



UNAIDS PROGRAMME COORDINATING BOARD

UNAIDS/PCB(34)/14.CRP6
Issue date: 20 June 2014

THIRTY-THIRD MEETING

Date: 1-3 July 2014

Venue: Executive Board Room, WHO, Geneva

Agenda item 9

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

Country Submissions

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INTRODUCTION

A total of 52 submissions were received from all the geographical regions of UNAIDS: 28 from Sub-Saharan Africa, nine from Asia and the Pacific, seven from eastern Europe, five western Europe and three from Latin America. These submissions make a case for addressing social and economic drivers of HIV through social protection towards goals of ending AIDS, extreme poverty, inequality and marginalisation.

The collection of submissions provide examples and evidence that social protection works for increasing access to and impact of HIV prevention, treatment, care and support. They also show how people living with HIV, including migrants, adolescents, young women and key populations at higher risk of infection have benefited from social protection programmes.

The submissions reflect the diversity, scope and different purposes of social protection. The majority of submissions reflect social protection programmes, which focus broadly on the general public but address HIV through their reach. Examples include social protection programmes that focus on people more than 60 years of age in high HIV prevalence countries.

Although the overall objective of such programmes is generalized, the focus enables reach to older caregivers who are providing HIV-related care and support to family members, including grandchildren.

A number of the submissions detail HIV-specific social protection programmes, focusing exclusively on HIV and people living with HIV. Examples include: programmes focusing on

the provision of free HIV services, financial incentives to influence behaviours and to improve HIV prevention outcomes, and, free-of-charge provision of food and nutritional supplements for people living with HIV who are accessing HIV or tuberculosis (TB) treatment, to encourage treatment adherence.

UNAIDS defines social protection as systems 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 people who are marginalized, with the overall objective of reducing the economic and social vulnerability. Social protection is more than cash and social transfers.. It encompasses economic, health insurance and employment assistance to reduce inequality, exclusion and barriers to accessing HIV prevention, treatment, care and support services.

Programmes focusing on social transformation to address societal attitudes, policy and legal reforms to protect the rights of people living with HIV, women and key populations were also the focus of a number of submissions. In combination with relevant available guidance and policy on HIV and social protection programming, these provide evidence and recorded experience that can help form a basis for effective action to address social economic drivers of HIV through social protection.

I. Africa

1. ALGERIA

Title of program: Micro-project information and support system for women and girls infected with and affected by HIV

Contact: Ministry of Health, Population and Hospital Reform
El Hayet Association for People Living with HIV

Implemented by: Government, Civil Society, United Nations or other intergovernmental organization

Programme under way since: 2011

Has the programme been assessed/ analysed? Yes

Is the programme related to the implementation of the national AIDS strategy? Yes

Is the programme related to the implementation of the national poverty reduction or social action strategy? Yes

Background:

The first case of AIDS was discovered in Algeria in 1985. Since then, combating HIV/AIDS has become a core priority, and the social dimension of care provided under the universal-access health system has remained a key objective for all national-level stakeholders. Nevertheless certain important factors have, on occasion, hindered effective implementation of a suitable programme. These include a socio-cultural context in which PLHIVs are not socially accepted, and difficulties approaching those sectors of the population that are in greatest need.

The socio-demographic profile of persons affected by this epidemic indicates that many are vulnerable women and girls. This vulnerability is linked to their HIV-positive status, or their position as parents of a PLHIV which, in turn, exposes them to potential marginalisation. As a result of increasing awareness of this situation, there is now a strong case for implementing targeted programmes to help women and girls to become more socially and financially independent and deliver sustainable impacts.

A dedicated programme focusing on the social protection of women and girls living with HIV, which aims to create an environment in which human rights and gender equality are promoted and encouraged, has been launched. This programme has been developed in conjunction with the implementation of:

- the joint programme between the Algerian government and the United Nations Entity for Gender Equality and the Empowerment of Women in Algeria (Al Insaf)
- the National Strategic Plan on STIs, HIV and AIDS
- the UNAIDS Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV
- the Joint UN Programme of Support on HIV and AIDS.

This programme has been developed by the Ministry of Health, Population and Hospital Reform, as the "lead entity in the national response to AIDS", and the El Hayet Association for People Living with HIV, in conjunction with the Ministry of Professional Education and Training and the Ministry of National Solidarity, Families and Women, via the National Agency for Management of Micro Credit (ANGEM), and with the support of UNAIDS.

Approach:-

Reach of the intervention:

Given the number of PLHIVs in the provinces of Tamanrasset (southern region), Algiers (central region) and Oran (western region), and the financial vulnerability of women living

with HIV, all partners agreed to develop micro-project information and support system for women infected with and affected by HIV.

This inclusive, participatory initiative focuses specifically on the issue of HIV/AIDS, covering health, environmental and social aspects. It is designed to target the marginal groups of society most affected by this issue, focusing on the empowerment of, and the provision of social protection for PLHIVs covered by the following frameworks:

- The United Nations 2011 Political Declaration on HIV/AIDS, ratified by Algeria
- The principles and guidelines of the National Strategic Plan.

Building on the experience of El Hayet acquired through previous socio-economic reintegration projects, all partners agreed to adopt an original, three-phase approach to the programme. The three phases are outlined below:

1. Identifying the beneficiaries and directing them towards the system:

With the support of the Ministry of Health, Population and Hospital Reform, hospitals have become welcoming, stable environments that represent a natural destination for women living with HIV. They provide women with information about the programme and direct them towards the existing system. The main objective of this system is to provide a range of professional training options. The women are also educated about the importance of empowerment and socio-economic reintegration, thereby enabling them to become contributing members of society.

2. Directing the beneficiaries to professional training centres:

Once the process has been explained, the women then receive support and guidance and are directed towards the Ministry of Professional Education and Training's professional training centres. They receive assistance with the preparation and submission of their formal documentation.

Once the formalities have been completed, they receive six months of professional training designed specifically for home-makers at a centre of their choice. Normally, they will choose the centre closest to their home to avoid the need for extensive travel and to ensure that they persevere with the specialism of their choice (sewing, needlepoint, embroidery, hairdressing or glass painting).

- This process also has another important dimension: women living with HIV attend the same sessions as other non-infected women at the training centres. The aim of this approach is to deal with issues surrounding stigmatisation and discrimination.
- Once they have completed their course, the women undertake an assessment in their chosen specialisation and receive a state diploma. This qualification then enables them to secure employment.
- The trainees each receive a subsidy of 8,000 dinars (\$100) per month throughout their course to cover transport and sustenance costs, and to enable them to buy the raw materials they need for practical work.

Securing micro-credit and creating income-generating activities:

Once they have received their certificate, the women are then put in contact with the National Agency for Management of Micro Credit (ANGEM), from which they receive interest-free micro-credit of between 40,000 dinars (\$500) and 250,000 dinars (\$3,000).

Improving life skills:

Women who wish to obtain micro-credit are not left to fend for themselves. They receive training from ANGEM, covering business management, sales and financial management techniques, as well as other aspects such as time management, stress management, teamwork and self-esteem – the cornerstones of successful social entrepreneurship.

The initiative was deployed initially in Tamanrasset (southern Algeria), and was subsequently rolled out in Algiers and the western region. It has proven extremely popular with women living with HIV, and the results of the implementation phase demonstrated the programme's success.

Geographical coverage: Tamanrasset (southern region), Algiers (central region), Oran (western region)

Period: 2011- 2013.

Target audience: women and girls infected with and affected by HIV.

Number of women having completed training programmes: 177.

Number of small businesses created through micro-credit: 89.

Number of indirect beneficiaries of these small businesses: 445

Impact of the intervention:

Through access to state-accredited training, the women have been able to enter the world of employment.

Through access to micro-credit and economic inclusion, women infected with and affected by HIV have been empowered, have become less financially vulnerable and, as a result, have been able to combat the stigmatisation and discrimination they may have faced through access to a stable, sustainable source of income. They have achieved this by creating their own small businesses with the support of the micro-credit system, or by securing employment in other public-sector or private-sector companies as a result of their new qualifications.

The impact of these income-generating activities is reflected in the beneficiaries' testimonies, and has also been identified in mid-programme evaluations, which indicate:

- Improved treatment observance: the women have the resources to travel to hospital, have a more positive outlook on life and take better care of their own health to ensure they can continue managing their projects.
- Better access to prevention: through their activities, women and girls come into contact with the outside world, learn about the risks associated with vulnerability and gender inequality, and are able to break the dependency chain.

Care and support for dependants:

The initiative has had an impact beyond women and girls infected with or affected by HIV. They are now better able to provide for their families (children, parents, spouses) and, as a result, have improved their quality of life.

Funding and management:

The success of this initiative lies in the multi-sector nature of the intervention.

- The various partners have worked together to develop a shared approach in the interests of women and girls infected with and affected by HIV. This ongoing collaboration has been based on free, universal, discrimination-free access to existing national systems: initial contact at hospitals, professional training centres and the National Agency for Management of Micro Credit.
- During the first phase, responsibility for implementation and management was assigned to the NGO, since it is in direct contact with the beneficiaries.
- UNAIDS supported the launch and deployment of the system, through the AI Insaf joint programme.

This process, involving institutions, civil society and UNAIDS, represents a major advance in the implementation of a social policy that meets the needs of PLHIVs and forms part of a sustainable, participatory approach.

Lessons learned and recommendations:

The success of the intervention is based on:

- The focus on socio-economic reintegration, based on an analysis of the key vulnerabilities of women and girls living with HIV;
- The fact that the intervention formed part of the national response and reflected international agreements ratified by Algeria;
- The multi-sector nature of the intervention;
- The fact that national systems have been created to ensure that the intervention is sustainable and that resources are targeted as effectively as possible;
- The fact that the intervention was led by PLHIVs, represented by NGO El Hayet.

The advocacy activities that raised awareness among the various stakeholders and, in turn, led to the availability of different facilities during the projects as well as other benefits such as the provision of free premises for women living with HIV to sell their home-made products and the opportunity for several women to attend national and regional exhibitions.

Difficulties encountered:

- When attempting to sell their products, the women often encountered fierce market competition from other low-price, imported products
- The fact that the women work from home means that they cannot sell their products to all potential buyers
- Limited support from men in efforts to sell the products, including the parents of these women and girls.

Annexes:

<https://www.hightail.com/download/ZUcxeVd0UnFLVlhYk1UQw>

2. ETHIOPIA

Title of program: The impacts of Economic Strengthening Interventions on Retention and Adherence to HIV treatment and Care and Practicing Risky Behaviours

Contact: WFP

Implemented by: Government, Civil Society, United Nations or other intergovernmental organization

Programme under way since:

Has the programme been assessed/ analysed? Yes

Is the programme related to the implementation of the national AIDS strategy? Yes

Is the programme related to the implementation of the national poverty reduction or social action strategy?

Background:

Treatment is rightly the 'cornerstone of an effective response'. Adequate treatment not only allows people to live longer and healthier lives, but also curbs the transmission of HIV.

However, under the 2013 WHO guidelines, over 16 million PLHIV who are in need of ART do not have access yet. Coverage in low- and middle-income countries represented only 34% of their 28.3 million eligible people in 2013. Issues of retention in ART programs and long-term adherence to treatment care regimens have often been ignored. To date, only 65% of people living with HIV in Africa who enrolled on ART remain on treatment as assessed after three years; therefore programs that achieve high retention rates and good long-term adherence are needed and can serve as models for other programs.

PLHIV are often temporarily unable to earn a living and can find themselves in a situation of economic shock associated with the health care costs. The impact on the most vulnerable

populations is many fold worse. This situation can quickly lead to increased food insecurity, forgoing treatment, selling off assets or sending children to work instead of school. Food and nutrition assistance is therefore an essential part of a comprehensive HIV treatment and care package. But, one of the concerns for food assistance programs has been the issue of sustainability as food support for PLHIV and their families can be very costly. There is increasing interest in exploring options to link PLHIV with economic strengthening activities and livelihood support once they graduate from food support, which is often linked to having recovered from malnutrition. These programs could be specifically for PLHIV or as part of general social protection schemes within a country.

Approach:

HIV specific: Economic strengthening (ES) encompasses strategies and interventions that supply, protect and promote growth of assets (physical, human, financial, social and natural assets) of vulnerable populations. The ES scheme pursued by WFP comprises of different interventions tailored for food insecure PLHIV in three categories.

1. For PLHIV categorized as food insecure with severe hunger or destitute, initially it provides food and assets in the form of short term and targeted financial and/or physical assets (provision) and increasingly assists to develop resilience.
2. For food insecure PLHIV with moderate hunger the intervention focuses on building their capacities to enable them reduce risks or cope with shocks (protection). It involves assisting these households to smooth their income and consumption and manage cash flows.
3. For better-off but still food insecure PLHIV households without hunger, the intervention is geared towards expanding their household income and assets through linkage to long term livelihoods opportunities to enable them meet the increasing expenses of basic needs, health and education (Promotion).

ES participants from all the three categories are organized into Village Saving and Loan Associations (VSLAs) so that they can save from their sources, loan and invest in different business activities. A range of capacity building trainings and intensive technical support are provided for the first three years of engagement in ES activities.

Synergies between sectors services and programmes: Ethiopia's national HIV and AIDS authority (F/HAPCO) oversees services run by health facilities, community organizations and consumer associations. The food support component is funded by the Network of PLHIV (NEP+), an initiative funded by multilateral donations and PEPFAR.

Reach of the intervention: Programmatic and geographic reach. Primary focus of the intervention – HIV prevention, treatment, care and support, social transformation, economic support or empowerment or program enhancement, which populations were targeted according to the epidemic profile of the country, the number of people reached and geographic coverage.

For ART to have therapeutic success strict lifetime adherence; which includes taking medications, following a diet and/ or executing lifestyle changes – corresponding with agreed recommendations from a health care provider (WHO, 2003), is mandatory. Non-adherence to ART treatment has devastating consequences- increased morbidity and mortality through suboptimal viral suppression, increased risk of drug resistance, and increased risk of HIV transmission; and more generally to higher health-care costs and a loss of or reduction in individual income, potentially translating to lower economic productivity at the country level.

The economic strengthening component is part of a larger program, total funding (need) for which is \$107 million (48% funded through PEPFAR). Other components include

programming for OVCs, PMTCT and NACS. Off the PEPFAR funding, the Economic Strengthening component is \$20 million, with a target of 26,000 beneficiaries.

For the quantitative aspect of this study (only among subset of beneficiaries), observational case-control design was employed to compare ES participating and not participating PLHIV attending their ART at eight health facilities in Afar and Beneshangul-Gumuz regions.

Inclusion criteria to the study for the ES participants were:

- PLHIV on HAART for one year or more regardless of the type of their treatment regimen
- age is >18 years
- Having food insecure households at their entry into ES
- Participating in ES activities for one year or more

A questionnaire was developed to gather key socio-economic and demographic characteristics and their current and retrospective practices with regard to adherence, retention, and practicing risky behaviours. ART clinic records of the interviewed clients were also consulted to gather data particularly in regard to their compliance to care services.

Impact of the intervention:

Preliminary indication shows that participation in ES scheme increases the likelihood of optimal adherence and decrease the probability of engaging in negative coping mechanisms exposing one to HIV reinfection or infection through the practice of risky behaviors. This is explained by the contribution made by the ES in mitigating possible set-backs for adherence like depression, living alone/ internal stigma, food insecurity, poverty, homelessness, etc. that are common in most PLHIV in resource-limited settings.

From the analysis (smaller subset), the household income and food security status of households engaged in ES activities has shown substantial increase over the course of nine months since the start of ES scheme. Large numbers of ES participants are trained in intensive business skills and are provided with matching fund after the data for this study was collected. Consequently, more changes in level of income and food security status are expected in the forthcoming follow up assessments as the training and the additional capital will boost ES participants chance to expand and diversify their businesses.

Financing and management:

This project is funded by PEPFAR and managed by the government of Ethiopia and WFP. Major partners are represented by the government, civil society and the network of PLWHA.

Lessoned learned and recommendations:

Lessons Learned:

- Appropriate trainings and continual technical support can develop the enthusiasm and commitment of PLHIV.
- Coordination committees, where properly involved has key role in implementation of ES activities.
- Most ES participants are interested in individually operated businesses than group-based enterprises.
- Food support is vital to encourage savings by chronically food insecure ES participants.
- Competition-based experience sharing and reward-based matching fund transfer are powerful tools to improve savings, loan utilization and business performance of ES participants.

Sustainability Strategy:

- National Nutrition Program: NACS is an integrate part of the Improved Nutrition Service Delivery for Communicable and Non-communicable diseases – launched in June 2013
- National Nutrition Blended Training Material for Health Professionals: NACS fully integrated – National validation workshop – 24 March 2014
- Initiatives of marketing of specialised nutritious products: Work in progress
- Social Protection Policy: Social assistance for PLHIV and OVC is now part of the drafted policy pending approval by house of parliament
- Economic Strengthening Initiative: Enables food-insecure PLHIV to be food secure and influences the drafting of the upcoming FHAPCO Economic Strengthening Strategy

Annexes: -

3. GHANA

Title of program: Ghana national social protection strategy

Contact: UNAIDS

Implemented by: Government, Civil Society, United Nations or other intergovernmental organization

Programme under way since: 2000

Has the programme been evaluated /assessed? Yes

Is the programme part of the implementation of the national AIDS strategy? Yes

Is the programme part of the implementation of the national poverty reduction or social welfare strategy? Yes

Background:

Since Independence the Government of Ghana has implemented various policies and interventions to provide healthy life, secure retirement and cater for the needy including those affected by HIV and other diseases. With the upsurge of HIV and AIDS, the Government of Ghana realized that efforts at promoting accelerated growth will be hampered if productive citizens are affected by the disease. Ghana therefore recognised HIV and AIDS as a developmental issue of critical concern and anchored its HIV response within human resource development paradigm and included HIV programs within the key thematic areas of its Poverty Reduction Strategies.

In order to tackle extreme poverty and achieve the United Nations Millennium Development Goals the government of Ghana developed and launched the National Social Protection Strategy (NSPS) in 2007 and implemented rigorous but new social protection measures to support mitigation of the impact of the HIV epidemic and safeguard the health and socio-economic wellbeing of individuals, with a focus on the most the vulnerable at community level. The resultant social protection interventions implemented include the following:

- Livelihood Empowerment against Poverty (LEAP) cash transfer programme which focused also on poor households affected by HIV;
- Establishment of a Social Insurance Scheme, (National Health Insurance Scheme - NHIS), by Act of Parliament in 2003. The scheme is accompanied by a series of payment exemptions for vulnerable groups, including pregnant and postpartum women. Premiums have been paid for identified PLHIVs to secure insurance cards so that they can receive health care including Anti-retroviral drugs (ARVs) without paying payment at the point of care by late 2013
- Specific Social Welfare services that include supply of food directly to PLHIVs and school feeding programs in public basic schools in Ghana. Programmes to prevent and

respond to child protection problems such as child labour, trafficking and sexual exploitation

- Enactment of new laws to tackle issues of discrimination, domestic violence disability and human trafficking.

Approach:

HIV Specific Social Protection Interventions in Ghana: PLHIVs are protected from paying for ARVs and other related drugs and services through registration with the National Health Insurance Scheme. This ensures that services due PLHIVs are promptly received without the barrier of cost at health facilities. The World Food Programme provides direct food rations freely to PLHIVs in the three resource poor northern regions of the country which has greatly increased the nutritional status of PLHIVs in those regions.

UNAIDS, in collaboration with the Columbia University Millennium Villages Programme (MVP) supports the Amansie West District of Ghana to strengthen prevention of mother-to-child HIV transmission (PMTCT) services at the village level with the aim of creating "MTCT-free cluster of communities. The program includes payment of transport fares to enable PLHIVs access treatment and participate in monthly support meetings. UNAIDS collaborates with the Ghana AIDS Commission, Commission on Human Rights Administrative justice and the Human Rights Advocacy Centre to implement a legal Aid Scheme for Key Populations who face various human right abuse in the country.

HIV Sensitive Social Protection Interventions: Government and partners are implementing the 'Livelihood Empowerment Against Poverty' (LEAP) programme which functions by providing direct cash transfers to vulnerable groups and poor people in Ghana including children orphaned by HIV. There are also Free Antenatal Services for pregnant women for at least 4 visits. This includes women living with HIV who also benefit from PMTCT programmes. Traditional Forms of Social Protection are also encouraged in the program where healthy members of the family, especially women, freely take care of sick members including those living with HIV.

HIV Relevant Interventions: Government is implementing the Ghana School Feeding Programme which covers all children in public basic schools in the country including children living with or affected by HIV. Sexual and Gender Based violence programs have included in their implementing protocols the facilitation of immediate medical redress including HIV Testing and Counselling and access to Post Exposure Prophylaxis for HIV for victims.

Reach of the interventions:

- The PMTCT intervention activities with the MVP covers 30 cluster communities in the Amansie West District of Ghana and has contributed to uptake of HIV testing among pregnant women from 30% at baseline to over 98% in 2014.
- The NHIS support program has reached 73, 136 (30%) of PLHIVs according to 2012 estimates. National uptake for the scheme is about 40%.
- The cash transfer program of LEAP reached 71,000 households in all 10 regions of Ghana as of June 2013 and has led to a significant increase in the number of children aged 6-17 (16 percentage points) and aged 0-5 (34 percentage points) enrolled in the National Health Insurance Scheme. In addition, children in the age group 6-17 are less likely to be ill (5 percentage points) [LEAP briefing paper of the MWGCSP, Oct 2013].
- The School Feeding Program is in its 9th year and has reached about 2 million pupils, as at September 2013, from 4,920 public primary schools throughout the country. [Ghana Government portal <http://www.ghana.gov.gh/>]

Impact of the intervention:

The UNAIDS MVP PMTCT program has contributed to reduction to increase update of HIV testing and improvement in overall antenatal care within the clusters. Getting PLHIVs enrolled on to the NHIS has removed part of the cost barrier to treatment and contributed to improved adherence and appointment keeping at HIV treatment sites. The LEAP program has had significant impact both on beneficiaries and their families including those infected and affected by HIV, especially in relation to food security, health, education, savings and investments, as well as on their wider communities particularly in terms of community development and economic growth.

The school feeding program has contributed to general improvement in literacy and numeracy skills of children in affected community as a result of increase in the enrolment in basic schools.

Financing and management:

- UNAIDS funds the integrated MTCT free program which is managed by the MVP of the Amansie West District.
- The enrolment and payment of premiums of PLHIVs on the NHIS is coordinated by the Ghana AIDS Commission and the National AIDS Control Program in collaboration with relevant UN agencies and managed by staff of the HIV treatment sites. It is funded by the government of Ghana, Global fund and other bilateral and multilateral development partners.
- The LEAP program is managed by the ministry of Gender, Children and Social Protection, funded, by the government of Ghana, World Bank and DFID with technical support from UNICEF.
- The school feeding program is managed by the government of Ghana, funded by the government of Ghana, the Netherlands government (till 2010) with technical support from the World Food Program and other partners.

Lessoned learned and recommendations:

- High level political mobilization, buy-in and commitment coupled with a democratic and peaceful environment are critical for enabling the development and implementation of social protection activities in developing economies like Ghana.
- Enactment of good laws, like the Act (613 (2002), that established the Ghana AIDS Commission,
- Supports and galvanizes governments to seek a multi-sectorial approach rather than just health system approach in responding to HIV and AIDS issues. Good social protection laws and strategies therefore facilitate the addressing of the drivers of HIV through social protection measures.
- Involvement of key stakeholder groups at the national level like the National Development Planning Commission of Ghana is critical for the success of implementing social protection activities, especially those impacts on the social and economic drivers of HIV.

Challenges:

- Weak interagency coordination making it difficult to ensure the effective complementarity of programmes
- Some of the schemes are donor dependent and will stop when funding from the donor ends.
- Ghana is experiencing economic challenges with pressure on government to control spending. It is the concern of civil society groups interested in social protection programs that funding to these programs those impacts on the social and economic drivers of HIV

will be cut and may contribute to reversal of the gains made by the country if the country does not receive the necessary external funding support timely enough.

Annexes:

1. LEAP Briefing paper, October 2013, 2. National Strategic Plan 2011-2016. 3. National HIV Policy 2013.

4. KENYA

Title of program: Window Of Hope for Sex Workers

Contact: Bar Hostess Empowerment and Support Programme (BHESP)

Implemented by: Civil Society

Programme under way since: -

Has the programme been evaluated /assessed? Yes

Is the programme part of the implementation of the national AIDS strategy? Yes

Is the programme part of the implementation of the national poverty reduction or social welfare strategy? No

Background:

BHESP is an organization for and by all women working in bars and sex workers in Kenya. BHESP was founded in the year 1998 by a group of these vulnerable women as a 'loose' association to advocate for their rights and recognition. BHESP mission is to "influence policy and facilitate provision of quality health services, human rights awareness, legal services and economic empowerment for bar hostesses and sex workers". BHESP has a vision to see a "society where bar hostesses and sex workers are treated with respect and dignity and their rights upheld." the organisation's leadership has a mixture of both sex workers and a few non-sex workers. Although BHESP works with and for sex workers and offers its services directly to sex workers.

Sexual transmission is the primary driver of Kenya's epidemic. Sex Workers (SWs) in Kenya continue to experience an extremely high burden of HIV with 29.3% of all female SWs living with HIV. Although definitive data are not available, it is estimated that 30,000 women labour as SWs in Kenya in addition to thousands of male sex workers. SWs are subjected to high levels of stigma, discrimination and harassment in Kenya. This is mainly fuelled by moral judgments precipitated by culture in addition to lack of proper information. Majority of projects targeting SWs in Kenya are exclusively on HIV prevention whereas the link between violence and HIV is well documented which requires human rights programming interventions. SWs work occurs in complex environments dominated by power structures within family, community, workplace and the state. Within this context, SWs experience human rights violations including physical violence, emotional abuse, rape, and extortion. The relationship between SWs and law enforcement authorities can generally be described in terms of harassment, violence, abuse, and repression with respect to the police, and by fear on the side of SWs. SWs have no way to claim their individual human rights under the current operating laws and policy framework. They are unable to keep themselves safe as they seek to support themselves and their families because they are relentlessly subject to police harassment, arrest and abuse. SWs have also developed stereotypes about all parties in the sex exchange, including their clients, police and bar owners. SWs operating in such an environment thus find it difficult to avoid internalizing the stigma associated with sex work, leading to feeling negative about their work, experiencing anxiety which sometimes leads to depression, poor self-esteem and the lack of confidence in their approach to sex work. Gender norms, the increased risk of violence, stigma and discrimination, poor work

environments, and lack of legislative frameworks all play a critical role in intensifying vulnerability to HIV infection and enjoyment of rights and freedoms for those engaged in sex work. In addition, the stigma that sex workers face can make it hard for them to access health, legal, and social services.

Approach:

BHESP felt the greater need to build constituencies of SWs who understand their rights as citizens and who are able to support one another in awareness creation on HIV/AIDS, safe sex, human rights, equality before the law and equal protection of the law and response to violence. BHESP also realised that as the SWs community grows there is need for constant vigilance to mitigate violence against SWs. Similarly there is need to quickly respond to cases where suspected SWs are charged under municipal by-laws which are reportedly misused as tools to extort and SWs for money or sexual favours. BHESP has been facilitating access to legal aid and psychosocial support by training SWs as paralegals. Paralegals reach out to their peers, facilitate rights awareness and in instances of rights violation report the cases. BHESP has also been building her bail revolving kitty to bail out sex workers arbitrarily arrested by police or county officers. BHESP also partners with human rights organisations in Kenya for legal aid support. Acknowledging the environment and legislative framework that SWs in Kenya are operating in, BHESP have been building strategic partnership with the police force, the prosecution and the County governments' leadership aiming at developing a vibrant relationship between SWs and authorities. BHESP has placed great emphasis on sensitization of the police, prosecution and county leadership with regard to the trial process for SWs and advocates for non custodial sentencing or simple fines for SWs prosecuted for engaging in sex work. BHESP bails out sex workers who have been arrested by police or council officers. As majority SWs are the breadwinners in often single parent households, bail outs and fines payments mitigates greater socio economic challenges within the families they support. BHESP also acknowledged the existing stigma and discrimination manifest between SWs and health providers which in many instances hinder health services access by stigmatised populations. In this regard, BHESP introduced provision of bio medical services in safe spaces where SWs and MSMs easily access. These safe places are the drop in centres and wellness centres which SWs and MSMs are made aware of service provision. Services provided in these centres include HIV Testing and Counselling, pap smear and cancer screening, lubricants and condom demonstration and distribution, Reproductive and Family Planning and counselling services. The safe spaces have proven an innovative avenue to ensure increased access of health services to most at risk populations.

Reach of the intervention:

Majorly, BHESP activities have been in Nairobi and Mombasa counties and in Thika town where the concentration of SWs is high. To date, BHESP has helped form and strengthen 30 SWs networks, trained over 500 paralegals and over 600 peer educators, provided over 1,000 SWs with biomedical support, undertaken 15 free legal aid clinics, bail out 400 SWs, taken 70 cases to courts and have successfully won 10 cases.

Currently, BHESP has been hosting a learning site for sex workers programming in Africa hosting many visiting organizations, government officials and program managers for learning owing to her being identified as a best practice in comprehensively undertaking structural and biomedical interventions with an emphasis on respecting the rights of SWs.

Impact of the intervention:

BHESP has been using a human rights-based approach in undertaking lobbying and advocacy activities with the government and law enforcement personnel. This partnership

provides an entry point for further engagement with county leadership in policy development and formulation and creates opportunities for sensitization that would not be previously available. The strengthened relationship has translated to improved security for SWs in terms of reduced instances of harassment from local authorities. These discussions have helped open space for the recognition of sex workers, and some police officers have started protecting the rights of sex workers as well as helping sex workers with the distribution of condoms. Also in empowering sex workers to understand and know their rights, BHESP has empowered SWs to understand policy analysis skills, form strong advocacy groups from the community level, and improve communication skills. The trained paralegals and peer educators drawn from SWs and MSMs networks have not only assisted in increasing rights awareness, reported cases of violence, helped in case management but also created the much needed rapport with the law enforcers. Due to increased knowledge on their rights and legal support to those who require most sex workers have become assertive and demand for their rights. The paralegals have also improved service delivery because they provide services in friendly environments and act as leaders among their colleagues while at work in the hot spots. A more informed sex worker constituency will result in reduced risky behaviour, greater regard for personal safety while conducting sex work and increased avenues for support and protection. The established drop-in and wellness centers accelerated health and HIV services access to SWs and MSMs in need and provide spaces for learning and replication by other actors.

Financing and management: -

Lessons learned and recommendations:

- Program experience demonstrates that local participatory design, implementation and continuous evaluation can succeed when stakeholders, particularly the beneficiaries are involved in the various phases of a project's lifecycle.
- Comprehensively undertaking structural and biomedical interventions critical in addressing stigma, discrimination, harassment and violence while meeting the health needs of SWs.
- Integration of services targeting SWs and bar hostesses is critically important, feasible and acceptable by the targeted population. Opening safe spaces for SWs and other vulnerable and stigmatised populations critical in increasing services access and for learning and replication by others.
- Successful interventions by one group of bar hostesses and sex workers can be shared with others and effectively adapted to meet their local contexts.
- Working with peer educators drawn from SWs has assisted the project gain access to the target population.
- Developing the capacity of beneficiaries to participate in program implementation encourages ownership and helps the scaling-up process to develop complementary ways of working together that best serve local responses.
- Discussing leadership and personal security issues strengthen facilitation teams and help them bond with local stakeholders.
- Frequent policy discussions, based on concept and process analysis, are vital and most effective if they include field implementers, local communities and beneficiaries.

Annexes:

<http://www.onebillionrising.org/8733/rise4justice-blog-serial-killer-loose-targeting-sex-workers-pimp-naomi-mwaura/>

5. KENYA

Title of program: Examining the various factors that determine the spread, progression of HIV in Nakuru County, Kenya

Contact: Ambassadors of Change NGO

Implemented by: Civil Society

Programme under way since: 2013

Has the programme been evaluated /assessed? Yes

Is the programme part of the implementation of the national AIDS strategy? Yes

Is the programme part of the implementation of the national poverty reduction or social welfare strategy? Yes

Background:

HIV continues to undermine social economic development in the region despite massive investment and increased HIV intervention programs.

Approach:

The intervention is HIV specific, HIV sensitive, HIV relevant.

The Ministry of Health through NASCOP provided training to community health workers and members of people living with HIV on the National HIV Strategic Plan, intervention strategies, HIV testing and counselling, ART treatment, male circumcision and PMTCT services to pregnant women and data on HIV prevalence and the diversities.

Ambassadors of Change in partnership with Hope for Women Network designed and carried out operational research to identify the key determinants of the disease, most vulnerable populations, access to health care and social support networks and impact of intervention programs.

Ecosystem and Social Economic Development organization engaged in poverty reduction programs among women by training on micro-financing, table banking structures to enhance their social economic status towards poverty reduction, HIV risk and vulnerability in collaboration with Ambassadors of Change. Over 35 networks of people living with HIV and AIDS have been trained on savings and investments.

For people living with HIV, socio-economic status is a fundamental determinant of health status of individuals and population as it determines the living conditions, nutrition status, health behavior and access to health care. Poverty is over 50% among people living with HIV and is a contributing factor to malnutrition. KAIS (Kenya AIDs Survey) report shows some disparity between wealth and HIV prevalence, 7.52% for the poor and 6.45% for the wealthy (NASCOP 2009).

There are no social protection schemes specific for people living with HIV though women access Women Development Fund designed for the general population. APHIA Plus has an orphan programme that supports OVCs with clothing, shoes, and food supplements at household levels through the community health workers.

Reach of the intervention:

The programme is planned to reach a population of 1.7 million within the Nakuru County and primary focus is HIV prevention, treatment, care and support, social transformation, economic support and empowerment of women on gender equality, sexuality, HIV and human rights. Promote male circumcision as an intervention strategy which is now a policy to encourage male circumcision as a preventive measure in addition to other measures (NASCOP 2008). Over 35000 male adults have been reached and reported to have been circumcised in the past one year within the county.

Widow inheritance remains a challenge to HIV reduction initiatives. Widows have a high prevalence of HIV at 20.1% (NASCOP 2009). The ritual involves unprotected sex with

widows by the inheritors while widowers also remarry when their wives die and this further spreads HIV in the community. The programme has increased awareness, level of knowledge among women and girls on the negative impact of widow inheritance and early marriages.

Impact of the intervention:

Number of pregnant women giving birth and accessing PMTCT services has increased resulting in reduction of infants born HIV positive. Stigma associated with HIV has reduced and married couples go for testing, counselling and demand for ART has doubled.

Financing and management:

Global Fund remains the main source of funding for HIV programming, treatment, care and support. The financial sustainability is unpredictable due to global economic down turn and reliance by the government on donor funding.

The major partners include NASCOP, Kenya AIDs NGOs Consortium (KANCO) and Network of People Living with HIV in Kenya (NEPHAK).

Lessoned learned and recommendations:

Women of low social economic status rely on male partners for all their needs and cannot negotiate for condom use, also sell sex for money as a means of survival. Gender associated social –cultural practices greatly predispose women and girls to HIV. Determinants of disease are closely interlinked. HIV leads poverty and therefore creates a vicious cycle. Gender and norms make women more vulnerable, Enhance ARV treatment as prevention. Need to address the gender dimensions of HIV.

The factors that helped success of the intervention included:

- A strengthen referral systems engaging well trained community health workers;
- Established networks of people living with HIV both at the national and grassroot levels and women rights networks;
- Treatment access advocates/activists;
- Traditional leaders who were ready to embrace change as culture gatekeepers;
- Provision of health as aright within the Kenya Constitution and the HIV Act that addresses the rights of people living with HIV;
- Support by politicians for male circumcision and campaigns for women to deliver in public hospitals.

Challenges:

- Data capture, analysis, coordination, storage in public hospitals;
- High stigma level at the community and among health providers;
- Costs of travels to health clinics;
- Non-adherence to medication by HIV positive patients;
- Religious misconceptions on the healing power of prayer;
- Low literacy levels on ARV treatment;
- Poor access to health care services among rural populations;
- Poverty levels among women and the elderly;
- Deeply rooted cultural values and norms;
- Gender inequality;
- Stock out and shortages of condom;
- Discrimination on sexual orientations eg sex workers and men who have sex with men.

6. KENYA

Title of program: Cash Transfer for Orphans and Vulnerable Children (OVC) in Kenya

Contact: World Bank

Implemented by: UN or other inter-governmental organisation

Programme under way since: July 2009

Has the programme been evaluated /assessed? Yes

Independent evaluation conducted by a research team of the University of North Carolina, Chapel Hill, North Carolina, USA. The document is accessible at:

<http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0085473>

Is the programme part of the implementation of the national AIDS strategy? -

Is the programme part of the implementation of the national poverty reduction or social welfare strategy? Yes

Background:

While poverty rates in Kenya are markedly higher in rural areas (49.7%) compared to urban (34.4%), often residents of informal urban settlements also experience great deprivation. Poverty rates tend to be especially high among vulnerable groups such as children (53.5%), including orphans and vulnerable children (54.1 %), older people (53.2%), and people with disabilities (57.4%). In 2009, there were approximately 2.4 million OVC living in Kenya (representing almost 30% of the total number of children living in poverty), and approximately 600,000 of those lived in extremely poor households. The living conditions of OVC have made it difficult to provide them with basic services. The number of OVC has been continuously rising in Kenya, mainly because of the widespread problem of HIV/AIDS. In July 2009, the World Bank has rolled out the Conditional Cash Transfer for Orphans and Vulnerable Children (OVC) project in Kenya. The US\$50m Project development objective (PDO) was to increase social safety net access for extremely poor OVC households through an effective and efficient expansion of the CT-OVC Program. The CCT for OVC project was designed to increase social safety net access for extremely poor OVC households, through an effective and efficient expansion of the government's CT-OVC Programme.

On July 23 2013, the World Bank has approved US\$10m additional financing to Kenya's OVC CCT program and received US\$56.4m co-financing from DFID. The Bank will support Kenya's National Safety Net Program for Results (PforR) operation to help the government to achieve the key results required to deliver its objectives. The objectives of the project additional financing are to (i) expand the coverage of the CT-OVC Program and (ii) strengthen its capacity to effectively deliver the National Safety Net Program (NSNP), of which the CT-OVC Program is a part. The closing date of the original project has been extended by two years to December 31, 2015. The additional financing will enhance the impact of the CT-OVC Program (and the broader NSNP), which has proven to be an effective means of supporting poor and vulnerable households taking care of orphans and vulnerable children (OVC).

Approach:

The HIV relevant project provided technical assistance to strengthen the government's capacity to manage the CT-OVC Programme at national, provincial, district and local levels. The project also focused on improving governance and accountability through the implementation of awareness campaigns, a communication strategy, and enhanced oversight and accountability mechanisms (including spot checks and citizens' scorecards). A new payment delivery mechanism has been selected to offer a cost-effective, efficient, accessible, accountable and secure system for the delivery of cash payments. The project tested the extent to which cash transfers can promote the use of education and health

services for OVC. To create incentives for caregivers to comply with the co-responsibilities (such as sending the OVC to school and making sure they are fully vaccinated), the program has introduced penalties for non-compliance in some of the districts. Synergies between sectors of health, social protection and public sector governance were established.

Reach of the intervention:

The CT-OVC Project has met its targets: the coverage of the Program increased from 82,371 households in Fiscal Year (FY) 2009/10 to 153,000 households in FY2012/13. Of these, 60,000 were supported by the World Bank credit and were receiving regular payments. As a result, the number of households targeted for this HIV care and support related project has been met.

Impact of the intervention:

The CT-OVC Program has had a significant positive impact on a range of outcomes. The findings from the second round (2007-2011) of a quasi-experimental impact evaluation implemented by the University of North Carolina and the Transfer Project reaffirmed earlier evidence that the Program is positively impacting household welfare and shows findings in areas not previously explored including adolescent health and local economy effects. The Program continues to have a significant impact on consumption and a modest impact on household productive assets, with a significant reduction of on-farm child labor. There are similarly positive results for health and education outcomes among children and evidence, for the first time, that the Program reduces the vulnerability to HIV among adolescents in beneficiary households.

In addition, the Project supported a range of activities that have contributed to the strengthening of the social protection sector in Kenya. The Project supported the Social Protection Secretariat with the policy development and capacity building, which was instrumental in the drafting and recent approval of the National Social Protection Policy providing the underpinning for the legislative and institutional framework for the social protection sector. It has also contributed to the building of capacity of the Social Protection Secretariat to carry-out its mandate to coordinate the social protection sector. Concurrently, the Project has enabled the government to (i) contract a new payment service provider (PSP) for the CT-OVC Program to provide transfers to beneficiaries electronically using two-factor authentication, thus significantly improving the security of the payments over the existing paper-based system; (ii) strengthen the complaint and grievance mechanism for the Program; and (iii) invest in monitoring and evaluation, which is generating an important stream of information on program implementation and results.

Financing and management:

The delivery of the broader NSNP is coordinated by the Social Protection Secretariat and implemented by the Ministry of Labour, Social Security and Services (MLSSS) and National Drought Management Authority (NDMA). The Project is being financed by the World Bank (US\$60m total) with the DFID co-financing (US\$56,4m).

Lessoned learned and recommendations:

Independent impact evaluation has found that Kenya CT-OVC, a major government social welfare program that is intended to alleviate poverty, reduces the likelihood of sexual debut among young people age 15–25 by 23%. Importantly, this program did not focus on HIV or include any messaging about HIV prevention, and is similar to large scale social protection programs currently operating across Africa, thus adding to the evidence base that addressing upstream structural drivers of risk such as poverty can have important effects on

reducing HIV risk. More work is needed to understand the mechanisms through which these programs reduce risk, and to determine if distinct mechanisms have differential relevance across outcomes. Rigorous evaluation of other large scale cash transfer programs will help elucidate the role of poverty alleviation programs in improving the health of populations, including in the arena of HIV prevention.

Annexes:

Full text of the independent impact evaluation of the CCT OVC project is available at:
<http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0085473#abstract0>

7. KENYA

Title of program: Kenya Cash Transfer for Orphans and Vulnerable Children (OVC-CT)

Contact: UNICEF

Implemented by: Government

Programme under way since: 2007

Has the programme been evaluated /assessed? Yes

<http://www.cpc.unc.edu/projects/transfer/countries/kenya>

http://www.unicef.org/evaluation/files/OPM_CT-OVC_evaluation_report_july2010-final_Kenya_2010-019.pdf

Is the programme part of the implementation of the national AIDS strategy? No

Is the programme part of the implementation of the national poverty reduction or social welfare strategy? Yes

Background:

There is growing interest and increasing evidence that cash transfers are addressing HIV prevention in Africa. Several experiments in Eastern & Southern Africa have provided proof of the concept that conditional cash transfers can delay sexual debut, and reduce the incidence of HIV and sexually transmitted infections among young women. However most countries in the region have large scale cash transfer programs that are unconditional, poverty targeted and provide support to families and that are also showing impressive impacts on HIV outcomes, including mitigation, as well as HIV prevention.

This case study documents the impact of a large scale government social protection program, the Kenya Cash Transfer for Orphans & Vulnerable Children (CT-OVC), on HIV behavioral risk among young people (males and females) age 15-25.

The CT-OVC, implemented by the Children's Department of the Ministry of Labour, Social Security and Services, is Kenya's largest social protection program, reaching 150,380 households across the country in early 2014. Eligibility is based on poverty and having at least one orphan or vulnerable child below age 18. Families are provided a flat monthly allowance of approximately US\$23, paid directly to the caregiver, there are no punitive conditions attached to the transfer though caregivers are informed that the money is for the care and support of children.

Approach:

The intervention is considered HIV sensitive as it was designed to target households and children affected by HIV and other vulnerabilities, and has been shown to have impact on HIV outcomes. The OVC-CT is being implemented by the Ministry of Labour, Social Security and Services in Kenya.

Reach of the intervention:

The CT-OVC currently reaches 150,380 households with at least one orphan or vulnerable child below the age of 18 years. The primary focus of the intervention is to address household poverty and vulnerability, and to support households to care for orphans, maintaining them in school and ensuring access to health care and other social services.

Impact of the intervention:

During the initial rollout of the CT-OVC in 2007, UNICEF and the Government of Kenya (GoK) designed a quantitative study to evaluate the impact of the program on primary indicators of consumption, food security and children's schooling. A follow-up survey was conducted on these households in 2009 to assess the two-year impacts of the program. In 2011, with funding from the National Institute of Mental Health (NIMH R01-MH1093241-03), researchers from University of North Carolina at Chapel Hill (UNCCH) collected a third wave of data from study households, which included a special module on sexual behavior and mental health administered directly to a maximum of three household residents age 15-25. Survey instruments and protocols were based on the Kenya Demographic & Health Survey (DHS) and approved by the Ethics Committees of UNC and the Kenya Medical Research Institute.

The analysis sample was restricted to individuals who had not had sex at baseline since the CT-OVC could not have affected their debut. The resulting sample size was 1443 individuals age 15-25, two-thirds of whom were in the treatment arm and of which 38 percent were female. At the time of the survey, 39 percent of the sample had debuted; among this group 42 percent used a condom at last sex, six percent had two or more partners in the last 12 months, and 14 percent had at some time given or received gifts in exchange for sex.

Young people residing in households receiving the cash transfer were significantly less likely to have experienced their sexual debut. The odds ratio for the treatment effect was 0.69 and was robust to the inclusion of factors that were not balanced across the study arms at baseline. The prevalence ratio associated with this effect is 0.82. Alternatively, the effect size in terms of percentage points is 8.8, which is 23 percent of the mean among the treatment group. Impacts on females were quantitatively larger than for males, but not statistically different.

The results of this study show that a major government social protection program that is not conditional and intended to alleviate poverty, the Kenya CT-OVC, reduces the relative odds of sexual debut among young people ages 15-25 by 31 percent, which, in relation to the mean, implies a 23 percent reduction in the likelihood of sexual debut which also reduces the risks for HIV transmission. The study also demonstrated a positive effect on the mental health of the young people, an important factor to strengthen young people's agency to adopt and practice protective behaviours.

Financing and management:

The CT-OVC is managed and implemented by the Department of Children Services of the Ministry of Labour, Social Security and Services. The budget is generated by general tax revenues (32%), development loans (39%) and foreign aid donations (29%). Major partners include UNICEF, DFID, the World Bank, University of North Carolina, Save the Children and FAO.

Government of Kenya is financing an expansion of the CT-OVC to reach over 300,000 households by July 2014, and is moving towards an integrated National Safety Net

Programme within which CT-OVC is one component. Overall coordination is by the Social Protection Secretariat within the Ministry of Labour, Social Security and Services.

Lessoned learned and recommendations:

These results are promising for HIV prevention for two reasons. First, age of sexual debut is a risk factor for HIV infection, thus indicating that a poverty-focused cash transfer program can have positive spill overs on an important HIV related outcome for young people. Second, the Kenya CT-OVC is similar in design and approach to many other national cash transfer programs, which increases the generalizability of these results across Africa.

Annexes: -

8. KENYA

Title of program: Response to the Social and Livelihood Needs for HIV/AIDS Prevention in East Africa

Contact: UNODC

Implemented by: UN or other inter-governmental organisation

Programme under way since: June 2011

Has the programme been evaluated /assessed? No

Is the programme part of the implementation of the national AIDS strategy? Yes

Is the programme part of the implementation of the national poverty reduction or social welfare strategy? No

Background:

The project interventions relates to Sub-Programme III, entitled 'Improving health and human development' of the Regional Programme for Eastern Africa. The project advocates for evidence- and human rights-based drug dependence treatment, building the capacity of service providers to deliver drug dependence treatment and HIV/AIDS prevention within a continuum of care.

UNODC is the main executing agency of this project. It works in close cooperation with several community-based civil-society organizations (CSOs) that are serving the targeted population. Cooperation has also been established with national government institutions in Kenya and other targeted countries, as follows: Kenya: Ministry of Health, National Campaign Against Drug Abuse Authority (NACADA), National AIDS and STI Control Programme (NASCO); Uganda: Ministry of Health, Butabika Hospital; Tanzania: Drug Control Commission- Tanzania; Zanzibar: Commission for National Coordination and Drug Control Zanzibar (CNCDC) Ethiopia: Federal HIV/AIDS Prevention and Control Office (HAPCO), Food, Medicine health Administration and control Authority, Federal Prisons Authority (FPA).

Programmatic and geographic reach: The project is benefitting 5 countries in Eastern Africa region, namely: Kenya, Tanzania, Uganda, Ethiopia and Zambia. Kenya and Zambia have been the primary beneficiaries during the first 2 years but in 2014, Uganda, Ethiopia, Tanzania and Zanzibar have also received awards.

Approach:

The project is a mix of HIV specific, HIV sensitive as well as HIV relevant. It is designed to contribute toward HIV prevention, treatment, care and support for most marginalized people using drugs and among prison populations affected by HIV. The main target group of this

project consists of marginalized individuals that are living with AIDS or are vulnerable to HIV infection as a consequence of drug dependence, imprisonment or recent release from prison. Additional target groups are NGOs and government institutions concentrating on community health and social service activities targeting drug users and ex-prisoners as well as social and health care workers that are active in the field of drug abuse, treatment and rehabilitation.

The project has a unique design that supports PWID financial protection, through sustainable livelihood thus reducing negative coping strategies, vulnerability to HIV and addressing inequalities that drive the HIV epidemic, particularly those related to gender. The project supports PWID who are HIV positive ensuring retention in health services and promotes economic self-sufficiency that will lead to eventual social reintegration.

Reach of the intervention:

Kenya: Primary focus of the intervention – basic and medium term socio-economic support and livelihood assistance as part of HIV prevention, treatment, care and support.

Target Population: This project primarily targeted injecting and non-injecting drug users and prisoners post release. Special efforts were made to reach females who use drugs particularly those who inject drugs. According to the epidemic profile for Kenya, overall HIV prevalence of people who inject drugs (PWID) is 18.3% compared to 5.6% among the general population as per the 2012 Kenya AIDS Indicator Survey. Female drug users have a significantly higher prevalence of 44.5% compared to 16% among male drug users.

The number of beneficiaries reached in Nairobi and Coast Regions through 6 CSOs:

- Over 1400 active drug users and those in recovery benefited from the daily feeding program, 57% of whom were PWID, 36% female drug users and 2% former prisoners.
- 125 drug users received vocational training in farming; tailoring, soap making, tuk tuk driving and briquette making, 19% of these were PWID and 55% females.
- About 70 PWUD developed marketing skills, 14% of them PWID.
- Of the 42 individuals who received small loans and training under a micro-credit scheme in Nairobi, more than half were regularly servicing the loan, 24% had fully repaid and only 17% had defaulted by end of 2013.
- Most female drug users in Coast region were reached by simple and innovative interventions such as sewing and soap-making.

Impact of the intervention:

Project achievements by the end of 2013:

- 66 CSO staff trained on socio-economic and livelihood assistance, proposal writing and project management
- 97% of clients accessed HIV risk reduction counselling and psychosocial support,
- Two thirds of project beneficiaries tested for HIV, and over 80% of HIV infected initiated antiretroviral therapy.
- About 14% of PWID had received sterile injecting equipment at least once through a pilot Needle and Syringe Program (initiated by other partners),
- About 16% reported safer sex behaviours through reduction of sexual partners and regular condom use.
- Almost 30% of all beneficiaries in Nairobi and Coast regions were able to grow their capital and initiate small enterprises.
- 56% of 70 individuals were able to increase their income using their marketing skills
- Majority of female drug users reported improved health status, self-confidence and reunification with their families

- In Bomu Hospital 92% were HIV positive with a median CD4 count 154cells/mm3 (IQR80-340). All HIV infected were initiated on HAART - 85% on 1st line regimens and 8% on 2nd line regimens. By June 2013, all were alive and had acquired basic tailoring skills while accessing health services including drug addiction counseling and spiritual-psychosocial support. Higher median CD4 count 459 cells/mm3 (IQR 253-742).96% reported fewer sexual partners with 85% reporting condom use. 35% were gainfully employed all were re-united with their families.

All grantees reported on project outputs using quarterly and annual programmatic and financial reports. Project monitoring evolved over time and eventually included an income and profit tracking tool and a user-friendly Excel-based longitudinal client monitoring tool that facilitated reporting of project outcomes for selected cohorts in terms of access to HIV prevention and drug dependent treatment services, risk behaviours, HIV positivity and family status.

Financing and management:

Every year UNODC ROEA awarded small grants to CSOs in targeted regions and countries using a competitive bidding process. An independent grants committee at UNODC HQ had overall authority for approval with or without modification. Thereafter, grantees received funds in instalments, the bulk of funds disbursed in the first quarter as per the approved work plan and budget. Implementation was thereafter monitored through quarterly and annual financial reports. All implementers were cautioned against exceeding any line item by 10%. Annual consultative stakeholder meetings provided an opportunity for experience sharing by existing and new grantees, with identification of best practices and lessons learnt as well as problem solving of implementation bottlenecks. Partners with slow implementation were offered a chance to seek a no-cost extension. Independent audits were also performed at end of project to assure appropriate use of funds.

A fulltime UNV in Nairobi has the overall responsibility for day to day project management, with technical support from the Regional HIV and AIDS Advisor and a National Project Officer.

CSOs rely on skeleton staff for overseeing the day-to-day implementation, supervision, monitoring and reporting: a Project Coordinator, Finance/Admin Officer, M&E officer, Field Supervisor plus a few outreach workers.

The community-based civil-society organizations have engaged in income generating activities (IGAs) that are able to create revenue that sustains the projects. They have also been exposed to various entrepreneurship training and have also been linked to financiers, who give loans that are used to expand the businesses. CSOs share lessons from the first two years regarding which business and farming ventures are more likely to be sustainable.

Major partners.

Government of Kenya:

- Ministry of Health – Division of Mental Health,
- National AIDS and STI Control Programme (NASCOP),
- National Authority for the Campaign against Alcohol and Drug Abuse (NACADA)

Civil Society Organizations as grantees:

- Nairobi Outreach Services Trust (NOSET) - Nairobi,
- Muslim Education and Welfare Society (MEWA) – Mombasa and Kilifi,
- Reachout Centre Trust (RCT) – Mombasa and Kwale,

- Bomu Hospital - Mombasa
- The Omari Project (TOP) – Malindi
- PSYCACA – Nakuru

Lessoned learned and recommendations:

A cohort analysis done in Kenya at the end of 2013 established that socioeconomic assistance for PWID is effective in: educating PWID and improving access to HIV prevention and treatment services, reducing risky sexual and unsafe drug use practices, reducing their HIV vulnerability, increasing economic self-reliance and improving overall quality of life.

Key factors that contributed toward project success: organizational capacity building of 6 CSOs through: infrastructural support, procurement of office equipment and furniture; provision of farming equipment, solar lamps, consumables and other supplies as per the approved grant proposal. CSO capacity building in institutional set-up, legislative and policy environment, coordination, political mobilisation and support, advocacy.

The short project life span vis-a-vis long term investments. Not all livelihood interventions deliver the results immediately. It is therefore difficult to assess the long term impact of the project within the project period. Many CSOs lacked prior experience with implementing IGAs and initially experienced challenges running and accounting for their businesses. However, through training they have continued to improve their business skills.

Annexes:

Annex 1. Report of the Regional Stakeholders meeting held in Zanzibar March 2014
<https://drive.google.com/file/d/0B-QSTLz2s-riajQ3WFpINHFLTXM/edit?usp=sharing>

Annex 2. Sustainable Livelihood Programme Brochure 2013
<https://drive.google.com/file/d/0B-QSTLz2s-ribWxTc1hQYUdpNWM/edit?usp=sharing>

9. LESOTHO

Title of program: Evaluating the impact of short term financial incentives on HIV and STI incidence among youth in Lesotho: a randomized trial

Contact: World Bank

Implemented by: UN or other inter-governmental organisation

Programme under way since: -

Has the programme been evaluated /assessed? -

Is the programme part of the implementation of the national AIDS strategy? -

Is the programme part of the implementation of the national poverty reduction or social welfare strategy? -

Background:

Conditional cash transfers and other financial incentives are being tested as an HIV/STI prevention strategy to incentivize safe sex. This study tests the hypothesis that a system of rapid feedback and positive reinforcement using a lottery scheme as a primary incentive to reduce risky sexual behavior can be used to promote safer sexual activity and reduce HIV incidence among young people in Lesotho, one country with very high HIV prevalence.

The study objective was to test the efficacy of the lottery incentive scheme in reducing HIV incidence. Participants were randomly assigned to either a control arm (n=1347) or one of two intervention arms eligible to receive lottery tickets: high (n=1116) or low (n=963) value lottery (1,000 or 500 Malotis or South African Rands). All arms received STI testing,

counseling, and STI treatment every four months during two years. All participants were tested for HIV at baseline and after 16, 20 and 24 months. Village level lotteries were organized every 4 months in which STI negative individuals from the intervention arms were eligible to participate and during which 4 lottery winners (2 males, 2 females) per village were drawn.

Approach:

The HIV specific intervention linked the receipt of lottery tickets to negative results for rapid tests for curable STIs: syphilis and *Trichomonas vaginalis*. Synergies between social protection and health (HIV prevention) sectors were built.

Reach of the intervention:

An unblinded, individually randomized and controlled trial with 3426 participants, males and females 18-32 years old drawn from 29 rural and peri-urban villages in 5 districts in Lesotho.

Impact of the intervention:

The primary study outcome is HIV incidence. After 2 years of intervention, HIV incidence was significantly lower among study participants eligible for the lotteries (OR 0.75, 95% CI 0.58 - 0.97), especially among women (OR 0.67, 95% CI 0.52 - 0.86), and in the group eligible for the high prize lotteries (1000 Rands) (OR 0.69, 95% CI 0.50 - 0.98). No harm was reported.

Financing and management: -

Lessoned learned and recommendations:

The study results indicate that short-term financial incentives to engage in safe sex can lead to a measurable decline in HIV incidence. It would however be advisable to replicated and potentially scale-up such an intervention in other settings.

Annexes:

Full study abstract is available at: <http://pag.ias2013.org/abstracts.aspx?aid=553>

10. LIBERIA

Title of program: Social Cash Transfer (SCT) Programme

Contact: UNAIDS

Implemented by: UN or other inter-governmental organisation

Programme under way since: 2009

Has the programme been evaluated /assessed? Yes

Is the programme part of the implementation of the national AIDS strategy? No

Is the programme part of the implementation of the national poverty reduction or social welfare strategy? Yes

Background:

The project is part of Government of Liberia poverty reduction and social protection strategy. It is implemented by the Ministry of Gender and Development with funding from the European Union, through UNICEF.

The project is designed to achieve three main objectives:

- 1) Reduce poverty, hunger and starvation in all households which are extremely poor and at the same time labour constrained

- 2) Increase school enrolment and attendance and improve the health and nutrition of children living in target group households
- 3) Generate information on the feasibility, cost-effectiveness and impact of a social cash transfer program

Approach:

The programme currently targets:

Households that is extremely poor and labour-constrained. For the programme, extreme poverty is determined by a household's access to food, level of material assets, and alternative means of support. A household can be labour constrained because:

- There is no adult between the ages of 19 and 65 in a household;
- There is an adult between 19 and 65, but he or she is not able to work because of a chronic illness or disability; or
- There is an adult between 19 and 65 but that person is not able to work because he or she is caring for at least three young children, disabled, or elderly people.

The project is HIV relevant given the fact that PLHIVs who are labour constrained and OVCs can benefit from the project. There is a strong synergy with the education sector to ensure that children from deprived households, including OVCs, have improved nutrition and financial support to ensure increase attendance and retention in school.

Reach of the intervention:

- The project currently covers two (Bomi and Maryland Counties) out of 15 counties in Liberia and has reached 3,448 households;
- Selection into the programme is based on objective evaluations of households in targeted counties through a demographic census and a poverty survey. Moving from clan to clan, monitors from the SCT Secretariat conducts a demographic census to determine if a household is labour constrained. A different set of monitors is deployed to perform a poverty assessment on households found to be labour constrained. Eligible households are defined as households that have been found to be labour constrained and at the same time extremely poor. After these two processes, the lists of presumptively eligible households are then reviewed by town chiefs and county social protection committees, who provide any necessary corrections based on their local knowledge. After training of chiefs, community members and beneficiaries, the payment process begins.

Impact of the intervention:

- A total of 3,448 household beneficiaries are on the payroll as of October 2013. Although, there is no disaggregated data that shows how many HIV infected individuals or HIV affected households benefited from this intervention, the programme evaluation indicates that:
- 90% of SCT participant households reported improved food intake for their families over the past year.
- SCT programme households spent more on education – an annual average of LD\$1831 – than their non-programme counterparts, who averaged LD\$1342 of educational spending
- Families enrolled in the SCT programme showed high degrees of health-seeking behaviour, leading to improved health outcomes for adults and children alike.
- The clear majority of programme households (65%) reported an improved economic situation over the past year. They were also more likely to own important household items such as mattresses, radios, chickens and houses.

- Because 93% of the cash transfer money was spent within the selected Counties, the impact of the programme was felt beyond the immediate beneficiaries. Business owners reported that they were coming to rely on SCT recipients as important customers

Financing and management:

The SCT Programme is operated by the Government of Liberia, with partnership support from UNICEF and funding provided by the European Union. It is administered by the National Social Cash Transfer Secretariat (SCT Secretariat), which is part of the Ministry of Gender and Development. The programme is overseen by the National Social Protection Steering Committee, housed in the Ministry of Planning and Economic Affairs.

The Ministry of Gender and Development (MoGD) has signed a service contract with a payment agency (Ecobank Liberia Limited) who delivers the cash. Under this service contract, the payment agency uses “cash in transit” method to pay beneficiaries once every two months at the designated pay-points, according to a payroll approved by the Ministry of Gender and Development. Under this arrangement UNICEF is the fund manager and has signed a tripartite MoU with MoGD, and the payment agency. The Ministry is responsible for generating and approving the payroll, supervising and reviewing liquidations from the payment agency, and requesting disbursement from UNICEF to the payment agency. UNICEF is responsible for performing regular reviews and audits, and for disbursing funds to the payment agency.

Lessoned learned and recommendations:

- Many families who met the poverty test but were deemed labour available face similar hardships to those faced by families who were selected. They expressed frustration with the process and the fact that they were excluded. Hence there is the need to expand the scale and coverage of the SCT
- Beneficiaries meetings at collection point for cash transfer provides opportunity for integrating HIV and reproductive health programmes into the SCT programme
- The SCT has reaffirmed the value of direct cash transfers to allow families to identify and meet their own priorities
- The SCT programme provides opportunity to link beneficiary families to existing livelihood-based programming, and give them the necessary financial support and skills to achieve self- sufficiency
- There is the need for increased government investment to sustain scale-up the SCT programme across the country
- There is the need to improve the selection criteria for the programme for better targeting of beneficiaries
- There is need to strengthen the capacity of the SCT secretariat for enhance the effective monitoring of the programme

Annexes:

- Evaluation Report and
- Project FAQs Sheet

11. MALAWI

Title of program: Effect of a cash transfer programme for schooling on prevalence of HIV and herpes simplex type 2 in Malawi: a cluster randomised trial

Contact: World Bank

Implemented by: UN or other inter-governmental organisation

Programme under way since: -

Has the programme been evaluated /assessed? -

Is the programme part of the implementation of the national AIDS strategy? -

Is the programme part of the implementation of the national poverty reduction or social welfare strategy? -

Background:

In 2007 in Malawi, HIV prevalence was 9.1% in young women, compared with 2.1% in young men. Prevention of HIV in girls is one of the most essential challenges to reach a turning point in the epidemic. Schooling has been suggested to be a social vaccine to prevent the spread of HIV. Although cross-sectional data suggest a correlation between school attendance and HIV status, only two studies have identified a possible causal link between school attendance and reduced risky sexual behaviour. Aiming to reduce current poverty and, by investment in the education of children, future poverty, conditional cash transfer (CCT) programmes have been popular in development economics since the late 1990s. Because CCT programmes increase household income and school enrolment, they are particularly suitable for investigation of the importance of education and poverty as risk factors for HIV.

This study assessed the effectiveness of cash transfers in Malawi for reduction of the risk of HIV and herpes simplex virus type 2 (HSV-2) infections in never-married girls aged 13–22 years. After comprehensive randomized sampling procedure, participants in the conditional cash transfer group received offers of monthly cash transfers dependent on regular school attendance and were administered home-based counseling and rapid testing.

Approach:

This HIV specific randomized trial built synergies between health, social protection and education sectors. Never-married women aged 13–22 years recruited from 176 enumeration areas in the Zomba district of Malawi and randomly assigned to receive cash payments (intervention group) or nothing (control group), were studied for behavioural risk assessments (at baseline and 12 months) and serological tests (at 18 months). The primary outcome measures were prevalence of HIV and herpes simplex virus 2 (HSV-2) at 18 months and were assessed by intention-to-treat analyses.

Reach of the intervention:

The trial of HIV prevention and social support focus was conducted Malawi's Zomba district, which is characterised by poverty, low school enrolment, and a high prevalence of HIV. The study participants were never-married girls aged 13–22 years, residing in sampled enumeration areas. 176 enumeration areas from three different geographical strata were selected for further sampling: urban (Zomba city, 29 enumeration areas), near rural (<16 km from Zomba city, 119 enumeration areas), and far rural (≥16 km from Zomba city, 28 enumeration areas). A comprehensive randomized sampling procedure yielded a baseline study sample of 4051 individuals of whom 3796 (94%) were enrolled and completed a baseline interview at the end of 2007. Of these study participants, 889 were baseline dropouts and 2907 were baseline schoolgirls. The study used conditional cash transfers, the

important component of social protection policy to improve the lives of poor people, to investigate their effect on reduction of the risk of HIV and herpes simplex virus type 2 (HSV-2) infections in girls.

Impact of the intervention:

The primary outcome measures was the prevalence of HIV and HSV-2 at 18 months, which were assessed following home- based voluntary counselling and testing (VCT). Secondary outcomes included syphilis prevalence, school enrolment, self-reported marriage, pregnancy, sexual behaviour, and knowledge of HIV/AIDS. Data for the behavioural outcomes were collected at both baseline and 12 month follow-up.

The cash transfer programme decreased the prevalences of HIV and HSV-2 infection after 18 months in girls aged 13–22 years who were enrolled in school at baseline. These effects are supported by changes in self-reported sexual behaviour; researchers detected no effects on age of sexual debut or unprotected sex, but individuals in the intervention group chose younger partners than did those in the control group and sexual activity was less frequent with those partners. This trial showed that an intervention without direct focus on sexual behaviour change can lead to meaningful reductions in HIV and HSV-2 infections.

This study also demonstrated that a simple intervention that provided cash to unmarried schoolgirls (and their parents) decreased risky sexual activity and reduced their likelihood of being infected with HIV and HSV-2. The research findings suggest that financially empowering school- aged girls might have beneficial effects on their sexual and reproductive health. The study results indicate that cash transfer programmes could be attractive to policy makers in sub-Saharan Africa when they consider the full array of benefits that they might provide.

Financing and management:

The research was funded by the Global Development Network, Bill & Melinda Gates Foundation, National Bureau of Economic Research Africa Project, World Bank's Research Support Budget, and several World Bank trust funds (Gender Action Plan, Knowledge for Change Program, and Spanish Impact Evaluation fund).

Lessoned learned and recommendations:

Cash transfer programmes can reduce HIV and HSV-2 infections in adolescent schoolgirls in low- income settings. Structural interventions that do not directly target sexual behaviour change can be important components of HIV prevention strategies.

Annexes:

The full research article is available online at:

[http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(11\)61709-1/abstract](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(11)61709-1/abstract)

12. MOROCCO

Title of program: AMALI (My Hope) Programme to reduce the socio-economic impact of HIV/AIDS on the vulnerable population and on persons infected and affected by HIV/AIDS

Contact: Association de lutte contre le sida [Association for the Fight against AIDS] (ALCS)

Implemented by: Government, Civil society

Programme under way since: 2006

Has the programme been evaluated /assessed? Yes

Is the programme part of the implementation of the national AIDS strategy? Yes

Is the programme part of the implementation of the national poverty reduction or social welfare strategy? Yes

Background:

The context in Morocco is particularly conservative. PLHIV and key populations, particularly SW and MSM, suffer greatly from stigma, on the one hand, and from poverty and vulnerability on the other.

The AMALI (My Hope) Programme for income-generating activities began in 2006. It is run by the ALCS in partnership with the Social Development Agency and the Global Fund to Fight AIDS, Tuberculosis and Malaria, and with the help of local development associations. The main objective of this programme is to break the vicious circle of poverty and vulnerability to HIV infection through achieving financial independence.

Approach:

This project aims to reduce the social vulnerability of the key populations most exposed to risks of HIV infection. It also aims to reduce the impact of that infection on persons infected and/or affected by HIV through the development of IGA. This initiative involves a synergy between a thematic NGO (ALCS) and a public body, specifically the Social Development Agency, along with local development associations. The aforesaid Social Development Agency (ADS in French) is one of the main implementers of the social development policy in Morocco.

Reach of the intervention:

The AMALI Programme is a national programme that currently covers seven sites where there is a high concentration of vulnerable key populations (PLHIV, SW, MSM) infected and/or affected by HIV/AIDS, specifically: Agadir, Casablanca, Marrakesh, Fez, Rabat, Taroudant and Tangier.

The programme will be available in other places where levels of infection require it: a Tetuan site is scheduled for 2014. The programme will also involve other key populations: IDUs and migrants.

In seven years of programme operations, over 500 IGA-related requests have been received and processed with 146 beneficiaries being able to launch their projects. The overall sum involved is 2,104,647.85 dirhams.

Impact of the intervention:

The impact of the AMALI Programme is both psycho-social and economic. The IGA contribute to giving beneficiaries moral satisfaction and a certain financial independence.

Psycho-social impact

Persons living with HIV often find themselves in a depressed and anxious state following news of their diagnosis, but especially because they are rapidly confronted with the difficulty of living with a chronic, potentially life-threatening, disease that requires substantial treatments. They must also face stigma and the loss of social and family support. The inability to work and the loss of employment complicate the already precarious situation of PLHIV targeted by the programme.

In a comprehensive sense, the fact of having an IGA allows people living with HIV to regain self-confidence and self-esteem, to be independent and to have an income.

Economic impact

The IGA have helped beneficiaries out of poverty. According to an internal evaluation conducted in 2011, with results published in 2012, interviews show that, in 67% of cases, beneficiaries earn an average monthly income of 1,500 dirhams, with individual incomes

ranging from 400 to 6,000 dirhams. The remaining 33% of interviewees say that they live with what they have.

Some 39.5% of beneficiaries have been able to make monthly savings, with sums ranging from 300 to over 2,000 dirhams after all project costs have been paid.

Some 65.7% of beneficiaries have increased their income.

Of those questioned, 15.2% said that were no longer in poverty.

In a general sense, the AMALI Programme has successfully contributed to improving the economic power of PLHIV and of vulnerable and affected persons.

Funding and management:

Potential beneficiaries of the IGA programme are identified by ALCS offices. They receive information during group information sessions, as well as awareness-raising and guidance.

- Local association partners assist beneficiaries in establishing and implementing their projects. They conduct feasibility studies with the technical support of the Social Development Agency (ADS).
- A meeting of the Local Approval Committee is called to assess projects.
- Once a project is approved, interest-free loans are provided in two lots, in sums ranging from 500 to 2000 euros. Beneficiaries are offered support visits by local associations.
- The programme has been strengthened at the level of the current sites. It is gradually being extended to other sites where ALCS offices are operational, and where there is a heavy concentration of vulnerable key populations infected or affected by HIV/AIDS.

The programme is co-funded by the Social Development Agency and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) for five years.

Global Fund contribution:

- Phase 1 amount: 1,422,985.60 dirhams
- Phase 2 amount: 2,541,089.60 dirhams

These cover:

- Programme management costs
- Conducting activities scheduled in the Programme Prodoc, specifically:
 - Programme extension
 - Organizing training sessions on HIV/AIDS infection and IGA
 - Mid-term and final evaluation
 - Developing communications about the programme (leaflets, press conference etc.)

Contribution of the Social Development Agency:

- Amount for the five years: 990,000,00 dirhams
- Funds dedicated to financing projects
- Capacity strengthening through training for project implementers

Lessons learned and recommendations:

The factors that contributed to the success of the intervention include good coordination between the programme partners. The Social Development Agency participates through its budgetary contribution for funding projects and its expertise in IGA. The ALCS is responsible for identifying, advising and providing psycho-social monitoring of beneficiaries. The local association partners, supported by the ALCS and the ADS regional offices, offer hands-on support to project implementers. The Global Fund makes a financial contribution to the programme management.

The most significant difficulties experienced by the beneficiaries arise from repayment of agreed sums, related either to annual repayments or to payment deadlines.

Beneficiaries also experience difficulties in managing their projects. This can be explained by the beneficiaries' limited levels of education and limited capacities in terms of accountancy and project management. In some cases, it is the deterioration of a beneficiary's state of health that presents a major obstacle to project sustainability.

Annexes:

- Présentation du projet PPT
- Rapport d'évaluation interne du programme AMALI
- Photos PPT

13. MOROCCO

Title of program: Support for comprehensive care for persons infected and/or affected by HIV in Morocco

Contact: Association de lutte contre le sida [Association for the Fight against AIDS] (ALCS)

Implemented by: Civil Society

Programme under way since: January 2000

Has the programme been evaluated /assessed? Yes

Is the programme part of the implementation of the national AIDS strategy? Yes

Is the programme part of the implementation of the national poverty reduction or social welfare strategy? Yes

Background:

The ALCS was created in 1988, two years after the appearance of the first case of HIV in Morocco. Since then, its main concern has been access to HIV prevention and treatment. In that time, the association has been involved in a process of awareness-raising among public authorities and public opinion on the importance of an early response to HIV infection. It has also been advocating for access to ARV therapies and a reduction in their cost. As a consequence, use of antiretroviral therapies began in Morocco in 1999. The ALCS has established a programme of therapeutic education and psychological and social support for persons infected and affected by HIV (PLHIV). Over the years, there has been a considerable increase in the number of PLHIV, most of whom come from disadvantaged socio-economic backgrounds. In addition, there has been a strategy of decentralization for state-run specialized care centres. These factors have led the ALCS to restructure its first project as a "Programme to support comprehensive care for persons infected and/or affected by HIV in Morocco". This involves contributing to therapeutic care, therapeutic mediation and psychological, social and economic support. It is therefore a question of comprehensive assistance for PLHIV (patients and their families), as well as for the teams of carers in order to provide them with the conditions necessary for quality medical care. It is a multi-disciplinary programme in which various professionals may participate, depending on the needs of individuals. The programme includes various components, intended to reduce the vulnerability of persons infected and affected by HIV, and in order to improve their quality of life.

Approach:

The ALCS programme to support the care of PLHIV aims to contribute to improving the quality of life of persons infected and affected by HIV. This programme provides medical support to PLHIV, adults and children, screened in ALCS-run free and anonymous screening centres (CIDAG) or in health-care centres. This assistance is provided by therapeutic and social mediators who offer psychological support in the short term or at the request of medical advisors. The mediators also facilitate access and integration of PLHIV

into the care systems, and are involved in managing appointments. They offer travel tickets for patients in need, as well as other services of a social nature, e.g. food items, purchase of breast milk, and clothing. The main purpose of this activity is to avoid, as far as possible, losing sight of PLHIV and to keep them in the care system. In addition, the programme attempts to ease certain shortages of human resources in the health-care system by making qualified personnel available to specialized health-care centres. These include secretaries, therapeutic and social mediators, psychologists and archivists. The same is true of material resources such as travel tickets, treatments for opportunistic infections and the side effects of ARV, formula milk, paramedical supplies etc. The aim is always to promote optimal conditions for PLHIV to have ongoing access to care. Scientific advances in the field of HIV mean that the infection has become a chronic, and not a life-threatening, illness. This means that the care programme for PLHIV tries to steer suitably qualified individuals towards an IGA-based economic support programme, supported by the Social Development Agency (ADS from its initials in French), which is also intended to empower persons infected or affected by HIV.

Reach of the intervention:

The assistance programme is based on a comprehensive support approach to all persons infected or affected by HIV who are monitored at various specialized health-care centres. The aim is to improve their quality of life. Currently, the programme is present in all the cities in Morocco that have health-care centres for both adults and children. There are ten of these: Casablanca, Rabat, Marrakesh, Fez, Meknes, Oujda, Nador, Tangier, Beni-Mellal and Agadir. The programme is also present in four other cities where there may be health-care centres in the future: Laayoune, Safi, Taroudant and Essaouira. Thanks to national and international funders, the programme involves implementation of the following activities:

- Therapeutic care
 - Drug-based care: purchase of drugs for treatment and prevention of opportunistic infections, as well as for relieving ARV side-effects.
 - Biological and radiological care: the ALCS takes responsibility for biological and radiological analyses not available in health-care centres for patients living with HIV.
 - Contribution to funding paramedical material: the ALCS covers the purchase of paramedical items, such as drains or prosthetics, where necessary, for the poorest patients.
- Therapeutic mediation for persons infected or affected by HIV (adults, pregnant women, children)
- Psychological support for patients and their families
- Social support for patients and their families - the ALCS offers:
 - Transport services for the poorest patients and their families who are geographically distant from health-care centres
 - Purchase of kits for pregnant women including bottles, nappies, baby-clothes etc., and bedding for hospitalized patients
 - Patient nutrition, provision of a number of food hampers
 - Assistance for patients in the various administrative procedures, steering them towards other associations and social services. These tasks are conducted by social workers recruited by the ALCS.
 - Thanks to Drosos, a residential centre has been established in Agadir to meet the needs of the poorest persons who are geographically distant from the Hassan II Hospital. This is also a welcoming space, where beneficiaries are listened to and can relax.

- Economic support for patients and their families.

Income-generating activities (IGA) have been developed within the framework of another ALCS programme, "AMALI", in partnership with the Social Development Agency (ADS). That programme involves enabling people living with HIV/AIDS, along with the poorest people, to create their own economic activities in order to meet their needs more effectively.

Impact of the intervention:

The multi-disciplinary team, involved directly or indirectly in health-care activities for persons infected or affected by HIV/AIDS, was able to attend to 3,929 PLHIV in 2013. At national level the team provided:

- 6,969 therapeutic mediation sessions, of which 1,403 were initial sessions and 5,566 were follow up sessions
- over 1,428 travel tickets acquired on the ALCS budget, in order to provide transport for PLHIV who live far away from health-care centres
- 708 food hampers for the poorest
- 823 assessments including: 716 biological assessments and 107 radiological assessments not available to PLHIV in health-care centres
- over 4,182 medical prescriptions for treating opportunistic infections and ARV side-effects.

Assessments conducted by international consultants recommended by funders have taken place. They say, "the ALCS fills a significant gap in providing social support to persons living with HIV. ARV treatment is essential. However, other elements relating to care and treatment are necessary. The treatment provided by the ALCS to patients to give them access to diagnosis and treatment of opportunistic infections, and the provision of social support, are greatly appreciated by persons living with HIV. The ALCS uses a comprehensive approach to providing care and support services by giving access to micro-finance and social, medical and psychological support."* ALCS-DROSOS programme for HIV and AIDS prevention and care. Midway review, May 2012

Funding and management:

Since it was established, this programme has always been of interest to funders, which is why it has always been co-funded. As such, various funders have contributed, for example: the Global Fund to Fight AIDS, Tuberculosis and Malaria; ESTHER; BMS; the DROSOS, GSK and ViiV Foundations; Sidaction France and Sidaction Morocco, among others.

The interest shown by funders is partly due to the programme's careful management. At policy level, this is provided by an internal health-care committee established by the ALCS. The committee is responsible for the development of intervention strategies, as well as the recommendations necessary for keeping abreast with progress in research and innovations in the field. At technical level, management is provided by a national coordinator who is responsible for implementing programme activities, in cooperation with the teams at each site. The national coordinator also ensures that goals are achieved.

Through the quality of the human resources available to it, its capacity in advocacy matters, its management of financial flows, and its quest for new partners, the ALCS has clearly shown its commitment to ensuring the sustainability of this project.

Lessons learned and recommendations:

The role and place occupied by PLHIV in the programme, and in the implementation of activities, are the reason for its success. These factors demonstrate the level of ownership assumed by the target population.

The programme relevance and the quality of its activities were the reason why the Ministry of Health took it on. In 2009, inspired by the ALCS programme, the Ministry developed a national programme of psycho-social support (PNAPS). The ALCS continues to play an important role in this. Every time it is updated, the legal framework governing care in the case of HIV infection accords an important place to the programme activities, especially therapeutic mediation and psycho-social support. It should also be noted that the close cooperation and ongoing consultation between the ALCS and the Ministry of Health remains a very important factor in the programme's success.

Annexes:

Rapport d'évaluation du programme sur le site d'Agadir (région la plus touchée par l'épidémie)

Rapport d'évaluation mi-parcours sur les sites soutenu par la fondation Drosos

14. RWANDA

Title of program: 1) Girinka: One cow per poor family 2) Mutual de Santé

Contact: ILO

Implemented by: Government

Programme under way since: 2006

Has the programme been evaluated /assessed? Yes

Is the programme part of the implementation of the national AIDS strategy? Yes

Is the programme part of the implementation of the national poverty reduction or social welfare strategy? Yes

Background:

- 1) This programme is initiated by the President of Rwanda to alleviate poverty and improve nutrition among the poor. It is a public social protection programme which poor households of PLHIV also benefit.
- 2) Mutuelles des Santé aims to improve access to health care.

Approach:

- 1) The programme is not HIV specific but is HIV sensitive and HIV relevant. It improves poor PLHIV household's nutrition, sustenance and employment. It provides a stable income source for a family and a source of soil nutrients via manure to improve small scale cropping activities for livelihood.
- 2) Each men and women in the informal economy can participate by providing a pre-payment. With risk-pooling, the mutual provides financial access to health services in a fair and equitable manner.

Reach of the intervention:

- 1) The programme is national in scale and so far has already benefitted over 177,200 families and continues to expand. It is a form of economic support for all eligible poor households.
- 2) Over 90% of men and women in informal economy are covered by Mutual as of 2012.

Impact of the intervention:

- 1) A family that receives a cow is immediately empowered to move out of poverty and reduce malnutrition by getting cow milk for home consumption. They sell the surplus mil to generate income. Below a quote from a PLHIV who is a participant of Girinka:

“I am a widower living with HIV and I am among the beneficiaries of the programme and there are also many other cases. The Girinka programme has provided a stable income to my household. I have manure and I am also getting milk for consumption and selling the surplus to my neighbours. I am able now to provide the basic necessities to my family (pay medical insurance (Mutuelle de Santé), and send my children to school and more.”

- 2) The Mutual has improved health insurance coverage of Rwanda populations and enabled increased health service utilization by the population in need and helped individual as well as households to effectively increase financial and health risk protection by reducing out-of-pocket medical payments. People can now go to health centres before they become seriously ill because they have health insurance coverage. Early detection and treatments leads to early recovery and less negative long-term sequela and are less costly. Below a quote from one of the head of household of a beneficiary:

“Health seeking behaviour upon sickness changed among households with the expansion of health insurance. Nobody who has subscribed to CBHI (the Mutual) is afraid of seeking treatment when they need to at the health facility now.”

Financing and management:

- 1) The eligibility criteria are clear and fair. There is a Girinka committee at the village level which prepares a list of potential beneficiaries from the village and sends it to the sector level for verification. Once verified, it is forwarded to the district, which then transfers the list to the Ministry of Agriculture for the delivery of one cow to each of the eligible families. The selection is based on objective criteria of poverty status and by people who know the beneficiaries well locally. The programme does not only support those very poor families, but also other vulnerable groups such as people living with HIV, widows, orphans and other disadvantaged individuals and groups.
- 2) It was jointly financed by the government and the GFATM at the start; it is gradually taken over by the government for full financing.

The financial risk protection from Mutual (CBHI) On the one hand, taking into account the perspectives of health care providers, the number of insured end-users utilizing health services has substantially increased as there has been significantly reduced direct illness-related spending associated with insurance coverage. On the other hand, CBHI helped people to saving money on health services by reducing out-of-pocket payments.

Lessoned learned and recommendations:

- 1) Girinka is based on community level input and the programme has multiple benefits: food security, nutrition, economic empowerment and livelihood support. It is from the very top leadership of the country: the President.
- 2) Increased access to universal health care through CBHI has reduced significantly the morbidity and mortality among PLHIV. People infected and affected by HIV now have equal access to health care and medical treatments.

Annexes:

A brief extract from the ILO Rwanda SP-HIV report (The full report was shared on 8th May).

15. SENEGAL

Title of program: Education and Professional Training Support Programme for HIV/AIDS Orphans and Vulnerable Children (OVCs) in Senegal

Contact: Executive Secretariat of the National AIDS Council

Implemented by: Government

Programme under way since: 2008

Has the programme been evaluated /assessed? Yes

Is the programme part of the implementation of the national AIDS strategy? Yes

Is the programme part of the implementation of the national poverty reduction or social welfare strategy? Yes

Background:

Senegal has a high rate of HIV/AIDS, with a prevalence of 0.7% (EDS5, 2010-2011) in the population as a whole, and higher rates of prevalence among key vulnerable populations: 18.5% among sex workers (SWs), and 21.8% among men who have sex with men (MSMs). According to 2010 figures from General Practitioners, the total number of people infected stands at 74,140, with 12,487 HIV/AIDS orphans and vulnerable children (boys and girls aged 0-17 years). In the same year, the number of children under 15 infected with HIV stood at an estimated 2,207, while the number of new infections in the same age bracket was 1,320. There were around 580 deaths (Epidemiological Record no. 13, November 2008). In 2007, a national assessment of the situation of orphans and vulnerable children was conducted, with the support of partners. The results of this assessment were presented to stakeholders in January 2008. This marked a key turning point in the understanding of the impact of HIV/AIDS on children in Senegal and led to improvements in interventions for this population group.

The Executive Secretariat of the National AIDS Council (SECNLS) developed a school support project targeting 5,000 OVCs, with the assistance of the World Bank. This project was implemented between 2008 and 2011. The beneficiaries of this project received free schooling or professional training via a direct payment under a new social protection mechanism.

The stakeholders involved in implementation of this project were as follows:

- The Executive Secretariat of the National AIDS Council, the entity responsible for the national response
- The Trust Agency, which assisted the SECNLS with financial management aspects
- Postefinances, a fund transfer organisation with more than 140 offices throughout the country and signatory to a service agreement with the Executive Secretariat of the National AIDS Council.

Approach:

Between 2008 and 2011, this programme targeted OVCs at risk of non-enrolment or drop-out, or requiring professional training. The beneficiaries were identified via a situation analysis, conducted with significant assistance from civil society organisations involved in providing psycho-social support to PLHIVs and OVCs. These included PLHIV associations, and public-sector, private-sector and community support organisations for PLHIVs and teachers. The families of the children concerned were allocated funding to help them pay the school-related costs (pre-school, primary school and secondary school), or to fund apprenticeships. This funding covered the following academic years: 2008-2009, 2009-2010 and 2010-2011.

Central level: The SECNLS managed the project at all levels, through the existing system under the national multi-sector AIDS intervention programme: coordination of the MAP, the technical department responsible for supporting OVCs; the Monitoring and Evaluation Unit for collecting information about the project, the Trust Agency appointed to handle the payments, and the Regional Support Units (UARs) for coordination of the project within each region

Postfinances and its sub-entities (La Poste and the PF agencies): transferring funds through the provision of a savings book for each OVC.

Bursary values

- 108,000 XAF for pre-school
- 125,000 XAF for the first part of primary school ("CI" to "CE1" classes)
- 135,000 XAF for the second part of primary school ("CE1" to "CM2" classes)
- 145,000 XAF for the first secondary school cycle ("6ème" to "3ème" classes)
- 165,000 XAF for the second secondary school cycle ("2de" to "1le" classes)
- 280,000 XAF for a course of around two years

The amount of funding per family depended on the number of children covered by the programme in the family (up to a maximum of 3).

In the academic years between 2008-2009 and 2010-2011, a total of around 2,000,000,000 XAF was transferred to dedicated OVC savings accounts.

Reach of the intervention:

The funding provided for the children was transferred directly to the parents or respondent via savings accounts, primarily to cover their school or training costs. Part of the funding was also intended to help feed the beneficiary or beneficiaries and members of their family, as well as cover health, transport and other equipment costs.

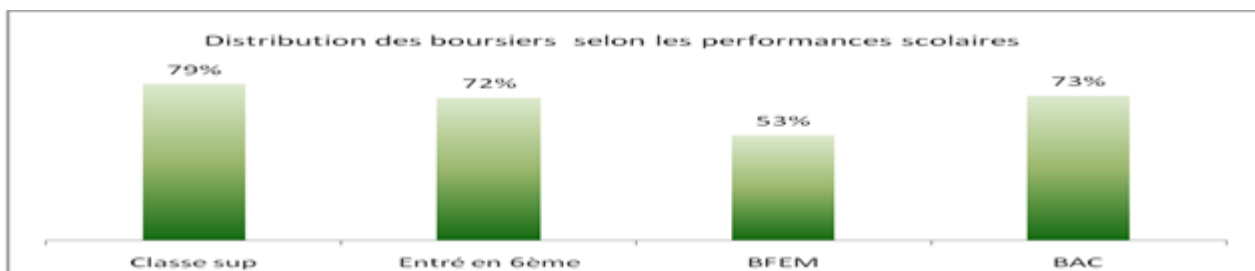
The monitoring process involved a monthly OVC monitoring record (health, notable events, expenditure monitoring, school/training monitoring, recommendations, expenditure planning for the following month).

Between 2009 and 2010, 5,217 children were enrolled in the project across the country.

According to the situation analysis data, the regional breakdown was as follows: Dakar 34%, Diourbel 3%, Fatick, 6%, Kaffrine 1%, Kaolack 7%, Kédougou 1%, Kolda 7%, Louga 6% , Matam 5%, Saint Louis 6%, Sédhiou 2%, Tambacounda 5%, Thiès 10% and Ziguinchor 8%.

Impact of the intervention:

- In order to enrol in the project, children required a birth certificate. This meant that many children now possess this official citizenship document for the first time.
- The project contributed to the creation of a reliable database covering OVCs.
- The project led to increased school enrolment among girls. 52% of the bursary recipients were girls and 48% were boys.
- The majority (67%) of the OVCs who received bursaries went to state schools. This was the case in all regions except Dakar, where 73% of the beneficiaries were in private schools and 27% in state schools.
- In 2009, the OVCs who received bursaries under the MAP achieved generally satisfactory school results: 79% moved up into the next class, 72% of those who sat the "6ème" class entrance exam passed, 53% passed the BFEM (end of middle school assessment) and 73% passed the baccalaureate. All of these figures were higher than the national average pass rates.



[translation of image above:

- "Distribution of bursary-holders by school performance"
- "Higher class"
- Entry into "6ème"
- "BFEM"
- "BAC"]

Effects on school enrolment and drop-out rates: For children:

- Improved participation in school life for OVCs
- Improved social integration of OVCs.

For parents:

- Improved self-esteem among parents
- Improved resilience to shocks due to the flexible way in which the bursary could be used
- Improved PLHIV association leadership through involvement and responsibility
- Improved commitment from authorities to dealing with the problem.

How has this impact been measured?

The impact was measured through a combination of quantitative evaluation, using routine data approved by a Multi-Sector Monitoring Group, and qualitative evaluation managed by an expert, who was appointed by the donor in June 2010.

Funding and management:

Within the SECNLS: the technical department responsible for supporting OVCs, the Trust Agency appointed to handle the payments and the fund transfer organisation (Postefinances)

- the Monitoring and Evaluation Unit for collecting information about the project
- the Regional Support Units (UARs) for coordination of the project within each region.

The operational aspects of the OVC monitoring process are handled by the usual organisations (departments and associations) that work with PLHIVs and their families.

In addition to the bursary allocations, funding is also assigned to the monitoring organisations via the regional Support Units to support monitoring of psycho-social, family, school and training aspects among OVCs.

What steps have been taken to ensure the project is financially sustainable?

The following steps were taken to ensure that the project was sustainable:

- Request for the government to create a dedicated budget line for OVC educational support
- Local authority assistance in allocating school bursaries to the children in their area
- Private-sector involvement
- Individual sponsorship strategy
- National civil society involvement.

Lessons learned and recommendations:

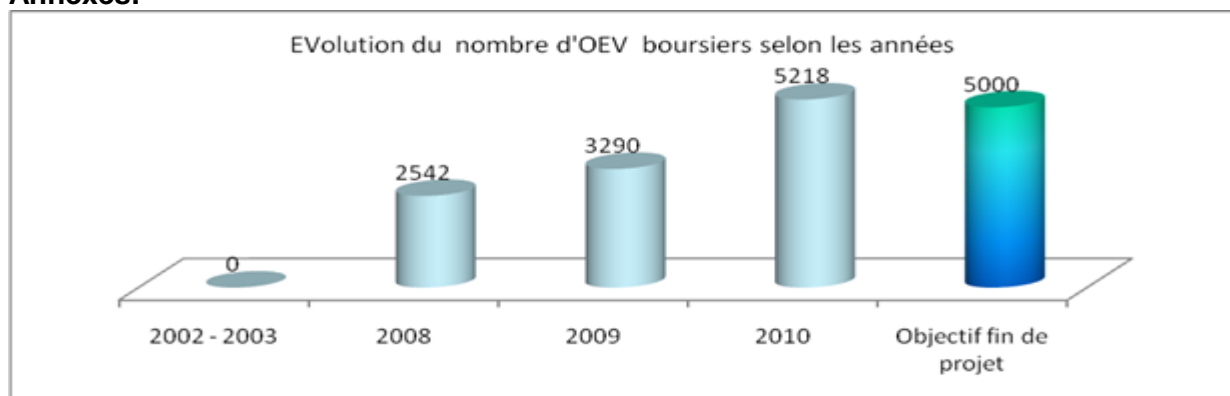
The success of the project was based primarily on the following aspects:

- The involvement of political and administrative authorities in the project, which facilitated cross-sector collaboration and ensured that official records could be obtained for the children.
- The establishment of a transparent OVC selection and fund management procedure.
- The involvement of civil society associations, and PLHIV associations in particular, throughout the country.
- The creation and operation of the Regional Multi-Sector Monitoring Groups.
- The relatively consistent value of the bursary, which covered not only school costs, but also certain food and health costs for the children.

What difficulties were encountered?

- Poor communication surrounding the project.
- The fact that many children and parents lacked the necessary official documents.
- The loss of funding following the withdrawal of the World Bank.

Annexes:



16. SIERRA LEONE

Title of program: Enhancing livelihood and skills acquisition for People living with HIV (PLHIVs) in Sierra Leone

Contact: Network of HIV Positives in Sierra Leone (NETHIPS)

Implemented by: Civil Society

Programme under way since: -

Has the programme been evaluated /assessed? Yes

Is the programme part of the implementation of the national AIDS strategy? Yes

Is the programme part of the implementation of the national poverty reduction or social welfare strategy? Yes

Background:

The programme addresses element of social protection through:

- provision of “social services” such as education, healthcare to people living with HIV and AIDS (PLHIVs)
- “Social assistance” to PLHIV to support their day to day lives such as nutritional support etc.

In socio- economic terms, self-esteem of PLHIV is maintained when they are able to interact in their communities to generate income to address basic needs. Hence, access to employment is critical to poverty alleviation and overall economic growth.

Within the limits of social protection, the national response to HIV in Sierra Leone have engaged PLHIVs on two fronts:

Firstly, economic empowerment programmes for PLHIVs in support groups are carried out using community based approaches.

Secondly, cash transfer and skills acquisition (agricultural livelihood and, financial management etc), are strategies adopted to reach PLHIV and affected persons as beneficiaries. Approach focused on two tiers; support group and regional level for the purpose of inclusiveness. At both levels there is leadership and coordination provided by the PLHIV umbrella organization with technical backstopping from NAS and UNAIDS.

Livelihood training in some cases were also facilitated by FAO and agricultural extension workers of the Ministry of Agriculture and Forestry

Approach:

The intervention is HIV sensitive with the covert objective of addressing stigma and discrimination against PLHIVs. Economic empowerment intervention is done through community based approach to facilitate socio – economic interactions between PLHIVs and HIV negative persons. This promotes community acceptance of PLHIVs.

At a second level, skills acquisition is used to target individuals to promote self -reliance and also for the purpose of sustainability. The PLHIV umbrella organization (Network of HIV Positives in Sierra Leone- NETHIPS) with support from UNAIDS Country Office (UCO) mobilised funds (USD100,000) from the Japanese Government through the Japanese Embassy in Ghana and has constructed a vocational skills development centre in the outskirts of Freetown in Grafton to be commissioned soon. UNAIDS Country Office, Her Excellency the First Lady of the Republic, the Minister of Lands, the National HIV/AIDS Secretariat and the Grafton Community were instrumental in the acquisition of the 4 acres land free of cost at this strategic location in the Western Area. In the spirit of collaboration and national compliance, the Ministry of Education Science and Technology has consented to provide oversight in the educational administration of the facility and will facilitate opening it to the public irrespective of HIV status. This ultimately will address HIV stigma and discrimination and enhance community acceptance of PLHIVs as PLHIVs and HIV negative persons will be in the same learning environment.

Reach of the intervention:

Economic empowerment of PLHIV is a primary focus of the national HIV Strategy as means of fighting stigma and discrimination. Beneficiaries are organized in support groups of PLHIV and at regional level of the network of HIV positives (NETHIPS) with the national NETHIPS coordinating the overall scheme and the NAS providing technical backstopping. Twenty two of the 40 support groups nationwide with an average membership of 150 PLHIV and 4 regional network s with a membership of about 300 received funding. Thus the total direct beneficiaries are at 4,500 PLHIV when compared to the 63,000 PLHIV nationwide. The skills training centre is designed to offer courses in Masonry, Textile and fabric designing, welding, soap making, Artistry and Electrical Engineering and each is expected to

enroll a maximum of 30 students. Thus in a year to 18 months there will be a turnover of 180 graduands adding to the needy middle-level manpower of the country.

Impact of the intervention:

The impact of the intervention is measured in economic terms to determine ability of beneficiaries to address basic needs. Mostly, PLHIV registered with support groups are poor, meaning they cannot afford their personal expenditure. As such they depend largely on care and support services provided through implementing partners. This is not sustainable as HIV funds dwindle or donor investment priority changes. However, economic empowerment and skills acquired paves the way to economic freedom and sustainability. The interventions have/will empower PLHIV to realize increase in household income, pay fees for children, house rents, provide food at home, medical care etc. At group level, members have been able to pay medical bills for the chronically ill and equally enhanced follow up of persons defaulting treatment. At skills level, it will create a level platform for PLHIV to compete for technical jobs with non-positive individuals.

Financing and management:

To enhance the capacity of PLHIV, funds are managed by the NETHIPS with financial monitoring by the NAS. Importantly, funds are received by the NAS as the coordinating authority of HIV in Sierra Leone which in turn disburses in tranches to NETHIPS. NETHIPS has a programme team with technical ability to implement projects. This team work with the NAS and UNAIDS to meet programme goal. Monitoring of output is done regularly by NETHIPS and report shared with NAS and UNAIDS.

The skills training centre will be managed by the Network of HIV Positives; finances received from tuition and other facilities will be used to expand on the facility. The Ministry of Education will ensure that the syllabus is in line with the tertiary and vocational units of the Ministry and also providing salaries for the tutors. The National AIDS Secretariat (NAS) will provide day to day oversight as well as partners including UNAIDS

Lessons learned and recommendations:

Success of intervention can be attributed to:

- The NAS assumed its full coordinating role whilst galvanising partners including the Ministry of Education, Lands, the First Lady bringing out their relevance and comparative advantages in the project.
- The establishment of NETHIPS with a well-structured executive, membership, office space and 'living' above stigma.
- The enactment of the HIV commission ACT of 2011 provides the legal environment for PLHIV to interact without being stigmatized or discriminated against.
- UCO fully committed to its advocacy role in mobilising partners for the greater and meaningful involvement of PLHIV

The critical challenges are:

- Need to reach out to the other support groups with the livelihood Challenge of support group leadership authority by some members
- Private sector yet to be fully mobilised into schemes that enhance livelihood of PLHIVs
- NETHIPS is yet to procure the equipment needed to run the skills training centre and may affect the scheduled time to officially opening of the school

Annexes:

Evaluation report

17. SOUTH AFRICA

Title of program: CASH PLUS CARE: Cash plus care and support halves incidence of HIV-risk behaviours amongst boys and girls in South Africa

Contact: Oxford University/University of Cape Town

Implemented by: Government, Civil society, UN or other inter-governmental organisation

Programme under way since: -

Has the programme been evaluated /assessed? Yes

Is the programme part of the implementation of the national AIDS strategy? -

Is the programme part of the implementation of the national poverty reduction or social welfare strategy? Yes

Background:

South Africa has an established system of child and adolescent-focused social welfare cash transfers and school feeding that are designed for poverty alleviation. Some also access care and support from a mix of private, public and family institutions. None of these programmes and supports are available to all adolescents in the country. This allows a 'natural experiment' approach with longitudinal data.

We know that cash transfers can reduce HIV-risk behaviors, especially for girls. But evidence also shows that young people who receive less 'care' or social support have higher HIV-risk behaviors (Hillis, 2000, Richter 2013). This suggests that the opposite may be true: that provision of care may reduce HIV-risk behaviours. We tested whether cash and cash plus care had HIV-prevention benefits.

Approach:

HIV-relevant programmes

Reach of the intervention:

For national rates of coverage, please see RSA government documents. Below reports rates of consistent service coverage in our 1-year longitudinal study:

Cash/poverty alleviation:

Child support grant/foster child grant: 56%

School feeding: 72%

Food gardens: 5%

food parcels: 0.1% [removed from analysis due to low access]

soup kitchen 0.4% [removed from analysis due to low access]

free school transport 0.9% [removed from analysis due to low access]

free school uniform 0.6% [removed from analysis due to low access]

Care:

Positive parenting (25%)

Teacher social support (8%)

home-based caregiver: 0.7% [removed from analysis due to low access]

school counsellor 3.7% [removed from analysis due to low access]

Impact of the intervention:

'Cash plus care' reduces incidence of HIV-risk behaviours for both adolescent boys and girls.

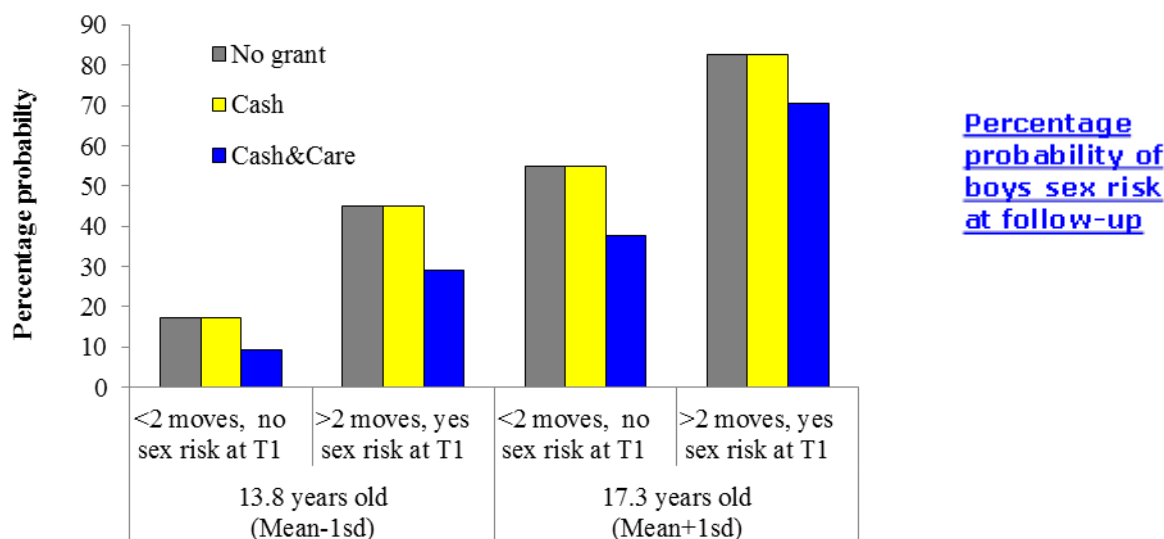
Citation: Cluver, L, Orkin, M, Boyes, M, Sherr, L. Cash plus care: social protection cumulatively mitigates HIV-risk behaviour among adolescents in South Africa. In press. AIDS. (please see attached policy brief)

Methods: Prospective observational study with random sampling. Longitudinal multivariate logistic regression controlling for confounders of cash and care access, and HIV-risk behavior.

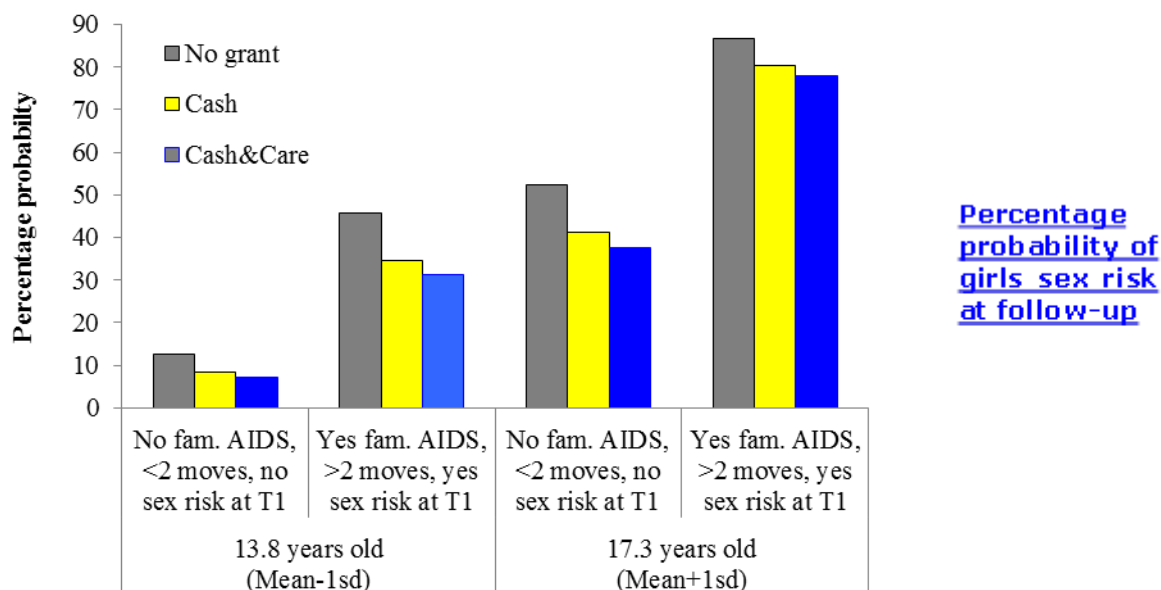
Sample: 1-year longitudinal study of 3401 adolescents in South Africa. 2 provinces, 4 urban and rural sites, stratified random sampling of high HIV-prevalence census enumeration areas and interviewing of all homes with an adolescent within areas. (<2•5% baseline refusal, one-year follow-up, 96•8% retention)

HIV-risk behaviors: incidence of transactional sex, age-disparate sex, past-year initiation of sex, unprotected sex, casual partners, multiple partners, sex whilst using substances, pregnancy.

Findings: Finding 1: for boys, cash support alone did not reduce HIV-risk behavior. But when boys received cash plus care, they showed a halved incidence of HIV-risk behaviours (OR.5). Boys with no cash or care had a 42% chance of HIV-risk behavior at follow-up, but boys with cash plus care had a 17% chance.

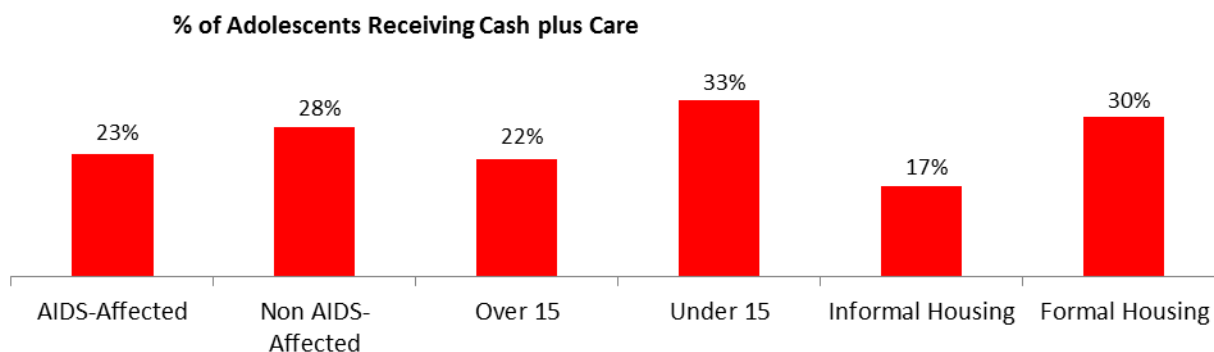


Finding 2: for girls, cash support alone did reduce HIV-risk behavior (OR .6). But when girls received cash plus care, they showed a halved incidence of HIV-risk behaviours (OR .55).



Finding 3: When adolescents access cash plus care, 1-year follow-up HIV-risk behaviour was reduced from 41% to 15% for girls and from 42% to 17% for boys. 'Care' included positive parenting and teacher social support.

Finding 4: Girls in AIDS-affected families and boys in informal-dwelling had higher HIV-risk behaviour. These high-risk groups were more likely to receive cash but were less likely to receive cash plus care.



Financing and management:

In this national sample, adolescents received support from various sources, with the most vulnerable adolescents being less likely to receive both cash and care support.
Some programmes provided by government (i.e. child cash transfers)
Some provided by NGOs (i.e. food gardens)
Some provided by schools/government (i.e. teacher support, some food gardens)
Some provided by families (i.e. positive parenting) and can be improved by provision of e.g. parenting support programmes.

Lessoned learned and recommendations:

- For girls cash transfers reduce HIV-risk behaviour. But cash plus care has a 10-50% greater effect.

- For boys, cash alone is not enough, but cash plus care cuts HIV-risk behaviour in half (boys are a difficult to reach target group for HIV-prevention).
- Access to social protection remains varied. Some services, such as school counsellors and school transport reached less than 5% of adolescents.
- Highest-risk adolescents (AIDS-affected girls, older adolescents, shack dwellers) were less likely to get combined cash plus care. Providing this may reduce HIV-risk behaviour.
- Child-focused cash transfers and school feeding are statutory and therefore predictable entitlements. There is strong public support for these programmes.
- Services provided by NGOs are more scattered, such as food gardens and home-based care.
- There is less support for care services provided to adolescents (especially older adolescents) than there is for young children. These findings suggest that care has very important HIV-prevention outcomes.
- There are emerging evidence-based interventions to improve family and teacher support of adolescents. For example, REPSSI's teacher's certificate programme gives teachers skills in psychosocial support, and the WHO's Parenting for Lifelong Health programme shows pre-post improvements in positive parenting, supervision, reductions in abuse and increases in support from parents to adolescents in South Africa.
- Challenges to provision of care and support include lower access in rural areas and very high-crime areas, scattered NGOs where full reach is needed.

Annexes:

- 1) Policy brief
- 2) Draft paper (revise and resubmit, AIDS).

18. SOUTH AFRICA

Title of program: Child-focused cash transfers reduce incidence of HIV-risk behaviours amongst adolescent girls in South Africa

Contact: Oxford University/University of Cape Town

Implemented by: Government

Programme under way since: -

Has the programme been evaluated /assessed? Yes

Is the programme part of the implementation of the national AIDS strategy? No

Is the programme part of the implementation of the national poverty reduction or social welfare strategy? Yes

Background:

South Africa has an established system of child and adolescent-focused social welfare cash transfers, intended to alleviate poverty. Although the government has made great progress in increasing uptake of social grants, they are not yet available to all adolescents in the country. This allows a 'natural experiment' approach with longitudinal data.

Approach:

These programmes were not designed or intended to reduce HIV-risk behaviour amongst adolescents. However, evidence from World Bank RCTs indicated that cash transfers may reduce adolescent risk behaviour, and required testing in real-world conditions with government-administered cash transfers.

Reach of the intervention:

National reported rates of child-focused cash transfer coverage: 73%

Impact of the intervention:

Child cash transfers reduce incidence of transactional sex and age-disparate sex for adolescent girls.

Citation: Cluver, L, Boyes, M, Orkin, M, Pantelic, M, Molwena, T, Sherr, L. Child-focused state cash transfers & adolescent HIV- infection risks: A prospective multi-site study in South Africa. The Lancet Global Health, December 2013. 1:e362-70

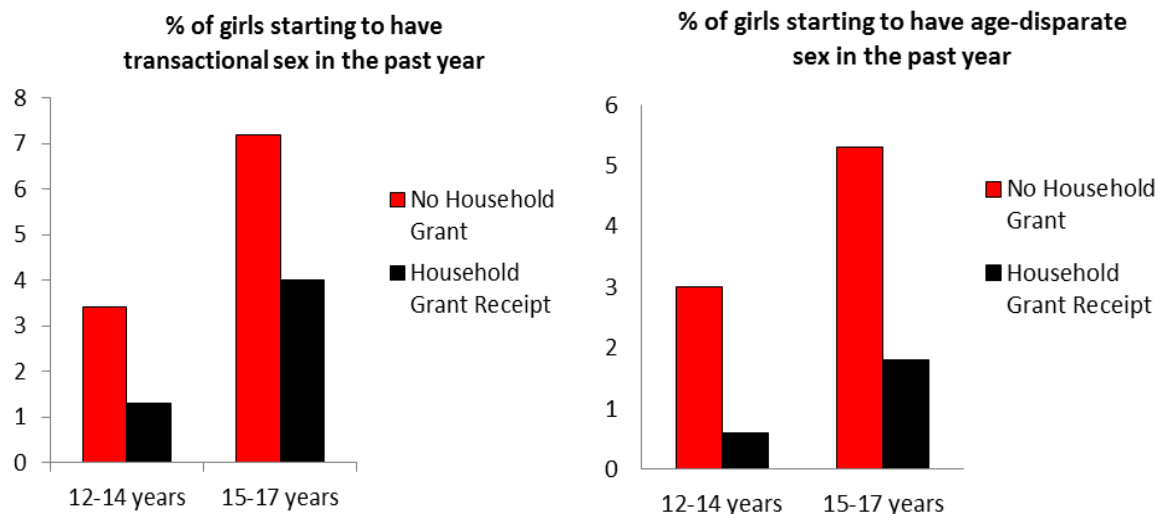
Methods: Prospective observational study with random sampling. Longitudinal propensity-score matching was used to replicate randomized controlled trial conditions in an existing programme, and additionally checked using multivariate regression.

Sample: 1-year longitudinal study of 3401 adolescents in South Africa. 2 provinces, 4 urban and rural sites, stratified random sampling of high HIV-prevalence census enumeration areas and interviewing of all homes with an adolescent within areas. (<2.5% baseline refusal, one-year follow-up, 96.8% retention)

Findings: Finding 1: Child-focused cash transfers reduce by half the risk of incidence and prevalence of transactional sex for teenaged girls. (sex in return for money, school fees, food or shelter)

Finding 2: Child-focused cash transfers reduce by two-thirds the risk of incidence and prevalence of age- disparate sex for teenaged girls (having a sexual partner more than 5 years older)

Finding 3: Cash transfers did not reduce multiple partners, unprotected sex or sex whilst drunk or using drugs. No consistent effects were seen for adolescent boys.



Financing and management:

National government cash transfer programme, since 1998. This is coordinated by the Department of Social Development and the South African Social Security Agency (SASSA). Funded from national treasury budgets. Originally only children under 7 years, now extended to under 18 years. Means-tested for low-income families. Extensive outreach programmes by government in recent years have increased uptake.

Lessons learned and recommendations:

Findings from this study:

- Cash transfers to poor households allow teenage girls to make safer sexual choices. They reduce reliance on 'sugar daddies' to provide basic needs.
- Adolescent girls in families with a child-focused cash transfer have 50% less risk of transactional sex and 70% less risk of age-disparate sex.
- Currently, child-focused cash transfers reach around 70% of eligible children. Full scale-up could prevent 77,000 new cases of transactional sex in South African girls each year.
- Cash transfers do not reduce all HIV-infection risks, and must be part of combination prevention approaches (see accompanying submission: Cash plus Care).
- These findings are effective in real-world conditions of government programmes.

Legislative and policy environment (from sources e.g. UNICEF/EPRI 2012):

- The effects of child cash transfers in South Africa are facilitated by the legislative environment. Child grants are statutory and therefore predictable and regular entitlements.
- There is strong popular support for child grants.
- One challenge to child-focused grants are opinions that they enable teenage pregnancy. However, the scientific evidence shows the reverse of this – they reduce teenage pregnancy (UNICEF/EPRI 2012, Cluver, in press).
- Challenges to child-focused grants include reduced birth registration in very low-income and rural families, and difficulties for orphaned children where parental death certificates are not available.

Annexes:

- 1) Policy brief
- 2) Paper in the Lancet Global Health (December 2013).

19. SOUTH AFRICA

Title of program: How do cash and care reduce adolescent HIV-risk behaviour?

Contact: Oxford University/University of Cape Town

Implemented by: Government

Programme under way since: -

Has the programme been evaluated /assessed? Yes

Is the programme part of the implementation of the national AIDS strategy? No

Is the programme part of the implementation of the national poverty reduction or social welfare strategy? Yes

Background:

This paper is to be read after the two submissions: 'Child-focused cash transfers reduce incidence of HIV-risk behaviours amongst adolescent girls in South Africa' and 'Cash plus care and support halves incidence of HIV-risk behaviours amongst boys and girls in South Africa'. The information on approach, reach, impact and financing of interventions is the same.

This brief aims to identify how cash and care reduce HIV-risk behaviour for adolescents in South Africa. Knowing how interventions work can help us understand them and make informed policy choices.

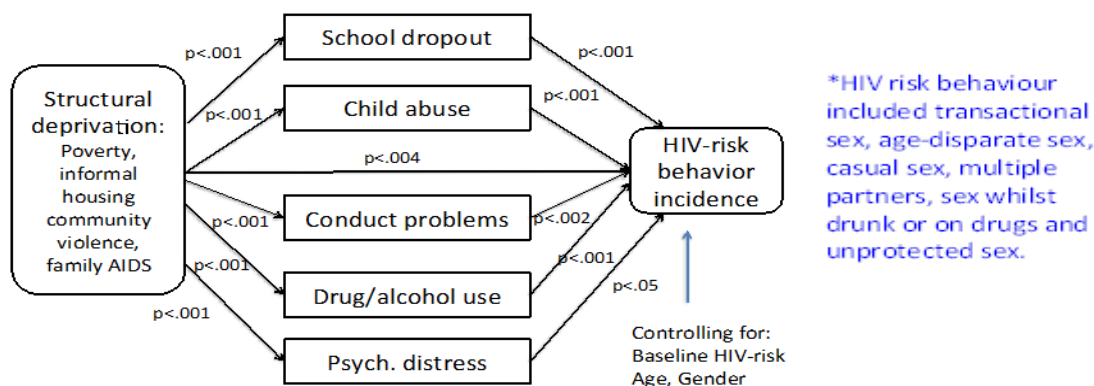
Analyses used the longitudinal national dataset described in the accompanying briefs (n=3515), and are based on discussion with the IATT on Social Protection Care and Support, UNICEF, UNAIDS & WorldVision. With a team of researchers (M Orkin, L Sherr, M Boyes, L Kaplan, L Cluver) we used longitudinal multiple moderated mediation analyses (in PROCESS). Preliminary analyses show key findings.

- 1) Structural deprivation causes negative social and psychological impacts. These pathways increase adolescent HIV-risk behaviours.
- 2) Cash and care work together to interrupt pathways from structural deprivation to risk behaviours and thus reduce adolescent HIV-risk.
- 3) Adolescent HIV-prevention knowledge alone does not impact these pathways to HIV-risk.

1. Structural deprivation causes negative family, school and psychological impacts. These pathways increase adolescent HIV-risk behaviours.

We ran multiple mediation models on longitudinal data (n=3515) to test possible pathways from structural deprivation (poverty, high-violence communities, informal housing and family AIDS) to increased incidence of adolescent HIV-risk behaviour. This showed that structural deprivation increases likelihood of psychosocial problems (child abuse, school dropout, clinical-level depression or anxiety, drug or alcohol use, conduct problems). These psychosocial sequelae then increase incidence of adolescent HIV-risk behaviours (for example, adolescents using alcohol are less likely to use condoms).

Fig. 1 Pathway from structural deprivation to HIV-risk behavior for adolescents in South Africa (multiple mediation model)



2. Cash and care can interrupt pathways from structural deprivation to risk behaviours and thus reduce adolescent HIV-risk.

We tested whether cash, care and HIV-knowledge can interrupt these negative pathways. For example, the Zomba trial showed that unconditional cash transfers reduce school dropout (Baird 2012). We see that in this South African sample, cash and care have three ways of interrupting HIV-risk:

- Cash and Care directly reduce HIV-risk behaviour as well as directly reducing psychosocial problems that lead to HIV-risk (blue lines).
- Cash and Care interact with structural deprivation: this means that they have even greater effect in reducing risk for those who are living in informal settlements, who are very poor, and at highest risk (red lines)

- Cash and Care interact with psycho-social sequelae: this means they have greater effect in reducing risk for adolescents with mental health distress, who are abused or who have dropped out of school.
- HIV-knowledge alone does not directly or interactively reduce HIV-risk behaviour in this sample.

Fig.2 Interrupted pathway from structural deprivation to HIV-risk:

ADOLESCENT GIRLS

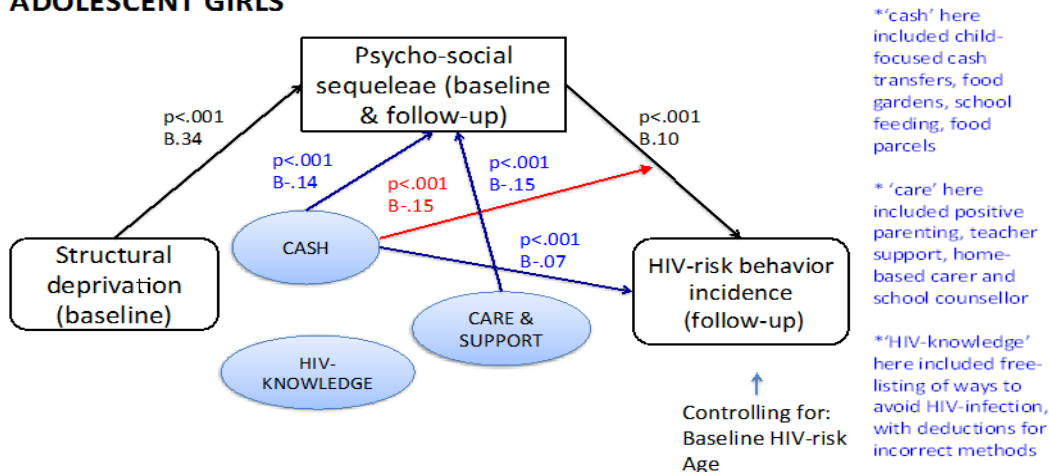
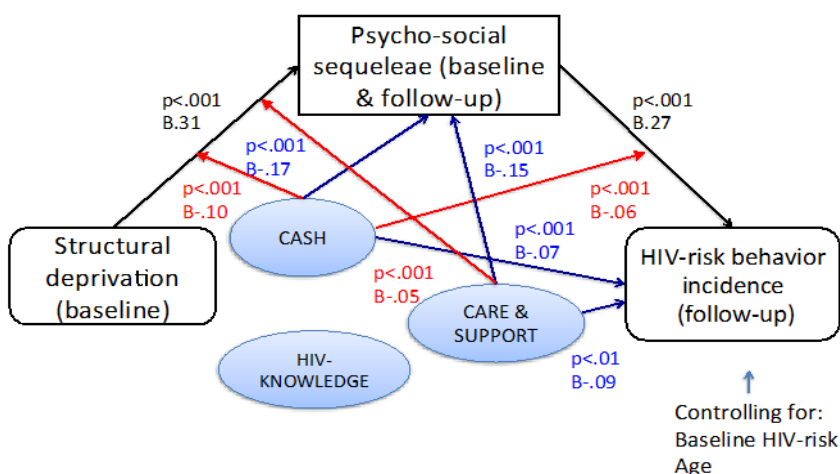


Fig.3 Interrupted pathway from structural deprivation to HIV-risk:

ADOLESCENT BOYS



The R-square of these models is .24 for girls and .23 for boys, meaning that this explains almost a quarter of the variance in adolescent HIV-risk behaviors.

Lessoned learned and recommendations:

- Cash and care both work by interrupting pathways that lead adolescents to HIV-risk.
- There are important ways that cash and care reduce HIV-risk. These include keeping adolescents in school, improving their emotional and behavioural health, and reducing child abuse.

Further analyses will be completed by end June 2014. Please contact Dr Lucie Cluver for updates.

20. SOUTH AFRICA

Title of program: Foster Child Grant (FCG) and Child Support Grant (CSG)

Contact: UNICEF

Implemented by: Government

Programme under way since: 1998 (CSG)

Has the programme been evaluated /assessed? Yes

Is the programme part of the implementation of the national AIDS strategy? No

Is the programme part of the implementation of the national poverty reduction or social welfare strategy? Yes

Background:

The process and justification of the HIV and social protection intervention, the form, whether situated in private or public institutions or a mix of the two.

In response to the HIV and AIDS pandemic, the South African government has instituted a number of interventions aimed at minimising the impact of the social and economic drivers of the pandemic. The provision of social grants is one good example of these responses.

The Foster Child Grant (FCG) was first introduced as a statutory provision for children in need of care and protection, i.e. children whose family system is unable, for whatever reason, to care for them, so they fall under state protection with a court order and regular supervision. In the last ten years, however, coverage of the FCG has increased ten-fold due to the orphan crisis arising from children losing their caregivers to HIV and AIDS related illnesses.

In addition to the FCG, the government of South Africa provides a number of social grants. By far the largest of these is the means-tested Child Support Grant (CSG). Although aimed at addressing the high levels poverty and inequality inherited from the apartheid years, the CSG has been found to have highly positive impacts on HIV and AIDS. These impacts show not only in the ability of the CSG to help mitigate the consequences of HIV/AIDS (by providing income support to very poor families), but also prevent HIV transmission by reducing risky behaviour that might expose especially adolescent girls to the risk of acquiring HIV and AIDS in the first place.

Approach:

The CSG can be defined as HIV relevant since it seeks to provide monthly income support to all children aged 0-18 years whose caregivers meet the minimum eligibility criteria (essentially, a means test). The FCG, in turn, can be defined as HIV sensitive as it provides for children in need of care and protection, which includes those orphaned children who have been placed in foster care with their extended family. While neither one of the grants is meant exclusively for children affected by HIV and AIDS, coverage of the FCG has escalated as a consequence of South Africa's HIV and orphan crisis, while the CSG has been shown to be very effectively targeted on HIV-vulnerable households and to have to strong positive impacts on HIV prevention among adolescents. Importantly, these impacts are greater the earlier in life a child starts receiving the grant. This means that the positive outcomes recorded among adolescents do not just depend on receipt of the grant at that particular age; instead, access to the grant in a child's early years reveals very positive impacts many years later, when the child reaches adolescence.

Both grants are administered by the South African Social Security Agency (SASSA), under the Department of Social Development. In delivering the grant, SASSA also collaborates with other departments such as the Department of Home Affairs in providing the required documentation.

Reach of the intervention:

South Africa's existing social grants were designed to address poverty, inequitable distribution of income and other social ills inherited from apartheid. All the same, the high numbers of orphans resulting from the spread of HIV and AIDS have led to a considerable expansion of the scope of the grants, particularly the Foster Child Grant.

Both grants have a national coverage. The Child Support Grant is an unconditional, categorical, means-tested program. It was introduced in 1998, initially covering all children 0-7 years of age whose caregivers met the means test eligibility requirement. Over time the scope of the CSG has extended to cover all children 0-14, and now all eligible children from birth to 18 years, thereby currently reaching about 11 million children out of a total child population estimated at 19.5 million.

At the same time that the age-eligibility of the program was expanding, the size of the grant was also being systematically raised. When the CSG started, each eligible child was entitled to receive a grant of R 100 per month. This has increased over time and now reaches R 300 per child per month (approximately USD 28.5 per child) as at end 2013.

In turn, the Foster Child Grant reaches close to half a million children who are deemed to be in need of care by a court order. The individual grant value currently amounts to R800 (about \$76) per month. Overall, the annual cost of this grant to the national fiscus is about R5.3 billion per annum (about \$504 million).

Impact of the intervention:

According to DSD (2012), using propensity score matching, the analysis of adolescent risky behaviours provides evidence of the Child Support Grant's impact in significantly reducing six main risky behaviours – sexual activity, pregnancy, alcohol use, drug use, criminal activity and gang membership.

The evidence documents statistically significant associations between receipt of the Child Support Grant in adolescence and:

- reduced sexual activity and a fewer number of sexual partners, particularly when the adolescent also received the grant in early childhood. Adolescents in households receiving the CSG are about 16 percentage points more likely to abstain from sex;
- reduced pregnancy, again particularly when the adolescent also received the grant in early childhood;
- reduced alcohol and drug use, particularly for females, and with the effect strengthened by early childhood receipt of the CSG.

Adolescents who started receiving the grant at an early age were less likely to engage in risky behaviours of sexual intercourse, alcohol use, drug use and criminal activity than those who started later. They were also likely to have fewer sexual partners and less likely to have early pregnancy.

Financing and management:

The South African Social Security Agency (SASSA) administers and manages the payment of social benefits to qualifying residents. SASSA has over the years introduced innovative programmes of reaching eligible beneficiaries and has developed a state of the art payment system. Recently, a biometric-based payment system which uses a bank card was introduced to improve the delivery of grants.

Social assistance grants are financed through public resources which are raised through taxation. Government expenditure on social grants in 2013 is estimated to amount to R113 billion or 9.8 percent of the total national expenditure estimates. As a percentage of GDP, total expenditure on social protection is about 3.4%.

Lessoned learned and recommendations:

Social protection in South Africa is enshrined in the Constitution under section 27(1) (c) and 27(2). The right to social protection is reinforced by the Social Assistance Act and its regulations, which provide the legislative framework for social assistance provision to the eligible needy.

The extraordinary growth of child grants in South Africa in the last decade and a half attests to the very high level of political will to provide income support to the needy as one of the core strategies for narrowing the gaps created by the apartheid regime, and addressing the negative consequences of the HIV and AIDS pandemic in the country.

South Africa has set up a very effective policy and institutional framework for administering social grants, from which a number of countries can draw lessons. SASSA is the agency established to administer social grants on behalf of the government, and there is a legislative framework for appeal by potential recipients who are aggrieved. Civil society has also played a very important role in advocating for the extension of the age limit of the grants and increasing its size.

There are still challenges that need to be addressed to ensure that the objectives of South Africa's social grants in terms of reducing poverty and inequality and the effects of HIV and AIDS are attained. The challenges of the CSG, for example, are that there is still about 20 percent of eligible children who are not accessing the grant due to a number of reasons such as lack of documentation, misinformation, being a child of a teen etc. The FCG, on the other hand, has some backlog of children awaiting to be cleared through court processes before they can start receiving the grant, due mainly to the insufficient number of social workers in the country.

Annexes:

Number of social grant recipients by grant type as at 28 February 2014

Old Age grant	War Veteran's grant	Disability grant	Grant in Aid	Care Dependence grant	Foster Child Grant	Child Support Grant	Total
2,955,861	439	1,121,150	81,007	120,014	498,981	11,044,494	15,821,946

References:

DSD, SASSA & UNICEF. 2012. The South African Child Support Grant Impact Assessment: Evidence from a survey of children, adolescents and their households. Pretoria: UNICEF South Africa

Meintjies H, D. Budlender, S Geiese and L Johnson. 2003. Children 'in need of care' or in need of cash? Questioning social security provisions for orphans in the context of the South African HIV pandemic. Cape Town: University of Cape Town

SASSA & UNICEF. 2013. Preventing exclusion from the Child Support Grant: A study of exclusion errors in accessing CSG benefits. Pretoria: UNICEF South Africa

21. TANZANIA

Title of program: Kwa Wazee

Social protection of older people and their dependents in a HIV/AIDS context

Contact: Kwa Wazee Switzerland

Implemented by: Civil society

Programme under way since: 2003/04

Has the programme been evaluated /assessed? Yes

Is the programme part of the implementation of the national AIDS strategy? No

Is the programme part of the implementation of the national poverty reduction or social welfare strategy? No

Background:

Kagera situated in the border area to Uganda/Rwanda was one of the first areas in Sub-Saharan Africa to be severely affected by HIV/AIDS. This was reflected by particularly high prevalences of HIV and particularly high numbers of deaths related to AIDS.

As a response to the HIV/AIDS crisis the initiators of Kwa Wazee (like many other NGOs) initially had concentrated on orphaned/vulnerable children and on women and they had developed various forms of psychosocial support and facilitated income generation activities.

It took years to realize that the consequences of HIV/AIDS went far beyond the sick people and their households but had led to a livelihood-crisis which affected the whole family system. It took even longer to realize that older people were more than often the most vulnerable parts in the family systems: Not only because their highly increased role as main carers of orphaned children but through the rapid erosion of their traditional support system: A Kwa Wazee survey among 108 randomly selected over 60 years old participants revealed in 2008 that these people had raised an average of 6.22 children. While an average of 3.48 children were still alive - according to their response - less than one child of all of them (0.88) was in a position to give support to the oldest generation. Many of the surviving children had migrated to the towns or lived impoverished.

At the end of 2003 – a time when it was nearly impossible to get funds with a focus on older people – a small private NGO was set up (Kwa Wazee - for older people).

Approach:

The approach of Kwa Wazee was not HIV specific but it was based in an environment where the consequences of HIV were omnipresent. In this sense it could be described as HIV relevant social protection.

Designed small scale from the beginning, Kwa Wazee tried to provide support to a limited number of older people and their dependents through social pensions - and child supports for older carers. As essential added value Kwa Wazee understood itself as a learning laboratory in the field of ultra-poor older people and skipped generation households where very little knowledge seemed to exist in literature.

Over the years complementary programme parts of empowerment or protection were developed and networks were strengthened with international NGOs and also with governmental organisations.

Reach of the intervention:

The primary focus lay on most vulnerable older people headed households and skipped generation households, which included special programmes for children.

As described above, the main criteria for inclusion in the pension programme was not HIV/AIDS but the poverty/vulnerability status defined by age, health condition, condition of house and land, number of children in care.

The programme started in one ward in the Muleba District (Nshamba) and bit by bit extended to other wards.

- At the end of 2013, 1,100 older people received pensions and got child supports for a total of 700 children.
- 950 older people were members of one of 78 mutual support groups. Most of the children were also part of 'Tatu Tanu' mutual support groups. Savings, income generation, health and self-protection being the main objectives of the groups.
- The training of health assistants for peer to peer care and prevention, trainings in self-defense and self-protection, access to health facilities like eye clinics and advocacy in legal issues were the main areas of the complementary programmes of Kwa Wazee.

Impact of the intervention:

Again, strictly speaking, it is not possible to refer to HIV outcomes.

But the strong and immediate impact of the cash transfers for better social protection of older people headed households in a HIV/AIDS context was so obvious to the management of the programme that activities were soon extended.

It took a few years until conditions were given for a larger scale evaluation jointly commissioned by REPSSI, HelpAge International, World Vision and the SDC.

- In 2008 a quasi-experimental comparison group design showed a significant reduction of poverty in supported households, significantly improved food intake, significantly improved psychological well-being and a slightly improved health condition. Older people who got supported by cash transfers were strengthened in the reciprocity process with their family, their neighbours and in their community. Children growing up in supported households in addition to this had less hard work to do and had improved conditions for their education: "Salt, soap and shoes for school - the impact of pensions on the lives of older people and grandchildren in the Kwa Wazee project", 2008
- In 2012 a Marburg University study (in German language) found evidence that a stabilized livelihood situation by means of pensions and the formation of mutual support groups were decisive elements for the strengthening of the human capital of older people. "Evaluation of Social Cash Transfer Plus Programme implemented by Kwa Wazee ... based on Amaryta Sen's Capability Approach"; Borchard e.a. (2012)

- In 2014 a study by HelpAge International which focused on the feasibility of a pension programme in particularly remote areas strongly confirmed the vulnerability status of older people and the crucial impact of pensions for older people and their dependents. There were also indicators that HIV/AIDS related vulnerability had been reduced with the access to ARV for the middle generation: Less children growing up with grandparents, more inkind support. "Towards universal pensions in Tanzania - evidence on opportunities and challenges from a remote area, Ngenge ward, Kagera" (2014)

Financing and management:

Kwa Wazee Tanzania is run by a local listed NGO and a local management advised by a retired international expert, who was also co-founder of REPSSI.

The core activity, the pension programme, is funded by Kwa Wazee Switzerland and HelpAge Germany which are committed to a sustainable financing until the government of the Republic of Tanzania delivers on the pledge to introduce a national programme of social pensions.

Complementary activities of Kwa Wazee Tanzania are funded by various donors such as the Firelight foundation, Novartis Foundation, Symphysis Foundation.

Lessons learned and recommendations:

- HIV/AIDS affects the livelihood of the whole family system. Older people are among the most vulnerable members in their communities.
- Pensions and child supports have immediate and significant impacts for the supported households. Depending on the baseline cash transfers reduce extreme poverty, prevent households from falling into extreme poverty or they are a decisive element for stepping out of poverty.
- Evaluations of Kwa Wazee have shown, that an effective and socially accepted targeting of beneficiaries - for example people living with HIV or whatever vulnerability criteria are selected - is likely to fail in an environment of widespread poverty. Regarding social pensions the experience of Kwa Wazee clearly supports a universal approach.
- Kwa Wazee started without involving local authorities or civil society bodies. With the increasing success and the reputation of the organization ties were strengthened and institutionalized. While older people have become a distinctive part of the civil society in the district over the years, in many areas - and in particular in health issues - clear discriminations persist.
- To increase the impact of the approach, the cooperation with larger networks was obviously crucial. In particular with organizations like HelpAge Tanzania which have connections to relevant ministries and working groups in a national context.

Annexes:-

22. TANZANIA

Title of program: Community-based conditional cash transfer (CB CCT) pilot programme of Tanzania social action fund (TASAF)

Contact: Tanzania Commission for AIDS (TACAIDS)

Implemented by: Government, Civil society

Programme under way since: 2000 (TASAF) and 2008 (CB-CCT)

Has the programme been evaluated /assessed? Yes

Is the programme part of the implementation of the national AIDS strategy? Yes

Is the programme part of the implementation of the national poverty reduction or social welfare strategy? Yes

Background:

The Tanzania Social Action Fund (TASAF) was initiated in 2000 by the Government of Tanzania as one of its initiatives on poverty reduction anchored to Poverty Reduction Strategies (MKUKUTA) developed over time. Implementation started in 1999 with a pilot that covered eight poor districts on the Mainland. The first phase of TASAF (2000-2005) that covered 40 poor districts as well as Unguja and Pemba addressed key issues that were identified in the PRSP, i.e. reduction of poverty by improving the social and economic services in key sectors of education, health, economic infrastructure and water with emphasis on rural and peri-urban areas. The second phase of TASAF (2005-2013) that was scaled up and implemented in all districts was built on MDGs and MKUKUTA to assist meeting the targets by 2010 for MKUKUTA and 2015 for MDGs.

Despite remarkable success particularly in increasing access to improved services to communities, the extremely poor were not benefitting to the anticipated extent. As a result, the Community-Based Conditional Cash Transfer (CB-CCT) Pilot Program was introduced in Bagamoyo, Chamwino and Kibaha District Councils in 2008. The Pilot was aimed at improving access of services by extremely poor households. The Program was officially launched in December 2009 and the first payment delivered to the beneficiaries in January 2010. The Pilot targeted the extremely poor and vulnerable households and empowered them to invest in nutrition, health and education. Conditionalities (co-responsibilities) were introduced to ensure accumulation of human capital.

Rigorous impact evaluation was conducted and the report shows that the Pilot has increased school attendance especially among older children, literacy rate and grade progression, has also encouraged greater use of health services and reduced the number of days children are ill, and beneficiaries used their cash to buy productive assets (chickens, goats, pigs, turkeys, sewing machines) and to pay and join the Community Health Fund (CHF), the medical insurance implemented at the village level.

Towards the end of TASAF II and using an HIV grant from the World Bank (MAP), Tanzania Commission for AIDS (TACAIDS) teamed with TASAF, built staff capacity to identify, report on and address HIV vulnerabilities in 17 out of the then 21 regions. Although a formal evaluation of this component was not done, program reports listed improved coping mechanisms among the beneficiaries, including school attendance among orphans and improved food security in families.

Approach:

With the success of cash transfer programs elsewhere in the world, the Government of Tanzania, via TASAF, piloted the CB-CCT program in three districts of Tanzania to see whether, using a model that relied heavily on communities to target beneficiaries and deliver payments, the program would deliver the desired social protection and related health and education benefits, and was expected to be HIV-sensitive (targeting at least some impoverished people living with HIV (PLHIV) and persons at higher risk of or vulnerability to HIV infection) as well as HIV-relevant.

Target population: Population under the food poverty line; approximately one million households currently living below the food poverty line including the transient poor. Benefits from the CB-CCT: Basic benefit: US\$5 per month; Variable benefit: up to additional US\$5 per month. From the cash-for-work: US\$1.35 per day for up to 60 days in three months.

Participation in the two programs would be equivalent to approximately 35% of annual household consumption.

In the TASAF/TACAIDS community HIV interventions, 61.7% of the interventions were related to impact mitigation, 34.5% to prevention, 2.7% to care and support and less than 1% to enabling environment.

Reach of the intervention:

Since its inception, TASAF has supported more than 14,051 community projects across 40 districts as noted above and in the attached documents. A total of 18,682,208 people were supported to access improved social services. Direct beneficiaries of public works were 408,228 (47% women). A total of 1,566,655 vulnerable individuals from 313,331 households participated to implement income generating activities. CB-CCT supported a total of 11,576 households with 28,480 individual beneficiaries. Support was provided to 22,712 individuals to form 1,778 voluntary savings group and engage in savings activities. HIV-specific programming was not included, though targeting was to include individuals at high risk or vulnerability to HIV infection, as well as impoverished PLHIV in the target communities.

Impact of the intervention:

On the whole, the CB-CCT program led to improved outcomes in both health and education. Households used the resources to invest in livestock, in children's shoes, in insurance, and - for the poorest households - in increased savings. This suggests that the households focused on reducing risk and on improving their livelihoods rather than principally on increasing consumption. There is no evidence that the project had adverse effects on community cohesion. HIV specific impacts were not directly measured, though discussions are on-going among TASAF, the World Bank HIV department, UNICEF and other partners to ensure that such measures are integrated in to the on-going monitoring and evaluation of TASAF-III moving forward. Notably, based on the results of the impact evaluation of the CB-CCT pilot, and as a result of ongoing advocacy, TASAF is planning to reform the benefits structure during future scale up to include additional incentives to households to encourage secondary school attendance. Given what is already known about the protective effects of cash transfers on adolescents, this additional measure is expected to have a positive impact on reducing HIV vulnerability of adolescent girls.

Financing and management:

The TASAF programme is co-financed by the Government of Tanzania and the World Bank, with a very devolved and comprehensive management structure and roles from the national to community level, including:

Central level (TASAF): Overall management and monitoring, support to sub-national authorities, disbursement of funds. Coordination with other Social Protection actors;
Regional level: Follow up of implementation in LGAs; Project Area Authority (LGA, Unguja and Pemba) level: Provision of support to ward level extension staff, Technical support and guidance including training and follow-up of implementation in the villages, Selection of works and activities; Ward level: Direct provision of technical support to communities and households; Village/Mtaa/Shehia level: Selection of beneficiaries by Community Management Committee (CMC) under oversight of Village Council, endorsed by Village Assembly, overall support to program; CMCs: Day to day implementation management, collection of information to register beneficiaries and to verify compliance with co-responsibilities; Education and health sectors: Provision of information on compliance with

co-responsibilities; Payment Agents: Direct delivery of transfer to beneficiary households and reconciliation of payments.

Lessoned learned and recommendations:

The Programme is having positive results in accordance to its goals. There is a general shared perception between most of the stakeholders that the Programme is achieving expected results and having positive impacts for beneficiaries. These perceptions has been confirmed by a recent qualitative evaluation, that demonstrate very positive impacts of the Programme regarding increases in attendance to school and to health facilities and of the use of the resources for school supplies, food and other positive consumption by the beneficiary households, including:

- After an initial surge in clinic visits among beneficiary households, 34 months into the program participating households were attending clinics less often but were healthier: 5% less likely to be sick at all ages and 11% less likely for children age 0-4. For all four outcome-age group combinations, those health differences are even more marked for the poorest half of the beneficiary households: the poorest of the poor.
- In education, the program showed some clear positive impacts on whether children had ever attended school or if they completed Standard 7. There were no clear impacts on school attendance, although only 12% of children reported being absent the previous week at baseline, so student absenteeism at primary level may not be a major problem. In education, improvements in the primary school completion effect is particularly striking for girls, and literacy rates increase particularly for children who were poor school attenders at the beginning of the study.
- Some of the most consistent changes observed have to do with insurance. Beneficiary households are much more likely to finance medical care with insurance and much more likely to purchase insurance than their comparison counterparts. Insurance is also the one category of spending which households in every sub-group increase expenditures on.
- The program did not significantly affect savings or spending on average, although a five-fold, highly significant increase in non-bank savings is observed amongst the poorest households. Beneficiary households did invest in more livestock. Focus groups revealed that households purchased chickens and other animals and used them to create businesses (e.g., selling eggs or chicks) or easily sellable savings.
- Because this program relies so heavily on communities – to target, to deliver transfers, and to monitor compliance with conditions – there was concern as to the impact on community cohesion. On the contrary, beneficiary households were more likely to have attended village council meetings, to have contributed labour to a community development project (for female recipients), and to express trust in a range of community members.

A national scale up (TASAF-III), is being implemented in five “waves” to reach a total of over 1.2 million households, and includes the following components:

1. Establishment of a National Safety Net incorporating transfers linked to adherence to co-responsibilities (CCT) and participation in public works (PWP), for household with adults able to work
2. Support to community driven interventions which enhance livelihoods and increase incomes of supported beneficiaries.
3. Targeted infrastructure development (education, health and water)
4. Capacity building to ensure adequate program implementation at all levels.

Annexes: IE final report CB-CCT, Tz CB-CCT Endline Report - Executive Summary in Charts, Cash Transfer Program in Tanzania_presented_22Jan2013

23. TANZANIA

Title of program: Sexual Behavior Change Intentions and Actions in the Context of a Randomized Trial of a Conditional Cash Transfer for HIV Prevention in Tanzania

Contact: World Bank

Implemented by: UN or other inter-governmental organisation

Programme under way since: The trial began in early 2008 and lasted one year, with STI testing at baseline, 4, 8, and 12 months.

Has the programme been evaluated /assessed? -

Is the programme part of the implementation of the national AIDS strategy? -

Is the programme part of the implementation of the national poverty reduction or social welfare strategy? -

Background:

Information, education, communication and interventions based on behavioral-change communication have had success in increasing the awareness of HIV. But these strategies alone have been less successful in changing risky sexual behavior. This paper addresses this issue by exploring the link between action and the intention to change behaviors. In Africa, uncertainty

in the lives of those at risk for HIV may affect how intentions are formed. Characterizing this uncertainty by understanding the reasons for discrepancies between intentions and actions may help improve the design of HIV-prevention interventions. Based on an incentives-based HIV prevention trial in Tanzania, the longitudinal dataset in this study allows the exploration of intended strategies for changing sexual behaviors and their results. The authors find that gender, intervention groups and new positive diagnoses of sexually transmitted infections can significantly predict the link between intent and action. The paper examines potential mediators of these relationships.

Determinants of consistency between sexual behavior change intentions and actions were explored in the context of an incentive-based HIV prevention intervention (RESPECT trial) conducted in rural Tanzania.

Approach:

The HIV specific study offers an opportunity to observe the introduction of a clear incentive for behavior change and examine how individuals respond to that incentive given the constraints they might face in reducing their personal risk. The study analysis explores reported intended sexual behavior change strategies and their corresponding behavior change actions implemented to avoid unsafe sex among participants enrolled in a structural HIV prevention intervention trial taking place in rural Tanzania. This study is a parallel group randomized trial with three separate arms – a control arm with an allocation ratio of 50% and two intervention arms (low-value cash award and high-value cash award) with an allocation ratio of 25% each.

Reach of the intervention:

The study primary focus is the exploration of determinants of sexual behavior change intentions and actions in the context of an incentive-based HIV prevention intervention. In February-April 2009, 2,399 participants were enrolled in the RESPECT study, and were interviewed using a closed-ended, structured questionnaire. In June and July of 2009, 1,943

of the 2,399 participants returned for the 4-month visit of the study, and were again interviewed using a closed-ended structured questionnaire.

Participants included males and females, aged 18-30 (and spouses ages 16 or over), residing in one of 10 study villages within the Kilombero/Ulangu districts of the Ifakara Health and Demographic Surveillance System (IHDSS) in south-west Tanzania. The villages consisted of 8 rural villages and 2 semi-urban neighborhoods in Ifakara town, with participants evenly distributed across the villages. On average across the 10 villages approximately 20% of the 18-30 old residents were enrolled in the study. There were three exclusion criteria: being pregnant at the time of registration, having the intention to permanently migrate out of the IHDSS area within the next year, and unwillingness to participate if assigned to the control arm. Participants testing HIV-positive at baseline were eligible for enrolment.

Impact of the intervention:

At the 4-month structured interview, 1123 (57.8%) of the 1943 returning study participants indicated that they had changed their behavior over the past four months as a result of being enrolled in the study. Of the 1123 participants reporting that they had changed their behavior over the previous four months as a result of study enrolment, 93 (8.3%) said that they had abstained, 491 (43.7%) reported having fewer sexual partners, 139 (12.4%) reported having less risky sexual partners, and 333 (29.6%) said they had increased their condom use. Significantly more males than females reported changing behavior (69.6% and 46.3%, respectively, $p < 0.05$). Significantly more males than females reported abstaining and having partners who were less risky over the 4-month period. There were no differences in reported type of change at 4-month visit by intervention group, however, among women, those in the cash award groups were more likely to report any type of sexual behavior change at the 4-month visit compared to those in the control group ($p = 0.03$).

In terms of the influence of the cash incentive, it was found that being in the high-value cash award group is significantly associated with reporting unanticipated change at the 4-month visit ($p = 0.06$). Stratifying the model by gender, no gender differences were found in the effect of intervention group on unanticipated change. Also no evidence was found that the cash award had more of an effect on married women than it did on single women. Being in the cash award group does not appear to be more important for women in changing their behavior regardless of marital status. Both men and women are equally influenced by the cash award group.

Financing and management:

The study was funded by the World Bank Research Committee, the Spanish Impact Evaluation Fund and the Knowledge for Change Program managed by the World Bank, the William and Flora Hewlett Foundation through the Population Reference Bureau, the Berkeley Population Center, and a CDC dissertation grant.

Lessoned learned and recommendations:

Results from this analysis point strongly toward the notion that change among the study enrollees between baseline and 4-month visit was motivated by the baseline level of risk behaviors and the corresponding perceived level of risk. Perceived need for change as measured by baseline self-reported risky sexual behavior does in fact predict levels of intended and reported change in this study. Additionally, groups that generally reported less risky behavior, for example women and those of the non-Catholic Christian religion, were less likely than their counterparts to report any type of change. Researchers cannot say with

confidence that the cash award had significantly differential effects on men and women in motivating change because the point estimates are not significantly different. However, being in the low- value cash award group was marginally associated with reported change in the previous 4-month period only among women.

Annexes:

Full study report is available at the following link:

http://econ.worldbank.org/external/default/main?pagePK=64165259&piPK=64165421&theSitePK=469372&menuPK=64216926&entityID=000158349_20120314091944

24. TANZANIA

Title of program: Cash Transfer and Psychosocial Support for People Living with AIDS and their Children in Kagera (Muleba District) – Tanzania

Contact: KwaWazee

Implemented by: Civil society

Programme under way since: 2008

Has the programme been evaluated /assessed? No

Is the programme part of the implementation of the national AIDS strategy? No

Is the programme part of the implementation of the national poverty reduction or social welfare strategy? No

Background:

The programme was begun to support parents living with HIV to be able to support their children. It is based on the premise that support for children should begin long before their parents die, and that it is much better for the parents to be able to engage with and care for their children themselves. Further, it is cognizant that HIV has often resulted in weakened bodies, depleted assets and ability to work; contracted social networks and greater reliance on children as carers. ART has transformed AIDS to a chronic condition but many are still not well and need additional health support, economic support, and social support, including improved relations with their children. This is situated within an NGO context working closely with the local hospital.

Approach:

The approach is HIV specific. All participants are living with HIV and on ART. Adherence to treatment is a requirement for continued group membership.

An initial small pilot program initiated in 2008 in Nshamba/Tanzania for social protection for PLWHA through cash transfer has developed into a comprehensive program to keep ailing parents alive and enable them to care for their children. The cash transfer program has been extended through microfinance and enriched by the formation of mutual support groups, with training for the PLWHA and a program for their children.

The monthly amount paid to PLWHA varies according to health, ability to work and number of dependents. This is now paid into the beneficiaries' savings accounts every two months. Additional applicants for the program who could not be included in the grant scheme have been included in a microfinance component. Members are organized in groups which meet regularly. Topics of discussion in the group sessions include: Living positively, Organization building, Strengthening relationships with children and Economic development

Reach of the intervention:

The intervention reaches around 2'500 PLWHA and children affected by HIV and AIDS in 8 wards in Muleba district, Kagera region – Tanzania.

Impact of the intervention:

The number of beneficiaries has expanded from the original 127 on the cash transfer program to over 1'000 who have received loans of total value € 44'000 of which € 30'000 has been repaid. The accumulated capital through shares stands at € 3'200.

Year	Women	Men	Children	Total	Amount TZS	Single or emergency support	Amount	Total Cash Transfer TZS
2008	87	27	13	127	30'452'250			30'452'250
2009	127	36	29	192	44'331'000			44'331'000
2010	141	35	37	213	50'462'900			50'462'900
2011	160	41	36	237	39'046'000	133	3'884'000	42'930'000
2012	192	56	65	313	47'935'000	160	4'884'000	52'819'000
2013	221	44	84	349	57'352'000	216	5'974'000	63'326'000

In 2013 KwaWazee conducted an internal assessment with 107 beneficiaries of both the cash transfer and the microfinance programs. 69% consider the loan program to have made a significant contribution to keeping parents alive. The profit generated from the loans has been used for small investments such as buying chickens, goats, land or constructing or repairing houses (92); buying food (75), paying for children's education (57) and health expenses (57).

Rebuilding social capital: The role of mutual support groups

The core idea of the concept of "social capital" is that if the amount of human interaction increases, people are more likely to help one another and even later become more politically involved and identify and defend their rights. Pierre Bourdieu, one of the fathers of the concept, stresses the value of a "durable network of more or less institutionalized relationships of mutual acquaintance and recognition." (Bourdieu, "Forms of Capital" 1983, p.249). The possession of a membership in a group is regarded as an actual or potential resource.

The participants described unanimously how the number of social contacts and the social integration shrunk drastically after they have been tested positive. As ART brings the possibility of a prolonged life, building and rebuilding social capital is critical to reinforce the social security of the affected families and create a sustainable "floor" for the future.

Participants analyzed outcomes of being integrated in mutual support and loan group.

1. Learning skills and knowledge from the group and integrating them into own life.
2. Getting and giving support
3. Inclusion of the children ("Children know the group members and the importance of the group. They can be sent to the members to inform them when the parent is sick". "Group members care the children if the parents are not available")
4. Increase personal security
5. (Unexpected): Empowerment of women. Most women felt that the group made an important contribution to empowerment of widows. On a scale of 0 to 5 (5 = "the existence of the groups helped me very much to become a strong woman", 0 = "the group didn't contribute anything to make me stronger"), 19 of the 22 women opted for "5", 2 opted for "4" and one for "3".

Children as young carers

The “rebuilding of social relations” begins with the children who have often taken over the main responsibility for the day-to-day care of ailing parents. Children as young carers have for a long time been “invisible”.

The child&youth-led organization TatuTano which includes children living with PLWHA (55%) and children living with grandparents (45%) in April 2014 had 1’380 children and youth members organized in 206 groups that are engaged in: Training in agriculture, project planning, leadership and monitoring; Income generation: agriculture, chicken, goats, commerce etc; Savings: the 206 groups deposit monthly between 200 and 300 Euro on their group accounts; Self-defense: 1’350 girls have been trained in self-defense and are forming self-defense groups in their communities; Training in prevention of violence for boys (“Peace is a decision”): 300 boys trained and Educational support

An internal impact and formative evaluation of the self-defense program gave clear evidence of the positive impact on psychosocial well-being and security.

Financing and management:

The program is financed by the Charitable Foundation Symphasis. The management is carried out by a small team from Kwa Wazee under the direction of Dr. Kurt Madoerin – co-founder of REPSSI with advice from and support from REPSSI.

Lessoned learned and recommendations:

1. Social protection – especially cash transfer – help to mitigate the impact of HIV and AIDS, help to reduce the burden on children in an affected family and help to preserve the parents’ lives.
2. Long-term funding that is “drip-fed” – continuous and steady flow of small amounts of resources ensure families can sustain responses to keep parents alive and improve the life of children.
3. Cash transfer is “the leading edge of a broader social protection agenda” (JLICA 2009) which includes rebuilding of social capital and formation of capabilities. Capabilities are the precondition for an individual to carry out agency, where agency is defined as acting according to one’s personal values and goals, and thereby causing social, economic and political change.
4. Considering the great importance of the children of PLWHA in the care of their ailing parents each program for PLWHA should include a program for and with their children.
5. Children affected by HIV and AIDS – and there especially girls – belong to the Most Vulnerable Children. Sexual assaults are frequent, which is not only a traumatic experience but a risk for infection with HIV. A combination of self-defense for girls and of gender-training for a non-violent boyhood of boys constitutes an efficient tool for the protection of the young carers.

Annexes: -

25. UGANDA

Title of program: Expanding the role of People Living with HIV (PLHIV) and communities in increasing access to PMTCT services- Viiv Project

Contact: Community Health Alliance Uganda

Implemented by: Civil society

Programme under way since: January, 2012

Has the programme been evaluated /assessed? No

Is the programme part of the implementation of the national AIDS strategy? Yes

Is the programme part of the implementation of the national poverty reduction or social welfare strategy? Yes

Background:

Community Health Alliance Uganda (CHAU) is a national NGO registered in 2010. Formerly, International HIV/AIDS Alliance in Uganda, CHAU transitioned into a national NGO in October, 2013. CHAU is a local partnership of small grass-root organizations and PLHIV groups working to support community action on health in Uganda.

CHAU is currently managing several development projects focused on increasing access to PMTCT services aimed at reducing critical community barriers to PMTCT scale-up in four focus districts through strengthening and empowering communities to effectively participate in PMTCT services, increasing health seeking behaviours and uptake of quality maternal health, family planning and HIV information, services and commodities amongst young people (10-24) affected by HIV and uphold their sexual and reproductive rights. In addition, CHAU is building capacity of CBOs involved in provision of MSM services by ensuring increased access to integrated SRHR/HIV services and information thus reducing the spread and impact of HIV among MSM and build healthy MSM communities.

CHAU's portfolio of work spans technical and organizational capacity building of civil society organizations/networks of PLHIV, community systems strengthening and partnerships, HIV prevention, care and treatment. CHAU embraces community peer-led, and empowerment approaches where communities are active participants in their own development programs. Currently providing support to 12 PLHIV networks and 95 groups in 4 districts, we have contributed to increased access to antenatal care (ANC), HIV counselling and testing (HCT) and prevention of mother to child transmission (PMTCT).

Justification of the HIV and social protection intervention

This initiative was and is being undertaken by networks to build on the unity among membership in networks and communities so that they could support and learn from each other to cause development in their communities, improve saving culture and be borrow to strengthen their businesses. Funds saved by members are obtained from facilitation provided by networks after implementing community work. The Community Vision program is supportive of PLHIV and the communities to address challenges of poverty which is a hindrance to access/uptake for health services. Once they become economically empowered, the communities will better be in position to address HIV issues in their community. CHAU supports/operates a small grants program as block grants for PLHIV networks and their groups that they use to strengthen their organizations, raise additional resources as well as improve their programming quality. The resources have been leveraged to specifically generate additional resources for social protection by PLHIV networks, the Community Vision (CV) -an initiative where PLHIV in Luwero make weekly savings from which they are able to obtain loans at low interest. The CV has since been rolled out to communities to embrace the general population. Prior to this initiative, PLHIV were educated and encouraged by CHAU to start-up/join small groups at village, parish and sub county levels and helped them register. The sub-groups were then mobilized by CHAU into county level networks for increased voice and visibility when advocating for improved health in their areas. The PLHIV network's membership plays a critical role of supporting PMTCT services thereby increasing the uptake of other services like HIV and TB treatment adherence, linking and referring people in communities, following up each other to ensure adherence to treatment and appointment and creating awareness in their respective

communities on antenatal care, post natal care, Prevention of Mother to Child Transmission (PMTCT), HIV and family planning.

CHAU provides these services through a peer-led approach using network support agents (NSAs) who are people openly living with HIV in their communities, are trained and placed at health facilities to work alongside health workers to ensure referrals and linkages between communities and service delivery points. NSAs provide health education awareness, registration of patients, community mobilization and awareness; follow up of positive pregnant and lactating women to ensure reduced loss-to-follow up of HIV-positive pregnant women under PMTCT program. To ensure sustainability, the small grants program through CHAU to networks facilitates some of their work including; community engagement/dialogue meetings with leaders, Use of mass media, Community mobilization and awareness/edutainment through music, dance and drama/ reaching people in worship places/door to door awareness, follow up of mothers enrolled on PMTCT program, supporting and facilitating family support groups at health facilities, reaching men at work and fun places, and managing a voucher system through distribution of maternity kits to vulnerable HIV positive pregnant women.

CHAU has played a critical role in building and strengthening capacity of PLHIV networks and their groups to address challenges relating to poverty, building partnerships and collaboration to ensure a more effective community based HIV response. In order to address this challenge affecting uptake/access to HIV/PMTCT and other health services, network's capacities have been strengthened to ensure partnerships and links between PMTCT/HIV and social protection. The small grants program includes a monthly stipend to motivate network support agents and a social welfare/social protection funds transfer. The stipend is used to pay fees, increase agricultural production and catering for their membership/weekly savings in a savings/loaning scheme (to be shared in detail) initiated by the networks. Networks in Mukono and Luwero have partnered with local NGO's Human Rights Promotion and Awareness Forum (HRPAF) and Uganda Network on Law, Ethics & HIV/AIDS (UGANET), who're both national NGOs, who trained PLHIV as paralegals to support in communities. In this way, networks in Luwero attract free legal services for PLHIV and other vulnerable poor households.

Approach:

The Community Vision program combines a mix of HIV specific, HIV sensitive and HIV relevant to social protection programs in a way that PLHIV were at the centre of start-up of the savings/loaning initiative within the networks. After grasping how the initiative is run, it was then scaled up in the communities to embrace other community/village people not infected with HIV. Each CV group meets and saves weekly, where they have opportunity to borrow, provide HIV/AIDS and treatment awareness, carry out prevention work through disclosure of status, awareness on condom and safe medical male circumcision promotion. Synergies exist between PMTCT/HIV programs and human rights through partnerships with UGANET and HRPAF. As PMTCT/HCT programs are being promoted, integration of human and health rights for vulnerable communities is done, while linking and referring those in need of health and free legal services in an event that their human rights have been abused like land grabbing and as well as a means to curbing sexual/gender and domestic violence among others. Government departments like the police, health facilities/health workers, probation offices, community leaders/Local councils are very useful as paralegals work hand in hand with such offices to ensure justice/services are sought for their community members.

Reach of the intervention:

CHAU's work through the networks has programmatic and geographic reach of 4 districts (Luwero, Nakaseke, Iganga and Mukono) covering 60 sub counties and working through 12 networks, have reached 524,835 community members; including men, leaders, family support groups and pregnant women. The primary focus of the project is HIV prevention particularly ensuring PMTCT through increased access to ANC and PMTCT programs. Networks ensure increased awareness, referrals and linkages (referred 10,072 pregnant women for ANC/PMTCT), distributed 227,876 pieces of condoms and educated 36,088 HIV positive pregnant and lactating women on family planning, made 7,460 client contacts of follow up to support HIV positive pregnant and lactating women under PMTCT, advocacy for availability of ARVS for PMTCT among HIV positive pregnant and breast feeding mothers. MTCT accounts for 18% of transmission among the children in Uganda, therefore, the program targets pregnant women to educate and encourage them access ANC and HCT at health facilities but also focusing on communities including their spouses, families and general population to be supportive of these women and addressing stigma related to PMTCT.

Impact of the intervention:

The CV program as a social protection intervention by networks links and has relevancy to the Viiv project outcomes of increasing access to SRH/FP for HIV +ve women, increased utilization of HCT/ANC by pregnant women, retention in ANC and delivery in a health facility as such meetings attract big turn ups from communities yet platform is provided for awareness creation and referral for services. Luwero district networks particularly Nyimbwa multi-purpose group for PLHIV has excelled in this social protection intervention and provides a guarantee for success and enhanced outcomes with the scale up to the entire district and in future to Nakaseke district. CHAU's Viiv project with networks has contributed to the increased number of women attending ANC and those started on ARVs for PMTCT due to mobilization, awareness and follow up drives by PLHIV in the focus districts. The measurement is based on 2013 annual focused district service statistics, which revealed declining numbers of children infected with HIV from their mothers at facilities, increased health facility deliveries among others. Financial literacy and education has enabled networks scale up such savings and loaning groups at community/village level, networks have improved their economic status and people's saving culture. Through their weekly meetings, they invite guest speakers to educate them but also lobby for funds especially from politicians in need of votes.

Financing and management:

Each community vision (CV) group, based at network or village level selected its leadership, developed a constitution and registered the CV as a CBO. Finances are obtained through payment of membership fees and weekly savings contributed by members. To ensure ease of managing an individual CV, there is a seal of maximum of 30 members in each. Coordination meetings are held on a weekly basis when members bring in their savings, borrow and monitor their finances to ensure that those who obtained loans have paid back. The CV manages a bank account where funds are kept and on a quarterly basis utilize member contributions to hire an auditor to audit their books of accounts. Through CHAU'S work with networks, they embraced a partnership with Plan Uganda to extend financial capacity building and literacy to start up community vision alongside HIV/PMTCT and legal programs for the communities. CV is sustainable as it relies on community member's contributions and is not only community led but driven. Community members play a critical role on saving, decision making, monitoring their money and the interest it has harvested. Some communities have already made decisions to invest their money by procuring tents

and chairs which they hire out for events management and payments are banked until members agree again on what they want to use the funds for. The major partners to ensure synergy between these programs are CHAU, Plan Uganda and HRAFP.

Lessoned learned and recommendations:

Several factors helped success of the community vision (CV) as a social protection program. The intervention was initiated within networks of PLHIV in Luwero district whose offices are located within their communities to serve people in a radius of a county from where their members come. CV is community led and owned as membership comprises of people already known by each other in the network, and who pay membership fees and weekly contributions in form of savings. The proximity of members makes it easy to attend weekly meetings for saving, borrowing and monitoring their finances. Knowing each other helped build trust and selecting right people in leadership, participating in making their constitution and having the sub group registered. The government of Uganda through micro finance provides a favourable policy environment for communities to engage in savings and loaning schemes. CVs have helped address stigma relating to HIV/PMTCT and embrace more opportunities for awareness creation on health. The challenge so far is a few members fail to service the loans in time, but are usually provided more time for payment.

Annexes: -

26. ZAMBIA

Title of program: Response to Social and Livelihood Needs for HIV/AIDS Prevention

Contact: UNODC

Implemented by: Government, Civil society, UN or other inter-governmental organisation

Programme under way since: 2011

Has the programme been evaluated /assessed? No

Is the programme part of the implementation of the national AIDS strategy? Yes

Is the programme part of the implementation of the national poverty reduction or social welfare strategy? No

Background:

Zambia has one of the highest HIV prevalence rates in the world with an HIV prevalence rate of 14.3% in the adult population. However, although the national HIV Sero prevalence rate has now reduced to 14.3% (2007 DHS-Republic of Zambia), a recent survey conducted in Zambian prisons showed that the epidemic in prisons is still at a very high level with 27.4% of prisoners testing positive for HIV infection. Female prisoners had a higher HIV prevalence (43.3%) as compared to male prisoners (26%). (Simooya and Nawa, 2011).

According to the Human Rights Watch report, 2010, the prevalence of TB and HIV in Zambian prisons are significantly much higher than in the general population. The report further elaborates that TB rates are at a dangerous high of 15-20 percent more in the prisons than in the general population, with significant rates of drug resistance and multi-drug resistant TB (MDR-TB). The general population has a high TB burden of 387 cases per 100,000 members of the population, which currently stands at 13 million. (Human Rights Watch Report, 2010).

Most prisoners originate from deprived communities with relatively poor health status. The risk factors for communicable diseases in such communities are very similar to those found in prisons (including sex work and drug use). People with low sustainable livelihood

capabilities are caught in a vicious circle that further undermines their capacities on all levels - social, financial and health-wise.

The "Response to Social and livelihood needs for HIV/AIDS prevention" project works on the premise that when you build the capacity of prisoners and ex-prisoners through vocational skills training and facilitate their social re-integration in society, the chances of them re-offending are slim. This further reduces prisoners and ex-prisoners vulnerability to HIV and AIDS. The Zambia Prisons Service (public institution) and the Good Samaritan Centre a half-way house for ex-prisoners (private institution) are key partners. The government, through this project has further established an Inter-Ministerial Committee to oversee the social reintegration process of ex-prisoners.

Approach:

The approach adopted by the project is both HIV sensitive and HIV relevant. For example, the project has been supporting HIV positive prisoners/ex-prisoners both male and female as well as those who are not HIV positive but highly vulnerable to it, either through drug dependence, incarceration due to drug trafficking or sex work.

The idea is to build the capacity of prisoners and ex-prisoners through targeted vocational skills training and other identified resources e.g. access to educational and entrepreneurship programmes that will help them become employable or enhance their chances of setting up businesses that can sustain them beyond the prison walls, thus reducing their vulnerability.

Reach of the intervention:

The project sites were purposefully selected on the basis of capacity (based on population size, prisons with high capacity were selected), high prevalence of HIV and availability of vocational skills training centres. In addition, project beneficiaries were further identified on the basis of HIV status and vulnerability in terms of prior use of drugs, incarceration based on drug trafficking or sex work.

Geographically, the project identified four provincial prisons as project sites, namely;

- Livingstone State Prison in Livingstone, Southern Province (Population: 578 (553 Male and 25 Female) and HIV prevalence rate: 27.5%)
- Kamfinsa State Prison in Kitwe on the Copperbelt province, (Population: 1,510 (1,472 Male and 38 Female) and HIV prevalence rate: 26.1%)
- Lusaka Central Prison in Lusaka, Lusaka Province (Population: 1000 (912 Male and 88 Female) and HIV prevalence rate: 42.1%)
- Kabwe Maximum Security prison in Kabwe, Central Province (Population: 1593 (1533 Male and 60 Female) and HIV prevalence rate: 29.2%)

Note: Female prisoners had a higher HIV prevalence (43.3%) as compared to male prisoners (26%). It is worth mentioning that, the Good Samaritan centre (Half-way house) is situated in central province. However, there is no data related to HIV prevalence. The centre has a holding capacity of 80 and is able to accommodate both male and female ex-prisoners.

The interventions are mainly focused on social transformation and economic empowerment, though a deliberate effort to create synergies with existing HIV prevention, treatment, care and support efforts within project-sites has been made.

The following are the specific interventions:

- Vocational skills training
- Support towards procurement of items of immediate need e.g. food, hygiene and sanitary items (specifically for women).

- Procurement of computers and skills training equipment
- Advocacy and Community sensitisation on social re-integration of ex-prisoners

The project has currently reached out to 1,500 prisoners (900 Male and 613 Women) and 76 children in prison. 160 (144 Male and 16 Females) ex-prisoners at the Good Samaritan centre have equally benefited from the project.

Impact of the intervention:

The intervention has had the following impact:

- The Zambia Prisons Service and the Good Samaritan Centre (half-way house) staff are able to provide basic socio-economic assistance to prisoners and ex-prisoners at risk of HIV infection or living with AIDS
- Prisoners recently released from prison and at risk of HIV infection or living with AIDS are able to maintain a stable relationship with the Good Samaritan Centre (Half-way House) and comply with treatment activities
- Prisoners and ex-prisoners at risk of HIV infection or living with AIDS are now able to make healthy decisions and behave in a way that does not create risks to others or themselves
- Through the vocational training programme, prisoners and ex-prisoners at risk of HIV infection or living with AIDS have better access to and use improved income opportunities

The highlighted impact was measured using the following criteria;

- Number of services provided at the project sites in comparison to number of target group members before interventions started
- Number of target group members that maintain a stable relationship with the prison and half-way house and comply with treatment activities in comparison to number of target group members before project interventions started
- Number of target group members that relapsed to criminal behaviour and risky behaviour in general in comparison to number of target group members that relapsed before project interventions started
- Number of target group members that have access to improved income opportunities and use them.

Financing and management:

The interventions are managed and coordinated directly through UNODC in collaboration with the Zambia Prisons Service and the Good Samaritan Centre (Half way House for ex-prisoners). The project is solely funded by the OPEC Fund for International Development (OFID).

The Ministry of Home Affairs, in view of the current project has constituted an Inter-Ministerial Committee to oversee the welfare of ex-prisoners. The committee has representation from the Ministry of Community Development Mother and Child health (social welfare dept), Ministry of Youth and Sport, Ministry of Health and Ministry of Education. It is envisaged that this committee will be able to coordinate efforts targeted at social-economic re-integration of ex-prisoners through its existing structures countrywide.

Lessoned learned and recommendations:

The following factors have contributed to the success of the intervention:

- Political Will: The vice president, members of parliament and prison management have committed to ensuring that prisoners and ex-prisoner's welfare is prioritised.

- Strong Partnerships: The project has managed to garner support from key stakeholders. This was made possible through a collaborative process from inception.
- Project Acceptance: Prisoners and ex-prisoners are highly motivated and participate in project activities as these interventions provide hope of a meaningful life beyond the prison walls.

Annexes: -

27. ZIMBABWE

Title of program: Strengthening churches' capacity for effective support, HIV prevention and SRH among vulnerable youths in Bikita and Mutare rural districts

Contact: Family Aids Caring Trust (FACT)

Implemented by: Civil society

Programme under way since: 2011

Has the programme been evaluated /assessed? No

Is the programme part of the implementation of the national AIDS strategy? Yes

Is the programme part of the implementation of the national poverty reduction or social welfare strategy? -

Background:

Zimbabwe's key response to HIV has been, among other things, the prevention of new infections through the rolling out of the social and behaviour change communication that promoted abstinence, condom use and faithfulness. The national behaviour change programme was designed in a rigid top down format that participants undergo a series of cognitive developmental sessions contained in a standardized manual. These sessions stimulate debate and inculcate an understanding of the risks of contracting HIV associated with certain actions as well as discuss safer (less risk) sexual behaviour. However, this was not designed with sensitivity to young people as it focuses on married couples and sexually active adults. Hence, the need to improve children/youth participation in the current project.

Approach:

The intervention is HIV sensitive where it focuses on the general populace and mainly youths. The project has networked with projects within the organisation and other health service providers in order to provide holistic services to the beneficiaries (such as HIV testing, pre and post-test counselling and livelihood interventions).

Reach of the intervention:

The intervention is implemented in ward 20&24 of Bikita district and ward 16 &17 of Mutare rural district. The primary focus is HIV prevention through awareness targeting youth, women, people with disability and people living with HIV. Community sessions have been conducted using the SAVE approach. In order to mitigate the effects of HIV, livelihood initiatives have been started such as broiler keeping, nutritional gardens, sewing and goat rearing and ensure that the targeted beneficiaries are self-reliant. 3713 people have accessed HIV Testing & Counselling (HTC) since inception of the project, 903 beneficiaries benefitted from livelihood support while 1230 youths received psycho-social support.

Impact of the intervention:

- There is increased participation by churches and community members in HIV prevention; measured by the number of churches trained and mainstreaming SAVE, HIV and AIDS education and SRH awareness in their churches. It has been noted that some African

Independent churches that used to shun bio-medical treatment are slowly shifting their positions.

- Community leaders as custodians of communities were also trained on SAVE so that they support the church leaders who were trained on SAVE, measured by the number of community leaders cascading information to other community members.
- Improved knowledge on SRH has been measured by number of teen age pregnancy, STIs, new cases of HIV recorded, number of youths visiting youth friendly centres and accessing SRH information.
- Increased number of people accessing HIV testing and counselling (HTC) has been measured by the number of people getting tested.
- Increased self-reliance among vulnerable groups has been measured by the number of vulnerable people that are self-reliant and the number of livelihood initiatives that are functional.

Financing and management:

The project is led by the project manager and two project officers who coordinate the activities. However, at community level, pastors' fraternal and church coordinating teams have been established. These community structures are responsible for monitoring and coordinating project activities and ensuring sustainability after the current financing phrase. Despite the project being funded by Tear Netherlands, there is the pass on scheme that has been introduced to ensure project continuity even without external funding. The communities have also been implementing the UMOJA concept where they are empowered to utilise their locally available resources. UMOJA has made communities realise that they have a lot of resources such as human, material or financial which they can tap on in order to reduce their poverty. Other major partners in the implementation of the project are National AIDS Council, Ministry of Health and Child Care, Ministry of Agriculture and Mechanisation, Ministry of Women's Affairs, Gender and Community Development, Ministry of Youth Development, Indigenisation and Empowerment.

Lessons learned and recommendations:

- Implementing projects through churches is more sustainable and effective because of their proximity and permanence within the communities.
- There is also need to engage community leaders so that they have a buy in of project activities.
- There is need for strong links through networking and partnering of service providers.

Challenges

- Bureaucratic structures delay implementation of planned activities.
- The transfer of trained coordinating pastors in the wards of operation to other areas affect project implementation.
- Religious beliefs that discourage health seeking behaviours affect project success.

Annexes: -

28. ZIMBABWE

Title of program: Community Monitoring of OI/ART Services By People Living with HIV in Zimbabwe

Contact: National AIDS Council

Implemented by: Government, Civil society

Programme under way since: 2012

Has the programme been evaluated /assessed? No

Is the programme part of the implementation of the national AIDS strategy? Yes

Is the programme part of the implementation of the national poverty reduction or social welfare strategy? No

Background:

There were reports of challenges with supply of and access to antiretroviral therapy services by people living with HIV in Zimbabwe. This included reports of unavailability of ARV medicines and regular stockouts, malfunction of diagnostic equipment, and unaffordable user fees among others. In their totality, the challenges amounted to a disruption of services leading to drug resistance and death of people living with HIV across the country.

This gave rise to consultation across the divide of the national response but inherently involving people living with HIV. As a result, an agreement was reached to establish a community monitoring programme led by a multi-sectoral team of people whose responsibilities would among others include:

- To assess the availability of ARVs in the OI clinics
- To discuss best practices and challenges of the ART Programme.
- To discuss with OI clients the quality of services they get from OI clinics and challenges they face.
- To assess the state of diagnostic equipment for OI/ART services,

Approach:

The programme combines a mix of approaches and is multi-sectoral. Representatives are drawn from organisations representing people living with HIV, the national AIDS coordinating authority, the Ministry of Health and Child Care, community members, community based organisations and representatives of non-governmental organisations. In implementing the programme, it uses the following strategies:

- Visits to health institutions for interviews
- Observations
- Reports
- Stakeholders meetings to share reports and discuss solutions
- Follow up on implementation of recommendations

Reach of the intervention:

The programme is national in its reach and periodically, the team visits a specific province wherein a number of districts are visited. The team also responds to emergencies that are raised through the membership of people living with HIV and the media. To date all the country's ten provinces have been visited with over fifty districts having also been specifically visited.

Although the programme is largely in the domain of HIV treatment and therefore targets people living with HIV primarily, it also includes prevention and economic as well as social empowerment of people living with HIV and their dependants.

Treatment has become a major strategy of HIV prevention as its success limits the amount of viral load in HIV positive people. As such, people living with HIV through their support groups, as a result of the community monitoring programme, have become strong advocates of ART adherence for prevention. Through this programme, support groups have been

empowered to provide both treatment and prevention literacy to both HIV positive and negative people in various communities.

Impact of the intervention:

Through the community monitoring programme, there have been a number of positive outcomes that have been registered. Various provinces and districts have already scrapped user fees which were inhibiting access to treatment by people living with HIV. Although some resistance exists, there is a strong lobby currently with policy makers across the country to have user fees scrapped as a national policy position.

Through efforts of the programme, after noting gaps during field visits, treatment literacy was included in the successful proposal application to the Global Fund under the new funding model.

Specifically, there have not been reports of medicines stock-outs in the press or at meetings as the case was, following the work done under the programme.

Support groups have also become very active across the country as they provide the forums where people living with HIV meet and discuss their challenges, which are then communicated to the programme. In addition, the programme has been able to address cases of stigma, especially self-stigma as issues of access to treatment are getting quick and adequate attention.

The programme has also created unity in people living with HIV, who in majority now speak with one voice in such issues and as a result are being taken serious by policy makers.

Financing and management:

The National AIDS Council provides secretariat services to the programme, which is funded also from NAC and other stakeholders. The committee that runs the programme established its own structure, which reports to the National Partnership Forum and also gives feedback to organisations representing people living with HIV.

The major partners are:

- People living with HIV representative organisations (Zimbabwe National Network of People with HIV (ZNNP+)
- NAC
- Ministry of health and Child care
- CBOs
- And partners in the National Partnership forum

Lessoned learned and recommendations:

The programme, working independent from the institutional arrangements of NAC and the Ministry of Health and Child Care has been very successful as people living with HIV are in control. Although members are drawn from NAC and MoHCC, their presence is merely facilitatory as opposed to implementing.

Leadership by people living with HIV has therefore been very useful to enable easy participation and contribution of people living with HIV in all parts of the country.

By working with people from NAC and the ministry, the programme also has managed to obtain easy access to policy makers and decision makers, including local facility managers and administrators at health centres.

A major lesson from the programme has also been that the multi-sectoral response approach actually works if well implemented and managed.

Challenges have however been experienced in funding not only the actual programme, but the entire response in general. These have however derailed the programme as it highly prioritise and has become one of the key avenue for fact finding and feedback on issues of access to treatment.

Annexes: -

II. Asia

1. INDIA

Title of program: Increasing access to social protection for people affected by HIV in India

Contact: UNDP India

Implemented by: Government, Civil society, UN or other inter-governmental organisation

Programme under way since: 2009

Has the programme been evaluated /assessed? Yes

Is the programme part of the implementation of the national AIDS strategy? Yes

Is the programme part of the implementation of the national poverty reduction or social welfare strategy? Yes

Background:

In 2006, the Department of AIDS Control (DAC), the National Council for Applied Economic Research (NCAER) and UNDP conducted a study on the socio-economic impact of HIV in India. The financial burden on families affected by HIV was most significant and visible at the household level and there was a steady decline in employment of PLHIV in all occupational groups. There was a clear need for these families to be protected from health-related shocks by guaranteeing access to social protection instruments. UNDP India focused on securing such social protection services, be it from the state or the civil society, for PLHIV, especially women and girls, MSM, transgender and other vulnerable populations. The HIV epidemic continues to be concentrated in high-risk groups like female sex workers, injecting drug users, MSM & TG and migrants. Advocacy for inclusive policies/programmes for PLHIV in India was a challenge given the low HIV prevalence, although estimated number of PLHIV was high at 2.27 million. About one-third of the 606 districts have an adult prevalence rate of >1%. The national response to HIV and related issues cannot be seen in isolation, especially in light of the 12th national five year development plan of India which focuses on inclusion, integration and sustainable growth. This focus makes a strong case for increased public investment for HIV responses in the country and the need to optimize resources through integration and collaborative working between ministries. In this scenario, social protection becomes a key policy tool to help communities become resilient.

Approach:

A three-pronged strategy was implemented to deliver the Social Protection programme for people affected by HIV in India:

Modifications were facilitated in existing mainstream schemes to increase eligibility of PLHIV who seek entitlements and benefits. Some of the already existing social protection schemes were modified to add special services or service provisions that were needed or relevant to PLHIV, besides the existing services.

Exclusiveness (HIV-specific): PLHIV have certain needs specific to them, linked to impact mitigation of HIV on individuals and families. These specific needs are treatment, nutritional support and livelihoods. Besides, sensitivity and maintaining confidentiality of PLHIV applications, facilitation and advocacy were done to ensure that essential schemes be exclusive and can be accessed through channels that ensured stigma free environment and facilitate access.

Inclusiveness (HIV sensitive): Certain social protection schemes that already exist that did not require any modification in the scheme provision but only to include the PLHIVs in the list of beneficiaries. Reaching PLHIV with benefits of social protection schemes required their access to mainstream programmes and schemes.

Reach of the intervention:

While taking this three-pronged approach, the mainstreaming unit of DAC along with mainstreaming team within the State AIDS Control Societies (SACS) identified relevant Government schemes and worked towards modification of schemes as well as including PLHIV. Through ongoing advocacy at the national and state level following steps were taken:

- Different categories of schemes have been modified/ initiated such as health, access to treatment, nutrition, social security, livelihoods, housing, legal aid, grievance redress.
- On the directives of State Council on AIDS, 35 state and central schemes were amended
- As of Dec 2013, there were more than six hundred thousand PLHIV beneficiaries accessing these schemes

One of such example is Indira Gandhi National Widow Pension Yojana (IGNWPY) Rajasthan Amendments: The scheme was modified to include all HIV widows from 18 years of age instead of 40 years as provisioned in the scheme for non-HIV widows. Furthermore, while widows who had a male child above the age of 25 years were not given this benefit in the original scheme, this condition was withdrawn in the case of HIV widows, making them eligible to receive lifelong pension.

Process: Proposal was developed by Rajasthan SACS, UNDP, state mainstreaming unit along with the positive people's network justifying the need, the amendments and the benefit that would accrue to the HIV widows in the state. Proposal presented by RSACS to the Health Minister of the State and with his approval forwarded to the Department of Social Justice. Persistent advocacy efforts by RSACS/ SMUs and positive networks, along with the support of the nodal officer in the Department of Social Justice helped to get the orders released.

From a humble beginning in State of Rajasthan in the year 2009, there are more than 18,000 widowed women living with HIV receiving widow pension schemes. Many states have also followed suit. Across all states with modified pension schemes including widow pension, approximately 24,854 women benefited from this change by the year 2013.

Moreover, states have been increasingly covering transportation costs for HIV treatment patients, in the year 2010 over 31,000 people benefited from the programme which has increased to 213,409 in 2013

Impact of the intervention:

- Increased access to treatment because of payments for travel cost to access treatment by patients.
- Able to meet some of their basic needs: Food subsidy and medical aid.
- Enabled MARPs and PLHIV to assert their identity through getting voter's cards and the unique identification card (AADHAR).
- Reduced vulnerability and pressure on main source of income through access to pension, scholarships, subsidized food rations (AAY), housing grants (IAY for rural poor and RAY for urban poor).
- Mitigate the impact of HIV at household level by giving pension to women widowed by HIV

Financing and management:

- The major partners are civil society, DAC, key government ministries and UNDP.
- UNDP through civil society partners implemented an exercise for promoting social protection models in select sites in India. The purpose of the initiative was to develop effective, efficient and scalable models focused on vulnerability reduction and AIDS impact mitigation. The initiative worked with key population groups such as female sex workers, MSM, transgender, person who inject drugs and person living with HIV. Four different delivery models were piloted in three states of India which are 1) Single Window Model with facilitation by NGO 2) Single Window Modelled and facilitated by the District AIDS Prevention Control Unit (DAPCU) 3) State level NGO led model for facilitating access to social protection through existing targeted interventions with populations affected by HIV (Female sex workers, injecting drug users, MSM and transgender) TI NGOs 4) PLHIV Network led models
- All the models worked closely with community based organizations, NGOs (Targeted Interventions) and Government Departments (providing various development schemes). The aim of all these models was to increase access to social entitlements and schemes, track benefits and beneficiaries through a live database, advocate for changes in programme to make schemes HIV and key population sensitive and provide legal protection to those in need. The successes and lessons learnt from all four models have been significant; in the short 12 months (effective time in field 8 months); the programme reached 20,000 individuals, with 52% benefiting from at least one scheme.
- The kinds of benefits these key populations received include getting national identity cards, food coupons, housing, scholarships, medical aid, and soft loans for enterprises, education and for other livelihood options. A total value of application logged for benefits was India Rs. 141 million of which Indian Rs. 92 million worth of benefits have reached communities (during the modelling period alone). In addition, non-financial benefits were many - 33% of them got their identity card and this for the first time recognized them as citizens and opened the door for entitlement. Through this effort, the social protection agenda has been mainstreamed to at least 45 NGOs and CBOs working with most key populations and about 10 departments sensitized.
- One of the critical outcomes of this was the rejuvenation of the HIV prevention efforts as the CBOs/NGOs found that members became more active and participation in the prevention programme increased. As direct outcome of this prototype results, the Department of AIDS Control(DAC) have decided to scale up the "Single Window Model led and facilitated by the District AIDS Prevention Control Unit (DAPCU) " in all districts

in India. UNDP has currently developed operational guidelines for the DAPCU models, and is in the process of developing a web based portal on social protection to be piloted in 2 states in India. A module on south to south cooperation on social protection for DAC is also in the development. Through DAC the sustainability and scale-up of the model has been made feasible, in the current annual workplan of all State AIDS Control Societies a component on social protection has been budgeted.

Lessoned learned and recommendations:

Lessons Learned:

- Special provisions within mainstream social protection schemes helped PLHIV access benefits which were previously meant only for a targeted audience for e.g. relaxation in certain eligibility criteria of widow pension and Palanhar Yojana (guardian scheme) of Rajasthan, have increased PLHIV inclusion as scheme beneficiaries.
- Identification of HIV as a chronic disease on a par with cancer, TB, leprosy so as to extend similar provisions to PLHIVs (bus travel concession, Tabibi Sahay (subsidized housing), MBPS (monthly pension scheme), Palak Mata Pita Yojana (pension scheme for the guardians of vulnerable children)
- Grant of conditional below poverty line (BPL) status has helped PLHIV get inclusion into significant public ration schemes like Anadaya Anadaya Yojana (this scheme provides subsidized food rations for the poor).
- Schemes have also provided additional benefits to PLHIV and children living with HIV. Through the Integrated Child Development Scheme (ICDS) for malnourished children, PLHIV have received a double nutrition package under the scheme
- Routing of schemes (like widow pension, travel assistance, Palanhar, Tabibi Sahay, MBPY (old age pension scheme) through the ICTC/ ART centre helped to reach the PLHIVs getting registered/ visiting for follow up and provided a comfortable environment (less stigma and discrimination) for gaining knowledge and applying for schemes.
- Routing of schemes through the legal aid clinic (in the case of Tamil Nadu) helped to address legal issues, stigma and discrimination issues and hasten the application procedures for different schemes.
- Empowerment of positive people's networks to deliver social protection schemes – Jatan project of Gujarat which is handled entirely by PLHIVs from the State Level Network (form filling, maintenance of accounts, disbursement of travel money and report writing).

Facilitating factors:

- The positive people's networks (PPNs), NGOs and SACS have been the force behind the uptake of social protection schemes by PLHIVs.
- Other stakeholders like the State Ministries/ Departments, the District Administration and the Panchayati Raj (local governance) institutions also played a facilitative role through their commitment and cooperation.
- Assertive stand by end users (positive people's networks (PPNs) and NGOs) with the public administration system for stigma free access has helped in the realisation of rights and entitlements of the schemes.
- Increased awareness and knowledge about social protection schemes helped initiate the right steps to participate in them and also demand entitlements.
- Governance related aspects like issuance of central/ state government orders made it possible for the users and PPNs to demand services/ benefits.

Challenges:

Procedural issues like restrictive eligibility criteria, cumbersome application procedures, delays in receipt of benefits and opportunity costs either constrained PLHIV beneficiaries from participating in a scheme or affected the realisation of benefits accrued to them. Governance issues like undue delay, leakages, lack of quality in services further exacerbated the constraints faced by PLHIVs in accessing social protection schemes.

HIV related stigma and discrimination (both real and perceived) impacted the utilisation by current users and prevented prospective users from coming forward to avail the different schemes. Gaps in certain livelihood and health insurance schemes constrained the effective utilisation of these significant schemes. Targeting and coverage of populations with BPL card constrained many HIV households who were poor but not necessarily in possession of the BPL card. Lack of sufficient data, including gender disaggregated data made analysis of utilisation patterns of social protection schemes difficult.

Annexes:

- 1) Informational Brochure
- 2) Think Piece on HIV Sensitive Social Protection:
<http://www.swasti.org/images/projects/thinkpieces/Social%20Protection.pdf>
- 3) UNDP innovation series on HIV Sensitive Social Protection in India
- 4) Study on impact of HIV at household level: http://www.in.undp.org/content/india/en/home/library/hiv_aids/socio-economic_impactofhivandaidsinindia.html
- 5) SP project assessment

2.INDIA

Title of program: Vihaan: Strengthening care & support services and improving ART adherence for PLHIV

Contact: India HIV/AIDS Alliance

Implemented by: Civil society

Programme under way since: April 2013

Has the programme been evaluated /assessed? No

Is the programme part of the implementation of the national AIDS strategy? Yes

Is the programme part of the implementation of the national poverty reduction or social welfare strategy? No

Background:

HIV/AIDS epidemic in India is concentrated in core High Risk Groups (HRGs), including female sex workers and clients, men who have sex with men (MSM), transgenders and hijras, and people who inject drugs (PWID). According to the most recent NACO technical report (2013), overall HIV prevalence in India is estimated at 0.29% in 2011 with approximately 2.1 million people living with HIV (PLHIV). There are currently 768,000 PLHIV receiving treatment at 425 government ART Centres and more than 800 Link ART Centres. PLHIV registered at ART Centres (both on treatment and pre-ART) can avail services at 350 Vihaan Care & Support Centres (CSCs) as part of the national strategy to address the needs of PLHIV, including women and children, as well as HRGs. The care & support component of India's national HIV strategy (NACP IV), the Vihaan programme is funded by the Global Fund and implemented by India HIV/AIDS Alliance as principal recipient and 17 sub-recipients at state and regional level. The CSCs are run by sub-sub recipient organisations at district level and are located near the government's ART Centres. Overall nearly 75% of implementing partners are PLHIV networks. Vihaan complements the

successful ART programme of Government of India and works in 31 states and territories. CSCs provide services and support including treatment adherence, positive prevention, and social protection to improve the health and wellbeing of PLHIV and their families.

Approach:

CSC services are HIV-specific but are designed to also help PLHIV address issues beyond HIV. Services are primarily designed for PLHIV linked to ART Centres, but families and partners are also served with social protection and other services like testing. Implemented in close collaboration with the Department of AIDS Control at national level and the State AIDS Control Societies in each state, Vihaan works actively with other part of the government, including the Departments of Social Justice, Social Development, Women and Children, Panchayati Raj, and National Health Mission, to ensure the availability of social schemes for PLHIV. For example, given the particular experiences of isolation and disruption of family and community support structures, responses for PLHIV especially women living with HIV require dedicated interventions to ensure they are protected from violence. Community-centred approaches to prevention, response and redress are needed to provide an opportunity to scale up responses that are specific to local needs and require capacity to deal with HIV-related concerns. Linkages with the statutory and administrative structures need to be strengthened to ensure that PLHIV access the social protection schemes and services, and Vihaan works to make this happen. In a recent development, CSCs have linked up with TB testing and treatment centres in an effort to respond more effectively to the high level of HIV-TB co-infections among PLHIV and TB's significant contribution to PLHIV morbidity and mortality. Many Vihaan CBO partners have also linked up with local private hospitals, philanthropies and industries to expand service offerings further and contribute to wellbeing of their clients.

Reach of the intervention:

Vihaan is implemented in 31 states of India through 350 CSCs that aim to reach 1.2 million people by the end of March 2016.

Achievements through March 2014:

1. 192,141 PLHIVs are served and registered at CSCs who are on ART
2. More difficult to reach are PLHIV registered at ART Centres but not yet started on treatment: 64,156 are registered and receiving care & support services.
3. At least one family member of 4,769 PLHIV has been tested for HIV and has received test result
4. 32,059 PLHIV registered in CSCs have been successfully linked to a government social welfare scheme
5. 15,115 PLHIV lost-to-follow-up (LFU) have been tracked and brought back to treatment

Impact of the intervention:

Government estimates suggest that more than 150,000 die each year in India from HIV-related causes, even with access to free ART. A primary goal of the Vihaan programme is to support PLHIV on treatment and keep them on treatment to improve treatment outcomes and overall health and wellbeing. Specific efforts will keep more people in treatment and reduce loss-to-follow-up drop-outs. A range of CSC support services and linkages to social schemes and entitlements will improve the quality of life of PLHIV and their families, and efforts including Discrimination Response Teams will address issues of stigma and discrimination that continue to undermine PLHIV and deny them access to services they need. A robust monitoring and evaluation system has been designed in collaboration with

government and the donor, and baseline and endline evaluation studies will provide further data on impact.

Financing and management:

As noted above, Vihaan is funded by the Global Fund through a civil society PR (Alliance India), with 17 state and regional SRs. Over the course of Programme Year 2, Vihaan will expand to 350 SSRs working in 31 states and territories (increasing from 225 CSCs established in Year 1). The PR has ensured that strong management and compliance systems are in place at all implementation levels. Being the care & support component of the national HIV strategy, the Government of India is committed to continue funding when Global Fund support ends. The donor is currently committed to supporting the programme and its implementation by civil society. Vihaan now enjoys a strong partnership with the Department of AIDS Control and with PLHIV community and networks at every level.

Lessoned learned and recommendations:

After initial scepticism due to the size of the programme and involvement of so many PLHIV networks, the programme is now well accepted within the Department of AIDS Control and the State AIDS Control Society. Implementing a new care & support model for the country, Vihaan is aiming to have significant impact of PLHIV lives and health. One of the biggest gains of the programme is development of a larger body of data on care and support in the country and on PLHIV needs, probably nowhere else will there be data on such a scale. (Data from all 1.2 million Vihaan clients will be captured. The programme has strong data collection and confidentiality processes and policies.) Capacity building and technical support to state and district PLHIV networks has been quite effective. The programme has given an opportunity to learn discipline of services and reporting and being held accountable. This is helping these networks build credibility among stakeholders and increasing their capacity to apply for other funding and programmes.

The main challenges still remain persistent stigma and discrimination against PLHIV and their families, in society but also in services. The Discrimination Response Teams at CSCs are growing in effectiveness, and we hope that eventually they will become institutionalized. Our collaboration with the Government of India is generally strong, but occasional government stock outs can be a problem. Vihaan CSCs have been identified as a platform for community monitoring of drug supply to help support government efforts to ensure an uninterrupted access to ART for all PLHIV in India.

Annexes:

Vihaan: Summary Case Studies

Case Study 1: Addressing HIV stigma in communities

The HIV status of a school boy named Satinder Chaudhary (name changed) from Gagwal, Kathua, was disclosed at his school. He faced discrimination from his teacher in the form of verbal abuse, and he was not allowed to sit in the class. Even his elder brother who is also studying in same school faced similar treatment. Their mother reported this issue to the Vihaan CSC. The ORW who is from same locality took the lead and organized a meeting with the sarpanch (the local leader) and discussed the issue. The sarpanch then went to the school and enlightened the school authority and teachers. Following this, the boy and his brother are regularly going to school, and the CSC team is in regular touch with the family.

Case Study 2: Supporting pregnant women living with HIV

Ms. Seema (name changed), a pregnant women living with HIV, was convinced by someone that her baby will also be HIV positive. She was so scared that she refused to register at the PPTCT clinic. The Vihaan CSC peer counsellor and project coordinator counselled her repeatedly during home visits and motivated her to register at the nearest PPTCT clinic. After registration, a peer took her to ART Centre. A CD4 count was done, and she was found eligible to initiate ART. Currently she is on ART. After few months, she delivered a girl child who is not positive, and the CSC ensured that nevirapine oral suspension was given to the baby. The ORW and the counsellor are in touch with Seema on regular basis.

3. INDONESIA

Title of program: 1) Jaminah Kesehatan Bali Mandala (JKBM); 2) Desa Pakeraman: village SP programme to empower communities for religious and environmental protection.; 3) Getting to zero; 4) Provincial Social Agency HIV support per Ministry of Social Affairs mandate.

Contact: International Labour Organization

Implemented by: Government

Programme under way since: 1) The JKBM more improvement in 2013; 2) Desa pakeraman, more improvement in 2012; 3) Getting to zero, 2009; 4) Social support, 2010-2014

Has the programme been evaluated /assessed? Yes

Is the programme part of the implementation of the national AIDS strategy? No

Is the programme part of the implementation of the national poverty reduction or social welfare strategy? No

Background:

- 1) The Bali provincial government has its provincial social protection health insurance programme, called Jaminah Kesehatan Bali Mandala (JKBM). The provincial government continues to improve and extend its coverage targeting poor households to fill the gap left by Jamkesmas (the national social protection health insurance for poor households).
- 2) Desa Pakeraman: 5-10% of this fund can be used to address HIV. Specifically, it has been used to raise HIV awareness to community members, religious and community leaders, to reduce stigma and discrimination towards PLHIV.
- 3) Getting to zero: Local government (provincial, district/city) specifically targeting PLHIV and key populations, particularly commercial sex workers.
- 4) Livelihood support to PLHIV by Provincial Social Agency representing 50% of social assistance budget.

Approach:

The intervention is HIV specific, HIV sensitive as well as HIV relevant. It brought together the social health insurance administration at local government level, with community leadership as well as religious leaders, PLHIV and poor households and health service provision.

Reach of the intervention:

- 1) JKBM: Reach is Bali province.
- 2) Desa Pakerama: covers residents of all 1,483 villages in Bali province.

Primary focus of the intervention: HIV prevention, treatment, care and support; social transformation (de-stigmatization and reduction of discrimination); economic empowerment.

Target population: poor households including PLHIV households. Although it is meant for Bali provincial residents, due to its friendly and quality services, it has attracted PLHIV from other parts of the country to Bali so they benefit from the services.

- 3) HIV prevention: STI treatment, VCT and PADC testing for all sex workers; HIV treatment: distribution of ARV to + CSW regardless of CD4 status; food assistance to PLHIV of poor households; milk for PLHIV who breastfeed their new-borns.
- 4) Livelihood support to all PLHIV regardless of residential status by providing business start-up cash support. Reaching 20 PLHIV in Denpasar and 20 PLHIV in Tabanan.

Impact of the intervention:

- 1) It enabled PLHIV and needy household to have access to health services.
- 2) It enabled local communities in Bali to reduce stigma and discrimination both in general and for SP services which attracted PLHIV from around the country due to its reputation of being a PLHIV-friendly service.
- 3) CSWs have good access to STI treatment, HIV treatment and support.
- 4) The businesses initiated by PLHIV beneficiaries developed well and continued to thrive. However, due to the small fund available for allocation, it constrained PLHIV as to the type of business they could engage in. This is due to the limit of the funds available to the local government to invest in this programme.

Financing and management:

- 1) JKBM is financed by Bali provincial government.
- 2) Pesa Pakerama is co-financed by the Bali provincial governor and allocated via the Agency for Cultural Affairs (\$1,000). The head of district/city allocate complementary budget in accordance with their local budget capacity (range: \$2,000 to \$20).
- 3) Global Fund: most funds were channelled to provincial AIDS programme, the rest to local NGOs.
- 4) Ministry of Social Affairs: (\$150 US per selected beneficiary)

Lessoned learned and recommendations:

Success factors:

- Locally initiated and driven with local public budget commitment and leadership.
- Multisectoral mobilization: religious, community, governmental leaderships with coordination and collaboration with district/city health services.
- Civil society organizations provide facilitation to PLHIV to access the programme.

Challenges:

- Limited local public funds constrained the reach and expansion as well as impact of the livelihood support programme for PLHIV.
- Due to the good programme, PLHIV from other provinces tend to be attracted to go to Bali in order to benefit from the service, further burdened the already limited resources.

Annexes:

A brief extract of the ILO assessment of the Bali provincial SP-HIV programmes.

4. IRAN

Title of program: Positive Clubs: Providing psychosocial supports to PLHIV

Contact: UNAIDS

Implemented by: Government, Civil society, UN or other inter-governmental organisation

Programme under way since: 2006

Has the programme been evaluated /assessed? Yes

Is the programme part of the implementation of the national AIDS strategy? Yes

Is the programme part of the implementation of the national poverty reduction or social welfare strategy? No

Background:

Considering different socio-cultural contexts, a community based approach by engagement of PLHIV in managing their health and wellbeing in a stigma-free environment can provide more effective response to HIV. The Islamic Republic of Iran has tried to respond to the HIV epidemic by recognizing PLHIV as a part of the solution. In this connection, in 2006 the first Positive Club was established in Tehran. The project is currently expanded to 15 other centers in different provinces of the country. Positive clubs have been established and run through collaboration of the Government, United Nations, GFATM, local civil society organizations and network of PLHIV. The initiative supported by the network of beneficiaries proved to be effective in also mobilizing other sectors' capacities including private sector, medical universities, municipalities, Welfare Organization and other CSOs including Faith-based Organizations and Foundations.

Approach:

The objective of the positive clubs programme is to empower PLHIV to take responsibility for their own well-being and also to provide an enabling environment for PLHIV in order to mitigate the social and economic impact of HIV on the individuals and their family members. Positive Clubs in connection to other HIV service providing facilities help to support and scale up existing HIV counselling and testing, sexual and reproductive health and prevention, treatment, care and support services. This approach has added to effectiveness of HIV response and has contributed to maximize the impact of investment in other sectors. Positive clubs cover almost 5,000 PLHIV and their family members with a wide range of HIV specific, HIV sensitive and HIV relevant services. The combined approach has also provided complementary economic empowerment initiatives such income generation and job creation with a focus on women living or affected with/by HIV to reduce HIV burden on the families.

Reach of the intervention:

Educational sessions and capacity building workshops on different topics such as safe sex for People Living with HIV and their spouses, prevention of mother-to-child transmission, methamphetamine abuse, adherence to treatment, Nutrition, TB, has equipped members of Positive Clubs with knowledge of maintaining a healthier life. Moreover, providing interventions such as group therapies and development of self-help groups along with life skills trainings, vocational trainings, income generation schemes and sport activities have contributed to build up self-esteem and confidence of PLHIV. Positive Clubs provide the above services to almost 5,000 PLHIV and their family members in different provinces throughout the country.

Impact of the intervention:

This approach has not only resulted in reducing stigma and discrimination but also has empowered PLHIV to play prominent roles in solving other problems of the communities in which they live; for example women living with/affected by HIV by making special insect-

resistant bed nets and dissemination of health messages among local communities helped the Governor, medical university and other stakeholders halt leishmaniasis (skin sore) epidemic in one city. Meaningful involvement of PLHIV in advocacy and dialogue with decision makers also led to establishment of a specific mechanism for medical insurance of PLHIV.

Some of the social protection activities of PCs for the period of July 2011 to June 2013 are as follows:

- arrangement and provision of health insurance for 1746 people living with HIV,
- Registering 163 people living with or affected by HIV at technical-vocational centers,
- Holding 613 training sessions/ workshops on different topics (adherence to treatment, HIV and Nutrition, HIV/AIDS prevention, hepatitis, harm reduction, dental health, methamphetamine abuse, safe sex, etc),
- Providing dental prosthesis for 184 PLHIV and dental services to 288 PLHIV,
- Registering 226 PLHIV (including children and adults) in various classes such as music, English language, painting,
- Giving educational grants to 512 children living with or affected by HIV,
- Providing 3,255 sport tickets and 1,608 swimming pool cards for PLHIV and their families.

Financing and management:

The initiative is a fruitful result of collaboration of the Government, UNAIDS, UNDP (as Principal Recipient of GFATM HIV Grant), local NGOs and PLHIV. The project is supported by Government, United Nations, GFATM and local public sector partners. UNAIDS coordinates the activities with Medical Universities, Center of Communicable Disease Control of Ministry of Health, local civil society organizations and PLHIV as both beneficiaries and administrators of positive clubs. Positive Clubs initiative –as a critical part of the national response- has been included under the Support Strategy of the National Strategic Plan for HIV/AIDS to ensure their sustainability.

Lessons learned and recommendations:

Involvement of People Living with HIV in social protection programmes has not only resulted in reducing stigma and discrimination but also has empowered PLHIV to play prominent roles in solving other problems of the community. Meaningful involvement of PLHIV in advocacy and dialogue with decision makers also led to establishment of a specific mechanism for expansion of social support to PLHIV and their families. The above could not be attained without close coordination and collaboration of UNAIDS with UNDP, the Government and implementing local institutions as the main stakeholders of the initiative. This institutional set up in turn resulted in expanding advocacy among decision makers which led to further political mobilisation and support from other sectors. This experience clearly demonstrates how a community based approach by involving PLHIV and their families in HIV response can attract national and international resources to facilitate achieving prevention, treatment, care and support objectives which lead us towards the global vision of "Zero new HIV infections", "Zero AIDS-related deaths" and "Zero discrimination".

Annexes:

Annual Positive Clubs reports; Positive clubs Evaluation report

5. KAZAKHSTAN

Title of program: Prevention of tuberculosis and HIV in Kazakhstan

Contact: Kazakhstan School of Public Health

Implemented by: Civil society

Programme under way since: 2012

Has the programme been evaluated /assessed? No

Is the programme part of the implementation of the national AIDS strategy? Yes

Is the programme part of the implementation of the national poverty reduction or social welfare strategy? No

Background:

The programme is aimed at compliance with TB and HIV treatment regimen, improvement of prevention, diagnostics, and rehabilitation of high risk and most at risk population for HIV and TB including former prisoners, through elimination of barriers for health services access.

Programme is expected to establish intersectoral collaboration and a mechanism for working with former prisoners, where participation of government, the penal system and civil society will be met. Moreover, programme promotes an integrated approach to the treatment and civil support of PLHIV PLTB.

Approach:

The intervention is mix of HIV specific and HIV sensitive social protection.

The programme has developed a social support model for patients with TB and HIV according to existed experience. This is provided by multidisciplinary teams consisted from psychologists, social workers, lawyers, and volunteers. This teams support rehabilitation service for high risk population thus improving integrated care. It helps to improve access to services for them.

Intersectoral collaboration between the authorities, penitentiary department and civil society will help to protect health among former prisoners by establishment of follow-up mechanism.

Red Crescent Society, HIV/TB centers, NGOs and other community organisations are invited for capacity building to improve support for population at risk.

Reach of the intervention:

The programme is implemented across five sites - Temirtau, Karaganda, Almaty, Kyzylorda and Ust-Kamenogorsk Oblasts, with the aim to reach 1,500 people from the most at risk population (MARPs), of whom approximately 50% are released prisoners and other difficult to reach and high risk groups such as migrants, drug users and sex workers.

The ultimate beneficiaries are:

2.5 thousand of the broader population groups, among which the target audience (former prisoners, migrants, sex workers and drug users) was selected.

7.5 thousand people having close contact with clients, relatives and friends (each of 1.5 thousand representatives of the target audience has contacts with at least another 5 members of society).

Impact of the intervention:

During the first period the program psychologists regularly conducted individual and group counseling depending on clients' needs. Psychological support for clients and their families was diverse to address different problems. In general, psychological problems were due to diagnosis, fear of stigma and discrimination and personal denial of TB and / or HIV status. In addition, psychologists have worked with relatives with primary focus on HIV and TB prevention. Psychologists also participated in meetings of support groups. During second quarter of the year approximately 115 people and their families had received psychological support.

The programme was implemented in all planned sites. Each site had two peer-to-peer support groups, which consisted from 12-15 clients. Group meetings were organized per 3-4 times a month. It exceeds planned number of meetings (1-2) as was requested by clients themselves.

In all the regions involved in the program, there were information campaigns to mark the International Memorial Day of People Who Died From AIDS and the International Day Against Drug Abuse were organized. Medical professionals organizations , NGOs , media, school children, students , clients themselves and their families and relatives were involved in this campaigns.

Financing and management:

The project has been implemented by the British Red Cross in partnership with the Red Crescent Society of Kazakhstan and supported from the European Union.

The total project budget is EUR 300,000, with a grant from the European Union of EUR 150,000.

Lessoned learned and recommendations:

The experience showed that peer-to-peer groups were very effective and important approach. Clients can share their problems with peers, can be properly advised and even to spend time communicating with people without fear of stigma and discrimination. The fact that clients asked to increase number of meetings indicates that such groups are needed and interesting for clients.

Information campaigns increased unity between medical facilities, NGOs and clients which is helpful for further integration.

However, governmental support would be useful for programme sustainability. Due to lack of financing number of sites was decreased despite effectiveness of the programme. It happens with other HIV programmes also. Moreover, psychological and social support should be part of overall health care for PLHIV provided by state.

Annexes: -

6. PHILIPPINES

Title of program: The Out-patient HIV/AIDS Treatment Package of the Philippine Health Insurance Corporation

Contact: Philippine Health Insurance Corporation

Implemented by: -

Programme under way since: 2010

Has the programme been evaluated /assessed? -

Is the programme part of the implementation of the national AIDS strategy? -

Is the programme part of the implementation of the national poverty reduction or social welfare strategy? -

Background:

Philippine Health Insurance Corporation (PhilHealth) implements the national social health insurance program in the Philippines. Its goal is to provide all Filipinos the means to have financial access to essential health services. Through different membership categories, every Filipino must be enrolled to PhilHealth regardless of the income, social status, health profile and age. Depending on the capability to pay, premium are either paid by the enrollees or sponsored by the government and other sponsors. Premium of the poor are paid by the national government. Once they are enrolled, they are covered by social health insurance. If they get sick or need health care services, they can go to accredited health care providers which PhilHealth will pay for the services that they provided.

In order for Filipinos afflicted with HIV/AIDS to have access to treatment and health services PhilHealth introduced the Out-Patient HIV/AIDS Treatment Package in 2010 for those patients that need anti-retroviral treatment. The benefit package covers necessary laboratory exams, consultation fees and anti-retroviral drugs. All PhilHealth members and dependents are eligible to avail of the package when they need it.

The package was developed in coordination with the Department of Health, treatment hubs, patient's organization and other stakeholders.

Approach:

The PhilHealth Out-patient HIV/AIDS package is a benefit package for patients that need anti-retroviral drugs. It covers necessary laboratory examination, consultation fees, counselling and anti-retroviral drugs. Its goal is for every Filipinos that needs treatment for HIV/AIDS shall have financial access to much needed health care services. All PhilHealth members regardless of the income status and their qualified dependents are eligible for the package.

Reach of the intervention:

The PhilHealth Out-patient HIV/AIDS benefit package is designed for HIV/AIDS patients that need anti-retroviral drugs. It can only be availed of in selected hospitals all over the country that are designated treatment hubs by the DOH. All PhilHealth members regardless of the income status and their qualified dependents are eligible for the package.

Impact of the intervention:

Over the years, there had been increase in the number of members who availed of the package. Also, the utilization of the poor increased, which means that more poor can now have access to anti-retroviral treatment because of PhilHealth.

Financing and management:

The social health insurance program is guided by the principle of social solidarity. The premium collected from all the members are pooled and used to as benefit payments. The risks are shared among different income or age groups. Everyone contributes to the fund and everyone is eligible to receive benefits if they need it regardless of their age, income or health status. Through these, the patients afflicted with AIDS can get the necessary health services.

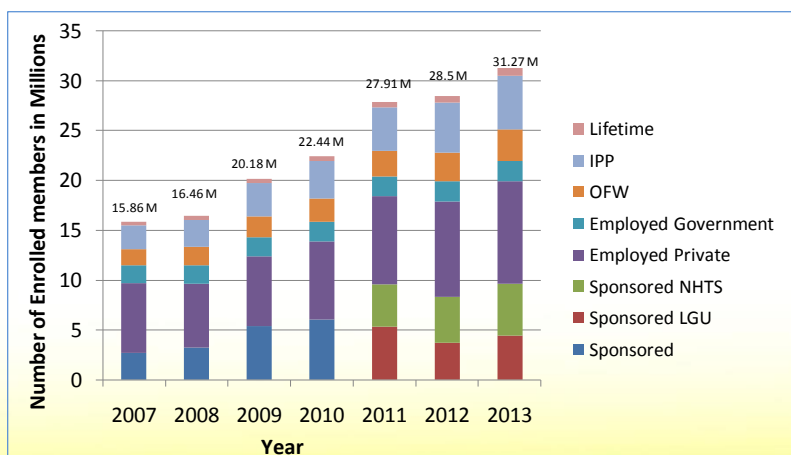
Lessoned learned and recommendations:

The OHAT package covers those on ART already. It does not cover the early stage of the disease when only monitoring is needed. As PhilHealth strives to expand its benefits, it must study carefully whether it would cover the pre-treatment phase.

Annexes:

1. PhilHealth Circular 19, s-2010 – sent as separate file
2. Graph of PhilHealth membership
3. Graph of claims for out-patient HIB AIDS package

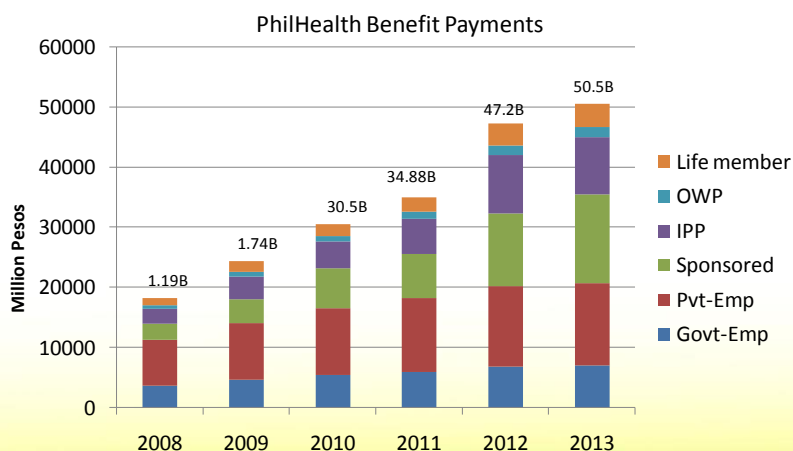
PhilHealth Membership



Source: Stats and Charts, www.philhealth.gov.ph



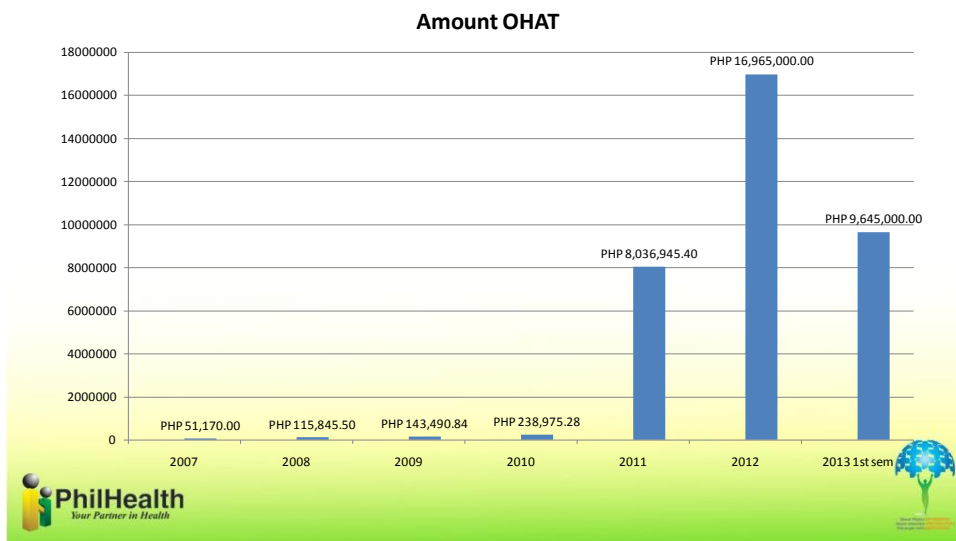
PhilHealth Benefit Payments



Source: Stats and Charts, www.philhealth.gov.ph



Benefit Payment Outpatient HIV/AIDS Package



7. SRI LANKA

Title of program: Improving livelihood skills of PLHIV and advocate for insurance coverage of HIV

Contact: ILO

Implemented by: UN or other inter-governmental organisation

Programme under way since: 2013

Has the programme been evaluated /assessed? No

Is the programme part of the implementation of the national AIDS strategy? No

Is the programme part of the implementation of the national poverty reduction or social welfare strategy? No

Background:

The ILO conducted an HIV-sensitivity of existing social protection programmes in Sri Lanka in 2012. The study found that all 20 national insurance companies with a presence in Sri Lanka, except one, explicitly exclude HIV in their insurance coverage policy. This excluded PLHIV from potential benefits of social protection that is available to the general population in the country.

Consistent with the Recommendation on HIV and AIDS in the World of Work (R200) and the Recommendation on National Social Protection Floor (R202), the ILO launched a project to advocate for access to insurance by PLHIV while improving PLHIV's livelihood skills so they have viable income to sustain their livelihood.

The ILO launched an advocacy effort to engage private insurance companies with an aim to have the HIV exclusion clause in insurance policy removed so that PLHIV and their families could benefit from accessing health, life and other insurance. Simultaneously, in order to

ensure PLHIV have a secured source of livelihood, the ILO conducted market assessment, individual PLHIV skills assessment and together with the PLHIV, developed individual livelihood skills training to improve their income generation capabilities. In collaboration with the national social security administration, trainings are provided to PLHIV and NGOs who support them, on social protection policies, programmes and procedures including eligibility.

This advocacy and capacity building effort engaged both the Ministry of Labour as well as senior leaders of private national insurance companies, in collaboration with PLHIV network, civil society organizations who could assist in capacity-building and the National AIDS Programme.

Approach:

The approach is relevant to HIV and is HIV-sensitive and specific.

The civil society organization partners to this effort enabled out-reach to PLHIV and facilitated assessing their needs and supporting them in strengthening their livelihood skills and social protection literacy, supported by the national social security administration and the Ministry of Labour.

Simultaneously, the ILO provided technical input to CEOs of national insurance companies to improve their awareness, knowledge on HIV-sensitive social protection as well as in estimating marginal cost projections should these companies remove the HIV exclusion clause from their insurance policies. The ILO also facilitated, through providing its technical input to respond to specific queries from these insurance entities' global reinsurers concerning the exclusion clause. There are twenty insurance companies operating in Sri Lanka and all of them are covered by this initiative.

It is truly a multi-sectoral partnership with the United Nations' facilitation.

Reach of the intervention:

This initiative was in Sri Lanka. Since the insurance entities operate at the national level, the impact is national.

The insurance policy change impacts on HIV prevention by enabling the HIV-households to have the means to cover catastrophic illnesses - in this case, HIV-related treatment expenses, thus retaining school-age children from these households in school. The life-insurance coverage also enabled such families to recover from the shock of losing the productive member of the household and with support of minimal means to restructure their future after the loss of a family member.

The livelihood skills training for PLHIV empowered them to become self-sufficient and build sustainable economic means for the household. Such effort empowered PLHIV to come out of from self-imposed isolation and engage back into gainful economic activities within their communities and the society.

Impact of the intervention:

By 2014, four major national insurance companies have reversed their HIV exclusion policy thus opened the door for PLHIV and their households to obtain health, accident and life insurance. In addition, the largest insurance company is now formulating an HIV specific insurance policy, as part of its corporate social responsibility effort. When this new policy

becomes a reality, PLHIV could potentially benefit from a wider range of social protection benefits.

This intervention sends a strong message to the society that PLHIV should receive equal access to opportunities afforded the rest of the populations thus help boosting PLHIV's confidence and sense of self-worth. By finding means to support oneself and one's families through strengthened livelihood skills, it preserves the dignity of PLHIV.

In addition to advocacy to all 20 insurance companies, 24 PLHIV peer-trainers were trained, 86 out of a total of 110 PLHIV were trained on social protection information and livelihood skills (including IT, how to start your own business, etc.)

Quote from a PLHIV in Sri Lanka):

"I have been living with HIV for nearly 8 years. I have a small business. I am very happy to learn that four insurance companies have agreed to provide insurance coverage for HIV. Prior to this, we did not have such option and there have been instances when children and dependants of positive persons have been helpless. This change will undoubtedly be helpful for positive persons and their families in case of medical emergencies. This can also help to enhance the quality of life of positive persons and their families. It will help reduce stigma and discrimination towards us, and also have a positive impact on our family members. I am thankful to the ILO for taking on this initiative."

Financing and management:

This is a small pilot initiative supported by the Japan Social Security Fund which will end in 2014. The ILO, Sri Lanka, through the National HIV project coordinator, manages and coordinates all the project activities.

This initiative strengthens also the three national PLHIV associations in Sri Lanka in terms of building their management capacities as well as resource mobilization skills with the hope to improve the sustainability of their support to PLHIV, based on the initiative.

The ILO is also assisting the PLHIV associations to find a way to get a permanent base for their operations and ways to cover their daily operation expenses so they could devote main efforts in their core function of supporting PLHIV and their households.

Partners to this initiative include

- The twenty national insurance companies, with the Janashakthi Insurance PLC Pvt Ltd. (the largest national insurance company and the one who did not have HIV exclusion clause) leading the effort to mobilize this sector in HIV responses.
- The Ministry of Labour
- The national AIDS programme
- The national social security administration
- The three PLHIV associations
- NGOs specializing in livelihood skills building, in management, etc.
- The UNAIDS

Lessoned learned and recommendations:

Factors contributing to success of this intervention:

- Evidence-based advocacy
- Engaging champion for the advocacy (the senior leader of the one insurance company that does not exclude HIV in its policy)

- Social dialogue with management, PLHIV workers with the support of the ILO and Ministries (labour, health and social security)
- Multi-sectoral public-private partnership
- Built-in means to strengthen sustainability – including policy change

Challenges:

- The starting point with only one out of 20 national insurance company that does not exclude HIV
- The very low capacity and resource base of PLHIV associations
- The near zero knowledge among PLHIV and most NGOs about available national social protection programmes, policies and schemes and the eligibility as well as application process and procedures
- The extremely prevalent self-stigmatization and general society discrimination of PLHIV which perpetuated many of the PLHIV to give up hope

Annexes:

This experience was included as part of the UNAIDS Secretariat, ILO, UNDP jointly organized social protection and HIV satellite session at the November 2013 International AIDS Conference for Asia and the Pacific. The abstract is attached.

8. THAILAND

Title of program: Health insurance policy and practice for all non-Thai populations in Thailand

Contact: Bureau of AIDS, TB and STIs(BATS)

Implemented by: Government, Civil society

Programme under way since: September 2013

Has the programme been evaluated /assessed? No

Is the programme part of the implementation of the national AIDS strategy? Yes

Is the programme part of the implementation of the national poverty reduction or social welfare strategy? Yes

Background:

In September 2013, the Government of Thailand launched a new policy, "Health Insurance for Migrants". With this step, the country has expanded Universal Health Coverage scheme to non-Thai populations residing and working in Thailand.

The new policy was designed to ensure access to health care for migrants, whether documented or non-documented. The policy introduced an insurance card that any migrant could buy at a public health facility. Having purchased the card, for a year, the migrant would gain access to a range of healthcare services, including maternal health and HIV treatment.

Approach:

Health insurance policy for migrants is an HIV sensitive initiative. It capitalises on the mechanisms and practices of the Universal Health Coverage scheme and integrates appropriate HIV services in the health service package for migrants.

Through a collaborative effort of the Department of Health Service Support & the Bureau of Health Administration at the Office of the Permanent Secretary under the Ministry of Public Health; Raks Thai Foundation; Foundation for AIDS Rights; other NGOs, including those

implement the GF grant (PHAMIT); as well as IOM and the UN family the policy is being promoted, rolled-out and implemented nationally.

Reach of the intervention:

The primary focus of the initiative is to ensure that documented and non-documented migrants have access to primary healthcare services, including HIV counselling and testing, PMTCT and ART. Health Insurance for Migrants aims to reach all non-Thai populations residing and working all over the country.

It is estimated that there are 3 million labour migrants and followers in Thailand, of them about 1.8 million undocumented.

Impact of the intervention:

Introduction of the Health Insurance for Migrants has been an important step in reducing disparity and ensuring equitable access to health services, including HIV-related, for Thai and non-Thai populations residing and working in Thailand.

Already in the first three months, about 63.5 thousand migrants purchased the insurance cards and obtained access to quality healthcare services. By May 2014, estimated 140 thousand migrants have got enrolled in the insurance scheme under the new policy.

Financing and management:

The Ministry of Public Health manages and coordinates the implementation of the Health Insurance for Migrants policy. The initiative was designed as eventually self-sustained, financed by the clients' payments for insurance cards.

The current price of the insurance card, which is valid for 365 days, is 365 Baht for children under 7 and 2800 Baht for children above 7 and adults.

The scheme will become self-sustained when the number of adult clients enrolled will exceed 200,000 per year.

Lessoned learned and recommendations:

Strong commitment at the highest political levels was a major factor of success of the initiative. The Prime Minister demonstrated personal commitment and leadership; all concerned ministries were appropriately engaged in the development of the new policy. The new policy was building on the success of the Universal Health Coverage scheme that was in operation in Thailand as of 2002.

Partnerships across the board have been instrumental in translating the commitment into practice. Civil society and communities advocated for extending the UHC to cover migrant populations, and worked together with the government to develop and operationalise the policy. International organisations supported the effort. Collaborative multi-sectoral effort continues in the national roll-out of the policy, utilisation of local opportunities, and analysis and removal of bottlenecks.

Four working groups have been set up by the Government to support the implementation of the policy and assist with resolving bottleneck:

- Group 1 looks at the impact of immigration, human trafficking and labour exploitation. Ministry of Labour leads the group in close collaboration with Ministry of Social Development and Human Security.
- Group 2 deals with public relations and promotion of the policy among migrants. Ministry of Public Health in collaboration with Ministry of Interior lead in this task.

- Group 3 was tasked to enhance international collaboration, plan and mobilise technical and financial support for the initiative. This group is led by Ministry of Foreign Affairs.
- Group 4 deals with the management issues, including verification of nationality of migrants.

The MOPH's Bureau of Health Administration at Office of Permanent Secretary was officially designated to provide an overall coordination.

Thailand's Health Insurance for Migrants policy being a big step forward in ensuring equitable access to health/ HIV services in the country, its implementation sets the new tasks that the country is effectively addressing:

- 1) Capacity on the ground is uneven, resulting in uneven progress in the implementation of the policy. Clear guidance on the operating procedures, including financing, will support health facilities in implementing the policy.
- 2) Migrants being mobile populations, ensuring continuous uptake of services, especially treatment, is yet a challenge. Collaboration between public health and CSO/ CBO will be instrumental in demand creation and adherence support.
- 3) Enhanced bilateral and multilateral collaboration among the concerned countries of the region will be required to ensure continuum of prevention and treatment for migrant populations across borders. Significant steps have been made in enhancing cooperation in this area between Thailand and Myanmar; action is being taken to strengthen collaboration between Thailand and Lao PDR; Thailand and Cambodia. ASEAN is viewed as a platform to enhance collaboration in the areas related to migration.

Annexes: -

9. CHINA

Title of program: Expanding Antiretroviral therapy to prevent HIV transmission in serodiscordant couples

Contact: -

Implemented by: Government

Programme under way since: 2011

Has the programme been evaluated /assessed? No

Is the programme part of the implementation of the national AIDS strategy? Yes

Is the programme part of the implementation of the national poverty reduction or social welfare strategy? No

Background:

Sexual transmission, including spouse transmission, has become the main mode of HIV transmission in China. Owing to social, cultural, and family factors, the condom use rate is low among serodiscordant couples. As a result, the spouse of people living with AIDS/HIV (PWA) has a higher risk of HIV infection. Many researches show that timely and effective anti-viral therapy can not only improve the physical condition of HIV-infected patient, but also can reduce the risk of sexual transmission, especially to reduce the risk of infection their spouses. Since 2011, Ministry of Health initiated the program to expanding antiretroviral therapy to prevent HIV transmission in serodiscordant couples in provinces including Yunnan, Sichuan, Guangxi provinces with high HIV epidemic and majority of PWA live in rural area.

Approach:

As a HIV specific intervention, this program took staff training at all levels of medical and health institutions to improve the capacity of antiretroviral therapy. A series of services, such as antiretroviral therapy, HIV testing for couple, patients' follow-up, condom promotion, etc was provided by medical institutions, laboratory testing setting, local CDC. As a key organization to implement the program, National Center for STD/AIDS Control and Prevention is responsive for the program design, monitoring and supervision.

Reach of the intervention:

For preventing the HIV infection among couples, this program tried to cover the serodiscordant families as much as possible in China. It has covered 58621 people of this group all over the country by the end of 2013.

Impact of the intervention:

As a result of promotion by this program, the coverage of antiretroviral therapy for serodiscordant couples has been improved from 44.9% in 2010 to 67.2% in 2013. And it showed a significant reduction of new infection among this group. Among all the couples on observation, the new infection of those families which received treatment is 73% lower than those not.

Financing and management:

As part of the national implementation strategy, this program has been all funded by the government. And the implementation took different departments' collaboration, such as the health administrative institution, CDC, medical agency and the testing laboratories and etc.

Lessoned learned and recommendations:

This program has protected the spouse of infection effectively. However, the cost of treatment, treatment risks, privacy protection, awareness of the need for treatment and peer influence affected willingness of the infected to accept treatment.

Annexes:

Table 1: Treatment coverage among the HIV serodiscordant couples in China

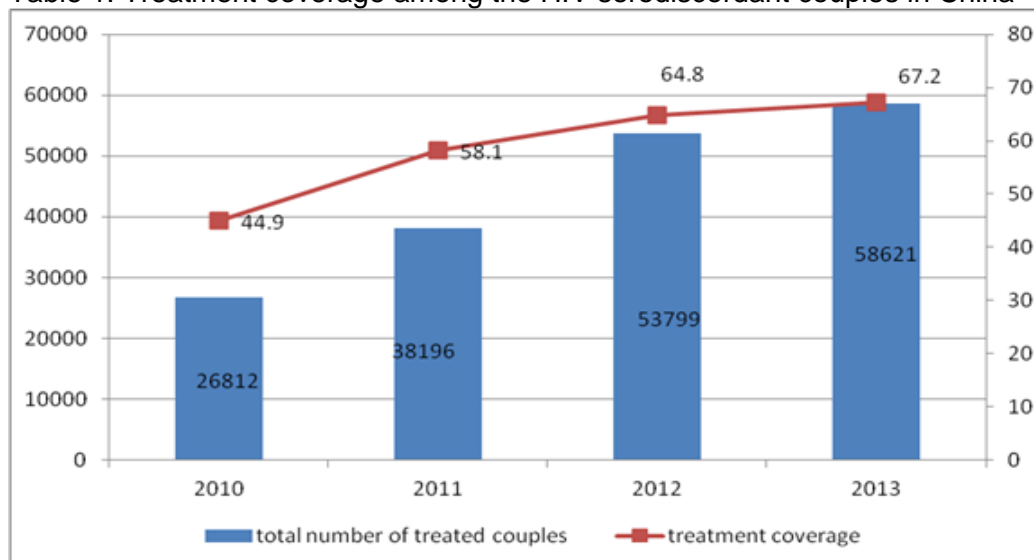
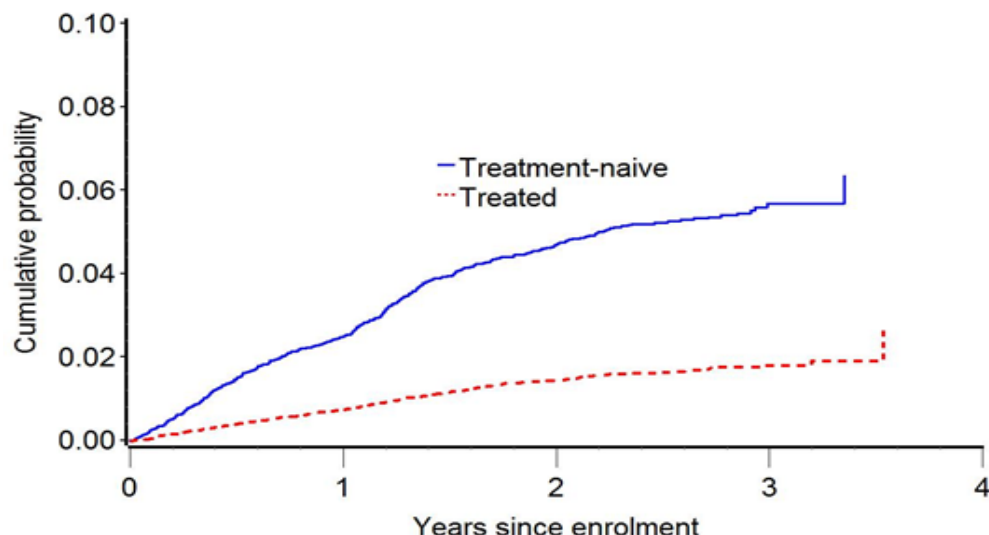


Table 2: National cumulative probability of new infection in 2010



III. Eastern Europe

1. POLAND

Title of program: The National Programme for Preventing HIV Infections and Combating AIDS

Contact: National AIDS Centre

Implemented by: Government, Civil society

Programme under way since: 1996

Has the programme been evaluated /assessed? Yes

Is the programme part of the implementation of the national AIDS strategy? Yes

Is the programme part of the implementation of the national poverty reduction or social welfare strategy? Yes

Background (in brief):

HIV prevention and AIDS response have been on the agenda of Polish health authorities since the beginning of the epidemics. The state policy on HIV prevention and combating AIDS has been defined in the National Programme for Preventing HIV Infections and Combating AIDS which first edition was implemented in 1996-1998. The National AIDS Centre (later called the Programme Coordinator) realizes the tasks on behalf of the Minister of Health. At present, the legal basis is constituted by the Regulation by the Council of Ministers on the National Programme for Preventing HIV Infections and Combating AIDS.

Approach (in brief):

A nation-wide implemented Programme involving entities at national and local level undertaking activities within HIV/AIDS. The Schedule for Implementation of the National Programme specifies and assigns the entities concrete tasks contributing to the achievement of the paramount objectives: 1/reduction of the spread of HIV infections 2/ensuring adequate access to information, education and services for HIV/AIDS prevention 3/updating the law in effect in the field of HIV/AIDS 4/widening the network of VCTs that perform anonymous and free HIV testing and counseling 5/quality of life improvement in the psychosocial sphere of HIV positive persons and persons suffering from AIDS, their families and relatives 6/improving the quality and availability of diagnostics and healthcare for HIV-

infected patients, patients with AIDS and those vulnerable to HIV 7/prevention of vertical infections 8/development of international collaboration 9/improving the monitoring of the epidemiological situation and activities and tasks related to HIV/AIDS.

Reach of the intervention (in brief):

The National Programme addresses the issue of broadly defined social protection by providing wide access to diagnostics and ARV treatment as well as by improving the quality and diagnostic and healthcare accessibility for people living with HIV/AIDS and vulnerable to HIV infection. Since 2001 until now, a 100% of the country coverage by voluntary counseling and testing centres (VCT) has been achieved. Free-of-charge HIV diagnostics and ARV treatment is being offered to patients who fulfil medical criteria including those at risk of marginalization, penitentiaries, those staying under arrest, migrants, asylum seekers and homeless as well as those who are not covered by health insurance. The National Programme also includes non-occupational post-exposure prophylaxis (accidents). ARV treatment is run by 21 hospitals, medical settings and their reference points throughout the country and in penitentiary settings. In 2013 the network of 32 voluntary HIV VCT centres embraced all 16 provinces in Poland. Counselling and testing are confidential and free of charge. The Programme: "Antiretroviral treatment of people living with HIV in Poland in the years 2012-2016" aims at decreasing the effects of the HIV/AIDS epidemic through providing ARV treatment combined with the monitoring of its effectiveness. The prophylaxis of vertical (mother-to-child) HIV transmission is one of the most important elements of the Polish response to HIV/AIDS. Its financing is secured by the Ministry of Health in the framework of ARV therapy programme. ARV treatment includes HIV positive pregnant women and infants who were born by their seropositive mothers. In the context of HIV testing in pregnant women the Decree of the Minister of Health stipulates standards on proceedings and medical procedures with regards to perinatal care of women during physiological pregnancy, child delivery and postpartum period and care of new-born child. Positive change in the prophylaxis of vertical transmission in Poland would not be possible without ongoing education (with the use of specific tools and techniques) targeting different groups and specialists such as: gynaecologists, primary health physicians, family doctors as well as nurses and midwives.

Impact of the intervention (in brief):

Based on the international guidelines, in 2011 Poland updated the law regulations on the HIV testing among pregnant women. At present gynaecologist should recommend the HIV testing to each pregnant woman. In recent years a 100% of HIV positive pregnant women with known status were covered by prophylaxis of vertical transmission in Poland. Thanks to implementation of ARV prophylaxis the percentage of perinatal infections decreased in Poland from 23% before year 1989 to the virtual zero presently. The most advanced medical techniques provide a chance of motherhood also for women that have HIV positive partners. Overall, in 2013 all patients (both HIV infected and with developed AIDS) who fulfilled medical criteria received ARV treatment. Based on evidence from healthcare settings where ARV treatment is carried out, in 2013, 7110 patients received such treatment, and among them 113 children (<18 years). In 2013 altogether 33271 persons did HIV tests in VCT centres in Poland and 381 infections were diagnosed. The process includes tailor-made counselling (pre/post test) considering personal needs of a patient in relation to risk behaviour and sexuality.

Financing and management (in brief):

The Regulation by the Council of Ministers on the National Programme for Preventing HIV Infections and Combating AIDS stipulates that the Programme Coordinator in collaboration

with obliged entities representing different fields of expertise and country regions (provinces) implements the Programme. Every five years on behalf of the Minister of Health, the Programme Coordinator elaborates the Schedule of Programme implementation. Specialized teams are formed in every province to coordinate and integrate local activities and cooperate in this regard with the Programme Coordinator. The Schedule (encompassing a five-year span) determines: the tasks (assigned to specific areas, main goals and detailed objectives), the indicators (assigned to each task), the entities implementing the task in the area of its substantive and territorial jurisdiction, and the implementation date. The Schedule for the Programme implementation is submitted by the Coordinator to the Minister of Health and to the Council of Ministers. At the end of the five-year span, the entities implementing the tasks submit reports on the performance to the Coordinator who then prepares and submits to the Minister of Health a comprehensive report on the implementation. The document is then passed on, to the Council of Ministers. In order to monitor the implementation of the Programme a system of data collection from the implementing entities is in place. The monitoring encompasses in particular:

- the entities obligated to implement the Programme and participating in its implementation,
- implemented tasks (concerning funding, the date of implementation, and the scope),
- the target groups of implemented tasks,
- coherence of undertaken activities with other statutory programmes.

Entities taking part in the implementation of the Programme shall introduce annual schedules to the monitoring system, along with annual reports and five-year reports.

Lessoned learned and recommendations:

Following the National Programme for Preventing HIV Infections and Combating AIDS, Poland can provide examples of lessons learned and good practices within the field of prophylaxis and risk reduction e.g. among populations that are most at risk e.g.:

- The Polish Government (the Polish Ministry of Health) through its agenda - the National AIDS Centre facilitates partnership with organizations and representatives of civil society. Such collaboration involves people living with HIV/AIDS in the process of shaping national policies and development of different recommendations at country level.
- The Polish Ministry of Health also finances selected programmes run by national NGOs in the field of HIV prevention and adherence to ARV.
- Establishing Advisory Council composed of National AIDS Centre, national NGOs and group of scientists whose aim is to advise on efficient prophylaxis and reduction of risk of HIV infection within MSM population in Poland.
- Since 2013 Poland has been implementing information campaign addressed to health care providers, primary health physicians, family doctors, gynecologists and nurses encouraging them to promote and propose HIV testing to their patients.
- Education of health care workers of different specialties and fields of expertise to make them more aware and sensitized to issues related to HIV testing and to health of MSM population.

Annexes:

Example of major entities implementing the National Programme for Preventing HIV Infections and Combating AIDS in Poland:

- Ministers proper according to the Programme goals

- National AIDS Centre
- National Bureau for Drug Prevention
- National Institute of Public Health-National Institute of Hygiene
- Institute of Venereology
- National Consultant on Laboratory Diagnosis
- Chief Sanitary Inspectorate
- Polish Scientific Association on AIDS
- National Health Fund
- Chamber of Physicians
- Chamber of Nurses
- Commissioner for Children's Rights
- Commissioner for Civil Rights Protection
- Commissioner for Patient's Rights
- Commissioner for Equal Status
- Healthcare institutions
- The Medical Centre of Postgraduate Education
- Others

2. GEORGIA, KAZAKHSTAN, KYRGYZSTAN, RUSSIA, TAJIKISTAN, UKRAINE

Title of program: Client Management Programme; Transitional Client Management

Contact: AIDS Foundation East - West

Implemented by: Civil society

Programme under way since: 2005

Has the programme been evaluated /assessed? Yes

Is the programme part of the implementation of the national AIDS strategy? No

Is the programme part of the implementation of the national poverty reduction or social welfare strategy? No

Background:

In the countries of the former Soviet Union persons living with HIV and individuals at risk of HIV infection (also called 'key populations': people who use drugs, sex workers, prisoners, street children, LGBT) often have multiple and simultaneous healthcare needs requiring services from several providers. Primarily due to high level of stigma and discrimination in the society and among the professionals who most often come into contact with key populations (doctors, law enforcement, prison staff, etc.), access to health services becomes limited. In 2005 AFEW introduced a unique Client management programme to improve the access of key populations to health care services.

Approach:

HIV client management is a collaborative process between the individual, the client manager, and local service providers aimed at improving access to appropriate and timely health and psycho-social care. Client managers assist individuals in assessing their specific needs (sitting together privately and making a list of needs) and developing strategies to best address these needs (where to go to meet this or other need). Due to high level of discrimination against key populations, clients are often accompanied by a social worker or the manager to hospitals for examination and medical care, government bodies to fix identification documents, disability allowances and get various certificates. In most of the cases medical and social services are provided to clients for free. Social workers and client

managers usually come from the community of key populations; they are regularly trained on human rights issues, ethics and the new approaches to work with the target group. At AIDS Foundation East-West, HIV client management initiatives strengthen the capacities of local governmental, non-governmental and community providers, as well as support local service coordination through the development of service provider referral networks. These networks not only assist in coordinating resources, but also facilitate client referrals and the smooth transition between services.

In addition to training and technical assistance, AFEW's programming involves policy development, the establishment of training resource centres, local training teams, the dissemination of informational and prevention materials, and support for innovative service models. Our activities seek to increase communication, co-ordination and collaboration both within the community and throughout the highly vertically organised and highly specialised pillars of the healthcare system.

At AFEW, treatment education among PLHIV is a broad approach that focuses on peer-based initiatives to raise awareness and to mobilise HIV-positive individuals around their right to treatment and to understand their treatment options, as well as promoting strategies to optimise treatment adherence and personal health and wellbeing.

Reach of the intervention:

Since 2005 AFEW's client management programme has been running in all countries of AFEW's target region: Belarus, Kazakhstan, Kyrgyzstan, Russia, Tajikistan, Ukraine and Uzbekistan. In some of these countries the programme has stopped or was significantly reduced by scope and reach due to various reasons but most importantly due to lack of funds. At the moment client management programme is still active in Kyrgyzstan and Tajikistan; some activities are carried out in Russia and Ukraine. In Kazakhstan this very successful programme has stopped in 2010 (see short video here <http://www.youtube.com/watch?v=dNutnv7Cidg>).

The focus of the programme is to provide direct HIV prevention, treatment, care and support services to key populations who otherwise cannot access them due to lack of knowledge, stigma and discrimination, lack of financial resources to get treatment or services, etc.

Since 2009 AFEW carries out transitional client management for prison inmates. This programme aims to assist in the development of systematic mechanism for social support of prisoners before and after release, as well as their subsequent rehabilitation. Though it is hard to define the number of people reached by client management and transitional client management, it is safe to say the number is a few hundred thousand people.

Impact of the intervention:

Greater number of people has access to free prevention, treatment, care and support services. Key populations have correct information on HIV prevention, harm reduction programmes, access to training and personal development opportunities.

Financing and management:

AFEW provides training and technical assistance to local NGOs that carry out client management programmes. NGO managers, social workers, consultants, psychologists, outreach workers and volunteers are trained on a regular basis during country and/or regional events like summer schools, camps where they get to meet their peers from other organisations and countries, share experiences, best practices and learn from each other. AFEW also brings together NGO representatives with state officials (police officers, doctors,

decision makers) to let the latter see the work of NGOs and understand the importance of it in HIV prevention, provision of treatment, care and support.

The client management programme is financed by AFEW, however, the idea is that after a certain period of time the NGOs need to be able to sustain themselves by providing paid services or producing goods. For example in Tajikistan some NGOs produce dumplings, operate stone processing shops and do carpet cleaning. In Kyrgyzstan NGOs produce and sell paving stones. This work engages key populations, who are trained accordingly before starting a business, and allows them to make a living. NGOs are then able to sustain themselves.

Lessoned learned and recommendations:

The client management programme has proved its effectiveness in increasing access to prevention, treatment, care and support for key populations. The programme needs to be expanded to enrol more people, both among key populations and service providers. The programme needs to become part of the national health care strategies and technologies.

Annexes:

Client management video from Kazakhstan (2009)

<http://www.youtube.com/watch?v=dNutnv7Cidg>

3. ROMANIA

Title of program: -

Contact: National Institute for Infectious Diseases "Prof. Dr. Matei Bals"

Implemented by: -

Programme under way since: -

Has the programme been evaluated /assessed? -

Is the programme part of the implementation of the national AIDS strategy? -

Is the programme part of the implementation of the national poverty reduction or social welfare strategy? -

Background

Since 2002, Romania has a special law (Government Decision no. 584/2002), which regulates diagnosis, access to treatment, and prevention of HIV/AIDS, alongside with measures of social protection of the patients (PLHIV, population living with HIV/AIDS). This law initiative is not singular, as several legal provisions guarantee access to health care, education, shelters and workplaces for the PLHIV.

Romania has a unique national program of prevention, surveillance, and control of the HIV infection, providing universal access to HIV/AIDS treatment since 2001, regardless any contribution of the affected patients to the national health care or social protection systems. The program is possible due to a partnership agreement between public authorities, pharmaceutical companies, patients, and international organisms. At the end of 2013, a number of 8,809 patients were beneficiaries of this program, receiving ARV therapy.

Governmental initiatives

The ARV treatment program in Romania is implemented according to norms approved by the Ministry of Health, under the technical coordination of the National Institute for Infectious Diseases 'Prof. Dr. Matei Bals' (NIID) in Bucharest for another eight regional HIV/AIDS centers in infectious diseases hospitals. NIID has also developed a sustainable relation with the NGOs acting in the field, enabling patients to get access to social protection programs, counseling, testing, and syringe exchange for infected drug users (IDUs).

The Ministry of Labor and Social Protection, alongside with the local authorities, is also providing a special allowance and access to shelters and workplaces for the HIV-infected people included in the national program.

The Ministry of National Education has developed a curriculum on 'Education for Health' and has implemented it in schools as a national program, with optional classes designed on 9 fields, including reproductive health. This module includes themes such as: 'Sexually transmitted infection – HIV transmission risk behavior', 'HIV/AIDS pre and post-testing counseling', 'Civil rights of the HIV infected persons', 'Solidarity with people in need', 'Stigmatization – consequences for people with chronic infectious diseases'.

Civil society initiatives

Due to the fact that Romania has already more than 20 years of experience in dealing with the HIV/AIDS infected patients, civil society had developed powerful social initiatives during this period, developing social inclusion mechanisms and providing health care education and counseling for the vulnerable groups of population.

Depending on the associated social issues, PLHIV can request general public services: night sheltering, hospital admission, home assistance, afterschool.

Romanian Anti-AIDS Association is disseminating HIV/AIDS information and providing social counseling through the AIDS helpline and in the regional HIV/AIDS centers, offering services of social and professional integration, psycho-medico-social services for IDUs, and advocacy for civil rights of HIV infected persons.

National Union of the HIV/SIDA Affected People Organisations is providing counseling in order to increase adherence to therapy and support PLHIV with co-infections (TB, HVC, HVB, STI).

The Foundation for People Development has developed and implemented mechanisms of socio-professional integration of vulnerable population, such as young HIV-infected persons. Therefore, it currently sustains two protected workshops, as social entrepreneurship projects: a Mosaic Factory and a workshop on techniques for production of advertising materials.

The Next to You Foundation of Romania offers different services to the HIV/AIDS infected persons, such as: psychosocial assistance for newly diagnosed patients and patients facing social inclusion problems; a Youth Club for developing independent life abilities; professional guidance; vocational therapy in painting, tailoring, artisanal workshops, and IT; employment in their own authorized protected units.

Vulnerabilities

Despite the great results of the national program's implementation, Romania is currently facing a series of new vulnerabilities, which need new strategic approaches in which concerns HIV prevention and social protection. These vulnerabilities are illustrated by an increased number of IDUs, of children born out of drug user mothers, of recombinant HIV due to transborder experiences, and of TB/HIV and HIV/HVB/HVC co-infection.

4. RUSSIA

Title of program: Legal protection and social support for drug-using women

Contact: Charity organization Chance Plus

Implemented by: Civil society

Programme under way since: 2011

Has the programme been evaluated /assessed? No

Is the programme part of the implementation of the national AIDS strategy? No

Is the programme part of the implementation of the national poverty reduction or social welfare strategy? No

Background:

The project is run by a non-profit organization with some support from state facilities, but with no support from the private sector. It operates in Yekaterinburg (1.4 million inhabitants), the administrative centre of Sverdlovsk oblast (4.3 million inhabitants). In Sverdlovsk oblast, women of reproductive age who use drugs and are affected by HIV are among the most vulnerable and marginalized groups. Yekaterinburg has 17,000-25,000 drug users, 30% of whom are women. According to surveys, these women avoid contact with social services, are marginalized, and experience physical and psychological violence inflicted by police. Both women and men who use drugs are considered outlaws in Russia, but women face additional stigma because of their gender. Therefore, addressing HIV among those women first of all requires addressing their social well-being and their legal situation. Consequently, the project decided that the best approach would be to combine mobilization of women who use drugs and are affected by HIV, and collaboration with government-run facilities that can provide support to those women. In addition to broader populations, the project has targeted women in local prisons. Human rights violations in prisons include violence, termination of parental rights, parole refusal based on drug use, forfeiture of pay, and illegal cancellation of visits from relatives. HIV-positive women who use drugs become subjects to such treatment more often than other inmates. As the Chair of Chance Plus was elected to a public committee on the monitoring of the penitentiary system, since 2014 the project has been implemented in prisons as well.

Approach:

The intervention is primarily HIV specific as it focuses on supporting women who are at risk of HIV. However, it also contains HIV sensitive elements because it helps strengthen local healthcare and social facilities and encourages the creation of inclusive social services for people affected by HIV. Considering the lack of national strategy to address HIV among vulnerable groups in Russia, the project is working on the ground to develop synergies with work done by other healthcare and social facilities in Sverdlovsk oblast, including social centres, drug treatment and rehabilitation facilities, and prison healthcare units. As a result, the project has developed a holistic approach to supporting women where legal, social, and health services complement each other, resulting in the empowerment of drug-using women who are HIV positive or at risk of HIV.

Reach of the intervention:

As noted above, the project's target group, vulnerable women, is one of the most marginalized groups in Russia in the context of both the HIV epidemic and Russia's economic and social development. During 2013, the project reached 344 participants including 308 new participants. Due to limited funding, the project's geographic reach was confined to Yekaterinburg, a city of over 1 million inhabitants. However, its programmatic reach was quite broad as it combines HIV prevention, treatment, care and support, as well as social transformation and empowerment resulting in diverse healthcare, social, and legal

services. These services are listed below:

1. Health services
 - Rapid testing for HIV and syphilis: in 2013, 222 women were tested for HIV (73 women were diagnosed with HIV for the first time), and all the women were referred to AIDS centres for examinations and treatment. Testing and further referral to treatment at the oblast AIDS Centre has shown positive results.
2. Social services
 - Support groups for drug-using women: help mobilize women's communities. The groups are operated by the women themselves.
 - Emergency response team: includes an outreach worker, a social worker, a psychologist, a lawyer and a legal consultant. The group employs peer counsellors. This group supports a 24-hour hotline to react to violence against women, including police violence, and to discrimination by other governmental institutions (including refusals of hospital treatment based on patients' drug use and other manifestations of stigma and discrimination). During 9 months of hotline operation, 183 requests for support were made, and the women received legal and psychological support. As a result, the project has created a database of cases of violence against women, facilitating case management.
 - Humanitarian aid: food packages, essential goods, and essential baby kits (including pampers, milk bottles, and pacifiers).
 - Education and training opportunities: One-day workshops on women's rights violations including with regard to drug use (reproductive health, violence prevention, rights protection, and HIV, hepatitis, and STD prevention) are popular among the women.
3. Legal services
 - Out of the 269 women who received social support, 23 received full legal assistance.
 - The prison project: Protection of social and constitutional rights as well as the humanitarian protection of inmates, aiming to prevent and document police violence and to provide legal and psychological assistance to its victims.

Impact of the intervention:

The project keeps track of its contacts with participants, as well of the number of medical tests, education opportunities, and consultations it offers, and of the materials being distributed. Annex I provides a table summarizing the outputs of the project in 2013. Its highlights include:

- Continued growth in the number of the project's contacts with participants, as well as of new participants, was observed throughout much of 2013, reflecting the participants' continued interest in the project and their increasing awareness of it. This growth in new contacts and participants peaked during summer, then slowed down but resumed afterwards.
- Over 200 rapid tests for HIV were done. As a result, 73 women learned about their HIV status which enabled them to seek treatment.
- Large numbers of women were engaged in self-help groups, STI treatment, women's consultations, and legal support.
- Over 80 women were trained.
- Large volume of humanitarian aid was disbursed to project participants.

In terms of the project's outputs, one of its main achievements is its ability to mobilize women to protect their social and legal rights through self-help groups and through

collaborating with partner institutions. Another achievement is the project's ability to establish connections with key government facilities that can potentially offer services to project participants. Overall, the project is an important step towards creating a comprehensive network of services targeting drug using women affected by HIV in Sverdlovsk oblast.

Financing and management:

The project is managed and coordinated by Chance Plus. In addition, referrals are co-managed by relevant organizations (e.g. social centre Karavella and rehabilitation centre Urals Without Drugs).

Funding is provided by the Andrey Rylkov Foundation for Health and Social Justice, as well as the Eurasian Harm Reduction Network. Obtaining government funding is impossible not because of the lack of government funds but because Russia's policy towards harm reduction is based on prejudices and denial. The project hopes that increased international exposure may ultimately help convince the Russian government of the utility of such projects and overcome its prejudices and fears. Until then, however, financial sustainability remains a challenge.

Lessons learned and recommendations:

The project's key success is due to the fact that its participants trust the project and are actively engaged in its services. While the policy and legislative environment is challenging to harm reduction projects, the project has successfully interacted with some government-run facilities. For example, due to an agreement with social centre Karavella during the treatment and rehabilitation of drug-dependent women their children are referred to that centre. Another example is collaboration with the rehabilitation centre Urals Without Drugs that reacted to earlier complaints by launching a ward for women. In addition, the project has decided to collaborate with other facilities that can help address violence against women, as well as with mass media.

The project has also experienced several challenges. As noted above, interaction with policymakers remains constrained due to the Russian government's position on harm reduction and HIV prevention among vulnerable groups. This is reflected in the attitudes of executive power structures, in particular law enforcement agencies. The project's cooperation with the local branch of the Federal Drug Control Service is constrained; as a result the project cannot distribute syringes. Another challenge is limited interaction with the city's harm reduction project, which is currently not very active and does not have a focus on women. A third challenge is related to working with women younger than 18; this work is complicated because the women's parents create obstacles to case management. Another challenge is related to working in cities outside Yekaterinburg. Work there is limited due to the lack of funds for transportation. A fifth challenge is related to the lack of a system to support victims of violence. Finally, working with women in prisons is complicated because of the control and limitations imposed by the penitentiary authorities.

Annexes:

Annex I: Project outputs in 2013

5. UKRAINE

Title of program: Project “Through transparent and efficient system of public procurement to saving lives of sick people in Ukraine” funded by All-Ukrainian Network of People Living with HIV/AIDS within the program “Building a sustainable system of comprehensive prevention of HIV/AIDS, treatment, care and support for vulnerable groups and people living with HIV”, supported by the Global Fund to Fight AIDS, Tuberculosis and Malaria, Round 10

Contact: All-Ukrainian Network of People Living with HIV/AIDS

Implemented by: Civil society

Programme under way since: 2013

Has the programme been evaluated /assessed? No

Is the programme part of the implementation of the national AIDS strategy? Yes

Is the programme part of the implementation of the national poverty reduction or social welfare strategy? No

Background:

According to the Ukrainian Center for Disease Control as of 01.01.2014 – 55,784 persons received ART in Ukraine. 43,790 people living with HIV are treated for the state budget funds. 111,393 HIV-positive people were in need of ART in 2013. Statistics shows the state underfunding of treatment for PLWH and officials constantly appeal to lack of funding of HIV/AIDS and TB programs from the state budget. But one of the problems which causes inefficient use and lack of public funds and contributes to significant loss of medications is inefficient and corrupt public procurement system. Monitoring of pharmaceutical market in Ukraine shows low efficiency of public policy on drugs price regulation, including ART and anti-TB treatment. In 2012 public procurement prices for certain drugs were 1.5-3 times higher than prices of similar drugs purchased by patients' organizations (e.g. All-Ukrainian Network of PLWH). It is estimated that out of 21 million USD spent for public drugs procurement in 2012 near 5 million USD were overpaid .

Approach:

In 2013 All-Ukrainian Network of People Living with HIV/AIDS in cooperation with the NGO “Anti-Corruption Action Centre” (AntAC) launched the civil society audit of public procurements in the field of HIV/AIDS and TB.

Reach of the intervention: Programmatic and geographic reach. Primary focus of the intervention – HIV prevention, treatment, care and support, social transformation, economic support or empowerment or program enhancement, which populations were targeted according to the epidemic profile of the country, the number of people reached and geographic coverage.

The program was implemented at national level in order to increase access of people living with HIV/AIDS to treatment and reduce HIV related death rate in Ukraine through monitoring and ensuring transparent and efficient system of public procurements. During 2013 55 public procurements of ARV and TB drugs, and test systems, which were carried out by MoH, National Academy of Sciences, and State Penitentiary Service, were monitored and analyzed.

Impact of the intervention:

During monitoring, in addition to over-inflated prices of public procurement of ARV and TB drugs, AntAC identified another important problem – collusion between tender bidders. Although the majority of ARV and TB drugs are produced by foreign companies, neither the manufacturers nor their authorized representatives participate in Ukrainian public tenders. In 2013, only 6 out of 6,500 pharmaceutical companies authorized for trading participated in

the public procurement of ART, sharing among themselves the market of \$30.9 million USD. And 8 companies shared 13.6 million USD in TB drugs procurement.

Together with MPs-members of GOPAC AntAC submitted 60 claims to different law enforcement and regulatory bodies (such as the State Financial Inspection of Ukraine, Antimonopoly Committee of Ukraine, Ministry of Economic Development and Trade of Ukraine, and the Prosecutor General's Office of Ukraine) challenging alleged violations of public procurement law and laws on conflicts of interest. Additionally, 37 information inquiries were submitted to regulatory agencies and government institutions that procure drugs. As a result, there were initiated 2 criminal proceedings, 7 investigations and inspections of ARV and TB drugs procurements by regulatory agencies.

As a result, it was possible to eliminate violations when the purchaser did not publish tender documentation, limiting tender competition; combined the procurement of different drugs in one lot, making it impossible for manufacturers and intermediaries who do not have access to all drugs announced in the lot participate in tender; to remove discriminatory requirements in terms of tenders (purchasing drug in particular form of production, despite the availability of appropriate drugs in alternative forms).

Consistent civil society audit has enabled significant reduction of public procurement prices of ART. In 2013, only in procurement of Efavirenz, Tenofovir+emtricitabine and Zidovudine/Lamivudine 1.5 million USD of state budget was saved, which in turn made it possible to purchase a 1 year treatment for more than 3,200 people living with HIV and increase access to ART under the state HIV/AIDS program.

Financing and management:

All-Ukrainian Network of People Living with HIV/AIDS sub-granted the project to Anti-Corruption Action Centre.

Lessoned learned and recommendations:

Strong team of lawyers, advocacy professionals that specialize in procurement monitoring and anti-corruption interventions and collaboration with MPs (GOPAC) and journalists helped project to success.

Challenges to be addressed:

1. Staging tenders among multiple companies controlled by one actual (beneficial) owner.
2. "Cartel agreements" between companies that belong to different beneficial owners but collude to win bids and increase profits.
3. Conversion of the state pharmaceutical factory into a shell company that purchases pharmaceuticals from offshore companies and sells them to the state procurer at unreasonably high prices.
4. Use of the State Register of Wholesale Prices for Medicines as justification for submitting bids with intentionally over-inflated prices for medicines.

Annexes:

Detailed information can be found in attached analytical report "Who Makes Money on Epidemics of HIV/AIDS and tuberculosis in Ukraine".

6. UKRAINE

Title of program: When women move forward, the world moves with them (in the framework of the UNODC initiative “Women for Women”)

Contact: Charity organization Club Svitanok

Implemented by: Civil society

Programme under way since: 2012

Has the programme been evaluated /assessed? No

Is the programme part of the implementation of the national AIDS strategy? No

Is the programme part of the implementation of the national poverty reduction or social welfare strategy? No

Background:

The project is aimed at improving mental, physical, and social well-being of highly vulnerable women and girls in Donetsk oblast of Ukraine. The region has 4.4 million inhabitants, the cumulative number of HIV cases at the end of July 2012 exceeded 44,532, and 39.1% of them are women. Based on the HIV situation in Donetsk, it is clear that women are at risk, and that addressing their healthcare needs entails addressing their social, economic, and legal needs as well.

The organization, Club Svitanok, adheres to GIPA and believes in the empowerment of the PLWH community, uses a non-judgmental attitude to drug users and respects harm reduction principles, promotes equal access to services for women and men, and recognizes the need for specific women-centred services. As a result, the project helps create a favourable nonviolent environment free of stigma and discrimination in order to ensure services for highly vulnerable women and girls; increase their awareness of HIV and safe behaviour; and empower them by developing their inner potential to control their lives and act in their own interests.

The project includes the following services: HIV counselling, mental health, psychology, self-help groups, humanitarian aid, outreach services to sex workers and drug users, case management and referrals to state clinics, home-based care, provision of medicines and diagnostics, shelter for abused women, legal support, summer camp for project participants, and education and awareness-building among activists and staff. As such, the project combines health, social, and legal approaches.

Approach:

The interventions are both HIV specific, in that they target HIV positive women, and HIV sensitive, in that they target women drug users and sex workers, victims of any kind of abuse, women leaders, as well as their family members, healthcare workers, and HIV/AIDS non-profits.

Synergies are ensured through client referrals from existing HIV and harm reduction projects, mutually reinforcing the services and creating a common platform to expand access to them. In addition, Club Svitanok collaborates with over 28 non-profits in the region, including PLWH community leaders, as well as with state and medical facilities; this helps attract clients from various cities and projects. As a result, there is an opportunity to create a chain of services for case management and referral of clients that responds to their needs.

Reach of the intervention:

The project combines healthcare, social, and legal support. Its geographic reach includes Donetsk and smaller cities in Donetsk oblast: Khartsyzsk, Volnovakha, Dimitrov, Artyomovsk, Makeevka, Kramatorsk, Druzhkovka, Shakhtarsk, and Thorez. In 2012, the project reached 580 women and girls, including 300 clients of existing HIV programs, 200 women who had no previous experience with HIV services, 50 HIV positive women 20 leaders of women's groups and communities, and 10 victims of violence. The project's target group responds to the epidemiological profile of Donetsk oblast, and the project's statistics demonstrate that it is able to retain existing clients and attract new clients at the same time.

Impact of the intervention:

The project keeps track of its clients, services, outputs and outcomes. Its main achievement is that it has expanded access to HIV prevention for women who inject drugs and engage in sex work in Donetsk oblast. It also helped alleviate the social consequences of HIV/AIDS, drug dependence, sex work and violence, and support victims of violence.

In 2012, the project had the following outputs:

- 500 female clients, including 200 new clients who have not used services before, received services at the Community Centre and on the streets, including counselling, social support, professional support by lawyers and psychotherapists.
- 25 female clients received social support including medicines, diagnostics, and transportation to healthcare facilities.
- Over 100 women, including women with children, received humanitarian aid for a total of US\$4,000, including clothes and shoes, Christmas presents, circus tickets for 13 families, and 20 DVD players.
- 25 women and 5 men attended training sessions.
- 20 women, including women with children, participated in Everest summer camp. The participants included 11 HIV positive people and 10 service providers.
- 1000 copies of a booklet for women were printed.
- Violence against HIV positive women in 12 families was addressed as part of a campaign against violence.
- In 2014, 70 women and 20 men in local prisons have received diagnostic and other services focusing on violence against women in the framework of a project developed with support from local authorities and international donors.
- Preventing interruptions in the ARV treatment of 3 women in a local prison.
- Using targeted donations, the project helped renovate a client's house.
- Case management was provided in three court hearings to protect women's rights, and two of the hearings were successful).

In addition to these outputs, the project had the following longer-term outcomes:

- A fully functional shelter for women with children was created and equipped. It includes a space where women who reside in the shelter or are receiving its services can temporarily leave their children.
- A team of trained HIV positive women counsellors was created and can be used to organize education, counselling, and social support for HIV, violence, advocacy, and women's empowerment. The team is taking part in EHRN's regional campaign "Women Against Violence" and in its Street Lawyers program. They are also taking part in the campaign "We have opened our faces for you to open your hearts to us!" (funded by Focus Media) that aims to reduce HIV stigma and increase tolerance.
- The project helped increase awareness of highly vulnerable women of safer behaviour, rights protection, and gender roles.

- The project obtained experience in case management for women released from prisons and for women whose parental rights have been terminated.

Financing and management:

The project is managed and coordinated by Club Svitanok.

Initial funding was provided by the Ukrainian office of UNODC in the framework of the initiative “Women for Women: Gender-sensitive HIV programmes for highly vulnerable women and girls in Ukraine”. It was continued in 2013 due to financial support from the Global Fund channeled through the All-Ukrainian PLWH network. In 2014, funding from the government of Donetsk oblast and from the organization Right to Health (funded by UN Women) was added. The clients cook and sell meals, which helps sustain the project.

In spite of the project’s successes sustainability remains an issue since the project is implemented by a non-profit organization and thus depends on donor support.

Lessoned learned and recommendations:

The main success factor is that the project and the support it provides are community-based. Most of the managers and staff are PLWH and people living with hepatitis, drug users, and former inmates. Other success factors include:

- The ability to recognize the role of men, therefore the latest training session on gender stereotypes was not a traditional training “for women” – it was a mixed event for both genders. The project to address violence currently works with men as well.
- Mutual integration between HIV testing and counselling, harm reduction, and care and support programs means that the project can manage a female client from her pre-test counselling to her ARVT treatment.
- Emphasis on human rights and encouraging clients to know and protect their rights. The project believes that a large number of complaints and requests for the government indicates good work.
- Focus on smaller cities in terms of both services and work with local governments and specialists. The presence of the project’s representatives in the municipal AIDS councils has improved the quality of work and provided additional opportunities for influence.
- Journalistic investigation helped address previously unsolved problems such as access to HIV testing in Khartsyzsk.
- Access to a pool of friendly healthcare specialists. This helps when a standard procedure for support provision is unacceptable, difficult, or impossible.
- Ability to work with children and teenagers attracts female clients. This is the only project in the city that works on treatment adherence among teenagers.
- Working in prisons. Because of that many clients turn for help after they are released.
- Collaboration with philanthropists and charities such as the Yelena Pinchuk Foundation has helped purchase expensive medicines, food, Christmas presents, and circus tickets; some churches and volunteers help collect clothes.
- Winning the trust of local healthworkers because the project helped equip three healthcare offices, including renovations, furniture, and equipment, rooms for inmates with HIV-TB coinfection, and HIV wards in a local prison.
- Ability to follow regional and global trends through observing updates to WHO protocols and guidelines, participating in conferences, and learning and exchanging experience.

The project’s main challenge is the lack of sustainable local funding for the women’s centre.

Annexes: -

7. UKRAINE

Title of program: Tuberculosis/HIV co-infection treatment in a Harm Reduction program

Contact: Charity organization Light of Hope

Implemented by: Civil society

Programme under way since: 2011

Has the programme been evaluated /assessed? Yes

Is the programme part of the implementation of the national AIDS strategy? No

Is the programme part of the implementation of the national poverty reduction or social welfare strategy? No

Background:

Ukraine faces a dual epidemic of HIV and Tuberculosis (TB). About 30-35% patients with TB in Ukraine are drug users, and in Poltava region this share is at least 40%. Up to 45% of people undergoing TB treatment also have HIV. Healthcare services could not manage the patients' treatment, and the medicines were provided once every 10 days. As a result, adherence to treatment became a problem resulting in low treatment effectiveness and even in resistant TB. This lack of capacity of the TB service to meet the needs of its many patients resulted in establishing a new model of medical and social case management of people with HIV/TB coinfection. The model was developed by Light of Hope and supported by the local TB clinic. Currently it is implemented in partnership between non-profit organizations and the state.

Approach:

The intervention is both HIV specific – it targets people with HIV and TB, and HIV sensitive – it helps improve the quality of TB service provision in Ukraine. The model is based on a multidisciplinary approach that includes collaboration between TB specialists, drug treatment specialists, infectionists, and social workers. They address patients' needs together thus creating an effective case management algorithm. This approach creates synergies between different programs and sectors, resulting in a more effective treatment regime and higher motivation for patients.

Reach of the intervention:

The intervention reaches drug users with HIV/TB coinfection in the city of Poltava. Clients can undergo TB treatment on the project premises that include two needle exchange sites, a community centre, two opioid substitution therapy sites, and a social adaptation site. Social workers play an important role by coordinating the treatment process.

As of March 2012, the project offered services to 38 PLWH with TB and drug dependence, as well as 22 patients receiving DOTS. During 2011, the project offered services to 62 patients with HIV/TB/drug dependence, as well as 28 patients receiving DOTS.

The project offers a broad range of health and social services, including counselling for drug dependence; consultations and training sessions on ARV and TB treatment adherence; provision of humanitarian aid to incentivize treatment adherence; support to opioid substitution therapy for this category of patients; free medical examinations; referrals to specialists in drug treatment, mental disorders, infections, and other areas; provision of medications; transportation of clients in severe condition to healthcare facilities; support for CD4 tests; counselling on hepatitis C and support with diagnostics; provision of shelter through a social hostel.

It is envisioned that the project will lead to the following outcomes:

- Social and healthcare services have become more proactive and responsive to the

- patients' needs.
- The project helped increase adherence to treatment in TB patients and support effective TB treatment.
- Collaborative approach created synergies that resulted in cost savings for healthcare services, NGOs, and clients.
- All of this has led to a reduced TB rates in Poltava, reduced TB mortality rates, reduced incidence of treatment-resistant TB, and improved quality of life of the patients. As a result, it is hoped that the project's experience will be used by other regions as well.

Impact of the intervention:

The project was evaluated by PATH experts and was praised by them. It has demonstrated:

- Effectiveness: demonstrated specific measurable results.
- Impact: the results are obtained through minimal use of resources.
- Replicability: the project can be replicated based on local resources and budgets by medical institutions in other regions of Ukraine.

Financing and management:

The intervention is managed by NGO Light of Hope in collaboration with the Poltava TB and drug treatment clinics and the Poltava AIDS Centre. The project is funded from the budget of NGO Light of Hope. While the organization has been able to implement the project so far, expanding the services further would entail expanding the range of partners and engaging the state more proactively, as discussed below.

Lessoned learned and recommendations:

Cross-sector collaboration between NGO Light of Hope and Poltava healthcare facilities is a key success factor. The project is built on a formal agreement with a TB facility. Collaboration has included training of social workers in case management for patients with TB/HIV/drug dependence, including for support to DOTS provision. Due to this collaboration, services are offered through local healthcare facilities as well as at home. It is planned to further train social workers by local medical facilities, which will result in the possibility to obtain state certification.

The project has encountered several challenges. First, there is a lack of sustainability as NGOs are addressing problems that should be addressed by the state. The project will become sustainable if its effectiveness is proven and further if it is integrated in the TB services with government funding, and if the range of social institutions involved in the projects is expanded. Unfortunately, NGOs working with drug users and PLHW generally refuse to participate in HIV/TB treatment although they are working with the same clients outside treatment services. Another challenge is related to the difficulty of arranging controlled intake of medications during weekends. A new treatment scheme is based on treatment days rather than on dosage – this may help eliminate the “weekend treatment” problem by extending the treatment period. Initially there was another challenge related to TB drug intake at home (patients could persuade nurses to provide medications for a few days bypassing the social worker). This went against the principle of controlled treatment. However, following an intervention by the chief physician of the TB clinic this practice was eliminated.

It is possible to use the project's experience to design collaborative campaigns to introduce these practices in other regions, including through designing appropriate regulations. Another direction is to expand the capacity building component. This would entail establishing a school to educate social workers in case management for clients with

HIV/TB/drug dependence.

Annexes: -

IV. Latin America and the Caribbean

1. HONDURAS

Title of program: Strengthening the national response to HIV with emphasis on orphans and vulnerable children

Contact: Ministry of Health

Implemented by: Government, Civil society, Private sector, UN or other inter-governmental organisation

Programme under way since: 2009

Has the programme been evaluated /assessed? No

Is the programme part of the implementation of the national AIDS strategy? Yes

Is the programme part of the implementation of the national poverty reduction or social welfare strategy? Yes

Background:

Since 2004 the Honduran government decided to include the component of orphans and vulnerable children by HIV (OVC) within the fifth pillar of the Strategy of Poverty Reduction, several efforts were made to visualize this population, so that a committee was formed for the Protection and Care for Orphaned and Vulnerable Children due to HIV, which was led by the Ministry of the Presidency with intersectoral participation of the government, civil society and international cooperation (PAHO and UNICEF), unfortunately this government leadership was not constant. However, this initial effort allowed the country to receive specific funding for orphans and vulnerable children by HIV / AIDS in Round 9 of Global Fund. This project ran from May 1, 2011 to December 31, 2013 and its purpose was to improve the quality of life and reduce the impact of HIV on orphans and vulnerable children due to HIV.

Approach:

This project had a mix approach of interventions, because it had emphasis on social protection. The main objective of this approach was to improve the quality of life of OVC throughout 7 pillars: health, education, nutrition, housing improvement, legal support, psychosocial support and income generation. The implementation of this project involved a cross-sectoral approach that sought comprehensive care for this vulnerable population. The program was based on the ecological approach, focused on the best interests of children, in recognition of the rights of children to survival, well-being and support and respect for their views, also addressing their families and their community.

Reach of the intervention:

To define the scope of the project a group of experts carried out an epidemiological analysis, and 3 main aspects were taken in consideration: a) geographic areas with 85% cases of HIV in the county, b) the number of people within reproductive age with HIV and, c) fertility rate; this was allowed a rough estimation of the total of OVC.

During implementation of the project, the children and their families received the benefits of each pillar, as a result some pillar were proven to be more sustainable than others, an example of this is the health pillar that manage to increase the number of children with HIV

receiving comprehensive care, . The project also succeeded in increasing the enrollment of children affected or infected in school and health programs. The project achieved a coverage of 12,600 children nationwide (an estimated of 21,173), it also supported families of black communities (Garifuna), that are considered within populations at higher risk of HIV infection in the country.

Impact of the intervention:

The project succeeded by improving the quality of life of these children, ensuring health comprehensive services for them, keeping them in the education system and improving nutritional status through the delivery of a monthly food basket for families who remained constant in the program for a year, 4,136 OVC (under 6 years of age or children with HIV under 18 years) received a monthly ration rich in protein and carbohydrates, each ration included 20 pounds of corn flour, 10 liters of milk, 1,350 ml of vegetable oil, 12 pounds of red beans and 10 pounds of rice; 428 families with OVC received technical and financial assistance, including seed capital (in the form of means of production) to strengthen the generation of household income, these pillar surpassed the goal that have been planned for the program (400 families).

Financing and management:

The project was financed by Global Fund, and it was executed and managed by CHF International. The NGO CHF International is and the Principal Recipient of the Global Fund HIV project. The implementation was done through various sub-recipients such as the National HIV Program of the Ministry of Health, the Commissioner of Human Rights and 8 national and international NGOs with OVC experience. The private sector collaborated by establishing an agreement with Walmart, so that the food baskets were delivered through their stores in the areas where the project was implemented, this was done to facilitate the access of the beneficiary families, and to create greater acceptance of people with HIV. Estigma and discrimination has decrease over time, but is still a negative factor in the national response to HIV. Families were having doubts whether or not they want to participate in the program, because they fear negative consequences due to discrimination against the children.

Lessoned learned and recommendations:

The most important lesson learned is that to achieve sustainability of the processes is essential that the Government creates a policy and legislative framework that will facilitate the implementation of social protection projects. Currently the government has created the Ministry of Social Development and the Ministry of Justice and Human Rights, these institutions should be in charge of regulating the social protection working in collaboration with the Health, Education, and Labor Ministry. Working in a coordinated manner and under the principles of harmonization and alignment of resources they can achieve sustainability of interventions and a real improvement in the quality of life of the most vulnerable populations. HIV remains a multi-sectoral and multi-causal issue requiring different sectors of society to work in a coordinated and articulated way.

Annexes: -

2. PERU

Title of program: Empowerment through Self-Management: a means of strengthening the response of Civil Society in the Treatment, Care and Prevention of HIV - AIDS in Lima and Callao, Peru

Contact: Sí, Da Vida

Implemented by: Civil society

Programme under way since: 2006

Has the programme been evaluated /assessed? Yes

Is the programme part of the implementation of the national AIDS strategy? No

Is the programme part of the implementation of the national poverty reduction or social welfare strategy? No

Background:

Peru is one of the countries affected by a concentrated HIV epidemic. The health Ministry acknowledges that only one in two of those living with HIV know their status. 38% of people diagnosed are at the advanced stage of having Aids symptoms. 80 % of all cases of People Living With HIV and Aids (PLWHA) are from slum areas, populations with limited access to public health, education, social and recreational services; also characterized as socio-economically vulnerable populations with low purchasing power, low political participation, marked by crime and family and sexual violence. 25.8% of the population of Peru live in conditions of poverty which in real terms means that 7.8 million Peruvians are poor. This type of vulnerable population is where HIV infection flourishes and because of the stigma and discrimination associated with HIV, it often goes unreported. The average profile of PLWHA in Peru was that of a young man, LGTB, with little resources, unemployed, migrant and socially excluded.

The second major problem is that the Peruvian state does not dedicate adequate funding to the prevention of HIV. There has been a big increase in the Health Budget in Peru during the last three years with 8.7% destined to healthcare in 2012, an increase of 1.7% from 2010. However when we look at neighbouring countries we see the shortfall in health expenditure; e.g. in 2012, Chile with 12 million less in population spent practically three times more on healthcare in the same year. When health is seen as the absence of illness, prevention suffers, as the majority of budget is spent on treating those who are ill rather than promoting prevention of illness. Our NGO intervention trains PLWHA and those affected by HIV to self-manage their chronic condition (Treatment as Prevention) and involves them in education for prevention of the spread of the virus (Primary Prevention).

Approach:

This is a HIV specific Social Protection project with the objective of promoting HIV/AIDS prevention education in the cities of Lima and Callao, Peru. This is achieved by training People Living with HIV and Aids (PLWHA), their friends and families and health professionals who work with them, through the HIV specific Chronic Disease Self-management Program (PSMP) and to subsequently train suitable participants in the program as tutors who replicate it in the future. Trained tutors, suitable volunteers and Health Professionals, who have been trained in the PSMP program, are further recruited to promote a healthy lifestyle in relation to HIV and aids through campaigns, lectures and participation in Civil Society events. We educate people as to the consequences of sexual behaviour and give them the tools necessary to respond, to be response – able, in this area of life and indeed in their life in general. We further provide a Center for on-going education, re-socialization activities and advocacy which coordinates with other organizations involved in the theme of HIV.

Reach of the intervention:

The primary focus of Sí, da Vida is prevention of the spread of HIV and to improve the quality of life of people living with this chronic condition. The backbone of the intervention is the application of the Positive Self-Management Programme, (PSMP) a program provided under licence from Stanford University, USA. Since we started in 2006 we have provided 109 PSMP programs on 29 different sites in the poorer sectors of Lima and Callao, in hospitals, health centres, community and Church halls, in prisons and in private houses. These have had a participation of 2,053 PLWHA, people affected who include partners, family and friends and Healthcare professionals, who are empowered by taking part in a 3 month programme of one meeting per week. From those who have completed the programme we have trained 138 people as instructors of the programme in 8, week-long residential trainings. We are aware that the concentrated epidemic affects the GTB community most and so target this community, while also being inclusive and gender sensitive. Of those who have been trained, 23 have successfully completed training as "Master Trainers" of the programme, registered with the University of Stanford.

We have developed a centre, "Sí, da Vida" as a space of encounter and on-going education where we have provided 30 multi-session workshops on the Dignity of the Human Person, Human Rights, Human Development and the improvement of self-esteem to prepare PLWHA, people affected and healthcare professionals who are empowered to participate in Awareness Raising and Prevention Campaigns. We carry out these campaigns in Hospitals, Sexual Health Clinics, Support Group settings and in clubs and recreational facilities frequented by people at high risk of infection with HIV; in bars, discotheques and city centre plazas. These activities create awareness in the public and combat the stigma and discrimination that exists against those who live with the virus.

Our Centre also serves as a "drop-in" centre where service-users can meet, talk about their problems, receive counseling or partake in the many re-socialization activities aimed at helping them overcome the trauma of a positive diagnosis or of the stigma and discrimination that such a diagnosis can bring. These activities vary from support groups and 12-step programmes to bingo, karaoke, cine-forum and Internet-café and attract approximately 200 visits every week. This re-socialization programme functions under the name, "Yo Soy" which means "I am", as participants are helped to see themselves as people with dignity and rights, living with chronic condition just like asthma, diabetes or chronic heart disease. They are encouraged to adopt the theme of the Centre, "A long life, a full life, a dignified life and a happy life". This group "Yo soy" was commended in 2nd place as "Best Practise in HIV 2011 – 2013" in an event run by the Peruvian Ministry for Health and the Peruvian National Institute for Health on World Aids Day 2013.

Perhaps one of our greatest successes is in the area of Advocacy, where having convoked other organizations we co-founded and have maintained and coordinated since its foundation, a collective called GIVAR, which monitors the supply of the antiretroviral medication necessary to control the advance of a HIV infection. These medicines, which are supplied by the state, often report shortages and through our advocacy the supply has improved immensely. This project was the awarded first place in the "Best Practise in HIV 2011 - 2013" on World Aids Day 2013.

Impact of the intervention:

From descriptive accounts, the intervention has had an enormous positive effect on the participants. We have applied a study; the, MOS-30, "Evaluation of the PSMP program in Peru" (attached) which shows the positive results.

The promoters who participate in prevention are all PLWHA and people affected which means that they speak from experience and are much more acceptable to the populations vulnerable to infection.

The fact that the “Yo Soy” re-socialization project was awarded 2nd place in the Best Practise in HIV 2011 – 2013 in Peru points to the benefits of the project which offers care and support to the most vulnerable participants. We also apply a questionnaire on the perception and satisfaction of service users in events organized by the “Yo Soy” project. The main outcome of the “Yo Soy” activities is the empowerment of the participants who are often transformed from shy, unsure and insecure people to become activists in the promotion of their rights.

GIVAR supports treatment through guaranteeing the supply of antiretroviral medication and furthers networking with other organizations for advocacy and political mobilization to promote social transformation..

Financing and management:

Sí, da Vida is an NGO with a board of Governors and members who largely come from the program instructors. There is a weekly meeting of instructors, a meeting of members twice annually and a board meeting every 3 months. The finance comes from external sources namely Misesan Cara funding from Ireland, The Catholic Diocese of Jefferson City, USA and the Columban Missionaries, Peru. Our major partners are The Peruvian Ministry for Health and Ministry for Justice; The Municipal Authorities of Lima and Callao; the collective of other NGOs who participate in GIVAR and of course our instructors. Our sustainability is in the fact that there is a chain-effect in that the instructors and promoters come from the participants in the basic program and are trained to replicate the program. The “Yo Soy” project has been successful in gaining local funding.

Lessoned learned and recommendations:

The main factor in the success of the project is that it started from the grass roots, responding to a perceived need, where cases of people seeking help occurred and self-management was seen as a tool which could help respond to the situation. Sí, Da Vida started its institutional life by collaborating with the oldest Support Group for PLWHA in Lima and offered its base program, The Positive Self-Management Program, initially to other support groups and progressively to hospitals and to people with a positive diagnosis who were not affiliated to groups. Through our prevention campaigns we became known and sought after. We also provide programs in jails and in faith based communities and provide prevention and awareness raising campaigns with the National Police Force, the Municipal Police of Lima, with army recruits and with high risk communities especially LGTB. The major challenge is to have the Ministry for Health create a policy where self-management is seen as a beneficial tool and offered to all people who receive a diagnosis for a chronic condition in order to improve their quality of life. We also need to promote a Social Model of Healthcare rather than the medical model that exists at present where prevention is prioritized as well as care and treatment.

Annexes:

1. Evaluation of PSMP program in Peru.

3. URUGUAY

Title of program: Affirmative Action for the transgender and transsexual people with the Social Uruguay Card (Tarjeta Uruguay Social – TUS Trans)

Contact: Ministry of Social Development

Implemented by: Government

Programme under way since: September 2012

Has the programme been evaluated /assessed? No

Is the programme part of the implementation of the national AIDS strategy? No
Is the programme part of the implementation of the national poverty reduction or social welfare strategy? Yes

Background:

TUS Trans Card is the first social protection action targeting trans people, one of the more exposed groups to HIV. It is an affirmative action within a social programme focused on extreme poverty situations, to which this group did not had access. The programme was limited to pregnant women and families with children under 18 years in a situation of extreme poverty. As most of trans people (trans women representing 99% of trans population) were treated as men without children, they were not covered by the programme.

Approach:

The programme is not a specific action for HIV people but an affirmative action for the HIV most vulnerable group in Uruguay, within the framework of a programme that reaches all families in a situation of extreme poverty (approximately 67.000 families).

Reach of the intervention:

The intervention consists of an economic transfer to buy foodstuffs and cleaning products in shops that have adhered to the programme for a monthly amount of 30 US dollars. The action is targeted to all trans people. The TUS Trans Card is available in the whole country and reaches a group of 1.088 people (see annex). There is not trustworthy information about the total number of trans people in Uruguay. They are estimated between 1.200 and 1.500 people.

Impact of the intervention:

There are no assessments yet of the programme that began in September 2012 (monitoring by the Direction of National Evaluation and Monitoring of the Ministry of Social Development is pending). Nonetheless, there are some results that can be highlighted:

- The symbolic recognition of a group of people whose sole interaction with the State was by means of the sanitary system or the police, as well as its social exclusion situation worsened by stigma and discrimination.
- The access to a set of foodstuffs and cleaning products, in the framework of a general programme
- The collection of relevant data for other actions: change of name and sex at the registries as well as access to training and employment programmes.
- Information about HIV positive carriers.

Financing and management:

The Ministry of Social Development has the administration of the programme by means of 35 offices covering the whole country. More than 1.200 servants received training on sexual diversity and non-discrimination to facilitate adequate attention to trans population.

Financing is assured by the national public budget for the Social Uruguay Card (50.000.000 US dollars) from which 397.000 US dollars annually are devoted to the TUS Card.

Lessons learned and recommendations: What factors helped success of the intervention, including institutional set-up, legislative and policy environment, coordination, political mobilisation and support, advocacy? What were the challenges?

LGBT movement have an increasing importance in Uruguay where Laws were approved regarding the change of name and sex in the registry (2009) and equal marriage (2013). The "parade for diversity" that includes several organizations of trans people had become one

the most popular annual parades in the country. Within LGBT movement organizations there is consensus regarding trans people as the most social excluded group, including family, education, working and health exclusion, as well as sexual trade as a survival mechanism.

After 2010 the Direction of Social Policies have included the human rights paradigm as a guideline, and from that perspective trans people is one of the most vulnerable social groups. With the help of trans organisations the Ministry has prepared the “Social Policies and Sexual Diversity Agenda”, including among its actions the TUS Trans Card.

Annexes:

- Ministerial Resolution creating the TUS Trans Card (only in Spanish)
- Information analysis, basis document of Transforma 2013 (only in Spanish)
- Territorial data

V. Western Europe and others

1. GREECE

Title of program: Outreach program for male sex workers (MSWs)

Contact: HCDCP, Ministry of Health

Implemented by: Government

Programme under way since: 10 January 2012

Has the programme been evaluated /assessed? No

Is the programme part of the implementation of the national AIDS strategy? Yes

Is the programme part of the implementation of the national poverty reduction or social welfare strategy? No

Background:

Assessment about the male prostitution in Greece was conducted and its specificities were recognised: Many male sex workers don't identify themselves as sex workers, especially if they identify themselves as heterosexual. This makes it difficult to approach them and to talk open about sexuality and their life circumstances. The taboo on homosexuality leads to further marginalisation. The double stigma on prostitution and homosexuality often leads to a lack of self-confidence, which makes it difficult for male sex workers to develop a professional attitude within their work. In the cases of migrant sex workers the stigma is triple and migrants face additional problems such as: language barriers, mobility, lack of information on their social and legal rights and health issues, lack of access to health services because of their illegal status, fear of the police. In general, male sex workers often face bad and unsafe working conditions, poverty, discrimination, stigmatization and marginalization, dependency on club owners or other persons involved in the prostitution scene.

The above mentioned factors minimize the self-esteem of a male sex worker and his ability to refuse unprotected sex and increase his vulnerability. Safe sex and health issues are not a priority, so male sex workers are vulnerable to HIV and other sexually transmitted diseases.

The objectives of this intervention are:

- Health promotion of the male sex workers
- Prevention of HIV/STDs transmission
- Change the attitude about risk behavior

- Link to health services
- Empowerment and increase of the self-estimation of male sex workers
- Increase the awareness of male sex workers and clients in matters of prevention of STIs and HIV and male prostitution
- To face stigma and discrimination of the male sex workers

The basic principles of the Intervention:

- Non-judgmental approach. We don't impose standards, values or beliefs.
- The action should not be detrimental to the male sex workers
- Meet their needs
- Right to confidentiality and anonymity
- Respect human rights, dignity, autonomy and choice
- Respect the views, knowledge and experiences of male sex workers
- Identify the different forms of male prostitution and the role played by customers in the transmission of HIV and STDs

Approach:

The intervention is HIV sensitive and HIV relevant. The intervention is based on the street work method.

Reach of the intervention:

The program started on January 10, 2012 and is addressed to men who have sex with men for money, as well as their clients. The intervention takes place at the historical centre of Athens. During 2012 and 2013 the team has completed 136 outreach activities. The program approaches the sex workers themselves but also the potential customers at: indoor environments like porn video stores with private cabins, bars, hotels, and male saunas and outdoor environments like public parks in Athens and other places in the city center. More specifically, the team has approached sex workers and clients in 6 porn cinemas, 2 cruising clubs, 3 saunas, 3 bars, 8 sex shops, 18 hotels and several outdoor environments (Pedion Areos, Omonoia sq etc). Especially designed material for HIV and STI's prevention for MSM was distributed (in Greek, and English), also material for HIV, STI's, Tuberculosis, Lice, Scabies and HIV testing (in Greek, English, French, Farsi, Arabic and Rumanian).

The intervention offers:

- Information leaflets about HIV, hepatitis, other diseases.
- Distribution of condoms and information about their use.
- Safer sex education.
- Education on safety in the scene.
- Access to free HIV test (through referral to the mobile units of KEELPNO).
- Access to free health services (through referral to mobile units of KEELPNO).
- Information about existing health services and link to them.

Impact of the intervention:

Since the beginning of the intervention, the outreach team informed or referred to different services 3.392 individuals, of which some declared openly that they work as MSWs, while others indicated they were clients. The team has regular contact and cooperation with 6 MSWs who act as peer mediators between team members and the target group. The outreach team has distributed more than 13.000 information leaflets, 3.500 gadgets and 11.000 condoms. During the years 2012 and 2013 almost 300 people were referred to hiv testing facilities.

Financing and management:

The intervention is managed by Mr. P. Damaskos, Head of the office For Psychosocial Support and Psychotherapeutic, of HCDCP. The fee of the outreach team is covered by the organisation through their overtime working hours wages.

Lessoned learned and recommendations:

- Any approach to male sex workers is particularly difficult because male prostitution is still a taboo, it is more hidden than the female prostitution, not professional, occasional and is not acceptable either by the male sex workers themselves.
- The approach must be done with great care and sensitivity to allow the creation of a trust relationship and the possibility to discuss issues about safety and sexual health.
- The creation of a trust relationship requires multiple visits to the sites so that the street work project can be integrated in the existing scene.
- Multiple visits are necessary also because of the frequent rotation of individuals in these areas.
- Stability of street work team members and the least possible rotation, is important for building relationships of trust with the target group (they contact us as individuals)

Concerning the team, seems to be significant:

- Group cohesion and bond on matters concerning the target group
- Preparation and debriefing
- Assessment, evaluation and redefinition of the goals

Proposals:

- The creation of printed material issued specifically for male sex workers in various languages, culturally sensitive is necessary
- Ongoing training of team members on male prostitution and sexual health matters and rights
- Extend the street work to transsexual sex workers and male sex workers in brothels
- Involve the clients to the de-stigmatization of male sex workers and to the promotion of condom use

Annexes: -

2. UNITED STATES

Title of program: Low-threshold harm reduction housing for active substance users living with HIV who are experiencing homelessness or housing insecurity

Contact: Housing Works, Inc.

Implemented by: Civil society

Programme under way since: 1997

Has the programme been evaluated /assessed? Yes

Is the programme part of the implementation of the national AIDS strategy? Yes

Is the programme part of the implementation of the national poverty reduction or social welfare strategy? Yes

Background:

A large body of research evidence links homelessness, housing instability and substandard living conditions for people with HIV to inadequate HIV health care, high viral load and increased HIV-related mortality. Homelessness and housing insecurity are also

independently associated with increased risk of acquiring and transmitting HIV infection. In the recent outbreak of HIV infection among injection drug users in Greece, those who were homeless were 2.3 times more likely to become HIV infected than housed injection drug users, after adjusting for risky behaviors.

Evaluations of housing-based interventions for persons with HIV (PWH) – including two randomized controlled trials conducted in the United States – indicate that housing status is highly amenable to cost-effective intervention and that improved housing stability over time is independently associated with: engagement with HIV care that meets clinical standards; effective antiretroviral therapy (as indicated by viral suppression); better HIV related health status (as indicated by viral load, CD4 count, lack of co-infection with HCV or TB); steep reductions in mortality (80% over 5 years in a one large study); significant reduction of HIV-related risk behaviors; and net savings in public spending for health and emergency services.

Rates of homelessness and housing instability are high among all PWH in the US (the U.S. government reports that 145,000 households with HIV, or 16% of all PWH, have an unmet housing need). PWH who are members of marginalized groups and those with co-occurring issues such as past or current substance use are most heavily affected by both housing loss and HIV disparities, often literally or effectively excluded from abstinence-based programs. Since HW's formation in 1990 with a mission to end homelessness and HIV, its housing programs have been targeted to underserved persons and have employed a low-threshold, harm reduction services approach in which neither program admission nor retention is conditioned on abstinence or a commitment to end drug use.

Housing supports have been part of the US AIDS response since the mid-1980s. Housing programs for PWH in New York City are operated by non-governmental organizations (NGOs) and funded through a combination of local, state and federal government grants and government-funded tenant-based rental assistance programs for PWH. Although acceptance is growing for low-threshold (sometimes called “housing first”) models of housing for active drug users, this type of housing has not been brought to scale to meet real need and is completely unavailable in many communities where drug use remains highly stigmatized.

Approach:

Housing subsidies and related support services are targeted to extremely poor individuals and households living with HIV (majority single adults) who are homeless or unstably housed. Housing insecure PWH are referred to housing programs by HIV medical providers, government agencies who administer subsistence benefits, or NGO social service providers. Supportive housing programs provide medical and social supports delivered on-site at a housing program and/or through referrals to medical and behavioural health care services. Low-threshold housing programs work with residents to reduce drug-related harm, with a focus on behaviour rather than status as a drug user. Housing is viewed as a health intervention for homeless and unstably housed PWH, with government and private funders of housing services increasingly requiring that NGOs track HIV medical outcomes among residents and holding NGOs accountable for health disparities.

Reach of the intervention:

Housing Works provides direct housing assistance for homeless and unstably housed persons living with HIV in New York City – as a critical enabler of HIV treatment, as HIV prevention to reduce the risk of ongoing HIV transmission, as a harm reduction intervention

for active substance users, and to provide the stability necessary to empower residents to work towards employment and other life goals. This case study describes two of Housing Works' low-threshold housing programs for substance users: Community Residences (CR) that provide 72 studio apartments at two sites as permanent housing for adults living with HIV that is co-located with medical and supportive services; and a Transgender Transitional Housing Program (TTHP) that provides 36 units of scatter-site apartments for transgender and gender non-conforming persons with HIV (TPLWA), and provides linkages to medical and support services.

Impact of the intervention:

Housing Works partners with researchers from the University of Pennsylvania to conduct community-based participatory research, including evaluations of the impact of HW housing program. Results show increased stability, improved HIV health outcomes, reduced HIV risk behaviours and reduced harm from substance use (as well as progress towards abstinence). Findings indicate that low-threshold housing operates independently of other factors as both prevention and treatment for PWH – by altering the HIV risk environment and improving the ability to adhere to medication. Housing supports provide an effective structural intervention for marginalized and stigmatized PWH who are housing insecure.

We conducted a retrospective review of program data for 66 current and 152 former residents of the two CR programs over a six-year period. Residents achieved high levels of stability (62% positive housing outcomes) despite high rates of substance use (95%), history of incarceration (82%), mental health issues (80%) and long-term homelessness (90%). Residents were almost three times more likely to have an undetectable viral load (less than 400 copies/ml) at the most recent check-up, compared to their viral load at the time of intake (OR=2.89, 95% CI=5.87, 1.42), and were 50% more likely to have a CD4 cell count above 200 cells/mm³ than at intake (OR=1.52, 95% CI=3.62, 0.64).

To evaluate the effectiveness of the TTHP, we compared viral load outcomes for 90 TPLHA who completed their stay in the TTHP (assessed at program exit) to a group of 90 homeless Housing Works HIV-positive clients on HIV medication, matched by race and age. We also conducted 30 semi-structured, in depth interviews with TTHP residents. After controlling for other factors, compared to the comparison group, a higher proportion of TTHP completers had suppressed viral loads (67% vs. 32%, $p<.01$). The qualitative results indicated that stable housing undermined chaotic and risky physical environments and facilitated service-utilization that ultimately reduced HIV risk and improved adherence.

Financing and management:

The CR facilities are owned by Housing Works with capital costs financed through government grant funding, government-backed bond financing and private donations. Operating costs for the CR and TTHP are funded with a combination of tenant-based rental assistance provided by local government for extremely poor PWH and grant funding for linked supportive services. Housing Works, as the NGO, coordinates and manages funding sources and the delivery of services and reports outcomes to funders, with regular oversight from government and private funders. Government funding comes from local, state and federal agencies charged with broader social protection responsibilities to meet housing and other subsistence needs for extremely poor persons. These agencies target housing supports to PWH in recognition that “mainstream” social protection programs are inadequate to meet all needs and due to the urgent public health imperative to meet subsistence needs of PWH as a critical enabler of strategies to prevent new infections and reduce HIV health disparities.

Lessons learned and recommendations:

The substantial empirical evidence of the impact of housing status on HIV health outcomes has been critical to successful advocacy for the creation and maintenance of HIV specific housing supports. Perhaps most importantly, implementation research has demonstrated that the public cost of housing supports for PWH are more than offset by the “savings” realized through reductions in public spending for health costs associated with advanced HIV disease and costs saved by averting downstream HIV infections. Cost analyses are being used to advocate for housing interventions at scale, and for housing that supports rather than excludes active drug users at high risk of poor health outcomes. Enabling PWH to maintain health and reduce the harm associated with drug use also helps persons to maintain or return to work (including participation in Housing Works’ job training program), reunite with children and other family members, and achieve other goals towards greater independence and well-being.

While most research on the relationship of housing status and HIV health outcomes has been conducted in North America, the available literature indicates consistent findings on the impact of housing insecurity in middle- and low-income countries. A systematic review of the global literature found that the estimated 100 million persons worldwide who are homeless experience dramatically higher rates of TB, HCV and HIV infection than persons in the general population in their areas. Among HIV-infected patients in Cote d'Ivoire, poor housing conditions (e.g., no refrigerator; no ventilation in bedroom) are associated with not being on antiretroviral treatment. In Ukraine, 28% of youth who are both homeless and orphaned are HIV-infected, and among female sex workers in India, residential instability is associated with higher rates of sexual violence, physical violence, accepting more money for unprotected sex, and a recent STI symptom. Research from Kenya suggests that lack of privacy in crowded informal settlements leads to earlier sexual experimentation and high-risk survival sex strategies among adolescents. It is urgently important to develop and evaluate housing-based interventions for PHW as a means to support treatment effectiveness and prevent new infections in all settings, including middle- and low-income countries, and for all key populations, including active drug users.

Annexes:

1. Employing use-tolerant, harm reduction housing to establish stability and connection to care among chronically homeless active drug users living with HIV/AIDS: Presented at the 2007 United States Conference on AIDS.
2. Housing as a structural intervention for transgender people living with HIV: Abstract selected for oral presentation at AIDS 2014 in Melbourne.
3. Housing is HIV Prevention and Care: Key Facts and Recommendations (2012). National AIDS Housing Coalition, Washington, DC.
4. Housing status as a key social driver of HIV health outcomes: Findings from a global survey of non-governmental organizations: Presented at the 3rd Structural Driver's Conference, Cape Town, 5-6 December 2013.

3. UNITED STATES

Title of program: The Housing Works Second Life Job Training Program (JTP)

Contact: Housing Works, Inc.

Implemented by: Government, Civil society

Programme under way since: 1991

Has the programme been evaluated /assessed? Yes

Is the programme part of the implementation of the national AIDS strategy? No
Is the programme part of the implementation of the national poverty reduction or social welfare strategy? Yes

Background:

Founded in 1990, Housing Works is a community-based, minority-controlled non-profit organization that provides housing, healthcare, and vital supportive services to homeless families and individuals living with HIV/AIDS in New York City. Our mission is to reach the most vulnerable and underserved among those affected by the AIDS epidemic and to provide them with a range of services designed to help them gain stability, independence, dignity, and improved health.

Many of the homeless and formerly homeless people with HIV (PWH) served by Housing Works lack the education, skills and/or work history necessary to obtain employment, and must rely on disability or public assistance benefits. The Second Life Job Training Program (JTP) for homeless and formerly homeless men and women living with HIV was one of the first programs established by Housing Works, in 1991, and in 23 years has trained and employed over 300 former clients. The JTP is New York State's only program of its kind that guarantees graduates full-time employment with health benefits and other fringe benefits such as school tuition reimbursement. The JTP provides prevocational training, job training, and job placement within Housing Work's structure of comprehensive services and is enriched by a strong case management approach that supports participants from day one through the first three months of employment with Housing Works. Program graduates make up 25% of Housing Works' 500 employees, and often go on to earn college and advanced degrees, and to employment beyond Housing Works in everything from social work to food services to graphic design.

Approach:

The JTP is an HIV specific job training program that provides vocational training and guarantees full-time employment with health benefits and other fringe benefits such as tuition reimbursement to its graduates, who are homeless and formerly homeless men and women living with HIV and AIDS in New York City.

Housing Works administers the program in 12-week sessions four quarters per year, and participants typically require 9–12 months to graduate, depending on their starting level and rate of progress. The program consists of multiple phases, including classroom vocational training, on-the-job shadowing, and post-graduation support to ensure job retention, including access to Housing Works' full suite of licensed medical, mental health, and substance abuse services and care. JTP is further enriched by strong case management that supports participants from day one through the first three months of employment. Ultimately, JTP helps participants meet the goal of moving from public assistance into the economic mainstream.

Graduates earn: a starting salary of \$25,000–\$27,000 per year and a full benefits package that includes health, major medical, hospitalization, and dental insurance; a progressive prescription plan; continuing education benefits; long- and short-term disability insurance; life insurance; and a 403(b) savings plan. For many participants, this is the first time they are receiving a stable, legal income; combined with case management support that connects participants to safety net support, graduates are able to make ends meet in one of the nation's costliest cities, some for the first time.

Moreover, graduation from JTP does not mark the program's end, but rather the transition to a new phase in which a Job Retention Specialist helps graduates maintain employment, provides career planning, and mediates on-the-job issues between graduates and their supervisors. Beyond meeting their employment needs, the Job Retention Specialist also helps meet graduates' medical and psychosocial needs by ensuring continued participation in Housing Works' primary care, intensive case management, mental health, substance abuse, and transitional housing programs. Other support structures, such as an Elders Program, also ensure that graduates remain involved in JTP and the greater Housing Works community beyond post-graduation employment.

Reach of the intervention:

The JTP addresses the economic marginalization of extremely low-income PWH by promoting stable livelihood and enabling PWH to earn income and secure medical insurance. The demographic profile of JTP mirrors that of Housing Works as a whole: more than 90% of Housing Works clients are Black, Hispanic, or other minority; about one-third identify as lesbian, gay, bisexual, or transgender; almost 30% have histories of chemical dependence or are currently using substances; 40% have chronic mental illness; and 50% have been incarcerated. Virtually all have histories of homelessness or are at chronic risk of homelessness.

Impact of the intervention:

Since the inception of the JTP, Housing Works has employed over 300 JTP program graduates (at an average rate of 7 jobs per quarter) within the agency or its entrepreneurial subsidiaries, moving them from public assistance into the economic mainstream at jobs that pay a living wage and include health insurance and other employment benefits. At any given time, 25% percent of Housing Works employees are its former clients, mostly graduates of the JTP. Evaluation of JTP program outcomes shows that: 84% of all JTP graduates remain employed at Housing Works for at least 6 months; 71% remain employed for at least one year; 45% remain employed at Housing Works for 2 years or more; and many graduates eventually move on from Housing Works to employment elsewhere.

Full time employment provides stability, independence and full health insurance benefits, enabling graduates to take control of their health and wellbeing and more fully engage with the larger community.

Financing and management:

The JTP program is operated and managed by Housing Works. Funding for the JTP has evolved significantly over its 20 plus years. Initially, the program was funded solely through revenue generated through Housing Works' thrift shops and other entrepreneurial ventures. Over time, the JTP has been awarded state and federal government grants and is currently funded primarily by New York State has a strong record of securing both public and private funding. Since 2008, the JTP has been funded primarily by the New York State HIV/AIDS Employment Initiative, one of the first government programs created solely to respond to the employment needs of low-income individuals living with HIV/AIDS. The NYS Initiative is a joint project (an example of co-financing across government sectors responsible for different public services) of NYS' Office of Temporary Disability Assistance (which administers public assistance) and the NYS Department of Health AIDS Institute (which is responsible for the delivery and oversight of publicly-funded HIV health care).

Lessoned learned and recommendations:

Housing Works has operated the JTP for over 20 years. Unique in its guarantee of a meaningful job with concrete career advancement opportunities, a decent wage, and a complete benefits package, the JTP has become a replicable model for job training and placement programs that serve low-income people with HIV/AIDS and other chronic, disabling illnesses. By merging the forces of economic development and social services, and by linking job creation with job training, the model creates a mutually supportive and self-sustaining relationship, promoting the necessary investment on both sides of the employment equation for long-term success.

Annexes:

1. Housing Works Second Life Job Training Description for applicants.
2. 2011 PowerPoint Presentation of JTP outcomes.

4. CANADA

Title of program: Committee for Accessible AIDS Treatment (CAAT)

Contact: Committee for Accessible AIDS Treatment [Case jointly prepared by: the Committee for Accessible AIDS Treatment (CAAT) and the Global Network for People Living with HIV North America (GNP+NA)]

Implemented by: Civil society

Programme under way since: 1999

Has the programme been evaluated /assessed? No

Is the programme part of the implementation of the national AIDS strategy? Yes

Is the programme part of the implementation of the national poverty reduction or social welfare strategy? No

Background:

The Committee for Accessible AIDS Treatment (CAAT) is a coalition of more than 30 Ontario based organizations from the legal, health, settlement and HIV/AIDS sectors. It was formed in 1999 to improve treatment and service access for marginalized people with HIV/AIDS. Since its inception, CAAT has been at the forefront of education, research, service coordination and advocacy on issues related to HIV, immigration and access. In 2001, CAAT undertook a groundbreaking collaborative community based action research project: Improving treatment access for people living with HIV/AIDS (PLHAs) who are immigrants, refugees and without status (IRN). The study documented the challenges faced by these vulnerable IRN-PLHA groups and engaged stakeholders from various sectors to develop a joint action plan to address these barriers. As a result of the study, several innovative initiatives were developed that continue to this day: 1) the HIV Treatment Access Program at the Toronto People with AIDS Foundation that facilitates compassionate access to HIV treatment medications for IRN-PLHAs; 2) the HIV and Immigration Service Access Training Program based at Regent Park Community Health Centre in Toronto that facilitates provider and PLHA skills development on HIV-immigration related issues; 3) providing accessible legal information on HIV and immigration in collaboration with the HIV/AIDS Legal Clinic of Ontario (HALCO); and 4) creating a provincial working group on health access for IRN-PLHAs without full status in Canada. Currently, CAAT engages the IRN-PLHA communities through various programs: 1) the Ethno-racial Treatment Support Network Training utilizing the train-the-trainer approach to enhance peer support networks, treatment literacy, and peer counseling skills; 2) the Legacy Mentoring Project pairing community leaders as mentors for IRN-PLHAs to achieve life goals; 3) the Newcomer Sexual Health Promotion Project outreaching to IRN-PLHAs not connected with services; 4)

the Canadian Institutes for Health Research (CIHR) funded Community Champions HIV/AIDS Advocates Mobilization Project (CHAMP) Study engaging community stakeholders to mobilize both non-HIV+ community leaders from the media, faith and social justice sectors and IRN-PLHAs to address HIV stigma in racialized communities.

Approach:

CAAT's works from a fundamental principle which is the greater and meaningful involvement of people living with HIV/AIDS (GIPA/MIPA), and with this focus, CAAT's work is primarily HIV specific in terms of providing social protection through program delivery (trainings, outreach, and research). In addition, as CAAT's work focuses on championing for the rights for racialized IRN-PHAs to ensure that social policies and provisions are equitable and accessible, the work of CAAT should not only be categorized as HIV specific social protection but that it also enhances both HIV sensitive (i.e. demanding for access for healthcare for IRNs) and relevant (i.e. ensuring that the broader communities are knowledgeable about HIV and immigration issues facing IRNs) social protection. As such, CAAT's programs have provided income (through capacity building, honorarium, employment opportunities) or consumption transfers (ensuring for medical and treatment access, and proper linkages to appropriate services such as legal or housing) to the poor, protect the vulnerable against livelihood risks and enhance social status and rights of the marginalized with the overall objective of reducing the economic and social vulnerability of the poor, vulnerable and marginalized groups.

Reach of the intervention:

CAAT's programming focus have been on culturally diverse communities, immigrants and refugee communities living with and affected by HIV/AIDS. Reflective of the overall epidemiology of HIV/AIDS in Canada. The geographic reach of CAAT's program is the province of Ontario in Canada, with most of the programs provisioned in Toronto, Canada and the service provider training on IRN-PLHA issues being expanded across the province of Ontario. The primary target population of CAAT are racialized IRN-PLHAs, and its programs emphasis community collaboration and empowerment to not only enhance the capacities and resources of the primary target population but also for service providers and the community at large. Programs focus on increasing the holistic social determinants for IRN-PLHAs through evidenced-based community-based research and community consultations. CAAT's work has consistently been praised as innovative and truly community-oriented and empowers those we work with.

Primary focus of CAAT's program is include the following areas: 1) Education and Outreach: The HIV and Immigration Service Access Training Program (Outreach & education programs for legal, social, settlement and health service providers on HIV and Immigration issues)and the Newcomer Sexual Health Promotion Project (outreach and education workshops that target newcomers living with and at risk of HIV/AIDS); 2)Community Development, Capacity Building and Service Coordination: (a) The Legacy Project: The Legacy project promotes the Meaningful and Greater Involvement of People with HIV/AIDS (MIPA/GIPA) through organizing structured mentorship support to support PHA graduates of other training programs to apply their learnt skills to pursue progressive employment or volunteer opportunities; (b) Ethno-racial Treatment Support Network (ETSN):ETSN is an intensive "peer treatment counsellor training program" with 3 levels. Level 1 focuses on treatment literacy and communication skills with health care providers. Level 2 focuses on peer counselling and support skills development. Level 3 focuses on facilitation and presentation skills development and mentored practice of program graduates as peer facilitators and trainers for subsequent training series; 3)Community Based Research:(a) Our current research study is titled: "Community Champions HIV Advocates Mobilization

Project”, or CHAMP, funded by the Canadian Institute for Health Research. The CHAMP study will pilot and evaluate the effectiveness of two training interventions in supporting the development of community champions to advance anti-stigma HIV prevention initiatives amongst ethno-racial communities; (b) CAAT chairs the ethno-racial research working group at the CIHR Centre for REACH in HIV/AIDS that comprises many diverse researchers, service providers and PHAs from across Canada. CAAT is currently leading an evaluative study to identify “Best practices in evaluating HIV prevention and health promotion interventions for ethno-racial communities”; (c) Collaborative research partnerships: in addition to our own funded research projects, CAAT play prominent roles as collaborators on many important research initiatives, including: (i) Employment Change & Health Outcomes in HIV/AIDS (ECHO) study (with OHTN); (ii) What’s in it for me? (ACT); (iii) Barriers and Facilitators of Research Study (OHTN); (iv) Keep it Alive Campaign Evaluation (ACCHO); (5) Newcomer MSM resource evaluation (BCAP/GMSH).

Impact of the intervention:

CAAT has a successful track record as a leader in PHA capacity building/health promotion (as cited in the following “wise practice” examples in the recently published “Living and Serving 3” report by the Ontario AIDS Network): a) CAAT’s governance policy/structure is systematically set up to ensure there is (a) majority PHA representation, and (b) at least one of the co-chairs is a PHA. To ensure MIPA and succession planning, CAAT systematically structured individualized paired mentoring of steering committee members to facilitate capacity building in leadership roles; b) ETSN: Ethno-racial Treatment Support Network runs an intensive peer treatment counselor training program (“Learning and Helping Out”) which builds PHA capacities in areas of treatment and health literacy, peer counselling and support skills. The program provides facilitator training and mentored support to enable the progressive engagement of peer graduates to take on the roles of facilitators and trainers in subsequent training; c) Innovative and meaningful PHA involvement in research: CAAT has championed strong GIPA/MIPA approaches to meaningfully engage PHAs in all stages of research activities. These include holistic approaches to engage/train PHAs as peer research associates; mechanisms to ensure all participants’ input are fed back to them; using innovative methodology to facilitate PHAs input into research recommendations; and that all knowledge transfer exchange activities involve PHA co-presenters and collaborators.

CAAT is a pioneering leader in the HIV sector on PHA mentorship and is looked upon by our partners/members as an expert training resource on the issue. Our currently funded Legacy Project (phase 1) supports GIPA/MIPA through facilitating mentoring and mutual learning opportunities amongst PHAs and allies to enhance life goal pursuit, increase community participation and career track development and to apply their skills to help address unmet needs in their communities. Through the successful implementation of the Legacy phase 1 program we have accumulated a great deal of unique and valuable knowledge in fostering effective mentorship related initiatives in the sector. The proposed project enable us to further build on our successes and facilitate our project staff/participants to further develop into a knowledge transfer agent role to help adapt and replicate our program models for other partners.

CAAT is a leader in cross sector collaboration: From our inception, CAAT has been a network of multi-sector, multi-cultural partners that include the health, social, legal, settlement, research, and HIV/AIDS sectors. We have a strong track record of developing and implementing multi-sector collaboration (e.g. multiple community-based action research studies, compassionate drug program etc.). This is particularly relevant and important for this project because (a) we can more effectively broker diverse partnerships to provide our

participants with learning and practical experiences in many areas of professional and community engagement interest; (b) we can more effectively engage diverse communities in collaborative activities/projects due to our track record & experience.

1) HIV/AIDS Immigration Service Access Training: We offer 3-4 rounds of this training each year to IRN-PLHAs and service providers to enhance their understanding on how to navigate the Canadian immigration systems as IRN-PLHAs. 95 % of IRN-PLHAs who have attended this training were able to successfully go through their immigration process. 2) Ethno Racial Treatment Support Network (ETSN): Through this treatment literacy and peer counselor training we have trained almost 200 of peer counselors. Most of our trained peers have moved on to get to paid positions in both the HIV/AIDS sector and the non-HIV/AIDS sector. 3) Legacy Project: CAAT has paired over 100 mentors and PLHA mentees to help achieve their life goals and promote reciprocal learning; 4) Research: CAAT has trained over 40 peer research associates in different roles/capacities through its different research projects. Many of our peer research associates have: gone back to school to pursue further academic studies; taken up staffing roles in other research studies; and increased their engagement in many KTE-related activities from our research activities, such as development of new programs (e.g. the CAAT Legacy Project was a direct outcome of our PHA mental health research study).

Financing and management:

CAAT receives funding from all three arms of the government (federal, provincial and municipal). CAAT's core program is funded by the Ministry of Health and Long term care of Ontario (AIDS Bureau), while the Legacy Mentorship program is funded by the Public Health of Canada, the Newcomer Sexual Health Promotion project is funded by the City of Toronto, and the CHAMP research study is funded by Canadian institute of Health research (CIHR). Major Partners: Please see the CAAT Annual Report addendum for the list of partners and collaborators. Management through PHA representation on Board/Steering Committee: At CAAT, we systematically set up our governance policy/structure to ensure that there is majority PHA representation and at least one of the Co-Chairs is a PLHA. To ensure MIPA and succession planning, CAAT systematically structured individualized paired mentoring of steering committee members to facilitate capacity building in leadership roles. When our network was established 10 years ago, many of our target group PLHAs were facing major challenges in accessing basic treatment and support; PLHA participation at governance level was minimal. Through strategic and collaborative efforts to address the health needs of our target communities, we gained trust, built strong partnership with PLHAs and were able to engage them in capacity building and increasing leadership roles. The policy provides for the systemic commitment of our agency to have a PLHA Co-Chair, and a PLHA majority on the Board. The structure creates an environment where leadership succession is planned and new PLHA leaders are mentored as part of the executive structure. We have successfully supported a governance structure with strong PLHA leadership, always exceeding the target standard of PLHA representation set in the policy. CAAT has evolved from a service provider-driven network trying to address treatment access issues to a primarily PLHA-driven network that focus more on addressing the holistic empowerment needs of the communities.

Lessoned learned and recommendations:

Factors that helped success of the CAAT program/model are CAAT demonstrates accountability and ethno-racial community ownership by being inclusive and responsive to the needs of its diverse communities and by honouring IRN PHA's lived experience which has built trust and credibility in the community. We have a history of being innovative and

resourceful and use Action Research to generate knowledge and develop evidenced based interventions by translating that knowledge into action.

CAAT excels at individual and system capacity building by its application of GIPA/MIPA principles and by being a relevant educator to both Peers and Providers. Most important of all CAAT walks the talk, in other words it lives its values. CAAT's unique model is a collaborative network of partners with shared values and a common mission that works in innovative ways to attain leverage and provide empowerment and hope.

Our approach of community-based research is a good example of GIPA in action. PHAs participate in research as partners, rather than subjects. Research can be defined as a project involving many researchers and a funder or it can be on a smaller scale to determine something like whether a new service is needed and whether the ASO can provide it. All CAAT research projects have championed strong GIPA/MIPA approaches that: engage PHAs in all stages of research activities to ensure that all participants who provide input receive feedback when preliminary findings are developed; develop collaborative methodology and forum to ensure PHAs have direct and substantive input into research recommendation development; and involve PHA co-presenters in research knowledge transfer exchange activities. CAAT uses a holistic community empowerment grounded approach to maximize meaningful involvement of target group PHAs in all stages of research, beyond the traditional role of being utilized only as peer research assistant and has pioneered an innovative training model to support target PHAs to drive knowledge transfer exchange from research (The Knowledge Transfer Exchange Ambassador training program).

Challenges CAAT faces include but are not limited to: Hostile political climate with punitive immigration policies federally and provincially along with criminalization of non disclosure and its impact on HIV stigma and new-comers. Loss of funding and negative funding environment for ethno racial organizations means more work and may lead to lack of self-care and volunteer and staff burnout. Appropriation by others who may not share our values and not follow up on what they have agreed to do. CAAT's brand suffers from a lack of visibility and confusion about CAAT's role as a capacity builder related to: lack of trade marking and marketing its program models along with insufficient access to funders and decision makers. Limited funding especially core funding and space, results in an over-reliance on volunteers and staff because needs are greater than resources which results in volunteers and staff being stretched in order to respond to needs confronted.

Annexes:

- 1) CAAT Annual Report 2013 attached
- 2) CAAT website: www.hivimmigration.ca
- 3) Living and Serving document Download Living & Serving 3: GIPA engagement guide and framework for Ontario ASOs

VI. Multiple regions

1. GLOBAL

Title of program: The Hidden, Unseen and Unheard

Contact: International Indigenous Working Group on HIV & AIDS

Implemented by: Civil society

Programme under way since: 01/01/2005

Has the programme been assessed/ analysed? Yes (www.iwgha.org)

Is the programme related to the implementation of the national AIDS strategy? -

Is the programme related to the implementation of the national poverty reduction or social action strategy? –

Which of the following ADVOCACY, CAMPAIGNING AND LOBBYING areas is the organisation engaged in?

- Access to HIV treatment, care and support
- Access to HIV prevention services
- Sexual and reproductive health and rights
- Social protection
- Human rights
- Gender equality
- Inclusion and participation of community in decision making processes
- Others: Indigenous Peoples rights.

Which communities did the programme target?

- Gay, bisexual and other men who have sex with men
- People who use drugs
- Sex workers
- Transgender people
- Women and girls
- Young people
- People living with disabilities
- People living in (extreme) poverty
- Mobile workers and migrants
- Internally displaced people (including refugees and internally displaced people)
- Prisoners and other incarcerated people
- Indigenous people

Background:

First international Indigenous group of its kind, IIWGHA exists to build a unified voice for Indigenous peoples in collective action against HIV and AIDS by creating partnerships with governments, Indigenous leaders, research bodies, and AIDS organizations.

The programme is committed to increasing knowledge and addressing the stigma of HIV and AIDS within Indigenous communities and supporting Indigenous-directed research and awareness initiatives.

Approach:

1. Increase the visibility of the impact of HIV and AIDS in Indigenous communities at the International level.

- Improve meaningful inclusion of Indigenous Peoples, and Indigenous People living with HIV and AIDS, in research, policy and program development at the national, regional and international level.
- Work towards the accurate representation of Indigenous peoples in HIV and AIDS epidemiological data with their own countries or regions.

Reach of the intervention:

- Establishing and maintaining Indigenous led and supported pre-conferences at Toronto 2006, Mexico 2008, Vienna 2010, and Washington DC 2012.
- Supporting in-country and inter-country indigenous led research collaborations. Eleven countries with 17 leaders as members.
- Supporting in-country leadership and Indigenous led care and prevention advocacy in HIV.

Impact of the intervention:

- Internationally the organisation has been recognized as a significant player within HIV advocacy for Indigenous Peoples - with invitations and inclusion at EMG meetings with UNAIDS, Conferences, and meetings regarding sexual health of Indigenous Peoples globally
- Raising the indigenous voice with input in to all the corresponding International AIDS Conferences
- Some governments in country have supported and applauded the efforts of the organization in raising indigenous issues in HIV

Key message or high level outcome:

The ability to advocate nationally, regionally and internationally with a common voice, theme and key message regarding Indigenous Peoples within the HIV epidemic is key. The flow on affect and high level outcome has been recognised by other Indigenous groups wanting to model their own International organizations on our success.

Lessoned learned and recommendations:

Challenges:

- Financial support - very low
- Language barriers
- Recognition as a vulnerable hidden population within the epidemic, resulting from colonies where indigenous peoples are homogenized into the dominant population.

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