

HIV and social protection

Resource kit for high-impact programming

This Guidance Note is part of the resource kit for-high impact programming that provides simple, concise and practical guidance on key areas of the AIDS response. The resource kit is jointly developed by the the Joint United Nations Programme on HIV/AIDS. The resource kit can be accessed at <http://www.unaids.org/en/ourwork/programmebranch/countryimpactsustainabilitydepartment/globalfinancingpartnercoordinationdivision/>.

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This note was prepared by the UNAIDS Secretariat in collaboration with the Inter-Agency Working Group on HIV and Social Protection, Care and Support. It draws upon the expertise of UNAIDS and the experience of its Cosponsors and partners on HIV and social protection.

This Guidance Note provides information on the recommended investments in HIV and social protection. It also highlights the definitions, principles, evidence and practices for effective HIV and social protection programming.

The guidance in this document applies to different population groups and calls for particular attention to specific groups, including key populations. Specific guidance will have to be developed to address in more depth the needs of key populations.

WHAT IS NEW?

- New guidance on HIV and social protection has been developed by UNAIDS and its partners. Please refer, for example, to:
 - HIV and social protection guidance note. Geneva, Joint United Nations Programme on HIV/AIDS; November 2011 (http://www.iattcaba.org/c/document_library/get_file?uuid=823521bc-67bd-4c9f-8912-cd05b372f53c&groupId=220781, accessed 19 June 2014).
 - Enabling HIV responses: national social protection floors, ILO/AIDS Technical Note Series on Enabling HIV Responses, No. 1, June 2013 (http://www.ilo.org/aids/Publications/WCMS_247711/lang--en/index.htm accessed 19 June 2014).
 - There is increasing evidence on the role of social protection in the response to HIV.
 - Cash transfer programmes can reduce HIV infections in adolescents and schoolgirls in low-income settings.
 - Financial instruments for social protection have also contributed to a 50% reduction in the proportion of people on HIV treatment lost to follow-up in a study in Uganda.
 - There is an increased likelihood of adherence to HIV treatment among people living with HIV who are employed compared to those who are unemployed.
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Introduction

The past decade has seen a dramatic increase in social protection programmes. Over 750 million people were reached through cash transfer programmes in 2009.¹ In sub-Saharan Africa, social protection programmes have grown rapidly: from 25 programmes in 9 countries in 2000 to 245 programmes in 41 countries in 2012. Although HIV-sensitive social protection programmes have yet to expand, the potential for scaling up the integration of HIV and social protection is enormous.

Social protection is relevant to HIV because it addresses social and economic inequalities, HIV risk behaviour and HIV-related stigma and discrimination, which exacerbate marginalization and vulnerability to HIV infection. HIV-sensitive social protection is the preferred approach, as this avoids stigmatization that exclusively focusing on HIV may bring about.² HIV-sensitive social protection means not exclusively targeting people living with or affected by HIV. Through an HIV-sensitive approach, people living with HIV and other key populations³ are served together so as not to exclude equally underserved groups.

HIV-sensitive social protection programmes acknowledge and take action in addressing and removing barriers that exclude or make accessibility difficult for key population groups who are often marginalized by society or governmental systems—in particular sex workers, people who inject drugs, men who have sex with men, transgender people and, in some contexts, migrant populations. These actions could include the training of social protection service providers, reviewing and adapting policies and procedures that may create barriers and specific programmes designed for particular key population groups.

Approaches to effective HIV and social protection programming also include the following:

- *HIV-specific social protection.* These are programmes that focus exclusively on HIV and people living with and affected by HIV. Examples include the provision of free HIV services and financial incentives to encourage individuals to access HIV services, cash refunds to address the opportunity costs of accessing services and free food and nutritional supplements for people living with HIV on HIV or tuberculosis (TB) treatment to encourage adherence.
- *HIV-related social protection.* These are programmes that are designed for the general public, but which tend to address HIV. Examples include social protection programmes that target older individuals (more than 60 years old) in high prevalence countries that

1 Hanlon J, Barrientos A, Hulme D. Just give money to the poor: The development revolution from the global South. Sterling: Kumarian Press; 2010.

2 HIV and social protection guidance note. Geneva: Joint United Nations Programme on HIV/AIDS; November 2011 (http://www.iattcaba.org/c/document_library/get_file?uuid=823521bc-67bd-4c9f-8912-cd05b372f53c&groupId=220781, accessed 19 June 2014).

3 UNAIDS in its 2011–2015 strategy, Getting to Zero, defines key populations as follows: “Key populations, or key populations at higher risk, are groups of people who are more likely to be exposed to HIV or to transmit it and whose engagement is critical to a successful HIV response. In all countries, key populations include people living with HIV. In most settings, men who have sex with men, transgender people, people who inject drugs and sex workers and their clients are at higher risk of exposure to HIV than other groups. However, each country should define the specific populations that are key to their epidemic and response based on the epidemiological and social context.”

will also reach geriatric caregivers who face the burden of providing HIV-related care and services.

- *Comprehensive social protection.* HIV-sensitive comprehensive social protection addresses a range of measures for policy and programming, such as legal reforms to protect the rights of people living with HIV, women and key populations; economic empowerment programmes; and referrals and linkages to maximize the impact of investments in and across sectors.⁴
- *Aid effectiveness.* Scaling up HIV and social protection programmes requires adhering to the principles of aid effectiveness. These include national ownership, working within existing national priority frameworks to determine each country's social protection measures and building upon measures to promote sustainability, including predictable and long-term financing and expanding coverage.
- *Systems strengthening.* Improving the effectiveness and coverage of social protection requires good governance of social protection systems and adapting legislation and policy frameworks for effective targeting. Other key requirements are the participation of affected populations and productive institutional arrangements for the coordination of actors.

1. Key elements

Purpose of social protection

Social protection has been defined as “all public and private initiatives that provide income or consumption transfers to the poor, protect the vulnerable against livelihood risks and enhance the social status and rights of the marginalized with the overall objective of reducing the economic and social vulnerability of the poor, vulnerable and marginalized groups.” Social protection is more than cash and social transfers—cash, food, vouchers, etc.—it encompasses economic, health insurance and employment assistance to reduce inequality, exclusion and barriers to accessing HIV prevention, treatment, care and support services.⁵

Social protection, due to its positive impact on HIV prevention, treatment, care and support outcomes, can positively contribute to attaining the UNAIDS vision of Getting to Zero and contributes to achieving the ten targets of the 2011 United Nations Political Declaration on HIV and AIDS from June 2011.⁶ Furthermore, UNAIDS in its Investment Framework has

4 HIV and social protection guidance note. Geneva: Jointed United Nations Programme on HIV/AIDS; November 2011 (http://www.iattcaba.org/c/document_library/get_file?uuid=823521bc-67bd-4c9f-8912-cd05b372f53c&groupId=220781, accessed 19 June 2014).

5 HIV and social protection guidance note. Geneva: Jointed United Nations Programme on HIV/AIDS; November 2011 (http://www.iattcaba.org/c/document_library/get_file?uuid=823521bc-67bd-4c9f-8912-cd05b372f53c&groupId=220781, accessed 19 June 2014).

6 The ten targets of the June 2011 United Nations Political Declaration on HIV and AIDS are 1) reduce sexual transmission of HIV, 2) prevent HIV among people who use drugs, 3) eliminate HIV infections among children, 4) ensure 15 million people living with HIV have access to HIV treatment, 5) avoid TB deaths, 6) close the resource gap, 7) eliminate gender inequality, 8) eliminate stigma and discrimination, 9) eliminate travel restrictions and 10) strengthen HIV integration.

classified social protection as a critical enabler and development synergy that maximizes the effectiveness of AIDS responses.

Key elements of HIV and social protection interventions should:

- Protect the financial streams of individuals and households affected by and most vulnerable to HIV to secure the minimum income necessary for care, child care, children's education, food and nutrition, water, housing and other essential items.
- Secure and increase access to essential medical and social services for people in need, including adolescents, women and key populations, including people living with HIV, to prevent risk of exposure to HIV infection and enhance access to HIV prevention, treatment, care and support.
- Advocate for enacting appropriate laws, policies and programmes to reduce stigma and discrimination of those living with and affected by HIV, including women and key populations, and reducing barriers to employment, housing and access to social services, including protecting the rights of workers living with HIV to retain their employment and for those living with HIV to ensure access to general health services as well as HIV-related medical services.

Examples of specific instruments of social protection include the following:

- *Financial protection.* These include savings-led microfinance, income-generating activities (IGA), food for work, public works schemes and financial incentives to reduce the risk of exposure to HIV infection, improve the lives of people living with HIV and the most affected key populations and protecting the employment rights of people living with HIV.
- *Increasing access to social services.* Social and health insurance schemes include services such as social security, publicly funded maternal and child health (MCH), sexual and reproductive health (SRH) and HIV prevention and treatment. Others may also include programmes that provide vouchers for school supplies, nutrition and food support to orphans and other vulnerable children (OVC) and the exemption of school fees for the most vulnerable adolescents, including OVC.
- *Single window.* This concept encompasses a one-stop service for the delivery of social protection programmes and employment services at the local level, which is increasingly becoming a useful example for the integrated delivery of HIV and social services. The single-window approach provides information and referrals to various services by allowing beneficiaries to access benefits from one location without having to navigate across complex and multiple service points.⁷
- *Appropriate laws, policies and programmes.* These include increasing birth registrations so that children and their families may easily access services; decriminalization, of HIV transmission, sex work and drug use; addressing stigma and discrimination facing women and key populations including people living with HIV; protecting the property and

⁷ For more information related to the single-window service concept, see <http://www.social-protection.org/gimi/gess/ShowProjectWiki.do?wid=1024>.

inheritance rights of OVC and widows; addressing inequality in laws governing marriage, property and inheritance for women; addressing domestic and other types of violence against women; the protection of the rights of migrants, including migrant workers; laws to protect against discriminatory employment practices (e.g. the firing of employees found to be living with HIV); enacting legislation to protect the rights of people living with HIV to access general health services (that is, beyond HIV-related health services, including, for example, dental services, etc.); and passing laws against insurance policy discrimination against people living with HIV.

- Another example includes the *national social protection floors* that advocate for a minimum set of nationally defined goods and services for everyone, including people living with HIV.⁸

Selected examples of the impact of social protection include the following:

- *Sexual behaviours and transmission of HIV.* In a study from Malawi, Baird and colleagues found that unconditional transfers ranging from US\$ 1 to US\$ 5 per month in addition to the payment of school fees reduced teen pregnancy and early marriage by 29% and 32%, respectively, among 13–22 year olds. The study also showed that cash transfer programmes can reduce HIV infections in adolescents and schoolgirls in low-income settings. In Kenya, an unconditional cash transfer of US\$ 25 per month to households reduced the odds of early sexual debut among 15–25 year olds by 31% over a 4-year period with a larger impact among females (42%) compared to males (26%).⁹ More recently, a study from Lesotho indicates a 25% reduction in the probability of acquiring HIV due to the financial instrument of social protection.¹⁰ Reductions in incidence of 51% and 71%, respectively, in transactional sex and age-disparate sex among adolescent girls have been attributed to South Africa’s publicly funded child-focused cash grant, highlighting the role of public social grants in HIV prevention.¹¹
- *Accessing HIV treatment.* Cash transfers, food vouchers and vouchers for transportation to reach clinics all serve to increase access and adherence to HIV treatment. In a study in Uganda, Emenyonu and colleagues found a significant reduction in loss to follow-up due to cash transfers. After one year, cases lost to follow-up were nearly half as low in the

8 A social protection floor is the first level of a comprehensive national social protection system. It consists of universal access to essential services such as health, education, housing, water and sanitation and other goods as nationally defined and social transfers which include cash or in-kind contributions to ensure income security, adequate nutrition and access to essential services. “Recommendation No. 202 concerning the National Social Protection Floors, 2012” is the International Labour Organization’s (ILO’s) standard on social protection endorsed by 185 member countries.

9 Handa S, Halpern CT, Pettifor A, Thirumurthy H. The government of Kenya’s cash transfer program reduces the risk of sexual debut among young people age 15–25. *PLoS One*. 2014;9(1):e85473. doi:10.1371/journal.pone.0085473.

10 Björkman-Nyqvist M, Corno L, de Walque D, Svensson J. Evaluating the impact of short-term financial incentives on HIV and STI incidence among youth in Lesotho: a randomized trial. In: Programme-at-a-glance.: TUPDC0106 Poster discussion session. 7th International AIDS Society Conference on HIV Pathogenesis, Treatment and Prevention, Kuala Lumpur; 2013 (<http://pag.ias2013.org/abstracts.aspx?aid=553>, accessed 19 June 2014).

11 Cluver L, Boyes M, Orkin M, Pantelic M, Molwena T, Sherr L. Child-focused state cash transfers and adolescent risk of HIV infection in South Africa: a propensity score-matched case-control study. *Lancet Glob Health*. 2013;1:e362–70. doi:10.1016/S2214-109X(13)70115-3.

intervention group (18%) than the control group (34%). The differences in adherence rates were more pronounced over longer time periods.¹²

A 2013 international literature review carried out by the International Labour Organization (ILO) found that those people living with HIV who were employed have 1.5 times better antiretroviral treatment (ART) adherence rates compared to unemployed HIV-positive persons. This finding demonstrates the utility of including employment assistance as a component of social protection programmes.

2. Focus populations

The populations of focus are those most in need of services according to the HIV epidemic profile for a specific context. Depending on the epidemic profile and evidence of those populations most affected, each country should prioritize which populations are to be reached. In general, the following groups are of special interest: people living with HIV, girls and young women, OVC and key populations—in particular sex workers, men who have sex with men, people who inject drugs and their partners and transgender people. People in prison, undocumented migrants, unemployed and underemployed persons, individuals working in the informal economy and in rural areas and indigenous populations are also of interest.

3. Data requirements

Epidemiology

For effective interventions on HIV and social protection, knowledge of the populations most at risk of acquiring HIV and its impact on them is essential for establishing the proper focus of HIV and social protection interventions. In particular, it is necessary to obtain data to identify in which populations most new HIV infections occur and why, in which populations the impact of HIV is most acutely felt, which populations are less likely to be reached by HIV services and the geographic distribution of these populations.

12 Emenyonu N, et al. Cash transfers to cover clinic transportation costs improve adherence and retention in care in an HIV treatment program in rural Uganda. In: Programme and abstracts of the 17th Conference on Retroviruses and Opportunistic Infections, Abstract 831, San Francisco; 2010.

Programmatic

The first step in effective HIV and social protection programming is to conduct a diagnostic assessment. This involves obtaining a combination of existing demographic and household income data augmented by a country's HIV epidemic profile. For instance, combining information on household income, the number and ages of household members, including children, the geographic distribution of key HIV epidemics in a country and matching this information with available social protection programmes could assist a country in identifying gaps in social protection coverage. This information would be used to prioritize social protection programmes in order to have an effective impact on HIV.

It is important to understand the distribution of and barriers to demanding and accessing HIV services and how social protection interventions can help overcome those barriers. This understanding would also help to increase access to HIV treatment, prevention and care services, as well as retain individuals in these services.

Which populations are not reached by services. Coverage gaps for both HIV and social protection programmes should be considered. Data disaggregated by age and sex include which populations are not being reached by both HIV and social protection services, the geographic areas in which they are located and why they are not reached by HIV services. Such answers would assist in tailoring social protection resources to ensure that people are able to equitably access critical services.

Key populations, often marginalized by society or not reached by state systems, are usually excluded or not able to access social protection programmes. Sex workers, people who inject drugs, men who have sex with men, transgender people, people in prisons, undocumented migrants and others are likely to be left out of social protection programmes. Special attention should be paid to ensure that these populations are covered by existing HIV and social protection programmes. In some cases, special programmes may have to be initiated to reach these key populations, service providers may need to be sensitized and trained and standard processes may need to be reviewed and adapted to ensure they are not creating barriers to access.

Effectiveness of and attrition from services. For those accessing HIV services, it would be useful to know for whom the services are not working effectively, their geographic locations and why the services are not working well for them. Answers to these questions, including obstacles to adhering to HIV treatment due to a lack of food and nutrition, would provide information on how to augment existing interventions to reduce attrition and render the services more effective. It is also relevant to assess the level of out-of-pocket health-care expenses, distances from services, the quality of the services and proportion of available workers to provide services for specific populations and geographic areas. Data on the proportion of programme beneficiaries graduating from social protection programmes when applied to HIV-affected populations could assist countries in designing appropriate social protection packages.

Sector-wide programming. For effective sector-wide planning, it is important to gather data on the key social protection players, the existing social protection programmes available, the geographic areas in which they operate, what they do, the size of their budgets on social protection and what is required in order for those activities to be HIV-sensitive. For example, exclusion clauses in health and life insurance policies or other benefits with regard to people living with HIV and key populations may exist. Making existing health insurance policies HIV-sensitive would require removing such exclusion clauses.

Financial

Those who plan HIV services should be well informed with contextually relevant unit costs for different instruments of social protection—for example, the annual unit costs of providing basic financial security and securing and increasing access to essential basic health and social services to an HIV-affected household. These costs should be available from existing social protection programmes in different sectors. Where this information does not exist, a system for collecting this data should be developed. Such information will inform the planning of HIV and social protection programmes.

For example, the cost per person of receiving cash transfers or grants as well as the costs associated with covering or removing exclusion clauses for key populations so that they may access health insurance or pensions and social services should be quantified. In addition, the expected financial payoffs in terms of the number of key populations reached by the intervention can also be quantified monetarily.

Specifically, the actuarial (insurance) costs of coverage for a person living with HIV over their lifespan should be assessed. This would include the costs of treating opportunistic infections as well as providing ART and care and support services. These costs should be balanced against a reduction in future treatment costs, improved productivity of recipients, and increased probability to graduate or retain and/or return to gainful employment.

Similarly, the costs of ensuring the basic financial protection of those most vulnerable to HIV or impoverished by HIV in existing social protection cash transfer programmes can be quantified if the unit costs are known.

4. Implementation challenges

Social and cash transfer interventions have been increasingly introduced, but have yet to be implemented to scale to produce the desired timely results at the population level. Knowledge and implementation gaps exist, which include:

- addressing key operational issues such as potential feasibility, costs and benefits of different models of transfers and their conditionality;

- addressing systemic barriers (including processes, human resources capacity, stigma and discrimination) to access by key populations, in particular people living with HIV, sex workers, people who inject drugs, men who have sex with men and transgender people;
- enhancing the long-term impact of cash transfers on health and development;
- understanding the optimal size of transfers and the degree of targeting likely to produce the desired results; and
- determining how to deliver and sustain transfers at the scale likely to produce the desired population-level effects.¹³

5. Main activities

A combined approach is recommended. This approach involves implementing a mixture of services targeting different levels of HIV vulnerability. For example, HIV vulnerability due to poverty, stigma and discrimination is addressed through poverty alleviation initiatives such as cash transfers to protect one's ability to access basic goods and services; stigma and discrimination are addressed by transforming laws and policies that exclude and discriminate against vulnerable people.

Table 1 shows the typical combination of HIV and social protection instruments and their relative contribution to the response to HIV.

13 Heise L, Lutz B, Ranganathan M, Watts C. Cash transfers for HIV prevention: considering their potential. *J Int AIDS Soc.* 2013;16(1):18615. doi:10.7448/IAS.16.1.18615.

Table 1

*HIV and social protection indicative instruments*¹⁴

	HIV prevention for those most vulnerable to HIV infection	Treatment for people living with HIV	Care and support for people living with and affected by HIV
<p>Financial protection</p> <p><i>Social protection for the very poor</i></p> <p><i>Livelihood support for the poor and vulnerable</i></p>	<p>Cash and food transfers for the very poor to increase household resilience and reduce risky coping mechanisms</p> <p>Income generation or micro-credit and entrepreneurial skills training to reduce HIV risk for key populations</p>	<p>Transfers to poor people living with HIV for better HIV treatment access and adherence</p> <p>Economic empowerment of people living with HIV for basic consumption, including food, housing and nutrition, to increase the effectiveness of HIV treatment for prolonged and improved quality of life</p>	<p>Transfers to mitigate the impact of HIV on individuals and households, in particular key populations, including income-generating activities, livelihood strengthening, micro-[financing and entrepreneurial skills training, such as how to start your own business], for the affected populations</p>
<p>Access to affordable, quality services</p> <p><i>For example. social health protection for vulnerable populations</i></p>	<p>Social insurance to prevent HIV (social security, public financing of reproductive health, maternal and child health and HIV prevention services, etc.)</p>	<p>Social health protection to ensure access to health care and prevent erosion of savings</p>	<p>Preventive insurance measures appropriate for those affected (pension schemes, funeral clubs, etc.)</p>
<p>Laws, policies and regulations</p> <p><i>Social justice for marginalized groups</i></p>	<p>Legal reforms, policy processes and protective regulations to reduce the risk of HIV infection and to reduce systemic barriers to access social protection programmes (e.g. decriminalization of key population groups or decriminalization of HIV transmission and exposure, review of administrative processes to remove accessibility barriers for key populations)</p>	<p>Protection of the right to health and treatment services and employment to improve the quality of life for people living with HIV, with particular attention given to key populations living with HIV (addressing discrimination) including for migrants (both-domestic and international-/cross-border)</p>	<p>Legal protections for affected populations (the property rights of widows and orphans, birth registration, addressing discrimination faced by key populations marginalized by society, etc.)</p> <p>Training of service providers on the needs of people living with HIV and other key populations, and to reduce stigmatizing and discriminatory attitudes among providers</p>

14 HIV and social protection guidance note. Geneva: Jointed United Nations Programme on HIV/AIDS; November 2011, p. 7 (http://www.iattcaba.org/c/document_library/get_file?uuid=823521bc-67bd-4c9f-8912-cd05b372f53c&groupId=220781, accessed 19 June 2014).

Comprehensive social protection programmes can only be scaled up if civil society and community engagement is included as an integral component of such initiatives. While many interventions are delivered nationally by governmental agencies, community mobilization and engagement is critical in identifying where, for whom and in what form social protection is needed, building demand for services, promoting entitlements and ensuring equitable access to and the sustainability of services. Civil society actors, including workers' trade unions, also play an important role in holding employers and governments accountable for the provision, quality and delivery of social protection services.

In resource-constrained communities, it is often women who are community caregivers. They are instrumental in supporting community members to access social protection services in hard-to-reach areas either directly or through referrals. Many interventions are also community led and delivered in communities and homes by caregivers, including people living with HIV. Such examples include home-based care, community child protection, psychosocial support and savings and credit schemes. It is critical that community caregivers, including domestic workers, are purposely supported and remunerated for their work, since many of them are also affected by HIV, poor and further impoverished through their caregiving functions. Accreditation of community care givers into the formal health-care system, for example, is one alternative. Another is creating incentives and career paths for formal employment for community care givers.

The following are examples of specific interventions to be considered depending on the country context, epidemic profile and existing social protection interventions:

- national assessments to generate evidence on the reach and effect (or impact) of existing national social protection programmes and to identify opportunities for the inclusion of HIV as a component;
- financial incentives for HIV prevention, such as voluntary medical male circumcision, including transportation refunds to offset the opportunity costs of accessing services;
- financial incentives to increase the collection of HIV counselling and testing results;
- financial incentives for HIV and TB treatment, such as transportation refunds to offset out-of-pocket costs and to increase adherence;
- the inclusion of people living with and most affected by HIV into existing cash transfer programmes where these populations are likely to be excluded;
- school block grants for the enrolment and retention of OVC in the education system;
- recruitment and retention of adolescent girls into school;
- free quality HIV and health services, especially for those most vulnerable and at risk;
- savings-led micro-financing, entrepreneurial skills training and other income-generating activities for people living with HIV;
- consultations to extend the social protection floors to include coverage of people living with HIV and key populations;
- food and nutrition programmes to increase access and adherence to HIV services (this includes both prevention and treatment services);

- funding for the basic operating and activity costs of support groups for people living with HIV;
- contributing towards national birth registration exercises to increase access to services for children, including OVC;
- training of actors on the policies, regulations and procedures to access social protection benefits to strengthen their literacy on the social protection system;
- training of national and local social protection programme administrators on being HIV sensitive;
- consultations to promote dialogues between national social protection administrations, national AIDS programmes and labour administrations to improve mutual understanding, coordination and collaboration; and
- consultations to ensure that national health insurance, life or critical illness insurance and non-contributory pension schemes and programmes include coverage for people living with HIV.

6. Key indicators

HIV and social protection targets can be identified from national AIDS strategic plans and the respective programme areas. Listed below are indicators which are illustrative of social protection programmes which should be disaggregated by age and sex as appropriate:

- proportion of the poorest households who received external economic support in the last three months (global AIDS response reporting (GARPR) indicator 10.2);¹⁵
- current school attendance among orphans and non-orphans (10–14 years old, primary and secondary school age) (GARPR indicator 10.1);
- domestic and international aid spending by category and financing sources for social protection and social services (national AIDS spending assessment, GARPR indicator 6.1);
- national capacity to implement and scale up HIV-sensitive social protection and HIV and child-sensitive social protection strengthened (joint United Nations team survey, UNAIDS);¹⁶
- national health financing and/or social protection strategies in place which explicitly address HIV (joint United Nations team survey, UNAIDS);
- percentage of total health expenditure that is paid out-of-pocket is less than 15% (WHO Global Health Expenditure Database (GHED));¹⁷

15 Jointed United Nations Programme on HIV/AIDS, United Nations Children's Fund, World Health Organization. Global AIDS Response Progress Reporting 2014: Construction of core indicators for monitoring the 2011 United Nations Political Declaration on HIV and AIDS. Geneva: Joint United Nations Programme on HIV/AIDS; 2014 (http://www.unaids.org/en/media/unaids/contentassets/documents/document/2014/GARPR_2014_guidelines_en.pdf, accessed 19 June 2014).

16 UNAIDS/PCB (32)13.9, UNAIDS 2012-2015, Unified budget, results and accountability framework (http://www.unaids.org/en/media/unaids/contentassets/documents/pcb/2013/pcb32/agendaitems/UBRAF_PCB_2014-2015_Matrix_16May2013GMA%20FINAL.pdf accessed 19 June 2014).

17 Global health expenditure database. In: World Health Organization/Global health expenditure database [website]. Geneva: World Health Organization; 2014 (<http://apps.who.int/nha/database/>, accessed 19 June 2014).

- refugees have the same access to ART as the host population (joint United Nations team survey, UNAIDS);
- number and percentage of HIV care and treatment clients vulnerable to food insecurity referred from clinical facilities to food security services (routine programme and clinic records, including referrals to food security services);
- number of individuals living with and affected by HIV who registered for income-generating activities/total number eligible for this service;¹⁸
- availability of non-discriminatory laws or regulations which specify protections for specific key populations and other vulnerable groups (GARPR Appendix 3, Part A III 1.1);
- percentage of adults and children currently receiving ART among all adults and children living with HIV (GARPR indicator 4.1);
- percentage of woman and men aged 15–49 who report discriminatory attitudes towards people living with HIV (GARPR indicator 8.1);
- percentage of adults and children living with HIV known to be on treatment 12 months after initiation of ART (GARPR indicator 4.1);
- number of eligible adults and children who newly initiated ART during the reporting period (year) (WHO GARPR indicator 4.1);
- women`s economic empowerment included in one or more of the development plans (GARPR Appendix 3, Part A I 2.2);
- number and proportion of schools implementing programmes to reduce HIV among young people;
- number and proportion of people living with HIV in support groups;
- number and proportion of people living with HIV who are clinically malnourished and receiving therapeutic food;
- number and proportion of people living with HIV who have health insurance or access to free quality HIV services;
- number of social protection programmes that include coverage for HIV services;
- proportion of total social protection budget allocated to HIV-related services;
- number and proportion of people living with and affected by HIV accessing psychosocial support services; and
- number and proportion of households most affected by HIV receiving a basic package of care and support as nationally defined.¹⁹

18 Guidelines for cash transfer programming. Geneva: International Committee of the Red Cross and International Federation of Red Cross and Red Crescent Societies; 2007 (<http://www.ifrc.org/Global/Publications/disasters/guidelines/guidelines-cash-en.pdf>, accessed 19 June 2014).

19 For example, packages that include a bucket and lid, water guard and spigot for safe water, bathing soap, long-lasting insect-treated mosquito nets and other goods.

7. Approaches to costing

The UNICEF-ILO Social Protection Floor (SPF) Costing Tool allows users to cost different social protection interventions. It also examines the affordability and sustainability of increasing the scope and coverage of social protection measures by providing quantitative figures. This tool can be used to analyse existing and planned social protection interventions. A manual that explains each step and suggests possible data sources accompanies the SPF Costing Tool.²⁰

8. Addressing gender, human rights and equity issues

Social protection—in particular, the notion of social protection floors—refers to a minimum set of nationally defined and guaranteed basic goods and services aimed at preventing or alleviating poverty and social exclusion. Social protection programmes are aligned with the High Level Panel Post-2015 report which asserts that no one should be left behind in social and economic development. That is, no person, regardless of ethnicity, sexual orientation and gender identity, employment, geography, disability or other status should be denied human rights and basic economic opportunities. Social protection guarantees are enshrined in international human rights conventions and are important to the realization of social, economic and cultural rights. Therefore, HIV-sensitive social protection needs to address and meet the needs of those most vulnerable to HIV and socially excluded, such as people living with HIV and other key populations.

Women and girls face special constraints in coverage for social protection because:

- Women are more likely to be unemployed, have shorter or interrupted careers, be in non-standard forms of employment, such as temporary, part-time or casual employment, and often earn lower wages than men for the same jobs.
- Women and girls face limited access to health-care services, including maternal and sexual and reproductive health services.
- Women and girls face a larger burden of care and family responsibilities, which impact their ability to participate in socioeconomic activities that are likely to provide access to social protection services.
- Women and girls are more likely to be poor or extremely poor than are men and boys and constitute the highest proportion of the chronically hungry.²¹
- Female sex workers face even more constraints since, in addition to the above, they face social and systemic exclusion based on their work.

Given the particular burden of the epidemic faced by young women in Africa, it is also necessary to strengthen investments in their needs, including through initiatives such as cash transfers for girls and school support for orphaned girls.

²⁰ See http://www.unicef.org/socialpolicy/index_56917.html, for the tool and a manual for its use.

²¹ Adapted from: World social security report: Providing coverage in times of crisis and beyond. 2010-2011. Geneva: International Labour Organization; 2010 (http://www.ilo.org/wcmsp5/groups/public/@dgreports/@dcomm/@publ/documents/publication/wcms_146566.pdf, accessed 19 June 2014).

Other types of structural factors make people vulnerable to sexual transmission. Gender-based violence, stigma and discrimination based on sexual orientation and gender identity, exclusion, harassment, and stigma due to one's social standing and criminal laws (such as those targeting sex workers, men who have sex with men, transgender people and people who use drugs) and belonging to a minority ethnic group or holding migrant status can increase one's risk by keeping individuals away from services. Social protection in the form of policies, legislation, and regulations can address factors that keep people at high risk of infection from accessing essential protective services. Furthermore, it can facilitate the realization of their social and legal rights and reduce stigma and discrimination, as well as protect inheritance rights—all of which contribute directly or indirectly to HIV prevention.

9. Additional information

Implementation partners

For social protection programmes to operate sustainably, government ownership with effective aid coordination and harmonization is critical. Given that different government agencies and ministries implement various aspects of social protection programmes, it is essential that collaborative relationships and coordination are forged among these actors. National AIDS authorities, as coordinators of national AIDS responses, need to liaise and collaborate with government actors working on social protection programmes. Social protection administrations need to coordinate with labour ministries for employment as well as unemployment assistance. Mechanisms for governance such as collaboration, coordination, accountability and leadership on social protection must be established, clarified and continuously monitored and strengthened.

It is also essential to create an enabling framework for community participation and engagement. Civil society actors—in particular people living with HIV—have an important role to play. They must be purposely supported with capacity building, including literacy around social protection systems in order to organize themselves and contribute to effective social protection implementation.

Social protection service providers

Social protection programmes are provided by the government and the private sector including agencies such as private companies, nongovernmental organisations, banks and micro-financing institutions, faith-based communities and others. Ministries of finance, labour, health, social welfare, gender and national social security administrations are often the primary providers of social protection services.

A list of international actors experienced on issues related to HIV and social protection is provided in Annex 1.

Annex 1: An illustrative list of key international actors on HIV and social protection

Africa Union
Canadian International Development Agency (CIDA)
Concern Worldwide
Danish International Development Agency (DANIDA)
Danish Refugee Council
Department for International Development (DFID)
European Union
German International Cooperation (GTZ)
The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)
HelpAge International
Horn Relief
International Committee of the Red Cross (ICRC)
International Labor Organization (ILO)
Irish Aid
Japan Social Development Fund (JSDF)
Joint United Nations Program on HIV/AIDS (UNAIDS)
PAM
STOP AIDS NOW!
Swedish International Development Cooperation Agency (SIDA)
United Nations Children's Fund (UNICEF)
United Nations Development Program (UNDP)
United Nations Entity for Gender Equality and the Empowerment of Women (UN Women)
United Nations High Commission for Refugees (UNHCR)
US President's Emergency Plan for AIDS Relief (PEPFAR)
The World Bank
World Food Program (WFP)
World Health Organization (WHO)
World Vision International

Technical assistance requirements

The Joint United Nations Programmes of Support on HIV and United Nations Joint Teams on HIV serve as entry points to accessing the technical and financial resources of specialized United Nations agencies on HIV and social protection. In some countries, joint programmes of support include international donors that work on poverty, health, labour and development, which also bring their own sets of expertise.

Resources for further reading

Guidance materials

C102 – Social Security (Minimum Standards) Convention, 1952 (No. 102). From: Convention concerning Minimum Standards of Social Security. Geneva: International Labour Organization; 1952 (http://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO::P12100_INSTRUMENT_ID:312247, accessed 19 June 2014).

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Ozler B. Presentation to UNAIDS, United Nations Children's Fund and Institute of Development Studies meeting on evidence around HIV and social protection, 14–15 June 2010. Brighton: Institute of Development Studies; June 2010.

Reports

First Session of the African Union Conference of Ministers in charge of social development, Windhoek, Namibia, 27–31 October 2008. Addis Ababa: African Union; 2008 (<http://sa.au.int/en/sites/default/files/Social%20Policy%20Framework%20for%20Africa%20-%20Final%20-%2018%20Nov%202008.pdf>).

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UNAIDS / JC2568 (English original, May 2014)

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