimination, and social exclusion, and thus contributes to efforts to reduce new HIV infections, AIDS-related deaths and HIV-related discrimination *(24)*. Social protection addresses demand-side barriers to accessing HIV services, with the potential to improve prevention, treatment, care and support outcomes. Social protection also helps to mitigate the social and economic impacts of HIV on people, provided such programmes are responsive to the needs of people living with, at risk of or affected by HIV *(33)*. Social protection can be considered HIV-sensitive when it is inclusive of people living with, at risk of or affected by HIV. Promoting HIV-sensitive social protection entails working with programmes designed for broad population groups (such as employees, people in the military, orphans and vulnerable children, households with incomes below a national poverty threshold, adolescents and youths, girls and women, pregnant women, people with disabilities, and elderly people) and ensuring they overcome the policies, social barriers and knowledge gaps that would otherwise prevent people living with, at risk of or affected by HIV from accessing needed services *(34)*.

Where reform of social protection programmes is too slow, inefficient or politically difficult, HIV-specific social protection strategies are required. HIV-specific social protection programmes are designed with and for people living with, at risk of or affected by HIV. Such programmes are essential to address pockets of vulnerability and neglect. They also aim to ensure pockets of vulnerability and neglect are covered in the long term by broader social protection programmes. For further details, see *HIV and social protection guidance note (34)* and *Social protection: advancing the AIDS response (35)*.

Tracking progress on HIV-sensitive social protection strategy implementation

The 2016 Political Declaration on Ending AIDS encourages Member States to strengthen national social and child protection systems to ensure that by 2020, 75% of people living with, at risk of or affected by HIV benefit from HIV-sensitive social protection *(1)*. UNAIDS is mandated to support countries in monitoring and reporting on progress towards global AIDS commitments adopted through the 2016 Political Declaration on Ending AIDS (and previously the 2001 Declaration of Commitment on HIV/AIDS, the 2006 Political Declaration on HIV/AIDS, and the 2011 Political Declaration on HIV and AIDS), with the objective of identifying progress, challenges and constraints in the AIDS response.

The Global AIDS Monitoring Framework outlines the indicators and reporting mechanism. The National Commitment and Policy Instrument (NCPI) is a component of the Global AIDS Monitoring Framework measuring progress in developing and implementing policies, strategies and laws related to the AIDS response. The NCPI

seeks to promote broad multisectoral consultation and engage civil society and other partners in monitoring and reporting on the AIDS response.

The NCPI consists of two parts: part A completed by national authorities, and part B completed by civil society representatives and other nongovernmental partners engaged in the national AIDS response. The NCPI has been a component of global AIDS reporting since 2003. It underwent an extensive review between 2014 and 2016, and the revised tool was integrated in global AIDS reporting for the first time in 2017. Data on social protection policies and mechanisms are reported by national authorities through part A, while civil society and other nongovernmental partners report on any barriers to accessing social protection mechanisms through part B. In 2017 a total of 121 countries submitted part A, and 119 countries submitted part B.

Analysis of the 2017 NCPI submissions reveals that of the 114 reporting countries that submitted the social protection parts A and B, 91 countries (80%) have a broader social protection strategy that is being implemented, 9 countries (8%) have a social protection strategy that is not being implemented, and 14 countries (12%) do not have an approved social protection strategy.

Analysis of the elements of HIV sensitivity indicate that 12 countries (11%) report having a social protection strategy implemented that includes all 6 of the following elements of an HIV-sensitive social protection strategy:

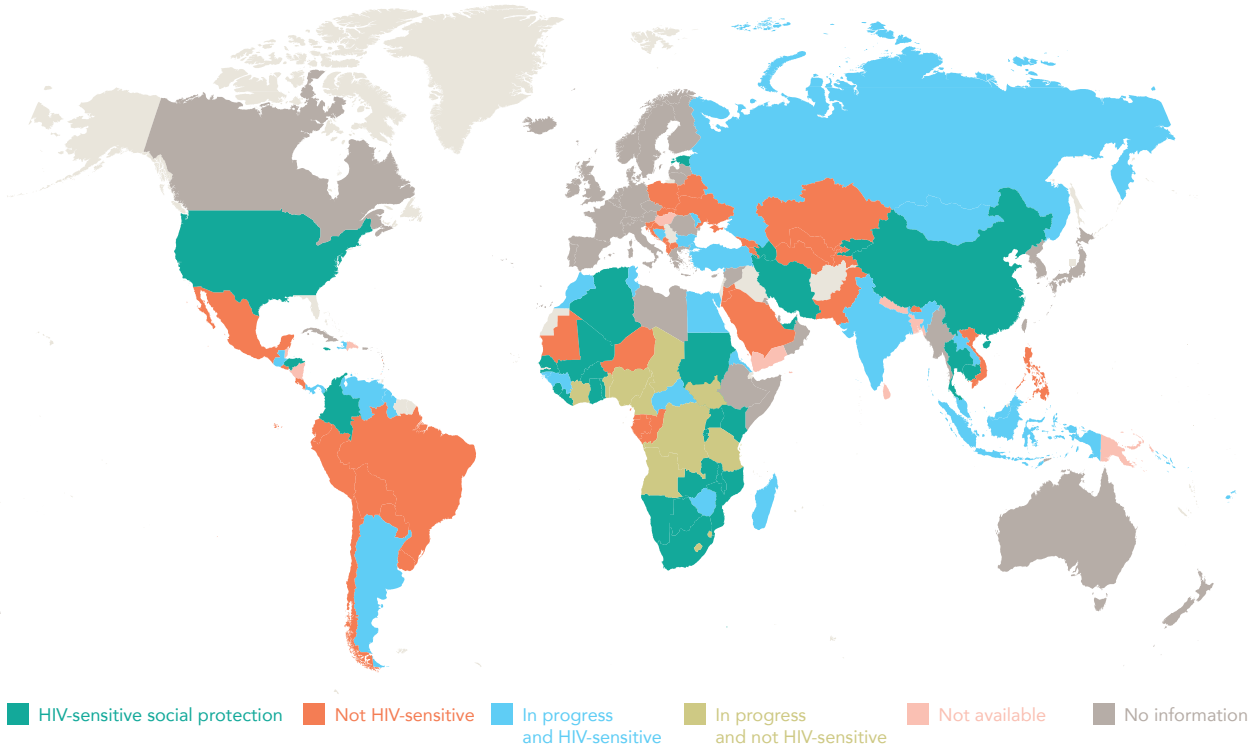
- Refers to HIV.
- Recognizes people living with HIV as key beneficiaries.
- Recognizes key populations as key beneficiaries.
- Recognizes young women as key beneficiaries.
- Recognizes people affected by HIV as key beneficiaries.
- Addresses unpaid work in the HIV context.

Overall, 71 countries (62%) reported having social protection strategies that refer to HIV, of which 68 countries (60%) recognize people living with HIV as key beneficiaries.

In general, countries are failing short of meeting their commitments on social protection, and only 11% of countries report having all six elements of HIV-sensitive social protection.

Figure 5 shows the availability of HIV-sensitive social protection worldwide.

Figure 5. Availability of HIV-sensitive social protection[a]



[a] Data is not collected for Australia, the United States of America or western Europe.

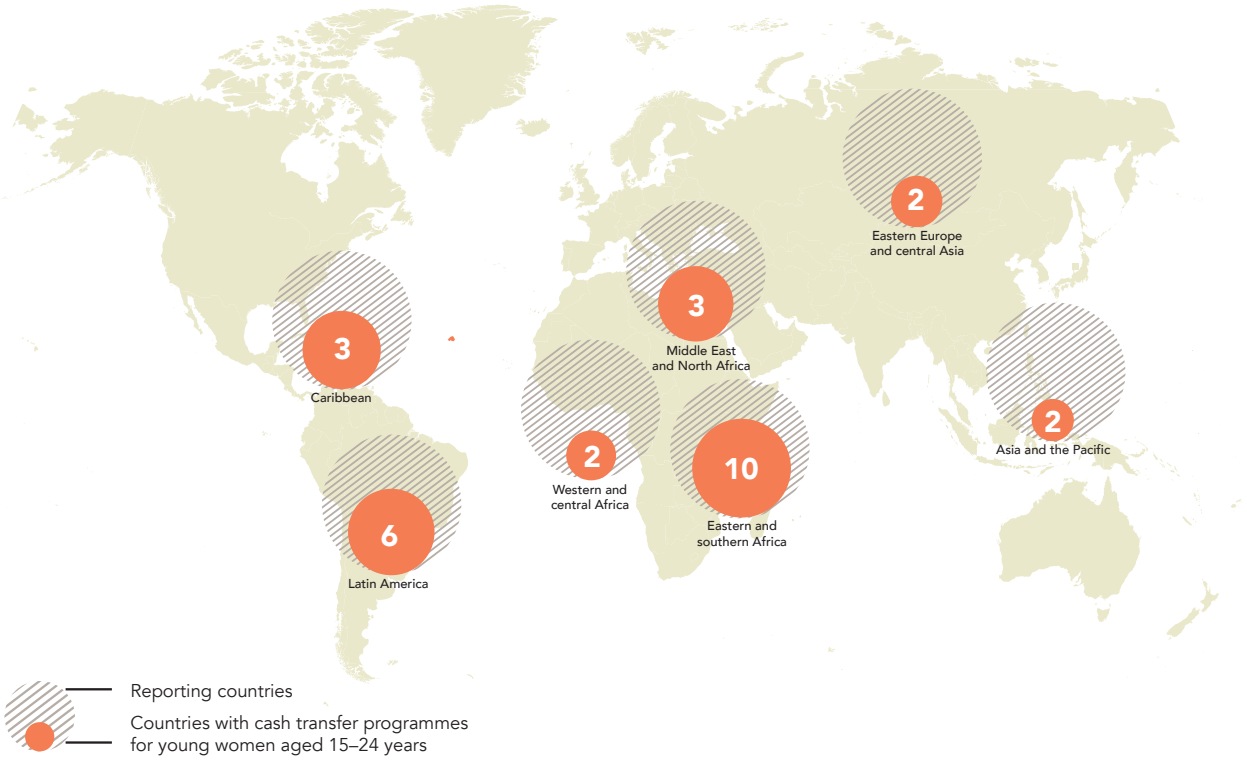
Source: National Commitment and Policy Instument. Geneva: Joint United Nations Programme on HIV/AIDS; 2017.

Recognizing the particular vulnerability that adolescent girls and young women face, a number of countries are developing cash transfer programmes that specifically target this group. Data from the 2017 NCPI reflect on the number of cash transfer programmes globally targeting young women aged 15–24 years. Results indicate that 28 of the 108 reporting countries implement cash transfer programmes aimed at young women in this age group (Figure 6).

Efforts to increase HIV service coverage through cash transfers and financial incentives

Recent reviews indicate that in combination with financial incentives, social protection—in particular, cash transfers—can make an even greater contribution to HIV prevention, treatment, care and support efforts. A combined approach of cash transfers and financial incentives can increase access to and use of HIV services, contributing towards decreasing new HIV infections and better treatment outcomes, including HIV viral suppression.

Figure 6. Status of Cash transfer schemes for adolescent girls and young women



[a] Data is not collected for Australia, the United States of America or western Europe.

Source: National Commitment and Policy Instument. Geneva: Joint United Nations Programme on HIV/AIDS; 2017.

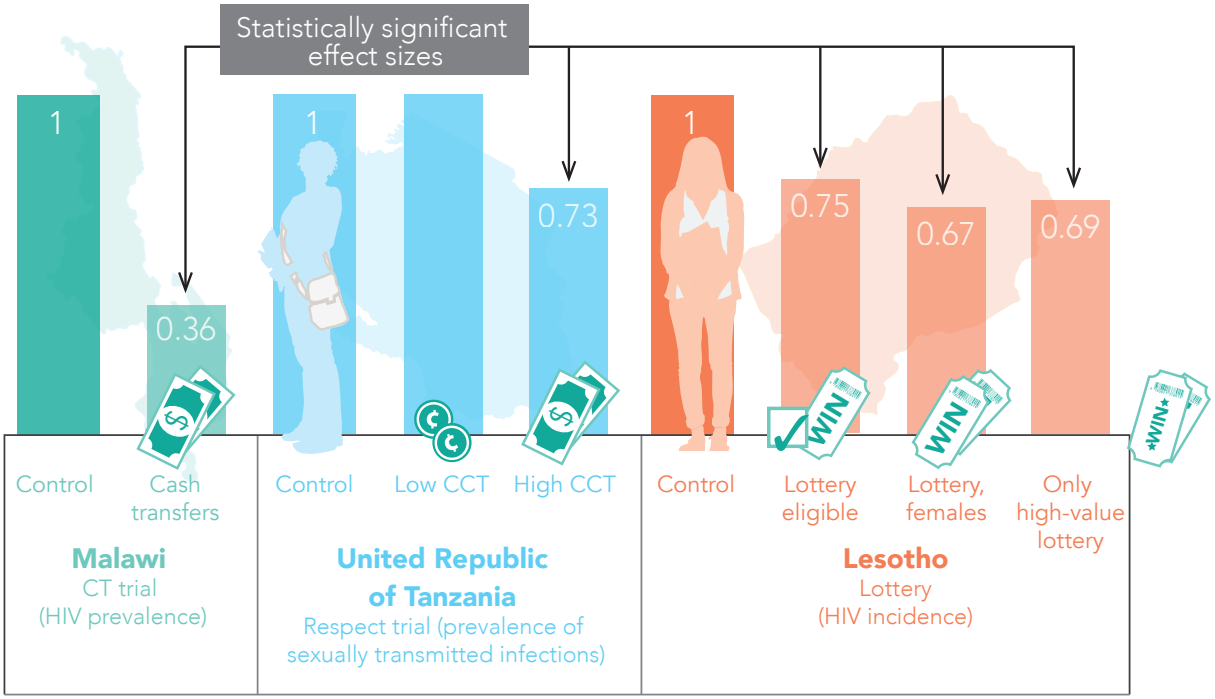
Reducing new HIV infections

Several randomized controlled trials have shown that cash transfers have led to reduced HIV prevalence and incidence. In these studies, school attendance and safer sexual health were directly incentivized through cash transfer schemes, and a positive effect on HIV outcomes was found *(36)*. In landmark randomized control trials in Lesotho *(37)*, Malawi *(38)* and the United Republic of Tanzania *(39)*, social protection including cash transfers and financial incentives reduced HIV risk behaviours, HIV prevalence and HIV incidence where it was measured. Figure 7 shows statistically significant effect sizes of cash transfers on HIV prevention.

A randomized control trial in the Zomba district of Malawi involving more than 1200 never-married, in-school and out-of-school girls and women aged 13–22 years provided cash transfers of US$ 1–15 per month and payment of school fees to young women and their parents. As a result of the programme, teenage pregnancies and early marriage fell by 29% and 32%, respectively. The cash transfers also reduced HIV infections by 64% and HSV-2 prevalence by 76% *(38)*.

In a study in the United Republic of Tanzania, US$ 10 or US$ 20 cash was given to young adults aged 18–30 years and their spouses conditional on being free from

Figure 7. Statistically significant effect sizes of cash transfers on HIV prevention



CCT, conditional cash transfer; CT, cash transfer.

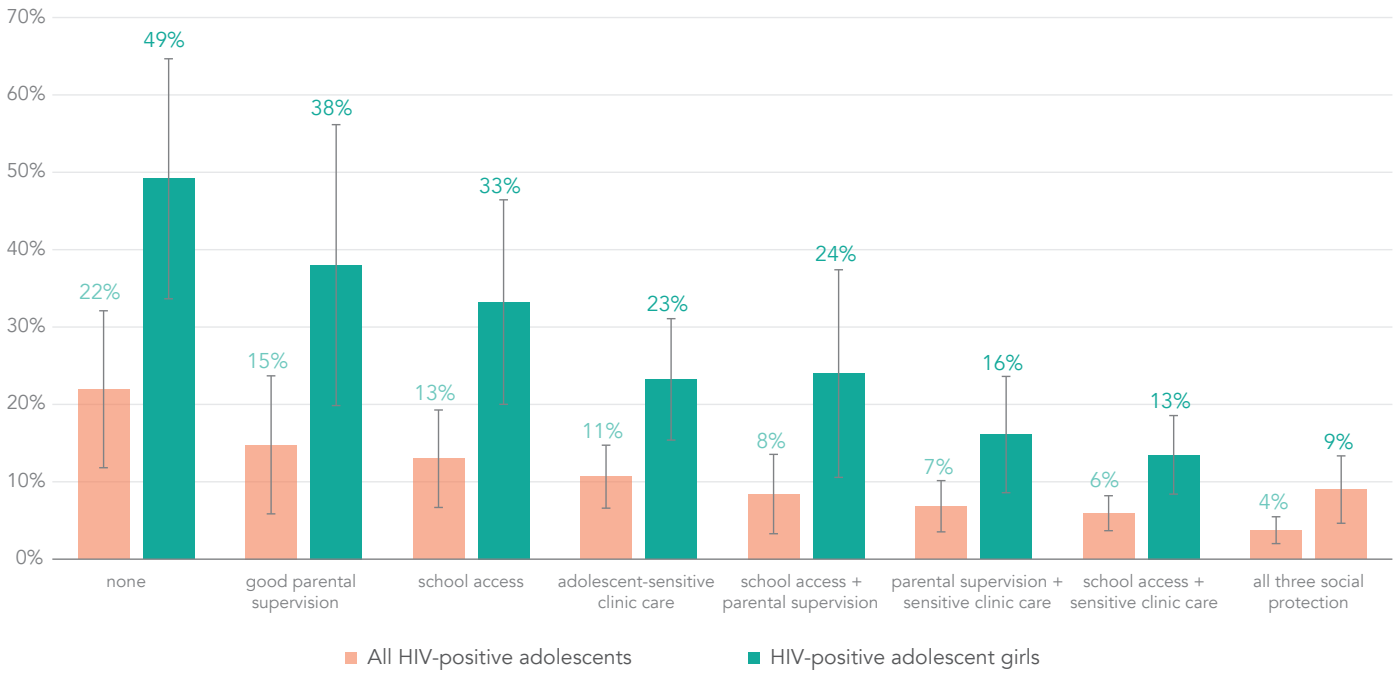
Source: World Bank, based on Baird SJ, Garfein RS, McIntosh CT, Ozler B. Effect of a cash transfer programme for schooling on prevalence of HIV and herpes simplex type 2 in Malawi: a cluster randomised trial. Lancet. 2012;379:1320–1329; De Walque D, Dow WH, Nathan R, Abdul R, Abilahi F, Gong E, et al. Incentivising safe sex: a randomised trial of conditional cash transfers for HIV and sexually transmitted infection prevention in rural Tanzania. BMJ Open. 2012;2:e000747; and Björkman-Nyqvist M, Corno L, Walque DD, et al. Evaluating the impact of short term financial incentives on HIV and STI incidence among youth in Lesotho: a randomized trial. Poster discussion at IAS2013, Kuala Lumpur, 30 June–3 July 2013.

sexually transmitted infections, including HIV, at 4-monthly testing. At 12 months (but not at 4 or 8 months) there was a 20% reduction in curable sexually transmitted infections for the high-value conditional transfer (US$ 20), but no reduction for the low-value transfer (US$ 10) *(39)*.

In Lesotho, a total of 3426 18- to 32-year-olds were randomized to a control group or to 4-monthly testing for sexually transmitted infections linked to tickets for a US$ 100 or US$ 50 quarterly lottery. After two years, a 25% reduction in new HIV infections was observed due to the lottery, with larger reductions among women (33%) *(37)*.

Results suggest short-term financial incentives to engage in safer sex can decrease HIV incidence, adding to the growing body of evidence based on applying social protection in achieving HIV prevention results. Cash transfers do not stand alone. A study in South Africa targeting adolescents living with HIV found that augmenting social

Figure 8. Predicted probabilities of unprotected sex among adolescents living with HIV by access to social protection interventions



Source: Toska E, Cluver LD, Boyes ME, Isaacsohn M, Hodes R, Sherr L. School, supervision and adolescent-sensitive clinic care: combination social protection and reduced unprotected sex among HIV-positive adolescents in South Africa. AIDS Behav. 2017;21:2746–2759.

protection with different elements of care and support can lead to reductions in HIV risk behaviours among adolescents, regardless of whether they know their HIV status, showing that social protection has a role in HIV-positive prevention programmes. In the study, the probability of unprotected sex among adolescents living with HIV without access to social protection was 22% in the full sample and 49% among adolescent girls. These probabilities reduced to 4% and 9%, respectively, with combination social protection: access to free education, good supervision from parents and guardians, and adolescent-sensitive clinic care. The effects were strongest for adolescent girls and young women. Figure 8 shows the impact on adolescents' HIV risk behaviours of combining different components of social protection.

In Kenya, food vouchers worth US $8.75–15 provided to individual men proved successful in encouraging men to access voluntary medical male circumcision. The effect was strongest in men who were already considering being circumcised and in men who received the higher-value voucher. Men offered the higher-value voucher were almost six times more likely to be circumcised compared with the control group. Overall, a significant increase in uptake of voluntary medical male circumcision services was recorded due to the incentive compared with men in the control group who did not

receive the incentive. This increase was large relative to the annual uptake of voluntary medical male circumcision in the population. Countries should consider incentives as part of demand-generation programmes *(40)*.

Studies from Kenya, Lesotho, Malawi, South Africa, the United Republic of Tanzania, Zimbabwe and others have provided proof of concept on the role of cash transfers in reducing HIV-related risk behaviours and HIV prevalence. Two large-scale randomized controlled studies in South Africa did not find an effect of cash transfers on HIV transmission *(41–43)*. While the two studies failed to show an effect of cash transfers on HIV incidence, their results nevertheless provide important insights into the effects of cash transfers on behavioural and other health outcomes. Education is strongly HIV-protective, particularly for adolescent girls and young women. In both studies, young women who dropped out of school were three times more likely to acquire HIV than those who did not drop out of school. In addition, girls who attended less than 80% of classes were three times more likely to become infected with HIV than their peers who attended more than 80% of classes. Tailoring social protection interventions, including cash transfers, to the relevant local context remains important. In both studies, school attendance was already high at 95%, and dropout remained low, limiting the effect of cash transfers on schooling and suggesting that cash transfers may work best in the context of low school attendance and among the poorest groups.

Education matters for HIV prevention

A recent and growing body of work has demonstrated causal associations between greater educational attainment and lower HIV risk in several sub-Saharan African countries. The mechanisms underlying this observed association may include increased exposure of more educated people to HIV prevention messages and uptake of related HIV prevention services, such as condom use, voluntary medical male circumcision *(44)*, antiretroviral therapy for people living with HIV, and selection of less risky partners.

In the early period of the HIV epidemic (1989–1990), it was widely believed that educational attainment was positively associated with HIV prevalence and that more educated populations tended to have higher HIV prevalence. In rural Uganda, researchers found a positive association between educational attainment and HIV prevalence among people aged 30 years and older. When age was controlled for, there was no significant relationship between education and rates of HIV infection during the early HIV epidemic *(45)*.

Ten years later (1999–2000), there was a significant inverse relationship between the level of education and the risk of HIV infection among young people aged 18–29 years. HIV prevalence decreased twice as much among more educated individuals (12 percentage points) than in their non-educated peers (6 percentage points), suggesting that more educated people responded better to the arrival of information about HIV and how to prevent it *(46)*. Additional evidence confirms the HIV prevention role of

education at primary and secondary school level and affirms that the level of education also contributes to HIV prevention:

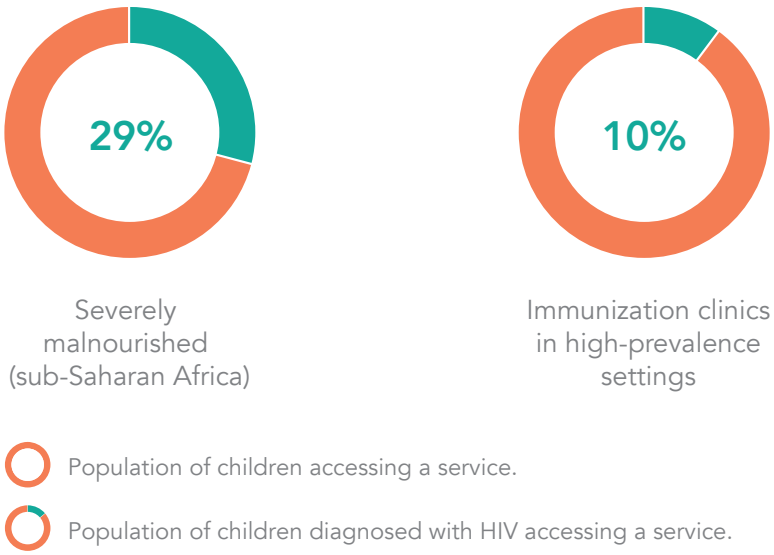
- A study found that one more year of primary schooling decreased the probability of a woman testing positive for HIV by 6% in Malawi and by 3% in Uganda, extending previous findings on the protective effect of secondary schooling on women's HIV status to primary schooling *(46)*.
- A study in rural South Africa found that each additional year of educational attainment was associated with a 7% reduction in the risk of HIV infection after controlling for age, sex, wealth and other variables *(47)*.
- A study of Botswana's policy reform that increased the length of junior secondary schooling by a year showed that the additional year of secondary schooling led to an absolute reduction in the cumulative risk of HIV infection of 8.1 percentage points relative to a baseline HIV prevalence of 25.5%. The effects were particularly large among women (11.6 percentage points) and robust to broad sensitivity analysis *(48)*.

Cash transfers for key populations

Experiences of how cash incentives and economic empowerment strategies are contributing to preventing new HIV infections among key populations are also receiving greater attention. In Mexico City, a study of 1745 men who have sex with men and male sex workers aged 18–25 years found that with a conditional cash transfer of US$ 288 per person per year, 70–80% of men would accept HIV prevention services and stay free of sexually transmitted infections. Testing verified they were negative for HIV and other sexually transmitted infections. This amount was lower for male sex workers, at US$ 156 per person per year. The average estimate of willingness to accept HIV testing was cost-effective and within the range of feasible allocations for prevention in the local context. A full annual course of antiretroviral therapy for a person living with HIV in Mexico costs US$ 5000–7000. Given the potential impact of cash transfers of HIV prevention, countries could explore extending the successful model to targeted HIV and sexually transmitted infection prevention for populations at risk *(49)*.

In Mongolia, female sex workers who participated in a savings-led microfinance programme exhibited a 22% greater decrease in the reported number of paying sexual partners compared with those in the control group. Women assigned to the microfinance group were more than three times more likely to report no unprotected vaginal sex acts and reported 50% fewer paying sexual partners at the six-month interval than their peers who did not participate in the savings-led microfinance intervention *(50)*.

Figure 9. Finding the children: opportunities to offer HIV testing



Source: 90–90–90: an ambitious treatment target to end the AIDS epidemic. Geneva: Joint United Nations Programme on HIV/AIDs; 2014.

Achieving the 90–90–90 targets

Evidence is mounting on how social protection including cash transfers can support the 90–90–90 HIV testing, treatment and viral suppression goals. Viral suppression refers to the decrease to undetectable levels of HIV in the bloodstream of a person living with HIV who is on treatment, thus improving their health and reducing the risk of transmitting the virus to others.

Evidence including a systematic review of the literature on incentivizing testing for HIV and sexually transmitted infections found higher rates of uptake of HIV counselling and testing in the incentive groups compared with the non-incentive groups, indicating the critical role of monetary and non-monetary incentives to increase testing, although programming guidance on integrating incentives in HIV counselling and testing remains lacking *(51–54)*.

Social protection programmes providing food to severely malnourished children in sub-Saharan Africa have the potential to reach 29% of children living with HIV with counselling and testing who would otherwise not be diagnosed with HIV (Figure 9) *(55)*.

In the United States of America, conditional cash incentives among people living with HIV with detectable viral loads increased the proportion of undetectable viral loads from 57% to 69% *(56)*. Another study in the United States found that people living with HIV accessing the Ryan White HIV Assistance Programme, a programme providing HIV treatment to underinsured people, were 94% more likely to be prescribed antiretroviral

therapy and 77% more likely to be virally suppressed compared with people with private insurance or no insurance *(57)*. These findings highlight the importance of insurance in some contexts to pay for HIV treatment as a critical factor for health providers to prescribe antiretroviral therapy to people living with HIV.

A study conducted in the Democratic Republic of the Congo found that offering women living with HIV US$ 5 cash incentives for attendance at an antenatal clinic for prevention of mother-to-child transmission services improved retention and uptake of services. The incentive increased by US$ 1 at each clinic visit, provided the women remained in care and adhered to the prescribed prevention services. At six weeks after delivery, 81% of women who received cash incentives were still in the prevention programme compared with 72% women who did not receive the incentive. Similarly, loss to follow-up was reduced by close to half (47%); and adherence to prevention services, including delivering in the health facility, increased by a third (32%) *(58)*.

Tuberculosis (TB) is the most frequent opportunistic infection in people living with HIV, whether or not they are on HIV treatment *(59)*. TB remains the leading cause of hospitalization and deaths among adults and children living with HIV *(60)*. HIV and TB independently and collectively can worsen poverty by reducing people's physical strength and ability to work, ultimately leading to loss of income. The economic impact on the household is exacerbated by the costs incurred while seeking health care. Social protection strategies tested in this study include access to health care, financial protection against the cost of seeking care, and poverty-alleviation strategies *(61)*.

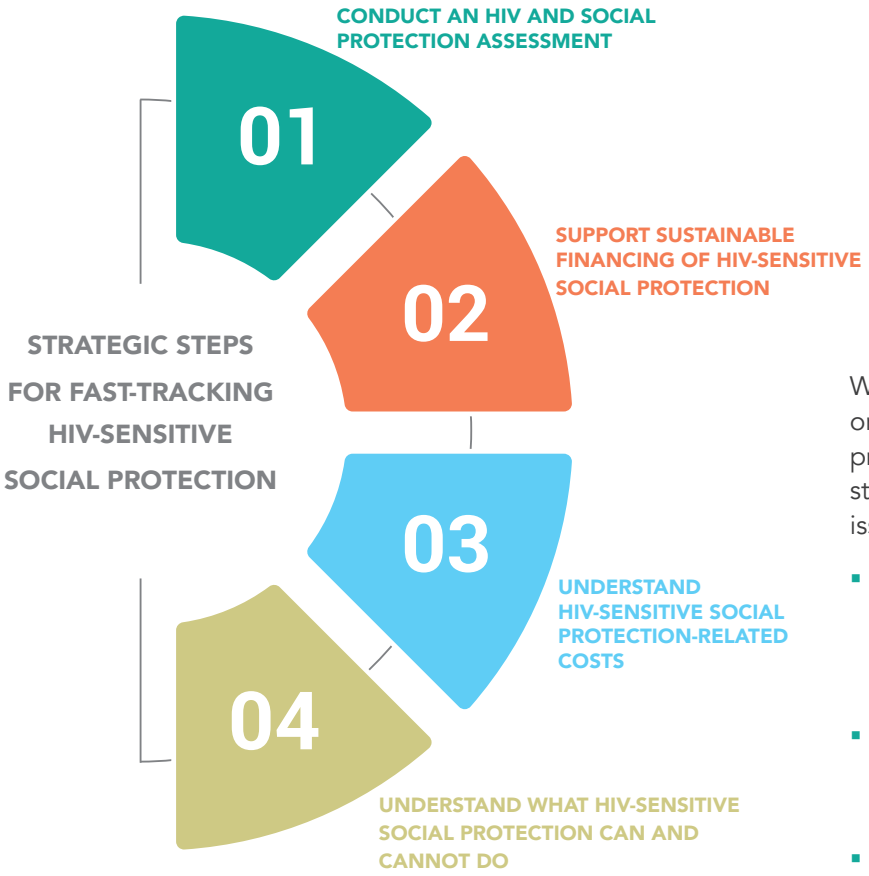
Rolled out in communities with a high HIV/TB burden, these strategies have the potential to improve people's access to HIV/TB services and reduce people's vulnerability to HIV and TB by improving their socioeconomic position and food security in terms of food availability and diversity *(62)*.

An evaluation of the role of *Bolsa Familia* (one of the largest cash transfer programmes in the world) in Brazil found 82.1% TB cure rates among people receiving the cash transfer. This rate was 5.2% higher than among people not exposed to the cash transfer. The association was higher among people not on the directly observed treatment, short-course regimen *(63)*, suggesting the cash transfer has potentially stronger effects among people who are less likely to access and be retained in standard TB care.

A 2015 study found that for a country spending 0% of its gross domestic product (GDP) on social protection, moving to spending 1% of its GDP on social protection was associated with a change of –18.33 (–32.10 to –4.60) per 100 000 people in TB prevalence, –8.16 (–16.00 to –0.27) per 100 000 people in TB incidence, and –5.48 (–9.34 to –1.62) per 100 000 people in TB mortality, highlighting that investments in social protection could reduce the burden of TB *(64)*. Governments should invest not only in diagnosing, treating and supporting people living with HIV/TB, but also in fighting poverty through social protection *(65)*.

Strategic steps for Fast-Tracking HIV-sensitive social protection

Figure 10. Strategic Steps for Fas-Tracking HIV-sensitive social protection



When exploring opportunities for introducing or enhancing the HIV sensitivity of social protection programmes nationally, stakeholders need to consider a range of issues, including:

- What is the legal environment and political economy of social protection that could support or impede its HIV sensitivity in the country and specific geographical area?
- Which geographical areas and populations are targeted by the available social protection programmes?
- What, where and how are the services delivered?
- Are people living with, at risk of or affected by HIV included in these programmes? If not, how much will it cost to remove barriers for people to access benefits?
- How sustainable, durable and large will the HIV outcomes (if any) of the social protection programmes be?

In addition, stakeholders will need to be conversant with the common myths preventing the scale-up of social protection programmes.

STEP 1

Conduct an HIV and social protection assessment

To help countries better understand their HIV and social protection landscapes, and strengthen their capacities for planning and implementing robust HIV-sensitive social protection programmes, UNAIDS and partners have developed an HIV and social protection assessment tool. The tool is available on the UNAIDS website (http://www.unaids.org/sites/default/files/media_asset/HIV-social-protection-assessment-tool_en.pdf) in

- English,
- French,
- Spanish,
- Russian and
- Portuguese.

The tool consists of an online survey that assists countries to gather information on the existing social protection programmes; the key social protection players; what the programmes do; which populations the programmes target; the geographical areas in which the programmes operate; the size of programme spending on social protection; whether people living with HIV, adolescent girls and young women at higher risk of HIV infection, and key populations are accessing social protection benefits; the key barriers people face in accessing social protection benefits; and what can be done to eliminate such barriers and include these populations in existing social protection programmes. The assessment also assists in understanding local evidence on social protection and HIV programming and data gaps in understanding how many people living with, at risk of or affected by HIV receive different kinds of social protection and social services.

Countries should conduct the HIV and social protection assessment before designing HIV and social protection programmes or advocating for HIV-sensitive social protection programmes. The assessment forms the basis for planning of effective HIV and social protection programmes. Detailed instructions and steps for conducting the assessment are in the HIV and social protection assessment tool.

Among the key information the assessment provides are the political economy of social protection programming in the country; the status, coverage and financing landscape of social protection programming; common myths on social protection programmes; and opportunities for increasing the HIV sensitivity of the programmes.

STEP 2

Support sustainable financing of HIV-sensitive social protection

Stakeholders should work with governments to secure sustainable financing of social protection programmes. Social protection programmes embedded in national plans and statutes are more likely to be sustainable. Political buy-in is key to sustainable financing

Table 1. Countries' spending on social protection as percentage of gross domestic product (GDP)

% of GDP	<1.6%	1.6–2.92%	>2.92%
Countries[a]	Albania, Argentina, Armenia, Azerbaijan, Bahrain, Bangladesh, Benin, Bhutan, Bolivia (Plurinational State of), Botswana, Bulgaria, Burkina Faso, Cabo Verde, Cambodia, Cameroon,[b] China,[b] Colombia, Costa Rica, Djibouti, Dominican Republic, Egypt, El Salvador, Ethiopia,[b] Fiji, Gambia, Ghana, Guatemala, Guyana, Honduras, India,[b] Indonesia,[b] Jamaica,[b] Jordan, Kazakhstan, Kuwait, Lao People's Democratic Republic, Latvia, Lebanon, Madagascar, Malaysia, Maldives, Mali, Marshall Islands, Mauritania, Mexico, Mozambique,[b] Nepal, Niger, Nigeria,[b] Panama, Papua New Guinea, Paraguay, Peru, Philippines, Poland, Republic of Moldova, Saint Kitts and Nevis, Saint Lucia, Samoa, Saudi Arabia, Senegal, Sudan, Suriname, Syrian Arab Republic, Tajikistan, Thailand, The former Yugoslav Republic of Macedonia, Togo, Tunisia, Turkey, Uganda,[b] United Republic of Tanzania,[b] Uruguay, Vanuatu, Viet Nam,[b] Yemen, Zambia,[b] Zimbabwe[b]	Belarus, Belize, Brazil,[b] Chile, Ecuador, Eritrea, Iraq, Kenya,[b] Liberia, Lithuania, Montenegro, Morocco, Nicaragua, Pakistan,[b] Rwanda, Saint Vincent and the Grenadines, Serbia, Seychelles, Slovakia, Slovenia, Swaziland,[b] Trinidad and Tobago	Bosnia and Herzegovina, Burundi, Croatia, Estonia, Georgia, Hungary, Kiribati, Kyrgyzstan, Lesotho,[b] Mauritius, Mongolia, Namibia, Romania, Russian Federation,[b] Sierra Leone, South Africa,[b] Timor-Leste, Ukraine[b]

[a] Only low- and middle-incomes countries are included.
[b] Fast-Track countries.
Source: Status of cash transfers. Washington, DC: World Bank; 2015

of social protection programmes *(66)*. Advocates should start with social protection goals that politicians can own and sell to their constituencies, such as ensuring social protection programmes are backed by national statutes, are non-discriminatory, are included in government planning cycles, and articulate the political and economic pay-offs and social welfare gains obtained from investing in effective functioning social protection programmes.

At the same time stakeholders should be careful to ensure HIV-affected communities are not "last in line" by addressing the policy and programme barriers that may prevent people living with, at risk of or affected by HIV from accessing social protection programmes. Barriers should be addressed early on in programme design and corrective measures undertaken during implementation. In cases where particular populations may be excluded or not accessing social protection programmes, as may happen in conflict and fragile contexts, there may be a need to establish HIV-specific social protection programmes to address gaps in coverage. Such programmes, however, should be developed with a view towards inclusion in broader government-led social protection programmes to ensure continuity and sustainability.

Table 1 shows countries' spending on social protection as a percentage of GDP. With the exception of Brazil, Kenya, Lesotho, Namibia, the Russian Federation, South Africa, Swaziland and the United States, all Fast-Track countries spend less than 1.6% of GDP on social protection but would benefit from increasing this.

Actors seeking to maximize the multiple impacts including HIV outcomes of social protection programmes may consider increasing their spending on social protection as a proportion of their country's GDP.

In countries spending less than 1.6% of GDP on social protection, stakeholders may consider joining efforts to advocate for increased budgetary allocations to expand social protection programmes, particularly social assistance in order to maximize the positive impact of social protection programmes, including on HIV outcomes. Normally social assistance programmes in low- and middle-income countries aim to meet 20% of household consumption budgets. Stakeholders should seek resources from the Global Fund to Fight AIDS, Tuberculosis and Malaria and development partners to support the expansion of stronger functioning of social protection above the 20% threshold to obtain more and widespread programme impacts *(67)*. See the 2014 UNAIDS *HIV and social protection guidance note (34)* for a list of funders working on social protection.

Countries spending more than 1.6% of GDP on social protection could undertake additional activities to strengthen the HIV sensitivity of existing social protection. In such countries, social protection programmes may be operating at scale and be small, but catalytic financing from HIV budgets may be necessary to ensure HIV does not fall through the cracks; however, the technical engagement of stakeholders working on HIV in social protection will be required. Depending on the HIV epidemic context, activities could include creating an enabling legal environment; addressing stigma and discrimination that prevents people living with, at risk of or affected by HIV from accessing social protection benefits; creating referrals and linkages to social services as necessary; and embedding HIV monitoring in social protection management information systems to gauge the breadth and depth of coverage and benefits received by people living with, at risk of or affected by HIV.

Investments in social protection do not replace investments in basic HIV programmes, such as preventing mother-to-child transmission of HIV; condom promotion and distribution; treatment, care and support for people living with HIV; pre-exposure prophylaxis; voluntary medical male circumcision; behaviour change programmes; and activities for key populations at higher risk, especially sex workers and their clients, men who have sex with men, transgender people and people who inject drugs; rather, they are meant to be catalytic and enhance the effectiveness of basic HIV programmes *(68)*.

UNAIDS Fast-Track modelling for ending the AIDS epidemic as a public threat by 2030 suggested that AIDS budgets should fund the total cost of cash transfer programmes to put and retain adolescent girls and young women in school in eastern and southern African areas with low secondary school enrolment rates at the 100% level through 2020, declining to 30% by 2030. The model suggests that social enablers and development synergies that include elements of social protection constitute 19% of total AIDS annual resource needs by 2020. The model further shows that investing US$ 240 in cash transfers per year per adolescent girl or young woman aged

15–24 years in areas of low education enrolment among adolescent girls and young women in eastern and southern Africa would lead to a reduction of 40% in new HIV infections among this group *(68)*.

Recent research indicates that multisectoral HIV programmes are more likely to be funded (but more likely to exceed individual decision-makers' willingness to pay thresholds) under a cofinancing model than if each sector computes the HIV programme's value independently. A co-financing model finds that it is possible to jointly fund structural interventions that have multiple benefits, for example on HIV, poverty, education, maternal and child health, but where no sector is willing to fund the total amount *(69)*, reinforcing the importance of creating a unifying platform for planning and financing HIV and social protection.

STEP 3

Understand HIV-sensitive social protection-related costs

Stakeholders will need to have contextually relevant unit costs for different instruments of social protection—for example, the annual unit costs of providing basic financial security and increasing access to essential health and social services to an household affected by HIV. These costs may be available from existing social protection programmes in different sectors and from HIV programmes. In cases where this information is not available, a method for collecting the data should be developed.

Data from the HIV and social protection assessment may also help in understanding the unit costs of providing HIV sensitive social protection. For example, the cost per person of receiving cash transfers or grants, and the costs associated with covering or removing exclusion clauses for key populations so they may access health insurance, pensions and social services, should be quantified. Such information will inform the planning of HIV and social protection programmes. Table 2 shows indicative unit cost estimates for HIV-sensitive and HIV-specific social protection.

Table 2. Indicative unit costs and expected outcomes from selected programmes

Unit cost	Expected outcomes	Reference
US$ 15 per month per adolescent girl or young woman	Reduce chances of contracting HIV by 60%; lower HSV-2 by 76%; reduce number of sexual partners by 25%; reduce early marriage by 40%; lower teenage pregnancy by 30%; reduce likelihood of dropping out of school in Malawi by 35%	Baird SJ, Garfein RS, McIntosh CT, Ozler B. Effect of a cash transfer programme for schooling on prevalence of HIV and herpes simplex type 2 in Malawi: a cluster randomised trial. Lancet. 2012;379:1320–1329
US$ 5 cash per antenatal clinic visit per pregnant woman living with HIV, increased by US$ 1 for each subsequent visit	Enables women to attend prevention of mother-to-child transmission services in the Democratic Republic of the Congo	Yotebieng M, Thirumurthy H, Moracco KE, Kawende B, Chalachala JL, Wenzi LK, et al. Effectiveness of conditional cash transfers to increase retention in care and adherence to PMTCT services: a randomized controlled trial. Abstract TUAD0202, presented at IAS2015, Vancouver, 21 July 2015
US$ 4.26–20 per month per person living with HIV	Enables people living with HIV to pay for transport to collect medicines and food and buy productive assets to enable them to earn a living in a low-income country	Miller C, Tsoka T. ARVs and cash too: caring and supporting PLHIV with the Malawi Social Cash Transfer. Trop Med Int Health. 2012;17:204–210
Food voucher worth US$ 8.75–15 per man	Six times more effective at encouraging men to undergo voluntary medical male circumcision compared with no incentive in Kenya	Thirumurthy H, Masters SH, Rao S, Bronson MA, Lanham M, Omanga E, et al. Effect of providing conditional economic compensation on uptake of voluntary medical male circumcision in Kenya: a randomized clinical trial. JAMA. 2014;312:703–711
US$ 30 per month per vulnerable household with a child aged under 18 years	53% reduction in incidence of transactional sex, 71% reduction in age-disparate sex, 16% less likely to have had sex, and fewer pregnancies compared with people who did not receive a grant	Cluver L, Boyes M, Orkin M, Pantelic M, Molwena T, Sherr L. Child-focused state cash transfers and adolescent risk of HIV infection in South Africa: a propensity-score-matched case–control study. Lancet Glob Health. 2013;1:e362–e370
US$ 288 cash incentive per year per man who has sex with men	Encourages men who have sex with men to test for and remain free of HIV in Mexico	Galárraga O, Sosa-Rubí SG, Infante C, Gertler PJ, Bertozzi SM. Willingness to accept conditional economic incentives to reduce HIV risks among men who have sex with men in Mexico City. Eur J Health Econ. 2014;15:41–55
US$ 44 for achieving prespecified targets, e.g. initiation of antiretroviral therapy, visits to antiretroviral therapy centre	Modest voucher incentives (food/household goods) improved linkage to and retention in HIV care but did not significantly impact on viral suppression among people who use drugs in India	Solomon SS, Srikrishnan AK, Vasudevan CK, Anand S, Kumar MS, Balakrishnan P, et al. Voucher incentives improve linkage to and retention in care among HIV-infected drug users in Chennai, India. Clin Infect Dis. 2014;59:589–595

STEP 4

Understand what HIV-sensitive social protection can and cannot do

Often stakeholders working on HIV and social protection will be faced with the question of durability of HIV impacts derived from social protection. Actors will need to understand that the durability of the effects of social protection including cash transfers on HIV prevention, treatment, care and support after the programme ceases is limited. The effects of cash transfers on HIV prevention, treatment and care cease once the transfers are withdrawn. Even the most effective interventions such as antiretroviral therapy, pre-exposure prophylaxis and condoms work only if they are used correctly and consistently. Voluntary medical male circumcision is a once-in-a-lifetime intervention whose HIV protective effect is sustained; for maximum protection, however, circumcised men are still required to adhere to safer sex practices, including reducing the number of sexual partners, and using condoms consistently and correctly. Similarly, social protection is not a substitute for, but is complementary to, basic HIV programmes.

In addition, stakeholders will need to be conversant with the common myths associated with social protection and cash transfer programmes and how to address such myths locally. Among the most common myths regarding social protection programmes including cash transfers are that they encourage dependency, increase the misuse of transfers through spending on alcohol and tobacco use, increase fertility, and do not encourage investments among programme recipients. Other myths claim that social protection programmes including cash transfers distort local economies and that they are generally unaffordable by low- and middle-income countries. Through rigorous approaches, these claims have been found to be what they are—myths and not backed up by evidence. In some cases, the opposite has been found. For example, in Lesotho, cash transfers decreased alcohol and tobacco use among recipients *(70)*.

Practical steps for Fast-Tracking HIV-sensitive social protection

Following assessment to clarify understanding of the political economy of financing HIV-sensitive social protection, relevant unit costs for increasing the HIV sensitivity of social protection programme, the HIV-sensitive social protection that can feasibly be attained in a given location, and for which particular populations, stakeholders should consider which combinations of HIV-sensitive provision provisions best fit and meet the local HIV epidemic and social protection context.

In general, stakeholders should consider enhancing the economic security of people living with, at risk of or affected by HIV; increasing the enrolment and retention in secondary school education of adolescent girls and young women with pathways to economic empowerment; and collaborating with like-minded movements for ending AIDS, poverty and inequality. This approach could take the form of four implementation pillars whose combinations, sequence and pace of implementation would be defined locally, depending on the HIV epidemic and scope of implementation of social protection.

Figure 11. Practical Steps for Fast-Tracking HIV-Sensitive Social Protection

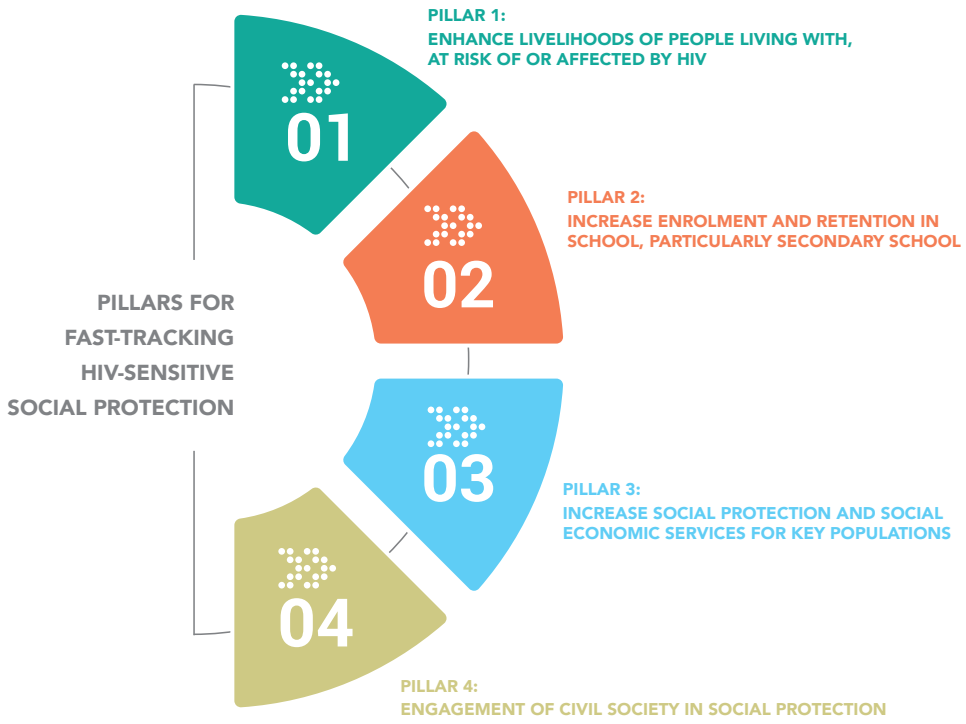


Figure 12. Social protection and livelihood services for people living with or affected by HIV

	Children and adolescents	Adults	People affected by HIV
Incentives	X	X	X
Social Assistance	X	X	X
Socioeconomic Approaches	X	X	X

PILLAR 1

Pillar 1: Enhance livelihoods of people living with, at risk of or affected by HIV

Pillar 1 includes scaling up and progressively broadening in scope and depth sustainable social protection programmes that enhance care, support and treatment outcomes for people living with HIV, and HIV prevention outcomes for key populations, women and girls, vulnerable families and caregivers. These programmes should include insurance programmes, food and nutrition support, employment and economic empowerment.

National capacity to implement and scale up HIV-sensitive social protection and child-sensitive social protection must be strengthened, and national health financing or social protection strategies that explicitly address HIV should be put in place. Depending on the epidemic profile, the AIDS response of each country, and the location and scope of HIV and social protection services, it may be necessary to refine or add new components of social protection services and create linkages to other complementary programmes, including social services as appropriate. Figure 10 shows the key proposed activities of enhancing the livelihoods of people living with or affected by HIV.

Specific efforts should be focused on the following activities:

- Financial incentives: reduce the number of people living with HIV and facing catastrophic costs due to the virus *(71)* by reducing barriers, including those related to the cost of accessing HIV services. To encourage the use and uptake of HIV services, clinic appointments should be linked with appropriate cash incentives or near-cash incentives such as food.

- Social assistance: increase the number of people living with HIV accessing social protection programmes and economic empowerment services by increasing the HIV sensitivity of social protection programmes and the availability of appropriate health insurance programmes; integrate food security and nutrition into national HIV, health and social protection, and increase access to these services for people living with HIV; and strengthen community-based organizations, support groups of people living with HIV, referral networks and linkages.
- Social economic approaches: increase the availability of socioeconomic empowerment opportunities, including formal employment opportunities, asset acquisition, access to savings-led credit, and income- and savings-based activities such as microfinance, child accounts and matched savings accounts. This approach would also help improve families' economic security and stability, thereby reducing intimate partner violence and child maltreatment *(72)*.

Implementation considerations

Financial incentives should be available to encourage eligible people to access and adhere to HIV treatment and be retained in HIV care. These incentives should be linked with clinic appointments and clinical outcomes, including viral suppressions as necessary and feasible by country context.

HIV programmes should also link with social protection programmes to provide economic strengthening and livelihood programmes for eligible people living with, at risk of or affected by HIV. Where provision of this service is not feasible, HIV programmes should work to connect eligible people to existing social assistance and economic empowerment programmes.

Subi project, Uganda: an example of a multi-pronged economic empowerment programme for adolescents

Uganda's Subi project focused on economic empowerment of families caring for children orphaned due to AIDS. The intervention had three key components:

- it promoted family-level income-generating projects (micro-enterprises) that enhanced economic stability, reduced poverty, and enhanced protective family processes for youths orphaned by AIDS;
- it promoted monetary savings for educational opportunities for children orphaned due to AIDS; and
- it provided an adult mentor to children.

Adolescents in the condition group received, in addition to the usual care, an economic empowerment intervention aimed at promoting asset accumulation for families. The intervention consisted of three major components:

i. workshops focused on asset-building and future planning;

ii. a monthly mentorship programme for adolescents with peer mentors on life options; and

iii. a child development account, dedicated to paying for secondary schooling, vocational training or a family small business.

The child development accounts were matched savings accounts with a match rate of 2 : 1 as an incentive for participants to save, but with a limit on the maximum savings that could be matched (equivalent to US$ 10 a month).

Results indicated that adolescents in the intervention group significantly increased their cash savings over time compared with adolescents in the control group. At 24 months post-baseline, 92% of intervention adolescents had accumulated savings compared with 43% in the control group. The largest changes in savings goals were the proportion of adolescents in the intervention group valuing saving for money to buy a home, pursue vocational training or start a business. Adolescents in the intervention group also had a significant relative increase over time in HIV-preventive attitudinal scores, most commonly towards perceived risk of HIV, sexual abstinence or postponement, and consistent condom use. In addition, adolescents in the intervention group had 2.017 (1.43–2.84) significantly greater odds of a maximum HIV-prevention score. To minimize HIV risk throughout adolescence and young adulthood, long-term strategies are needed to integrate youth economic development, including savings and income generation, with age-appropriate combination prevention interventions *(73)*.

PILLAR 2

Pillar 2: increase enrolment and retention in school, particularly secondary school

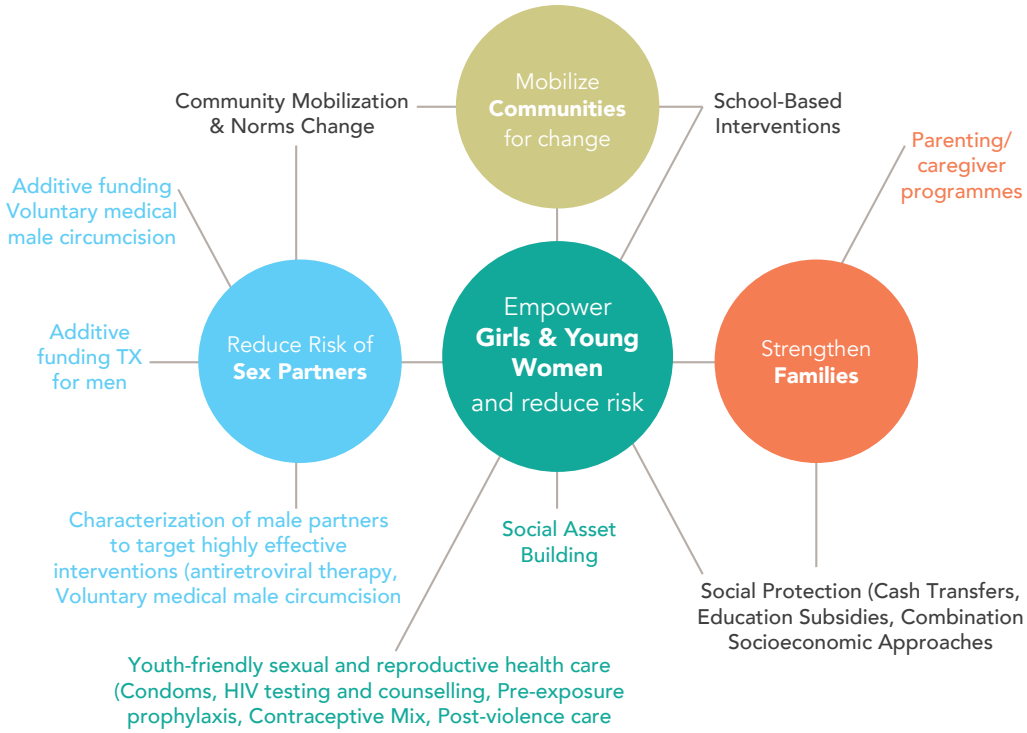
Increased financial pressure to accommodate new demands of transitioning into adulthood, such as new clothes, technology and social participation, may lead to students engaging in transactional sex and sex work. Adolescents physiologically transition into adulthood until age 18–19 years. Epidemiologically, this is also the period when new HIV infections increase dramatically among adolescent girls and young women. It is also the time when critical social support interventions including cash transfers provided for this group stop, thus making the group more vulnerable.

Stakeholders should consider increasing the number of adolescents entering and staying in secondary school. This may include deliberate efforts to increase the enrolment of children in primary school and support them to pass examinations for entry into secondary school. Appropriate care and support need to be provided to adolescents to enable them to enrol and stay in school. This could consist of combination supportive policies for repeat and re-entry into school; comprehensive sexuality health and reproductive health programmes, including access to condoms; education scholarships; fee-waivers; and empowerment programmes.

Figure 11 shows the activities by age band that may help adolescent girls and young women enrol and remain in school and support their safe transition into employment, specifically:

- Advocate for enrolling and retaining children, adolescents and young people in primary, secondary and tertiary education. Such advocacy would focus on increasing the demand for schools by removing barriers to attending schools, for example by removing user fees and other costs to education, such as school uniforms, books, tuition and transport. Supply of good-quality schools that enable children to learn should be encouraged through motivating and retraining teachers and equipping them with the right tools to improve learning outcomes.
- Provide cash transfers in combination with care and support to girls in secondary school who are likely to drop out of school. Girls who drop out and those at the margins of dropping out (attending less than 80% of classes) are three times more likely to acquire HIV than their peers who do not drop out and attend more than 80% of classes *(41)*. For such girls, reducing the cost of education is insufficient to reduce exposure to sexually transmitted infections, including HIV *(74)*. Providing cash transfers in combination with care and support, including school-based food and nutrition, sexual and reproductive health, mentoring, teacher support, and role modelling to secondary school adolescents are key strategies to reach adolescents and retain them in secondary schools.
- Develop complementary economic empowerment programmes targeting adolescents. Human capital accumulation through acquiring formal education and skills transfer to increase lifetime earnings are common strategies for economic

Figure 13. Core package of the Determined Resilient Empowered AIDS-Free Mentored Safe women (DREAMS) programme



Source: PEPFAR DREAMS core package: working together for an AIDS-free future generation of girls and women.

empowerment. Other strategies include savings-led microfinance to develop employment and income-generating opportunities designed to foster economic independence and greater equality and equity in attaining productive livelihoods.

Implementation considerations

Addressing the risks of dropping out of school is an important part of an effective HIV prevention strategy. HIV programmes may need to identify girls likely to drop out, and then understand and act on the predisposing factors for dropping out, such as early marriage, teenage pregnancy, hunger, abuse at school and in the family, orphan-hood and HIV infection in the family.

Adolescent girls and young women out of school or likely to drop out of school should be identified and linked to appropriate social assistance, cash transfers and economic empowerment services. Such services may not only help adolescent girls and young women enrol and remain in school but also protect them from HIV or enable them to cope with HIV.

Figure 11 shows the core component of the United States President's Emergency Plan for AIDS Relief (PEPFAR) and partners' Determined Resilient Empowered AIDS-Free Mentored and Safe Women (DREAMS) programme, which seeks to target and saturate selected geographical areas of a country with a package of approaches to prevent HIV infections among adolescent girls and young women.

PILLAR 3

Pillar 3: Increase social protection and social economic services for key populations

It is important to secure and increase access to essential health services for key populations. Examples include removing the legal barriers that key populations face in accessing services; advocating for free health care at the point of use, birth registrations, and provision of identity cards for populations most likely to be excluded from accessing health services, such as transgender people; refunding the costs of transport for health-care appointments (this is not the same as contingency programmes focusing on increasing incentives to increase access to health care for key populations); health facility-based feeding and nutrition programmes; housing and related subsidies; and reducing stigma and discrimination.

With the exception of people in prison, demand- and supply-side financial incentives may need to be provided to key populations and other high-risk populations to increase access to and use of HIV services. Demand-side financial incentives may be targeted at offsetting costs from seeking HIV services, such as travel and lost time from work and other economic activities. Supply-side incentives such as performance-based financing may focus HIV programmes towards key populations. The size, form, frequency and delivery of the incentives will have to be determined locally.

Key populations and other high-risk populations eligible for existing social assistance programmes may need to be connected to such programmes. Addressing the legal barriers that often prevent key populations from accessing HIV and social services would go a long way to enabling such populations to benefit from accessing such services. The absence of an enabling environment should not stop the provision of services to key populations. Subsidized housing for homeless people who inject drugs, access to food security programmes, transport vouchers and transport support systems that are free at the point of use are important services to increase the use of and retention in HIV services for key populations.

In addition to financial incentives and social assistance programmes, key populations and other high-risk populations may need access to livelihood-strengthening programmes alongside HIV services. These activities may include asset-building programmes, savings-led microfinance, financial management skills, income-generating programmes and other economic empowerment programmes. These programmes contribute to addressing the structural drivers that increase the vulnerability of people, including gender-based violence, inequality and disempowerment, such as:

- Remove barriers to accessing essential health services for people living with, at risk of or affected by HIV. Although health services may be free at the point of use, the accompanying services and the process of obtaining the services impose an economic cost that recipients may not be able to bear. Medical health, including antiretroviral therapy, may be free, but recipients may have to pay for certain tests or buy medicines for opportunistic infections from private pharmacies due to stock-outs

at public hospitals *(75)*. People may have to pay for transport or lose a day's wages to attend clinic appointments. Activities that bring good-quality services closer to people, reduce the number of hospital appointments, provide transport support, and offer other incentives that offset the opportunity costs of access to health care are especially required.

- Provide care and support as defined nationally to key populations. These are services that are crucial to the well-being and survival of people living with HIV and their caregivers, orphans and other vulnerable children. Care and support are needed from the point of diagnosis throughout the course of HIV-related illness, regardless of the person's ability to access antiretroviral therapy.

Voucher incentives increase linkage to and retention in care for people who inject drugs in Chennai, India *(76)*

People who inject drugs, a population that accounts for some of the fastest-growing HIV epidemics globally, lag behind other populations with regard to HIV-related outcomes. A piloted study evaluated the role of voucher incentives on linkage to and retention in care among people who inject drugs in India. In this randomized clinical trial, 120 people living with HIV who inject drugs, aged 18 years or older, not on antiretroviral therapy, and who reported drug use in the prior month were randomized to incentive or control conditions for 12 months. Participants randomized to the incentive arm received vouchers redeemable for food or household goods, ranging in value from US$ 4 to US$ 8, for achieving prespecified targets, such as initiation of antiretroviral therapy and visiting an antiretroviral centre. The primary endpoint was time to initiation of antiretroviral therapy. The median value of voucher incentives earned by participants in the incentive arm was 2200 rupees (1200–2600 rupees; about US$ 44), and the median value of voucher incentives earned by participants in the control arm was 1900 rupees (1600–2400 rupees; about US$ 38).

Modest voucher incentives improved linkage to and retention in HIV care but did not significantly impact on viral suppression among people who inject drugs in India, a disenfranchised and difficult-to-treat population. In this trial, the incentive was designed to compensate a day's wages of the average person who injects drugs in Chennai. Incentives were provided as food and household goods, providing additional benefit for participants' families. This modest incentive had a meaningful impact on linkage to care, initiation of antiretroviral therapy, and retention in care. People who inject drugs in the incentive arm also had more visits to government antiretroviral centres. These findings illustrate the potential of voucher incentives to improve multiple steps along the HIV care continuum.

Implementation considerations

Services for key populations are interdependent. HIV services yield the most benefit when they are provided in combination with other services and when an enabling environment is in place. An enabling environment may include laws and policies that do not criminalize the identity or social practices of key populations; however, provision of HIV services should not be delayed because an enabling environment is missing or other services are not in place.

In addition, key populations should have access to HIV services, regardless of their identity, drug use or status; for example, HIV services should not be delayed until people are no longer using drugs or alcohol. Although creating an enabling environment may be outside the control of HIV service providers, it is important that these providers address the enabling environment jointly with other sectors. Services should be provided in a confidential and respectful environment, preferably in areas where key populations frequent.

PILLAR 4

Pillar 4: engagement of civil society in social protection

Joining and building broader constituencies for good governance and inclusive HIV-sensitive social protection is a way to support and sustain HIV-sensitive social protection programmes. Although states and governments are primarily responsible for social protection, engagement of civil society in social protection design, implementation and monitoring is crucial. Civil society is defined as an arena for the expression of multiple voices, movements and organizations that intervene in questions of public interest outside of, but not necessarily independent of, the state. Civil society comprises groups that arise within neighbourhoods. Nongovernmental organizations form part of civil society; they are often among the most effective and visible actors of civil society. For these reasons, nongovernmental organizations can play a key role in building capacities that help other organizations representing vulnerable people become protagonists in the design of social protection programmes.

Notable of these nongovernmental organizations is the Global Coalition for Social Protection Floors, a global network of over 80 civil society organizations that supports and advocates for social protection nationally and internationally *(77)*, the Global Network of People Living with HIV (GNP+), the International Community of Women Living with HIV, international networks for lawyers and human right defenders, the International Association for Schools of Social Work, the Men Who Have Sex With Men Global Forum, international associations of sex workers, and Humanity and Inclusion (formerly known as Handicap International). Humanity and Inclusion is an independent development organization working in over 60 countries to include people (especially those with disabilities) left behind in development processes. Women in Informal Employment: Globalizing and Organizing, networks and associations of people who use drugs, and networks and associations of lesbian, gay and transgender people are also notable and relevant to be engaged in HIV and social protection processes.

Nongovernmental organizations provide social protection and social services, link vulnerable people to needed services, and influence public policies regarding the level and quality of services and who receives and does not receive services. Crucial tailoring and targeting decisions of social protection programmes tend to be made at the community level regarding which people and households qualify for social protection benefits.

Civil society and World Food Programme increasing food security in Ukraine to achieve the 90–90–90 targets

In Ukraine, thousands of people living with HIV in conflict-affected areas access food support through the All Ukrainian Network of People Living with HIV, a nongovernmental partner of the World Food Programme. In the Ukrainian Government-controlled areas of Donetsk and Luhansk, 6500 people living with HIV use a cash-based transfer programme that provides money for essential food. The assistance, which includes regular medical appointments and the monitoring of adherence to HIV treatment, has led to a fourfold decrease in treatment interruptions. In areas of eastern Ukraine not controlled by the Ukrainian Government, in-kind food assistance has given food to thousands of people *(78)*.

Community of Practice connecting to people living with HIV and key populations to social protection benefits in Ethiopia

In Ethiopia, research on access to social protection for people living with HIV and key populations found that populations that were members of the Community of Practice and Learning on Livelihoods in Ethiopia, a nongovernmental organization alliance, had more access to social protection services than their peers who were not members of nongovernmental organizations. Community of Practice partner organizations included Action for Self-Reliance, ComunitàVolontari per Il Mondo, Dorcas Aids International Ethiopia, the Hundee Grass Root Development Initiative, the Integrated Service for AIDS Prevention and Support Organization, the Jerusalem Children and Community Development Organization, the Meserete Kristos Church Relief and Development Association, the Network of Networks of HIV Positives in Ethiopia, and the Organization for Social Services for AIDS.

The factor with the greatest influence on the number of programmes from which a respondent obtained support was being a client of a Community of Practice partner programme (often this involved membership in a facilitated group or association). This differential—the "membership advantage"—was greatest for key populations and least for people living with HIV.

Key populations that belonged to a Community of Practice partner organization obtained social protection services on average from nearly eight times as many programmes as non-members. People living with HIV received 1.7 times social protection benefits, while people with disabilities and people not living with HIV or with no major disability received 3 times social protection benefits.

Non-members of the Community of Practice access primarily government-run social protection programmes, at a rate of 0.73 programmes, a third of the number accessed by Community of Practice members (2.1 programmes). This support is distributed even more unequally among all respondents: 57% of non-members receive no social protection support, but among key populations the proportion is 85% *(79)*. This suggests that key populations fare worse in accessing social protection benefits when they are not linked to nongovernmental organization that can broker their access to the benefits. Once key populations are connecting to organizations brokering benefits, they access more benefits than other populations.

Implementation considerations

Active and meaningful engagement of civil society—in particular, representatives of people living with, at risk of or affected by HIV—in the design and implementation of social protection is essential in leveraging social protection programmes to meet the needs of such populations. Individuals and communities need to be empowered to address and respond to stigma and discrimination and advocate for strengthening the legal and policy environment to address stigma and discrimination *(80)*. This may require that civil society organizations are supported to attain requisite administrative and financial management capacities to manage their affairs effectively and have the necessary resources and training to engage fully in social protection processes. The following specific efforts are required of civil society organizations:

- Build and forge alliances with like-minded national and international movements on social protection to advocate for addressing legal and socioeconomic barriers that impede access to social protection benefits.
- Invest in building the analytical technical capacities of civil society representatives engaging in social protection processes to contribute towards effective design and implementation of social protection programmes.
- Create early and ongoing awareness and political sensitivity of policy-makers into existing social protection processes as often as possible to effect corrective decisions as appropriate.

Conclusions

Countries should have the benefit of a detailed HIV and social protection assessment that identifies the needs, potential partners, and the extent to which current social protection is HIV sensitive. The assessment would help stakeholders, including the community, to come together with a common understanding of ways to broaden and deepen the coverage of existing social protection programmes, allowing people living with, at risk of or affected by HIV to access broader social services.

Countries should scale up and progressively broaden sustainable social protection programmes that enhance care, support and treatment outcomes for people living with HIV, and HIV prevention for key populations, adolescent girls and young women, vulnerable families and caregivers in relevant geographical areas and deliver as required combination social protection approaches, including financial incentives, social assistance and social economic approaches.

Formal education, especially secondary and tertiary school attainment, is an important structural determinant of HIV vulnerability. Investment in expanded access to secondary and tertiary schooling is an effective HIV prevention strategy and should be considered as part of combination HIV prevention strategies in countries with high HIV incidence. Special attention should focus on adolescents out of school or on the verge of falling out of school.

Investment in increasing access to social protection care and support for people living with, at risk of or affected by HIV is important. This investment includes a combination of financial incentives, social assistance and social services to meet people's psychosocial, physical, socioeconomic, nutritional and legal support needs and enhance the effectiveness of HIV prevention, treatment care and support services.

Active and meaningful engagement of civil society—in particular, representatives of people living with, at risk of or affected by HIV—in the design and implementation of social protection is essential in leveraging social protection programmes to meet the needs of such populations. Individuals and communities need to be empowered to address and respond to stigma and discrimination and advocate for strengthening the legal and policy environment to address stigma and discrimination. This may require supporting civil society organizations to attain requisite administrative and financial management capacities to manage their affairs effectively and have the necessary resources and training to engage fully in social protection processes.

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