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THIRTY-FOURTH MEETING

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Agenda item 9

Thematic segment: Addressing social and economic drivers of HIV through social protection

Background Note

Additional documents for this item:

- **Conference Room Paper 6 (UNAIDS/PCB(34)/14.CRP6):** Submissions on Thematic Segment – “Addressing social and economic drivers of HIV through social protection”

Action required at this meeting: none

Cost implications for decisions: none

EXECUTIVE SUMMARY

The global HIV epidemic is defined not only by the virus and medical interventions to control it, but also by social, economic and political conditions, including gender and income inequalities, human rights, and “the circumstances in which people grow, live, work and age, and the systems put in place to deal with illness,” that is, by the social determinants of health.”¹ Social determinants are driving the HIV epidemic in different directions: reducing HIV risk and vulnerability in some populations, while ignoring or intensifying them in others, along fault lines including socioeconomic divisions, gender inequality, xenophobia and homophobia.² This is known. Now, due to progress within and beyond the HIV field, much more can be done about it.³

There is ample evidence that social protection works for HIV prevention, treatment, care and support, and an increasing range of experiences of how social protection programmes have benefited people affected and living with HIV, including key populations, and young women. UNAIDS is committed to increase attention to social protection, explore what entry points to start with, and how to utilize the investment approach to make the best use of UNAIDS’ human and financial resources and partnership to reach shared goals. The following are imperative going forward:

High level political leadership: Political commitment to ending AIDS, extreme poverty and inequality is key. UNAIDS should inspire and facilitate dialogue on ending AIDS, extreme poverty and inequalities with Ministries of Social Welfare, Planning, Finance, Education, Gender and Social Development as well as Health and National AIDS Programs, donors, UN systems, partners and regional and global political, social and economic institutions and others.

HIV and social protection audits: UNAIDS should convene partners to further articulate a research agenda that lays out the pathways to social inclusion, social protection and equitable economic growth in different settings. Member states and civil society should be supported to conduct HIV and social protection audits to provide them with tailored packages of evidence and analysis on the nexus of HIV, inequality and poverty.

Mainstreaming: It is time for a new approach to HIV mainstreaming which builds on the scale and diversity of national health and development systems to meet the specific needs of people living with, affected by and at risk of HIV. The ultimate goal is ending AIDS, ending extreme poverty, inequality and social vulnerability. Advocacy by UNAIDS and Cosponsors for the economic empowerment of young women in high HIV prevalence settings, including through cash transfer schemes within broader inclusive economic development frameworks and social protection systems, to ensure their education, health and welfare is a concrete example.

Resource mobilization: UNAIDS can take the lead in mobilizing new resources at the country, regional and global levels to build social protection literacy for people living with HIV, key populations, women’s organizations and broader civil society. Efforts can also ensure networks of people living with HIV and civil society are actively involved in key consultations and prioritization efforts on ending AIDS, extreme poverty and inequality.

OVERVIEW

Background

1. The Thematic Segment of the 34th UNAIDS Programme Coordinating Board (PCB) meeting will consider how UNAIDS Secretariat, Cosponsors and partners can contribute to and leverage global progress toward social protection for all to help fill a critical HIV programming and financing gap on social protection and HIV, and join in common cause to ending AIDS, extreme poverty and inequality. Building on earlier PCB Thematic Segments on combination prevention, gender equality, and non-discrimination, the 33rd meeting of the PCB selected '*addressing social economic drivers of HIV through social protection*' as the theme for the 34th PCB Thematic Segment. The theme was chosen for three major reasons:
 - a) The AIDS response has generated impressive results. However, progress has been uneven and the HIV epidemic is far from over. The AIDS response shares many objectives with social protection efforts to end extreme poverty, inequality and to promote inclusive economic growth.
 - b) Social protection includes instruments designed to change the upstream social and economic drivers of poverty and inequality. Thus social protection offers a common platform for enabling and sustaining essential HIV treatment, prevention, care and support services, and also for sharing lessons learned from the AIDS response.
 - c) Consultations to define the post-2015 development agenda are entering their final stages, and social protection is a widely endorsed part of those discussions. There is also agreement that a strong AIDS response must be continued, and in the post-2015 era of integration, efficiency and country ownership, HIV responses that are multi-sectoral with cross sector health and development outcomes will be increasingly appealing.

Poverty, inequality, marginalization and HIV

2. The global HIV epidemic is defined not only by the virus and medical interventions to control it, but also by social, economic and political conditions, including gender and income inequalities, human rights, and the circumstances in which people grow, live, work and age, and the systems put in place to deal with illness, that is, by the social determinants of health.⁴ Social determinants are driving the HIV epidemic in different directions: reducing HIV risk and vulnerability in some populations, while ignoring or intensifying them in others, along fault lines such as socioeconomic divisions, gender inequality, xenophobia, and homophobia.⁵ This is known. Now, due to progress within and beyond the HIV field, much more can be done about it.⁶
3. AIDS is linked to extreme poverty and inequality. Over 60% of people living with HIV live in the world's poorest region—sub-Saharan Africa. In all countries, the populations most affected are poor and marginalized, especially young women, migrants, people who inject drugs, sex workers, men who have sex with men and transgender people, people in and/or recently released from prison, and homeless people. Though still high, HIV incidence is declining in sub-Saharan Africa but is rising in high and middle income countries of the Middle East North Africa (MENA) and Eastern Europe Central Asia (EECA) regions (with the exception of Ukraine). The expanding HIV epidemics in these regions are attributed to discrimination and social exclusion of, and insufficient investment in high-impact HIV services for key populations and people at higher risk to HIV infection.⁷

4. Globally, health, justice and other social welfare systems continue to have accountability blind spots when it comes to ensuring access to services for key populations at higher risk. For example, in the United States of America– the only country that provides this information – some 16% of people living with HIV are homeless and not receiving public assistance.⁸ AIDS will not be ended as long as the social protection and HIV needs of people living with HIV in extreme poverty, inequality and key populations and vulnerable populations are ignored or underserved. Nor will the AIDS epidemic be ended if social protection and HIV services are provided inequitably.

5. UNAIDS calls attention to the differences between the linked concepts of poverty, inequality, inequity, marginalization and vulnerability.⁹ While not all vulnerable populations are poor and not all poor people are marginalized, the poor and marginalized are differentially vulnerable to and affected by HIV, are less able to withstand the economic and social shocks of HIV. Their active engagement is critical to effective responses to the epidemic.

Box 1. HIV: Where development meets Human rights

“We have learned that people should no longer be subjects of development but active agents of change, achieving social justice from within. This means that civil society needs serious ongoing funding support as well as political freedom to act.”

Michel Sidibé, UNAIDS Executive Director High-Level Segment of the 22nd Session of the UN Human Rights Council, February 28, 2014

6. People who are displaced or marginalized through natural disasters, conflict, labor mobility, migration or incarceration face social dislocation, loss of income, social capital and social support. Income, social capital and social support systems, in most societies, are essential not only for psychosocial wellbeing but also as entry points to economic opportunity, (whom to ask about a job, existing service), personal security and access to justice (who will assist when one faces the police or a judge).
7. The relationships between poverty, inequality, inequity, marginalization and HIV are complex and dynamic. The devastating economic impact of HIV on individuals and households is well documented. The psychosocial and economic costs of treatment, care and support for people living with HIV are significant at any age, but an adult unable to work as a result of HIV also must withdraw his or her labor from the family economy. S/he may have to sell assets, adjust basic consumption to finance health care, and children may have to be withdrawn from school to provide care and support to an ailing family member.
8. For individuals and families who have few economic assets and reserves, increased expenditures and reduced income can mean a temporary or permanent plunge into poverty. Gender inequality and stigma and discrimination against people living with and affected by HIV can further curtail education and employment possibilities. This can lead to exclusion from social, economic and political opportunities, as well as from health services and political voice. Such affronts restrict people’s well-being, dignity, development and choices. These affect caregivers as well as adults and children living with HIV.
8. Conversely, people living with HIV who access and adhere to antiretroviral treatment can continue their economic productivity, leverage family and social resources, and build social and human capital for their families and their national economy. There is a wealth of evidence that poverty impedes adherence to antiretroviral treatment, whereas financial protection to cover care and support, including nutritional support, safe housing, and

transportation to health services, psychosocial counseling, and employment improve adherence to, and thus the effectiveness of antiretroviral treatment.¹⁰

9. The nexus of extreme poverty, inequality, vulnerability and HIV is intensified for women and girls, who, in many communities and countries bear a disproportionate responsibility for HIV care and support, while enduring limited autonomy, access to resources, and control of their sexuality. In a number of settings, gender-based violence is also rife.¹¹
10. Women are more likely to be unemployed, have shorter or interrupted careers, be in non-standard forms of employment such as temporary, part time or casual employment and often earn lower wages. In many settings women and girls face limited access to information and services, including those regarding sexual and reproductive health and rights. Women and girls face a larger burden of care and family responsibilities and are affected by gender specific constraints on access to resources. Women and girls are highly disproportionately represented among the poor, extreme poor and constitute the highest proportion of the chronically hungry. They are also disproportionately affected by HIV, especially in eastern and southern Africa. Social transformation strategies, including legal and policy actions, are needed to counter pervasive and multifaceted gender inequality that accounts for these differentials.
11. Mortality associated with HIV also places a particular burden on older members of affected families.¹² If children lose a parent or adult care-taker, it jeopardizes their future care and support, and increases their emotional and physical work. Six million AIDS-orphans in Sub-Saharan Africa are taken care of by their grandparents. Those households tend to be among the poorest in Africa, and can lead to inter-generational transmission of poverty. Increased care-giving demands and reduced income can lead families to take children out of school.¹³ Family care givers and informal support networks historically have been the backbone of the community based response, providing care and support with meager external assistance and even less financial support.¹⁴
12. The causal connection between extreme poverty, inequality and HIV risk is less linear and direct than that the connection between extreme poverty, inequality and access to and adherence to treatment,¹⁵ but it is now well established.¹⁶ Earlier analyses explored associations between household wealth and HIV prevalence with inconsistent results, but recent studies that focus on HIV incidence find that relative wealth, or income inequality, is associated with HIV risk, as is gender inequality.¹⁷ In the case of an income loss (due to death/sickness of caretaker, economic or natural shocks, etc.) a well-designed social protection system can prevent people from engaging in desperate survival measures (i.e. selling of livelihood assets, but more relevant in this case, engaging in transactional sex) and directly affect the ability to cope with such shocks.¹⁸

Box 2. The importance of community based care and support.

"It was caregivers and home-based care organizations at community level, with often minimal funding, that have been actively integrating HIV-specific services with those of other services and sectors – economic, social, legal, educational for many years – laying the groundwork for much needed large scale government and donor HIV-sensitive social protection initiatives."

Mike Podmore.2014. International HIV/AIDS Alliance

13. The HIV epidemic can disrupt capital optimization by striking at the young people and adult population who are critical labor and human capital inputs into the economy. AIDS-related morbidity and mortality reduces the size and quality of labor and human capital... Increased morbidity and mortality from HIV puts fiscal pressure on the government to allocate more resources to health care and in retraining and replacement of dying human capital in all sectors.

Social protection

14. A toxic combination of bad policies, economics and politics is, in large measure, responsible for the fact that a majority of people do not enjoy the good health that is biologically possible.¹⁹ Structural interventions and policy choices that would help countries and communities combat health inequities,²⁰ including social protection across the life cycle are thus recommended.²¹
15. Governments, civil society groups and development sectors are increasingly convinced that social protection is a necessary, feasible and affordable component of national strategies to ending AIDS, extreme poverty and inequality and to achieve equitable, sustainable development.²² Countries across the economic spectrum are examining, not whether to expand and regularize their social protection systems, but where to start, and what to aim for in the short and medium term.
16. UNAIDS is committed to increasing attention to social protection and to exploring entry points for work in this area to reach the goals of ending AIDS, extreme poverty and inequality.
17. In 2012 the International Labour Organization adopted the Social Protection Floors Recommendation (Resolution 202) at its International Labour Conference. This was in response to the food, fuel and financial crisis, which led the United Nations System Chief Executives Board for Coordination (CEB) to make social protection one of its nine strategic priorities in 2009.
18. UNAIDS defines social protection as “a system of public and private initiatives that provide income or consumption transfers to the poor, protect the vulnerable against livelihood risks, and enhance the social status and rights of the marginalized, with the overall objective of reducing the economic and social vulnerability of poor, vulnerable and marginalized groups.”²³

Box 3. Social Protection Floors – toward more coherent, efficient and comprehensive social protection systems

“The Social Protection Floor (SPF) approach provides a coherent and consistent policy tool, which addresses multidimensional vulnerabilities in an integrated and interconnected way. Nationally defined social protection floors offer a means to secure a renewed and comprehensive focus on poverty prevention and eradication, while also addressing broader development aspects related to health, education, inequality, decent employment and livelihoods, food security, [shelter], nutrition and inclusive growth.”

TST issues Brief: Social Protection. P.2

19. Article 25a of The Universal Declaration of Human Rights defines a universal entitlement to a broad range of social protection: “Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control”.²⁴ The Convention on the Rights of the Child (CRC) also recognizes that children have the right to social security, including social insurance, and states that social protection contributes to the realization of specific social security rights, as well as to a right to education and survival. (Articles 26 and 27). Social protection in most countries meets only some of these entitlements.
20. The vast majority of social protection programmes around the world are designed to reduce the vulnerability of the poor. In addition to supporting basic consumption, social protection instruments may focus on mitigating upstream causes of poverty, such as gender inequality, stigma or lack of education. Other instruments, such as social insurance or free legal services, improve people’s access to critical health and other social services. In contrast, more recent approaches recognize the social and political as well as the economic dimensions of poverty, and they call for policies and services that remove barriers to education, health care, legal aid and decent housing, to give people real opportunities to escape the poverty trap. They cite evidence that social protection is an investment in economic growth²⁵ and not a net drain on national income.

HIV-sensitive and HIV-specific social protection

21. National systems will do little for the AIDS agenda if they actively exclude or are not appropriate and accessible to people living with and affected by HIV, key populations and others most at risk of infection.²⁶ However, with relatively small technical and financial inputs, social protection instruments can be made HIV sensitive. Social protection is HIV sensitive when it is inclusive of people who are either at risk of HIV infection or susceptible to the consequences of HIV infection.²⁷ Promoting HIV-sensitive social protection entails development of programmes for broad population groups (e.g. employees, orphans and vulnerable children, households with income under a national poverty threshold, young people, girls and women, pregnant women, people with disabilities, people older than 50, etc). At the same time, programmes need also to focus on communities of people living with HIV and key populations at higher risk, ensuring that they overcome the policy and social barriers and knowledge gaps that would otherwise leave many people behind.
22. Making social protection programmes HIV-sensitive can have enormous impact for AIDS responses at relatively low cost. In India, for example, multiple HIV-sensitive social protection programs in several states reached more than 600,000 people living with HIV by the end of 2013 with a combination of social protections services including nutrition, livelihoods support, subsidized housing, legal aid, bus passes and various pension schemes.
23. Table 1 summarizes the different instruments and functions of social protection on HIV prevention, treatment, care and support.

Table 1. Social protection instruments and functions in HIV prevention, treatment care and support

	HIV prevention for those most vulnerable	Treatment for people living with HIV	Care and support for people living with and affected by HIV
<p>Financial protection</p> <ul style="list-style-type: none"> • <i>Social protection for the very poor</i> • <i>Livelihood support for poor and vulnerable</i> 	<ul style="list-style-type: none"> • Cash and food transfers to increase household resilience, keep children in school, and reduce risky sex and drug use. • Decent jobs, decent housing, income generation, micro-credit, savings clubs, economic skills training to reduce need for coping strategies that may lead to high-risk of HIV infection. 	<ul style="list-style-type: none"> • Transfers to poor people living with HIV for better HIV treatment, access and adherence. • Decent jobs, decent housing, economic empowerment of people living with HIV for basic consumption including food and nutrition, to make HIV treatment effective and to increase dignity and participation for prolonged and improved life 	<ul style="list-style-type: none"> • Transfers to mitigate the impact of AIDS on individuals and households including, orphans and vulnerable children and missing generation households, and care-giver support. • Income generating activities, livelihoods strengthening, micro finance and entrepreneurial skills training, such as how to start your own business
<p>Access to affordable quality services.</p> <ul style="list-style-type: none"> • E.g. Social health protection for the vulnerable 	<ul style="list-style-type: none"> • Social insurance to prevent HIV risk (social security, public finance of reproductive health, maternal health and HIV prevention services, etc.). • Decent jobs, decent housing. • Youth-friendly health services. • Services to prevent HIV 	<ul style="list-style-type: none"> • Social health protection to ensure access to health care and prevent erosion of savings, removing of transport barriers to access HIV treatment. • Decent jobs, decent housing. • Provision of 	<ul style="list-style-type: none"> • Disability insurance. • Preventive insurance measures appropriate for those affected (pension schemes, funeral clubs, etc.)

	transmission from mother to child, and sexual health services that are friendly to key populations,	free HIV treatment or at minimal cost. • Coverage of antiretroviral treatment within private sector insurance	
<p>Social transformation</p> <ul style="list-style-type: none"> • Laws, policy, regulation • Access to justice for the marginalized • Advocacy, convening, and public debate 	<ul style="list-style-type: none"> • Legal reform, policy process, and protection regulation to reduce HIV risks (e.g. anti-discrimination against people living with HIV, men who have sex with men, migrants). • Property rights and inheritance rights for orphans and vulnerable children and widows. • Social protection policy development includes key populations • Legal support to prosecute violence and exploitation, including gender-based violence, abuse and extortion of sex workers and people who inject drugs. 	<ul style="list-style-type: none"> • Legal reform, policy process, and protection regulation to reduce HIV risks (e.g. anti-stigma and anti-discrimination against people living with HIV, men who have sex with men, migrants). • Protection of rights to health services including universal access to antiretroviral treatment including for key populations, migrants and refugees. • Decent jobs, decent housing. • Implementation of ILO Resolution 202 in workplaces. • Trade policies and TRIPS flexibilities. 	<ul style="list-style-type: none"> • Support groups for people living with HIV. • Legal protection for the affected (widow's and orphans' property rights, birth registration, etc.). • Community dialogue to mobilize support for most vulnerable households. • Recognition and compensation for informal and home-based care-givers.

24. HIV-specific social protection strategies are required to meet needs of people living with HIV, key populations and vulnerable populations. These are programmes designed specifically with and for people living with and affected by HIV. They are essential in all countries and epidemic scenarios to address pockets of vulnerability and neglect. These programmes also aim at ensuring that pockets of vulnerability and neglect get covered in the long term by broader programmes. For example, the Committee for Accessible AIDS Treatment (CAAT) in Canada helps migrants living with HIV to access HIV treatment, job training, financial transfers, and legal aid on issues including immigration and equal rights.²⁸
25. Evidence from decades of programmes to support children affected by HIV indicates that greater benefits can be achieved where broader mandates and resources can be recruited, including people according to broader vulnerabilities (such as poverty level or occupation), rather than by HIV status. Programmes focusing on factors that drive HIV risk but take no specific action to directly address people living with or affected by HIV, may also lead to HIV-specific progress and results. For example, pension schemes targeting people older than age 60 in high HIV-prevalence countries such as Lesotho and Swaziland²⁹ are likely to reach caregivers of orphans and vulnerable children, including children affected by HIV.
26. Social protection systems also increase access to care and support by removing social and economic barriers. Care and support refers to education, health, social, economic and legal services for individuals and families affected by HIV to improve their quality of life. HIV care and support entails “a comprehensive set of services, including psychosocial, physical, socio-economic, nutritional and legal care and support.”³⁰ Caregivers contribute to HIV prevention as well as to treatment adherence and care and support.

Box 4. Care and Support.

“People say, treatment kept me alive, but the care and support saved my life. That’s a nice way to think about the alignment of protection, care and support with health interventions.”

Craig McClure, February 2014,
Road to Melbourne meeting
27. Long noted by networks of people living with HIV, social transfers of food and nutrition, and cash to cover transport costs, can greatly improve adherence to antiretroviral treatment for adults.³¹ However, while global guidance recommends a continuum of services for affected individuals and communities, care and support for people living with HIV is chronically underfunded and fragmented, and it often lacks critical elements such as palliative care and support for decent housing. Too often, only minimal HIV care and support services are delivered by national health and social welfare systems, and the gap is filled by civil society groups including faith-based organizations. In 2006 the Tear Fund estimated that faith based organizations in African countries contributed \$5 billion worth of labour to HIV programmes.³²
28. Social protection includes a wide range of interventions and providers but is primarily the responsibility of governments. The instruments offered can be contributory or non-contributory, meaning that individuals or households may or may not pay into social protection schemes. They can also be unconditional for all who meet eligibility criteria (e.g. national health insurance or state pensions), or conditional—provided in exchange for a particular action such as school or health facility attendance.

29. As for all HIV programming, ‘knowing your HIV epidemic and response’, knowing your social context and drivers, and knowing your affected populations is as crucial to leveraging HIV-sensitive, specific and relevant social protection. For example, analysis of a livelihoods programme in Ethiopia found that households at different levels of poverty respond to different economic strengthening services, regardless of their HIV involvement.³³ Detailed local knowledge, best provided by local insiders, is essential to matching social protection instruments to the people. This tailoring is essential in order to respect communities and make efficient use of resources.
30. Every country has a system of formal and informal social protection, although the philosophy, coverage, eligibility criteria, and content. For example, nearly 90% of older adults in high-income countries (HICs) receive some social or private pension benefits, whereas in low-income countries (LICs), only 20% of the elderly can rely on such income. The rest depend on family, faith communities, and other associations for needed assistance and increasingly remittances from kin in the diaspora. Low coverage and limited scope of social protection in low- and middle-income countries (LMICs) typically was explained in terms of the state’s limited ability to generate revenue through taxes, tariffs or other sources to finance public services.³⁴ A recent study of community perceptions of social protection found that in Malawi, participants viewed social transfers as ‘a gift’ for which they should be grateful and uncomplaining, whereas in the Occupied Territories, people viewed social transfers as a right to be demanded.³⁵
31. In the United States of America, nearly 40 million people, lack access to insurance cover for routine illness prevention and medical care.³⁶ Migrants, refugees and travellers often fall between the cracks, unable to access benefits at home and ineligible in their destination country.³⁷ Ethnic minorities, indigenous people, the rural and urban poor and marginalized groups, including sex workers, men who have sex with men, transgender people, people who use drugs, people in or recently released from prison, are often ‘last in line’³⁸ or actively excluded from public and private services.³⁹ In some countries, only some private sector employees, government workers and the military are covered. Thus while every country has a starting point for social protection, no country has achieved truly universal coverage.
32. People who need social protection, including the extremely poor (people whose income is below the poverty line of USD 1.25 per day) and key populations most at risk of HIV, usually have needs in multiple sectors (e.g. education, housing, health care, livelihood). Individual needs vary over time, for example, people recently released from prison often need housing, access to medical care and credit, social support, and assistance finding a job.⁴⁰ Orphans and vulnerable children may not only lack income and structure to access and make the most of social services, but critical positive parenting may also be absent.
33. Economic inequities that trap some people in poverty rest on underlying social stigma, policy choices and the type of social contract that exists between people and their governments.⁴¹ All of these can change.⁴² To combat cycles of poverty and enhance individual and

Box 5. The importance of engagement and leadership of affected communities.

“We highly doubt that closing the equity gap will occur without investing directly in the people who are currently excluded so that they have real influence in decisions about spending, development, and health.”

Charles King, for PCB NGO Delegation

community resilience, social protection's economic objectives must be complemented by actions to transform the structures (i.e., institutions, hierarchies, laws and regulations, cultural practices, etc.) that created inequalities of opportunity and reward. Figure 1 illustrates the pathways to HIV outcomes from social economic factors and their influence on life conditions and HIV risk.

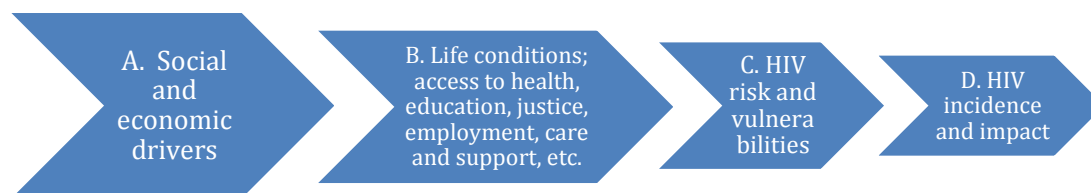


Figure 1: simplified illustration of the complex effect pathways link upstream, social and economic drivers and structural factors (A) to HIV outcomes (C and D) through mediating life conditions.

34. The HIV investment approach notes potential synergies between HIV programmes and those grounded in other sectors and constituencies that pursue shared goals. These include poverty reduction, education for all, gender equality, sexual and reproductive health and rights, inclusion of migrants and disadvantaged minorities, health and human rights literacy, access to justice, community planning, and good governance.⁴³
35. The UNAIDS' Investment Framework modelling of 2011 suggested that globally US\$22 to US\$24 billion would be required to bring HIV programmes to scale by 2015. Of that total, the model proposed investing 40% in enablers and synergies (15% and 25% respectively) and 60% in basic programmes. Updated modelling is underway, and proposed allocations may differ. However, it is clear that 'critical enablers' and 'development synergies' remain underinvested. According to one analysis, national HIV programmes in 2012 spent less than 2% of their total resources on these areas.⁴⁴

Ending extreme poverty, inequality and AIDS in the post-2015 agenda

36. The Post-2015 Thematic Consultation on Inequality noted that the richest 1% of the world's population now own 40% of global assets.⁴⁵ The world's 85 richest people were found to hold the same amount of assets as the bottom 3.5 billion.⁴⁶ The Consultation concluded that combatting inequality is essential both to realizing universal and indivisible human rights and to poverty reduction. The consultations also emphasized the need to overcome fragmentation and development silos, and instead, to address the MDGs jointly, in a more integrated way, the way they are actually experienced by people.
37. The Open Working Group on Sustainable Development Goals for the post-2015 agenda has recommended an overall, impact-level health goal for post-2015: 'Healthy lives at all ages for all', which includes "*by 2030 end[ing] the epidemics of HIV/AIDS, tuberculosis, malaria and neglected tropical diseases*. There are other recommendations for targets addressing HIV relevant issues of infant and child mortality, vaccination, maternal mortality, sexual and reproductive health and rights".⁴⁷ The High-Level Panel of eminent persons on the Post-2015 Development Agenda also recommended a goal on social protection, affirming that it is an

essential strategy to ensure the poor and vulnerable access the benefits of sustainable development.

38. The UNAIDS and Lancet Commission: Defeating AIDS—Advancing Global Health has expanded and deepened this analysis. In their deliberations, the Commissioners indicated that AIDS is not over, and that leaving the AIDS agenda unfinished could jeopardize the enormous strides achieved. The Commission argued that ending AIDS requires innovation, improved governance, and sustained, multi-sectoral action “including HIV-sensitive social protection, universal health care and education – as well as upon progress in creating more equal and inclusive societies that leave no one behind.”⁴⁸ The Commission challenged the AIDS movement to play a catalytic role in the “grand convergence”⁴⁹ of infectious disease levels in LMICs around levels found in high income countries, through transforming health systems.
39. The nexus and potential synergies of the HIV, inequality and poverty agendas was further delineated in a high level meeting hosted by the World Bank and UNAIDS in January 2014. The meeting synthesized the evidence that gender inequality, HIV-related stigma and discrimination, lack of access to education, and unstable livelihoods are key drivers of this trio. Participants reviewed seven structural intervention strategies with proven potential to combat the social drivers of HIV, inequality and poverty, including conditional cash transfers, national health insurance, universal education, housing assistance, food assistance, legal reform and community mobilization. They committed to intensify collaboration to align health and development efforts around country-led time-bound goals towards ending extreme poverty and AIDS; and toward including targets towards ending AIDS alongside universal health coverage in the Post-2015 agenda and accountability framework. They also recognized the need for better evidence, high level political advocacy and continued boldness of the AIDS community to reject cynicism and insist on declaring not what we think we can do, but what must be done: end extreme poverty and end AIDS.

Box 6. The importance of social drivers to end AIDS and extreme poverty

“Just as money alone is insufficient to end poverty, science is powerless to defeat AIDS unless we tackle the underlying structural factors. This requires sustained political will, social activism and unwavering commitment to equity and social justice.”

Jim Yong Kim, World Bank Group President, Social Drivers to End AIDS and Extreme Poverty Conference, January 6, 2014.

EXAMPLES OF HIV-SENSITIVE AND HIV-SPECIFIC SOCIAL PROTECTION

40. Strategies to combat poverty, social exclusion and inequality as encapsulated in more recent economic growth approaches are inherently valuable. Because HIV, poverty, inequality, inequity and human dignity are intertwined, these strategies also are good for HIV responses. Economic growth decreases poverty. It is estimated that 1% growth in the Gross Domestic Product (GDP) decreases poverty by 1.7%. One study estimates a 2/3rd fall in poverty from GDP growth with a third from reduction in inequality. Countries with higher levels of equality not only cut poverty further but faster than those with lower equality levels.⁵⁰

Box 7. The importance of Inclusive economic growth.

“They (people) don’t just want to escape poverty. They want to build and achieve all dimensions of prosperity including higher incomes, good health and quality education. And they want justice. Because where ever there is poverty and inequality, there is too often injustice.”

Jim Yong Kim, World Bank Group
President, World Bank Group Annual
meeting plenary session, Tokyo, Japan
October 11, 2012

Because richer and more equal countries tend also to have lower HIV disease burdens, inclusive economic growth is also invaluable for the AIDS response.

41. Because the global AIDS response is experienced in expanding the policy space and access to services for vulnerable people and in empowering people living with and affected by HIV, the knowledge, people and practices of the AIDS movement can be mobilized to combat poverty and inequality more broadly. Uniting forces for this is essential to sustaining a virtuous cycle of inclusion, poverty reduction, civic engagement, government accountability to the people, and improved health and wellbeing, ending AIDS, and shared prosperity.

Financial transfers

42. Recent reviews indicate that, cash transfers are a powerful tool for achieving HIV mitigation outcomes. In combination with other HIV and social protection activities, cash transfers, make even greater contribution to HIV prevention, treatment, care and support outcomes. A review of 16 studies in sub-Saharan Africa (Kenya, Malawi, South Africa, Tanzania, Uganda, Zambia, Zimbabwe), and North America (Mexico and the United States) found that, among the ten cash transfers programmes that measured sexual behavior, nine had a positive HIV prevention effect.⁵¹
43. The Mchinji Social Cash Transfer Programme in Malawi, which began in 2006, provides predictable financial assistance (about \$14 per month) to all families throughout the country who are in the lowest income quintile and are labor constrained. A study of the Mchinji Programme⁵² found measureable improvements in food security (fewer missed meals), child welfare (children in the households receiving cash transfers gained in height and weight, and were more likely to be in school and less likely to work outside the home). Cash transfer recipients increased use of health care and greater investment in economic assets and contributed economically to their communities (hiring labour, sharing food, spending in local markets, etc.). HIV outcomes included improved access and adherence to HIV treatment resulting from reduced transport barriers to health services.

44. In South Africa, a national study of an existing public funded cash transfer programme found among more than 3000 families receiving regular child support grants or foster child grants, adolescent girls showed a 53% reduction in incidence of transactional sex and a 71% reduction in age-disparate sex.⁵³ Another, independent, study showed that in South Africa adolescents in families receiving a child support grant were 16% less likely to have had sex. Girls who received a grant earlier in their childhood had less pregnancy than those who received a grant later in childhood.⁵⁴
45. An evaluation of Kenya's national, unconditional Cash Transfers for Orphans and Vulnerable Children programme⁵⁵, found a 31% reduction in the odds of sexual debut. A randomized control trial in the Zomba district of Malawi, with more than 1200 never-married, in-school and out-of-school women aged 13-22 years, explored the effects of making cash transfers to school girls, and their parents, conditional on their school attendance, and independent of HIV or reproductive health education. For girls who left school, no reduction in HIV or herpes simplex virus 2 (HSV-2) prevalence was shown. For girls who stayed in school, those receiving any cash transfer showed a 64% odds reduction in HIV-prevalence and a 76% odds reduction in HSV-2 prevalence.⁵⁶ This study adds important evidence to another analysis from Malawi on the importance of education as a structural intervention to reduce HIV infection.⁵⁷ As with Mchinji and the South Africa programme, this large-scale national programme was designed for poverty alleviation, not HIV outcomes, yet the impact on key HIV-relevant behaviors was clear.
46. In a study in Tanzania, either \$10 or \$20 cash was given to young adults aged 18-30 conditional on being free from Sexually Transmitted Infections (STIs) in 4-monthly STI testing. At 12 months (but not at 4 or 8 months) there was a 20% risk reduction in curable STIs for the high-value (\$20) conditional transfer, but no reduction for the low-value (\$10) transfer. There was some evidence that young women were more affected than young men. However, there was no reduction in HIV or HSV-2 risk.⁵⁸
47. In Lesotho, 18-32 year olds (n=3426) were randomized to a control, or to 4-monthly STI tests linked to lottery tickets for a high-value of \$100 or low-value \$50 quarterly lottery. After two years they found a 25% odds reduction in HIV-prevalence was attributed to the lottery. For women, a 33% odds reduction was shown and for the high-value lottery a 31% odds reduction was shown.⁵⁹ Overall, the evidence is strong that different modalities of providing cash transfers, particularly to young women, can reduce HIV risk and infection rates.
48. Cash transfers do not stand alone. Social protection is achieved through a mix of strategies. A study in South Africa tested impacts of augmenting financial support with social support from parents or teachers (n=3401) and found that 'cash plus care' increased HIV-prevention benefits over cash alone. Results showed reductions in incidence of multiple and concurrent partners and other HIV-risk behaviors by 50% for boys and by 55% for girls. In-depth studies are unpacking the psychosocial pathways through which social and economic drivers, such as poverty, lead to increased school dropout and increased HIV risk⁶⁰ (including dropping out of school, child abuse, behavioral conduct problems, drug and/or alcohol use, and psychological distress including depression), and how cash transfers and care can interrupt these pathways.⁶¹ This body of research illustrates the importance of designing and evaluating cash transfer strategies with a clear theory of change that is based on in-depth understanding of local needs and local resources.⁶²

49. Financial protection, through predictable financial assistance and other social transfers such as food and equipment, also enables poor households to secure basic needs including access to treatment. For example, the Girinka ‘one cow per family’ programme in Rwanda, initiated in 2006, has helped over 177,000 poor families to meet immediate nutritional needs. It has also helped to generate income sufficient to access the Mutuelle de Santé (national health insurance) and to keep their children in school. The Government of India provides over 25 protective programmes for poor and vulnerable households, ranging from widow pensions to support for universal basic education, 20 others that are designed to mitigate health risks through life, disability and health insurance, and 40 economic strengthening and livelihood schemes, including the famous Mahatma Ghandi National Rural Employment Guarantee.⁶³ Cambodia attributes its 92% antiretroviral treatment coverage partly to its programme to provide cash and in-kind support to people living with HIV.⁶⁴

Making national social protection systems HIV- and key population-sensitive

50. Inclusion of people living with HIV and key populations most at risk of HIV infection in national social protection systems is far from a given. Proactive investigation of laws, policies and practices is required. For example, policy and legal reviews and advocacy in India since 2007 have led to national and state-level changes in social protection eligibility rules to include people living with HIV. According to data from India’s National AIDS Control Organization (NACO), by the end of 2011, 35 state social protection schemes had started providing food, transport, housing and pensions for people living with HIV. Close to 600,000 people living with HIV are now accessing such schemes.⁶⁵

51. In China, Guatemala, Indonesia, Rwanda, Thailand and Ukraine, research conducted on barriers to access and use of social protection schemes for people living with HIV and key populations identified needs for policy changes in government and private sector programmes and led to relevant changes. The Chinese government issued a national decree prohibiting the denial of health services to people living with HIV, and the Indonesian government committed to ensuring inclusion of people living with

Box 8. Policy and legal reform can have a massive impact

“For a country like India, which spends close to two percent of its gross domestic product on social protection mechanisms, extending social protection to people living with HIV through state-led poverty reduction programmes can go a long way in ensuring that people [living with HIV] are able to secure a future for themselves and their families in this country of 1.21 billion people.”

<http://www.undp.org/content/undp/en/home/ourwork/hiv-aids/successstories/india--social-protection-for-people-living-with-hiv/>

HIV in the universal health scheme which will come into effect in 2014.⁶⁶ In Sri Lanka, leadership by one private insurance company – the only one that covered HIV-related health care in 2010 – is opening up the entire insurance industry to making health insurance and other insurance HIV-sensitive.⁶⁷

52. The government of Uruguay has identified transgender people as a most vulnerable group, enabling transgender people to register, change their name and sex on official registries (since 2009), and since 2012, the Ministry of Social Development of Uruguay has entitled transgender people to a monthly basket of foodstuffs and other supplies worth \$30.⁶⁸ Sex workers in Kenya have organized themselves under the Bar Hostess Empowerment and

Support program (BHESP) to prevent violence against sex workers, and increase access to legal services. Sex workers have been trained as paralegals and are able to support their peers to secure police bail and/or litigate cases in court.⁶⁹ In the USA, specific schemes assist the homeless, many of whom are people who inject drugs.

53. People-centred approaches reduce transaction costs and respond to multiple needs. The Government of Indonesia is piloting a 'single window' social protection approach that trains service providers in the full range of social protection services available, so that people living with HIV can obtain access to health, education, legal, housing and other services in one place. In Kwa Zulu Natal, South Africa, the provincial government has implemented a community-based 'war room' model⁷⁰ that has improved coordination among different social protection sectors (health, education, housing, justice) as well as members responsible for quality and for allocation of public resources, that are vertical to the district and provincial government structures.
54. HIV programmes in other countries are experimenting with different health and social service delivery models. A non-governmental organization (NGO)-based initiative working in Georgia, Kazakhstan, Kyrgyzstan, Russia, Tajikistan and Ukraine has trained government and NGO service providers to provide quality health services to people living with HIV, reducing stigma as well as improving knowledge on the specific needs of people living with HIV. A transitional client management' approach takes their model further, to provide integrated social support for people in prison and after release.⁷¹ These HIV-specific, NGO-based services are essential in countries where stigma and/or indifference leave people living with and vulnerable to HIV out of national social protection systems.

Social transformation and sustainability of social protection

55. Increasing equity and inclusion and decreasing stigma can be catalyzed and accelerated through community mobilization and action, community dialogue and mass media strategies.⁷² Inclusive programmes that are HIV specific but not exclusive break down prejudices while they expand social protection systems.⁷³ Examples of this include Algeria's vocational training and micro-loan programme for women living with HIV, the sex workers empowerment program in Kenya, or capacity building for faith-based organizations to provide sexual and reproductive health services for young people in Zimbabwe. In India, all targeted interventions—including the Avahan programme and the Sonagachi project—demonstrate the power of community self-organization and how, over and beyond their commitments to basic needs such as literacy and health care, the communities also worked to reduce and eliminate political and legal barriers to service access.
56. Public financing of social protection rests on a social consensus regarding the 'social contract' between citizens and government, and on mechanisms for enabling communities to hold officials and politicians accountable for how resources are distributed from the public purse.⁷⁴ Crucial tailoring and targeting decisions tend to be made at the community level regarding which households or individuals qualify for social protection. Transparent approaches such as participatory budgeting in Brazil, and participatory monitoring and evaluation of health reform in Nigeria (PATHS) have the potential not only to improve the design and focus of HIV and social protection, but also to increase trust in government systems, and to "renew the state-citizen social contract".⁷⁵

57. Governments and private social protection providers in HIC invest in public communication and social marketing to build support for their social protection policies. There is little evidence of this among governments or private social protection providers in LMICs. However, research in Uganda with a large international travel company suggests there is scope for involving the private sector in implementing and/or funding for social protection. Motivations include corporate responsibility, and branding, as an investment in intergenerational brand promotion.⁷⁶ Children who have food on the table courtesy of Brand X are likely to buy Brand X when they grow up.

UNAIDS INVOLVEMENT IN HIV AND SOCIAL PROTECTION

58. UNAIDS Cosponsors and Secretariat are advocating for HIV-sensitive social protection and providing technical support to government, civil society and private sector to expand coverage and depth. Cosponsor investment in social protection is longstanding and prominently positioned in the UNAIDS 2011-2015 Strategy, with relevant indicators and a modest budget of around US\$16 million allocated per biennium. In the 2012-2013 UBRAF, US\$ 16million of the core resources were allocated to the UNAIDS Cosponsors for social protection work. A further US\$ 151million of Cosponsor AIDS funds were leveraged for social protection. For the 2014-15 biennium, US\$16.8 million was allocated to UNAIDS Cosponsors with the leveraging of US\$180 million of other Cosponsor AIDS funds for social protection.
59. As a result of joint action, more than 25% of UNAIDS Secretariat Country Office and Regional Support Team workplans include social protection as a priority area. The real proportion is likely to be higher as UNAIDS Country and Regional teams plan and implement different aspects of social protection without labelling them as such.
60. A range of national and international advocacy events have been organized including regional conferences on HIV and social protection for Asia Pacific and sub-Saharan Africa. Others include panel discussions on HIV and Social Protection at the International AIDS conferences and regional AIDS conferences such as the International Congress on AIDS in Asia and the Pacific (ICAAP) and the International Conference on AIDS and STDs in Africa (ICASA).
61. UNAIDS and Cosponsors have led a vibrant process of building and applying evidence on the impact of HIV and social protection on households affected by HIV and HIV outcomes. UNAIDS been at the forefront of promoting access to health services for all, and eradication of poverty and exclusion for people living with, affected by and at higher risk of HIV. Much of the evidence and experience indicated in this document is associated with the work of UNAIDS Cosponsors, and is increasingly being used to advocate for the widespread expansion of HIV and social protection interventions.
62. Table 2 summarizes the UNAIDS goal and objectives on HIV and social protection. For details see the Unified Budget Results and Accountability Framework (UBRAF) reports on social protection for 2012-13 and 2014 midterm report.

Table 2: UNAIDS focus on HIV and social protection

1. People living with HIV and households affected by HIV are addressed in all national social protection strategies and have access to essential care and support	
Impact indicator B3: <i>increased access to HIV-sensitive social transfers (cash, food, in kind) by vulnerable people and households affected by HIV</i>	
Outcomes: Achievement aims for the Joint Programme	Outputs: results to which the Joint Programme contributes
Increased access to HIV-sensitive social transfers (cash, food, in-kind) by vulnerable people and households affected by HIV. <i>Indicator: Domestic and international aid spending by categories and financing sources on category 6 – social protection</i>	HIV-sensitive social transfers are incorporated into national social protection policies and programmes (cash, food, in-kind). Evidence based guidance developed in relation to HIV sensitive social transfers. Advocacy and communications strategy addressing investments in HIV sensitive social protection is developed.
National social protection plans and social health insurance schemes incorporate access to HIV prevention, treatment and care.	National social protection, social health insurance or other health financing strategies reviewed and revised to ensure increased access to HIV prevention, treatment care and support. Innovative ways to finance HIV-related health care promoted. Advocacy strategy for progressive and sustainable HIV financing is developed.
People and households affected by HIV have increased access to care, protection and support	National HIV strategies are reviewed and incorporate a comprehensive response to care, protection and support, including for key populations. Strengthened national care and support systems (both government and non-government).

WHAT NEEDS TO BE DONE TO SCALE UP HIV-SENSITIVE AND HIV-SPECIFIC SOCIAL PROTECTION

Key lessons learned

63. Poverty, marginalization, discriminatory laws, gender and socioeconomic inequalities and other socio-economic factors continue to fuel the HIV epidemic, but the cycle of poverty, inequality, discrimination and HIV can be broken. To end AIDS, more attention and investment is needed to address these social and economic drivers of HIV vulnerability and risk.
64. Cash transfer strategies work, especially in combination with complimentary investments. Cash transfers can reduce poverty and gender inequality and promote child protection, education, use of health services, and stigma reduction. Cash transfer strategies can boost HIV prevention, treatment, care and support.
65. Building broader constituencies for good governance and equitable growth through inclusive HIV-sensitive social protection is a way to support and sustain public and private financing of pro-poor policies and services. Political buy-in⁷⁷ is key, so advocates should start with social protection goals that politicians can own and sell to their constituencies, while ensuring that HIV-affected communities are not 'last in line'.
66. Social protection systems involve multiple stakeholders and sectors. Monitoring and evaluating their components demands data which may not easily be accessed. Communication, joint planning and coordination across sectors are rare. Fragmentation is rife. Overcoming this is critical to improving outcomes and to reducing costs.
67. The AIDS community can both learn from and contribute to the quest for comprehensive social protection. Country level experiences with the 'Three Ones', and the UNAIDS experience with the UBRAF, offer potential approaches to share.

What needs to change now – to make a difference in the future

68. There has been a quiet revolution on social protection in LMICs. HIV constituencies, Universal Health Care advocates, human rights advocates, Ministries of Finance and Planning, and other civil society, government and development partners need to be informed about affordability and benefits of social protection, and the groundswell of evidence and political support for nationally defined Social Protection Floors. Further awareness-raising is urgent, as it should inform country positioning within the post-2015 agenda process.
69. Social protection instruments such as national health insurance or waiving of fees for service are integral to achieving access to health services for all. It is also urgent to support governments and civil society to ensure that coverage of HIV treatment and adherence support, and structural as well as behavioral and biomedical HIV prevention, human rights protection and poverty reduction, are cited explicitly in any potential post-2015 goal on health.
70. Current efforts to build knowledge capacity on HIV and social protection, and social protection literacy need to be urgently increased, and HIV and social protection efforts must remain people-centred. The passion and expertise of the Greater Involvement of People

living with AIDS (GIPA) needs to be rolled out into the social protection field to ensure people living with and affected by HIV, key populations, civil society including faith-based actors and young people are able to be meaningfully represented and involved in the debate. Methodologies and instruments available to guide and assist—including the People Living with HIV Stigma Index⁷⁸, the Stigma Toolkit⁷⁹—need to be expanded to incorporate expertise from social protection.

Investing in HIV and social protection

71. Renewed attention to ‘upstream’ causes of HIV vulnerability and risk emphasizes that investment in development sectors including education, gender and youth, justice, and social welfare have synergistic benefits and are critical enablers of high impact HIV programmes. The urgency of preventing HIV infection led to investing HIV resources in reproductive health education to address sexuality, gender-based violence and sexually transmitted infections, not just for people most at risk but for all.⁸⁰ This has had multiplier effects in the education sector, and potentially for health systems, labor markets and so on. Investment in microfinance programmes for people living with and affected by HIV bring broader economic and social benefits. Community mobilization initiatives to promote AIDS competence and inclusion also bring cross-sectoral benefits.
72. Relatively small investments to make interventions HIV-sensitive can mobilize large resources for shared goals. For example, the Government of Tanzania has invested USD100 million per year on its social protection livelihood and economic strengthening initiative, with another USD100 million planned, and PEPFAR added just USD 2 million to promote HIV sensitivity. Co-financing of structural interventions to address poverty, gender inequality and HIV is both smart and fair.
73. Recent research indicates that such multi-sectoral HIV programmes are more likely to be funded under a co-financing model than if each sector computes the HIV programme’s value independently. With such a co-financing model, it is possible to fund structural interventions that have multiple benefits.⁸¹ This reinforces the importance of creating a unifying platform for planning and financing social protection. To assist, the Economic Commission for Africa and the Economic and Social Commission for Asia and the Pacific (ESCAP) have developed a social protection Toolbox⁸² to help governments, non-state actors and other stakeholders in moving towards universal social protection, through exchange of information and best practices.
74. Due to the broad reach of employer-based insurance and pension instruments, social protection is an arena where the private sector plays a major role in human security, human development, and human rights. This offers a platform for discussing and expanding private sector contributions to ending AIDS, extreme poverty, gender discrimination and other inequities.

An agenda for social inclusion

75. The strength of the evidence and the magnitude and variety of benefits that cash transfer approaches can bring to HIV objectives are noteworthy. Countries should start now to examine whether and how to include cash transfer strategies—for instance for young women in high-prevalence settings—in their HIV and poverty reduction work, as part of broader HIV and development strategies.

76. Experiences of UNDP, ILO, UNICEF and others has shown that, when governments examine the costs and benefits of making their social protection systems HIV- sensitive, they find it is affordable and worthwhile. Every country should have the benefit of a detailed audit of their social protection response including its HIV sensitiveness, of needs and potential partners, so that leaders in the key sectors, including the community sector, can be brought together to agree on the benefits and instruments needed. This way, coverage of existing social protection programmes can be broadened and deepened.
77. Participatory action research and implementation science are needed to weigh alternative methods and to establish quantitative as well as qualitative measures of progress and success. Lack of consensus on such measures has prevented inclusion in national and international HIV monitoring and evaluation frameworks in the MDG era. It is time to close this gap so that social inclusion and other social dimensions of well-being can be featured in accountability frameworks post-2015.⁸³

High-level coordination of HIV, poverty, inequality and social protection action

78. The convergence of efforts on HIV, extreme poverty and inequality will only succeed if it is led and coordinated at a high level. Ministers of Finance and Planning, Health, Education, Gender and Social Development, Labour and Public Works, and others need to be mobilized to take ownership of these issues. Concerted efforts to reach these leaders and corresponding regional economic communities, including the Africa Union and others, are critical to accelerate the end of AIDS and extreme poverty. Some countries have positioned their multi-sectoral HIV programme at a senior government level in order to have the political clout needed for multi-sectoral funding and coordination.
79. In the UNAIDS and World Bank high level meeting on ending AIDS and ending extreme poverty held in February 2014, the World Bank Group President reminded participants that the AIDS movement has always been daring, aiming as high as necessary to save lives. With common purpose, AIDS activists have led efforts to put bureaucratic concerns and interests aside, listen to affected communities, and collaborate on rights-based and evidence-informed action to meet the challenges of HIV. Such action and partnership is critical to achieving the goal of ending extreme poverty and HIV, using the engine of social protection.

Measuring progress of HIV and social protection

80. Integrated epidemiological and programme data, and global consensus on core terminology and standardized indicators for HIV prevention, treatment, care and support programmes⁸⁴ have been cornerstones of the AIDS response's ability to plan efficiently, to advocate and to be accountable for results and financial resources. There is also extensive regional experience measuring social and economic inputs and impact. For example, the EU provides member states with a Mutual Information System on Social Protection (MISSOC) that covers 12 main areas of social protection: financing, healthcare, sickness, maternity, invalidity, old-age, survivors, employment injuries and occupational diseases, family, unemployment, guaranteed minimum resources and long-term care. All countries and regions should have this kind of information, to promote learning and to provide peer pressure for improvements in programming to end AIDS, extreme poverty and inequality while promoting social progress and equitable growth.

THE WAY FORWARD

81. High level political leadership: Political commitment to ending AIDS, extreme poverty and inequality is key. UNAIDS should inspire and facilitate dialogue on ending AIDS, extreme poverty and inequalities with Ministries of Social Welfare, Planning, Finance, Education, Gender and Social Development as well as Health and National AIDS Programs, donors, UN systems, partners and regional and global political, social and economic institutions and others.
82. HIV and social protection audits: UNAIDS should convene partners to further articulate a research agenda that lays out the pathways to social inclusion social protection and equitable economic growth in different settings. Member states and civil society should be supported to conduct HIV and social protection audits to provide them with tailored packages of evidence and analysis on the nexus of HIV, inequality and poverty.
83. Research agenda: Similarly, UNAIDS should convene high-level partners to articulate a research agenda that lays out the pathways to social inclusion, social protection and equitable economic growth. The agenda should address the questions that country policy makers need answers on, including Ministers of Finance, Planning, Social welfare, Gender, and Justice, to convince them of the benefit of investing in transformative and protective/preventive social protection.
84. Mainstreaming: It is time for a new approach to HIV mainstreaming which builds on the scale and diversity of national health and development systems to meet the specific needs of people living with, affected by and at risk of HIV. The ultimate goal is ending AIDS, ending extreme poverty, inequality and social vulnerability. Advocacy by UNAIDS and Cosponsors for the economic empowerment of young women in high HIV prevalence settings, including through cash transfer schemes within broader inclusive economic development frameworks and social protection systems, to ensure their education, health and welfare is a concrete example.
85. Resource mobilization: UNAIDS can take the lead in mobilizing new resources at the country, regional and global levels to build social protection literacy for people living with HIV, key populations at higher risk, women's organizations and broader civil society. Efforts can also ensure networks of people living with HIV and civil society are actively involved in key consultations and prioritization efforts on ending AIDS, extreme poverty and inequality.

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END NOTES

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