



UNAIDS PROGRAMME COORDINATING BOARD

UNAIDS/PCB (35)/14.12
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THIRTY-FIFTH MEETING

Date: 9 – 11 December 2014

Venue: Executive Board Room, WHO, Geneva

Agenda item 4

**Follow-up to the thematic segment from the 34thPCB meeting:
Addressing social and economic drivers of HIV through social
protection**

Additional documents for this item: *none*

Action required at this meeting - the Programme Coordinating Board is invited to:

See decisions in paragraphs below

54. Take note with appreciation of the summary report of the Programme Coordinating Board thematic session on addressing the social and economic drivers of HIV through social protection;
55. Recognize the need to strengthen action to address the social and economic drivers of HIV in order to realize the goal of ending AIDS, and calls upon UNAIDS to connect, in the post-2015 agenda, HIV with the eradication of extreme poverty and inequality and the promotion of human rights, including the right to health, dignity and social protection;
56. Encourage the Joint Programme working collaboratively through its Social Protection Working Group and with other partners, to:
 - a. Facilitate country-level dialogues on ending AIDS, extreme poverty and inequality, and conduct HIV and social protection assessments to inform a new approach to mainstreaming HIV in different sectors, in order to meet the specific needs of people living with, most affected by and at risk of HIV;
 - b. Scale up social protection programmes that enhance HIV prevention, treatment, care and support, with particular focus on cash transfer programmes for young women in HIV high-prevalence countries;
 - c. Convene partners to articulate a research agenda that helps lay out the pathways to addressing the social and economic drivers of HIV and connecting the movements to ending AIDS, extreme poverty and inequality;
 - d. Build social protection literacy for people living with HIV, key populations, women's organizations, young people and broader civil society to increase access to social protection services;
 - e. Continue the strengthening and promotion of the Greater Involvement of People Living with HIV (GIPA) principles in social protection action including active participation of people living with HIV and other key affected populations in defining priorities and implementing programmes.

Cost implications for decisions: *none*

BACKGROUND

1. At its 33rd meeting in December 2013, the UNAIDS Programme Coordinating Board (PCB) agreed that the subject for the thematic session of the 34th Board meeting (1-3 July 2014) would be “Addressing social and economic drivers of HIV through social protection”.¹ This theme built on earlier thematic sessions on combination HIV prevention, gender equality, and non-discrimination. The UNAIDS Board underlined that the AIDS response shares many objectives with social protection to end poverty, inequality and to promote inclusive economic growth.
2. The theme of social protection and HIV provided the Board with the opportunity to explore how the Joint Programme and partners can leverage the global movement toward social protection for all, to help fill critical HIV programming gaps, and to promote the greater inclusion and participation of people living with and affected by HIV in the post-2015 development agenda.
3. In March, 2014, at the request of the Programme Coordinating Board Bureau, UNAIDS Secretariat initiated preparations for the thematic session of the 34th meeting of the Programme Coordinating Board thematic session by inviting Member States, Cosponsors, and civil society organizations to participate in the thematic Working Group (WG). Designated members of the WG included representatives from Member States, Cosponsors, PCB NGOs, people living with HIV and members of the UNAIDS Working Group on Social Protection. The Programme Coordinating Board WG met four times from 4 April 2014 through 27 May 2014.²
4. In addition, the UNAIDS Secretariat issued a call for contributions of country best practices in HIV, social protection, care and support. A template was provided, requesting information on the activities, implementers, content, scope, scale funding sources, and evaluation results. The Secretariat received 52 country examples - 28 from Africa; nine from Asia and the Pacific; seven from Eastern Europe and Central Asia, three from Latin America; four from Western Europe and North America, and one that crossed regions.³ These submissions helped the Secretariat and the Working Group enrich the Background Note⁴ and contributed to shaping the agenda and speakers for the thematic session.⁵
5. Throughout this consultative process, members of the Programme Coordinating Board thematic session WG called for a balanced session that updates the PCB on the state of the art in social protection, including its potential to support both immediate HIV outcomes and longer term social transformation, toward more equitable and inclusive societies worldwide.

¹ See *Decisions, Recommendations and Conclusions of the 33rd Meeting of the UNAIDS Programme Coordinating Board*, available at <http://www.unaids.org/en/aboutunaids/unaidsprogramme coordinatingboard/pcbmeetingarchive/name,89934,en.asp>

² See Annex A for the list of Working Group members.

³ For all documents related to the Thematic Segment of the 34th PCB meeting, see <http://www.unaids.org/en/aboutunaids/unaidsprogramme coordinatingboard/upcomingmeetingofunaidspcb/>

⁴ *Ibid*

⁵ *Ibid*

PROGRAMME COORDINATING BOARD THEMATIC SEGMENT INTRODUCTION AND KEYNOTE SPEECHES

6. A full-day was devoted to the session 'Addressing social and economic drivers of HIV through social protection' on 3 July 2014 in Geneva, Switzerland. Three broad messages framed the day's deliberations: social protection initiatives—in particular cash transfers—work for HIV prevention among young women especially in East and Southern Africa; Social protection programmes need to be HIV sensitive to better serve the needs of people living with HIV and those at most risk of HIV; and, investing in organizations and networks of people living with and most affected by HIV to co-organize is central to ensure that no one left behind by social protection programmes. The agenda of the day was divided as follows: Session 1: Social protection and HIV: Do financial incentives work for the HIV response; Session 2: Access in action: lived experience on social protection and HIV and Session 3: Ending AIDS: No one left behind.
7. In his opening remarks, Mr Michel Sidibé, UNAIDS Executive Director recognised the foresight of the Board in dedicating a thematic session to social protection. He said addressing social and economic drivers is critical to meeting the UNAIDS vision of zero new HIV infections, zero discrimination and zero AIDS-related deaths. Mr Sidibé emphasized that in striving to ensure no one is left behind, social protection must be at the centre of the ongoing AIDS response.
8. Mr Sidibé added that research commissioned by the International Labour Organisation (ILO) indicate that among people living with HIV who receive social protection in Rwanda, 95% are able to keep their jobs, 99% of their children remain in school, and 95% continue accessing antiretroviral therapy. He highlighted evidence from Malawi and South Africa on the HIV preventive effects of social protection. He stated that addressing social-economic marginalisation has benefits beyond HIV and will need co-financing from different sectors. The World Bank, ILO and other partners will be critical in onward HIV and social protection strategies. He acknowledged the important role that civil society groups played in securing a UN General Assembly (UNGA) high-level meeting on HIV/AIDS in 2016. He urged Member States, Cosponsors and civil society to prepare to give social protection an important place in the 2016 UNGA high-level meeting, which will be an important milestone in the post-2015 development landscape.
9. In his keynote address, Mr Guy Ryder, Director-General of the ILO, indicated the commitment of his organization to address social economic drivers of HIV as evidenced by ILO passing Recommendation 200 concerning HIV and the world of work in 2010 and Recommendation 202 on Social Protection Floors in 2012. He emphasized the importance of the workplace in addressing HIV, as people living with HIV who are in decent employment are 39% more likely to adhere to antiretroviral therapy. He continued that research conducted by ILO in four countries - Guatemala, Indonesia, Rwanda and Ukraine - indicate that social protection programmes reduce vulnerability to HIV and improve lives of people living with HIV. He alluded to the fact that while HIV responses have focused on HIV prevention and treatment, people living with HIV and affected communities also have broader health, education, employment, nutrition, housing, income and other livelihood needs, and these are interconnected to ensure survival and that people live in dignity.⁶

⁶ See, ILO. 2014. Access to and Effects of Social Protection on Workers living with HIV and their Households: An Analytical Report. http://www.ilo.org/global/publications/books/WCMS_248447/lang-en/index.htm

10. Mr Ryder cited numerous obstacles to a more effective response, including lack of awareness regarding social protection schemes and social protection coverage gaps with only 20% of workers worldwide accessing comprehensive social protection. Other obstacles he identified included eligibility criteria that exclude many people living with HIV particularly those in the informal economy, bureaucratic obstacles, high levels of stigma and discrimination towards key and vulnerable populations, and a common perception among decision-makers that social protection is unaffordable. The ILO Director-General indicated that the more social protection interventions are implemented, the more it is proven that social protection is affordable. He said, “Social protection is an investment, and it pays off. Investing in social protection is good for your population, good for your economy, and it is more costly not to make this investment.” He gave the example of collaboration between the International Monetary Fund (IMF) and ILO in Mozambique which showed that with proper identification of fiscal space and design of appropriate social protection programmes led by the government, social protection is affordable. Speaking for the ILO, he said “We will keep our foot on the accelerator until we reach the end of the road and everyone has access to social protection.”

11. Providing the perspective of a person living with HIV, Ms Morolake Aderinoye Odetoynbo of Nigeria, the other keynote speaker, indicated the need for education, employment and health insurance to be available to everyone regardless of the HIV status or nationality of the person. She emphasized lack of employment opportunities for people living with HIV. She stated that people living with HIV work often as volunteers but are side-lined when opportunities for gainful employment arise due to lack of formal qualifications. She noted that health insurance plans in many countries exclude people living with HIV and that too many people in need of antiretroviral therapy are insufficiently educated regarding its importance. Having moved to the United States of America (USA) to pursue her education, Ms Odetoynbo explained the obstacles she had experienced in accessing essential social services. She advocated for stronger efforts to meet the need of migrants living with HIV, nutritional needs of people living with HIV and against homophobic laws and social stigma attached to HIV. She concluded by asserting that social protection is not charity but social justice and urged policy makers to address poverty and inequality and ensure that no one is left behind in the AIDS response.

SUMMARY OF DISCUSSION AT THE 34th PCB THEMATIC SESSION ON ADDRESSING SOCIAL AND ECONOMIC DRIVERS OF HIV THROUGH SOCIAL PROTECTION

12. After the official opening session, Ms Catherine Sozi, UNAIDS Country Director, China, was introduced as moderator for the thematic day deliberations. Ms Sozi framed the day as a culmination of work by UNAIDS and partners in-countries, regions and the headquarters and through the Programme Coordinating Board thematic working group on ending AIDS, poverty and inequality.

SOCIAL PROTECTION AND HIV: DO FINANCIAL INCENTIVES WORK FOR THE HIV RESPONSE?

13. Mr David Wilson, Director of the World Bank’s Global AIDS Programme, reported that a quarter of the world’s people live on less than US\$ 1.25 per day. He continued that social protection programmes, reach more than 1 billion people worldwide in 146 countries and have grown fastest in Africa from 21 countries in 2009 to 37 countries in 2013, and that the momentum continues. However, two-thirds of people who live on US\$ 1.25 per day are not currently reached by social protection programmes, he said.

14. Mr Wilson continued that the World Bank is the largest funder of social protection. In 2013 its \$12 billion social protection portfolio in 93 countries funded a wide range of cash and non-cash transfers, public works, micro-credit and income generation, food and nutrition, technical assistance and institution-strengthening. He cited 53 impact evaluations over the past two decades that have shown the diverse benefits of cash transfer programmes on health, education and life-long earnings. He continued that modelling indicates that every dollar invested in social protection yields \$3 in economic returns. He said, the evidence for the health, economic and social benefits of well-designed social protection is overwhelming, yet in low and middle income countries, governments spend only about 1.6% of GDP on social protection, “often far less than they spend on fuel subsidies.” He explained that in addition to demonstrating the effectiveness of school feeding and of cash transfer programmes in reducing poverty and promoting non-HIV health outcomes, three randomized controlled trials that used biological endpoints have found that cash transfers reduce HIV transmission. Mr Wilson stated that in Tanzania, people offered up to US\$ 60 each annually to stay free of sexually transmitted infections (STI) had a 25% lower STI prevalence; in Malawi, a combined US\$ 15 monthly cash transfer to young women and the heads of household to ensure young people remained in school reduced by 60% new HIV infections regardless whether the young women remained in school or not; and in Lesotho adults offered a chance to participate in a lottery to win US\$50 or US\$100 every four months conditional on remaining HIV negative had 25% lower HIV incidence which reduced to 33% among young women. Although questions regarding durability of benefits and scalability of cash transfers remain unanswered, Mr Wilson concluded that sufficient evidence exists to expand these programmes. The World Bank is convening a series of meetings to explore how best to move HIV and social protection programming forward.
15. Dr Lucie Cluver, Associate Professor at University of Oxford focused on how government cash transfer and ‘cash and care’ programmes reduce HIV risk and vulnerability. In three studies Dr Cluver and her colleagues conducted in South Africa and published in international journals, the following results were obtained: a teenage girl who is not experiencing physical or emotional abuse and who is not hungry has a 0.9% chance of having transactional sex, compared to a 57% chance for a girl who experiences all of the indicated problems. In this way, the teenage girl also faces a 70% reduction in probability of engaging in age-disparate sexual relationships. Dr Cluver stated that while cash transfers do not prevent young people from engaging in sexual risk behaviours, such as multiple partners, they do ensure that young people make better decisions on the choice of, often younger, sexual partners.
16. Dr Cluver continued that cash transfers alone significantly reduce the odds of sexual risk behaviours by 40% for adolescent girls but not for adolescent boys. However, when cash transfers are combined with psychosocial care and support (‘cash and care’), boys experience a 50% reduction in risk behaviours as well as girls, she explained. Dr Cluver continued that the predictors of risk behaviours—including hunger, child abuse, living in informal settlements, community violence and AIDS affection in the family—lead to psychosocial factors including stress and mental health issues which in turn lead to HIV risk behaviours. She said that for the most structurally and psychosocially deprived adolescents and young people, cash and care produce better outcomes. In addition to their effect on HIV risk behaviours, social protection programmes also increase HIV treatment adherence, with the combination of cash and care resulting in 80% improvement in adolescents’ adherence rates indicated Dr Cluver. She concluded that cash transfers are proven to work for HIV prevention and treatment.

17. Ms Noxolo Leo Myeketsi, of Cape Town, South Africa, provided a personal example of the role of social protection in broader human development including reduction in HIV risk behaviours. Ms Myesketsi described how a child cash grant given to her grandmother helped her meet basic needs including school expenses, transport and food, enabling her to avoid transactional, age-disparate and intergenerational sexual relationships. She concluded that she is now pursuing her studies at University of Cape Town, an option that would not have been feasible without the grant provided to her grandmother. "I believe that without the grant assistance, I would not have been able to make healthy decisions in my life. Maybe I would have ended up being a sugar daddy's girl like others from my area and ended up contracting HIV," she said.
18. In her presentation, Ambassador Deborah Birx, the US Global AIDS Coordinator, focused on savings groups for economic strengthening. She stated that savings groups help women better manage their money, gain access to basic financial services where banks don't exist-or loans are too expensive, and strengthen social safety nets. She continued that these savings build on traditional practices common in almost every country within which the President's Emergency Plan for AIDS Relief (PEPFAR) works (e.g., *stockveldts* in Southern Africa, *tontines* in West Africa). This makes savings groups easy to understand, accept, and operate. Ambassador Birx continued that savings groups are proving to be a low-cost, scalable, and self-sustaining that beneficiaries value and are important for an AIDS-free generation – especially in the presence of other complementary interventions. She gave a snapshot of PEPFAR's investments in savings groups in more than 15 countries that have helped establish more than 13,000 savings groups with more than a quarter million beneficiaries. Members have saved over \$6.5 million. Savings are used for a variety of purposes, but chief among these is investing in the care and wellbeing of about 1 million children in their families, she said.
19. Ambassador Birx highlighted PEPFAR-supported programmes in Rwanda, Ethiopia and Côte D'Ivoire where tangible results were obtained as result of savings. She said in Rwanda 97% of orphans and vulnerable children continue to be enrolled in school even after discontinuing the programme, 88% have health insurance which is paid for by the family and 85% continue indicating high levels of psychosocial wellbeing; In Ethiopia, the World Food Programme (WFP) and PEPFAR supported savings groups among people living with HIV are associated with 97% adherence to ART relative to 84% of a comparison group. In Côte d'Ivoire, savings are associated with a reduction in intimate partner violence. She concluded that PEPFAR is ramping up support around cash transfers for orphans and vulnerable children and is watching with keen interest the discussion on social protection including cash transfers for the AIDS response.

Interventions from the floor

20. The panel's presentations were well received and resulted in extensive discussion among Board members. Different points were raised to support the assertion that social protection interventions work, are affordable and need to be delivered in combination with complementary programmes to reduce inequality, promote human rights, health, reduce poverty and promote food security.
21. It was noted that South Africa has one of the most extensive social protection schemes of any middle income country. Sixteen million South Africans currently receive social grants and the South African government spends 3% of its Gross Domestic Product (GDP) on social protection. Switzerland highlighted the social

protection programme that it supports in Tanzania targeting older people who are often marginalized and not targeted with HIV mitigation services. Through this work, it has been observed that pension schemes have significant impact on improving the dignity of older people and care for orphans and vulnerable people. Tanzania reported on the scale up of cash transfers for extremely poor households with pregnant women, and shared lessons learned on the importance of coordination and of including adolescents in its social protection programme planning processes. Rwanda outlined their comprehensive approach to HIV-sensitive social protection that aims to ensure universal access to education, health, food, shelter and psychosocial support. Concern was expressed that more new resources must be found to maintain the programmes that have contributed to Rwanda's 60% reduction in new HIV infections.

22. WFP noted that potential benefits of HIV sensitive social protection will not be achieved without better coordination between government systems and non-governmental actors, between health systems, food systems and other sectors, and without more in-depth study of how poverty influences all these jointly. The United Nations Children's Fund (UNICEF) also highlighted the need to better integrate systems – in this case, paediatric and adolescent HIV services. UNICEF indicated their work in supporting countries on social protection and building on community systems. Speaking for its Programme Coordinating Board constituency, France affirmed the importance of a multi-disciplinary approach to social protection and HIV. The United Kingdom outlined their research on the economic and social drivers of HIV vulnerability that are affected by social protection, including a GBP 6 million investment in the STRIVE programme—a consortium of six organizations conducting research on the structural drivers of HIV, housed by the London School of Health and Tropical Medicine.
23. Ambassador Birx clarified that the 10% re-authorisation in PEPFAR does not take away resources from social protection programmes for children but in fact signals to partners the need to increase the range of services including access to antiretroviral treatment that should be available to orphans and vulnerable children. The intervention from Morocco stressed that middle-income countries are often missed in social protection and cash transfer programmes because of the perception that these countries are not 'poor'. It was pointed out by the interventions from both Morocco and the Latin America PCB NGO representative that poverty and inequality are realities in every country and those that are most affected by HIV tend to be the poor and marginalized.
24. Ms Noxolo Myeketsi challenged countries to motivate young people to seek HIV prevention and treatment. She stressed the value of peer-to-peer strategies. Dr Cluver recommended that we "follow the evidence", noting that there is now extensive experience on how to tailor and roll out cash plus care programmes in African countries. "Hundreds of adolescents are being infected every day. We don't have time to delay. We just have to do it," she said. Mr Wilson reinforced this call, noting that young people in South Africa represent 25% of global new HIV infections and that social protection, and specifically cash transfers have shown dramatic effectiveness within this critical demographic. He urged the UNAIDS Joint Programme take this strategy into action in collaboration with governments. Dr Birx agreed that cash transfers could be added to treatment for prevention and medical male circumcision as evidence-based strategies for HIV prevention. The test, she said, will be how many countries include social protection in their next round of country proposals for the Global Fund to fight AIDS, Tuberculosis and Malaria (Global Fund) and PEPFAR.

25. In conclusion, Dr Luiz Loures, Deputy Executive Director, UNAIDS, observed that the morning session presented a new vision of the power and practicality of social protection within the context of HIV. He stressed that many low- and middle-income country governments believe social protection is unaffordable; however, the presentations of the sessions from ILO, IMF and World Bank include estimates that national coverage of basic social protection only requires investment of 2-3% of GDP. Africa invests 3% of government resources on social assistance, he stressed. He commended the session for pulling together diverse sources of evidence and research to better understand how social protection strategies affect HIV, and suggested that a coordinated, centralized search for evidence is needed “to fit the challenges of today.”

ACCESS IN ACTION: LIVED EXPERIENCE WITH SOCIAL PROTECTION AND HIV

26. Ms Catherine Sozi introduced the next panel as focusing on how best social protection programmes can be made HIV sensitive to respond to HIV and meet the multiple needs of people living with HIV, key populations and those most vulnerable to HIV. She then gave the floor to the panel speakers.
27. Dr Mehdi Karkouri, of the Association de Lutte contre le SIDA in Morocco spoke first. He described Morocco’s concentrated HIV epidemic, including the impediments to accessing HIV prevention, treatment, care and support experienced by key populations, who also tend to be poor and marginalised. He outlined how difficult it is for people living with HIV to obtain timely appointments for diagnostic tests because of long distances to HIV services, poverty, HIV related stigma and complicated social service system. Dr Karkouri outlined how, with Global Fund financing, his programme recruits social workers to assist people living with HIV. Support provided includes help to navigate multiple health and social service systems to obtain HIV treatment and diagnostic services, provision of transport refunds for clinic appointments, and attention to ensure meeting of basic needs including food, clothing and temporary shelter for those living in very distant places from the health facilities. He concluded that as a result of meeting the health and non-health needs of people living with HIV, the programme is able to retain and even increase HIV treatment adherence.
28. Dr Pornpet Panjapiyakul, of the Thailand Ministry of Health described how Thailand had taken steps to ensure migrant workers’ access to social security and health care. He indicated that Thailand has three million migrants of which 1.8 million are undocumented. He continued that migrants account for 2,700 of the country’s 460,000 people living with HIV. Through a new process that enables migrants to obtain national identification, migrants and their families are now able to access essential health care including HIV prevention, treatment, care and support, Dr Panjapiyakul explained. He continued that the policy stipulates a premium of 356 Bhat (USD11) per year for children and 2800 Bhat (USD 90) per year for adults. He indicated that 140,000 migrants including people living with HIV have so far been covered by the scheme and that the scheme would become self-sustaining when the number of enrollees reaches 200,000.
29. Mr Charles King, Executive Director of Housing Works, a non-governmental organization in New York City described how his organization had worked to overcome the effects of homelessness and substance addiction on the health and well-being of people living with HIV. He described the link between homelessness and HIV. He said evidence links homelessness, housing instability and substandard living conditions for people living with HIV to inadequate HIV health care, high viral load and increased HIV-related deaths. In the recent outbreak of HIV infection

among injection drug users in Greece, Mr King explained, those who were homeless were 2.3 times more likely to become HIV infected than people who inject drugs and are housed. Housing in itself, he continued, is an intervention for people who inject drugs. Among people who live in Housing Works' congregate housing programme, over 65% show viral suppression and about two-thirds either discontinue or reduce their drug use, Mr King explained. He also said the organization's housing programme facilitates access to voluntary harm reduction, mental health services, vocational training and work opportunities. Mr King urged greater financial support for housing and access to broader employment opportunities for homeless people as a key intervention to address the social and economic drivers of HIV.

30. Mr Krishan Ballabh Agarwal, Joint Secretary, Department of AIDS Control, Ministry of Health and Family Welfare, Government of India, explained that social protection is a right for all citizens of India and is provided through a member of national, provincial and local structures and organizations. He described how the national AIDS response has pursued a strategy to make its complex social protection system HIV-sensitive; modified certain mainstream social protection schemes, such as lowering the age of eligibility for pensions for widows; explicitly cited people living with HIV in the list of beneficiaries for schemes where they were not excluded but were sometimes ignored; and instituted HIV-specific services, such as travel reimbursement for antiretroviral treatment services and free HIV testing and treatment nationwide. As a result, he indicated, 35 state and central schemes were amended to include people living with HIV. As of December 2013, more than 600,000 people living with HIV beneficiaries are accessing social protection schemes which include transport refunds and subsidies for those who come to access antiretroviral treatment with compensation for the wages missed as result of clinic appointments, employment guarantees, widow pension schemes, subsidized housing, medical insurance and others. He continued that social security cards have been developed and are used to access social protection programmes. These services, he said, are sustainable because they are funded from domestic budgets that are protected by statutory policies. He said that people living with HIV received over US\$15 million worth of benefits from ongoing social protection programmes which are non-HIV resources. He concluded that to meet the broader needs of the AIDS response, social protection needs to be HIV-sensitive as well as HIV-specific.
31. Ms Maureen Owino, of the Committee for Accessible AIDS Treatment (CAAT) in Toronto, Canada, described the challenges that migrants experience in accessing HIV treatment, prevention, care and support services. She said fear of deportation is the most prominent barrier to accessing HIV services for migrants. Difficulties in understanding the migration process, lack of culturally appropriate counselling and multiple dimensions of vulnerability are others, Ms Owino said. The increasing number of migrants being charged with criminal transmission of HIV in Canada was another deterrent to accessing HIV services for migrants, explained Ms Owino. CAAT was created in 1999 and is managed by people living with HIV, including migrants.

Interventions from the floor

32. A number of interventions from the floor expressed welcome and appreciation for UNAIDS' efforts in placing social protection at the centre of the AIDS debate. Iran appreciated the examples from Morocco, and shared their experience of HIV-positive clubs, which provide economic and social support to over 5,000 people living with HIV and family members, funded by private sector and foundation resources in Iran. Speakers urged for efforts to provide psychosocial support and support groups to people living with HIV, to ensure that no one is left behind in the coverage of social protection. It was pointed out that UNAIDS should lead efforts to experiment and

innovate around increasing the resilience of most affected individuals and communities including homeless people, include social protection in the post-2015 agenda and make a persuasive economic case for investing in HIV and social protection to finance ministers and other policymakers. Speakers also appealed to the Programme Coordinating Board to advocate for “programme[s] that you would like to see for your sister or brother... one that would be a real expression of solidarity.” Only then, it was emphasized, would social protection be HIV sensitive and effectively meet the HIV and non-HIV needs of people living with HIV, key populations and those most vulnerable.

ENDING AIDS: NO ONE LEFT BEHIND

33. The last session focused on the experiences of key populations and the need for social transformation. Panel speakers were purposely situated in the inner circle of the room as practical demonstration of the GIPA (Greater Involvement of People Living with HIV) principle and the need to have those most affected at the centre of the AIDS response. The session considered how investment to empower organisations of key populations and people most affected by HIV is critical, within government efforts to ensure that no one is left behind.
34. Mr Andrés Scagliola, of the Uruguay Ministry of Social Development, reported on his country’s efforts to address the needs of transgender people. He said transgender people in Uruguay are poor, have a life expectancy of about 40-45 years compared to over 79 years for the general population. He said that HIV prevalence among transgender people in Uruguay is estimated at 29% compared to 0.7% in the general population. He continued that transgender people in Uruguay have difficulties to access and adhere to the HIV treatment because HIV services are provided centrally, far from places where transgender people live. Transgender people use hormone therapy and silicone injections to change their bodies without medical supervision, which can interact negatively with HIV treatment, he added.
35. Mr Scagliola explained that Uruguay’s social card has been an entry point into broader social security for low-income families. The social security card includes unconditional monthly transfers of US\$33 per month to poor households. In 2012 transgender people were included within the scheme. By 2014 at least 1088 transgender people have obtained the card. Mr Scagliola continued that the card has opened up access for transgender people to a range of social services including unconditional cash transfers, health, education and employment. He affirmed the right and dignity for all including transgender people and called for support from UNAIDS to evaluate the impact of the project on reducing the HIV vulnerability of transgender people.
36. Ms Penninah Mwangi, Director of the Bar Hostess Empowerment and Support Programme (BESP) in Nairobi, Kenya described herself as a sex worker and founder member of BESP, an organization formed in 1999 and managed by sex workers and bar hostesses. She said BESP emerged to respond to high level of sexual and physical violence experienced by sex workers at the hands of their clients and law enforcement staff, and the large number of sex workers who were dying from AIDS-related illness. Her organization trained sex workers on HIV prevention, treatment, care and support and human rights. Since its inception, the organization has helped form more than 30 sex worker networks and train 600 sex workers as paralegals and peer educators. Through the organization, more than 1,000 sex workers and 400 men who have sex with men were provided with services that included access to condoms, Post Exposure Prophylaxis (PEP), Pre Exposure Prophylaxis (PrEP), antiretroviral treatment and diagnosis and STI treatment.

37. Ms Mwangi explained that BESP has enabled bail for 400 sex workers in police custody, taken to court 70 cases of sex workers who had been detained by police on numerous charges and successfully won 10 of the cases. She stressed a lack of access to loan and microcredit facilities for sex workers, even when sex workers can earn sufficient resources to pay back the loans. She emphasized that sex workers have the right to the custody of their children and the right to remain in sex work. Ms Mwangi concluded by advocating for financial support for sex worker organizations to co-organize and deliver HIV services and eliminate violence and harassment experienced by sex workers.
38. Mr Derrick Malumo, of Zambia, former prisoner, released in 2013 explained that with support from the United Nations Office on Drugs and Crime (UNODC), UNAIDS and others, the Government of Zambia provides services for prisoners ex-prisoners living with HIV. He indicated that ensuring continuity of access to social services including HIV treatment, employment and housing for prisoners who are released into the community remains a challenge. People released from prisons experience homelessness and lack of economic opportunities. In 2008, the President of Zambia pardoned 2,000 prisoners. By 2014, over 800 were back in prisons for new crimes because they could not easily re-integrate in society. He called for increased access to social services for prisoners including housing, health and social-economic integration for over 18,000 prisoners who are currently serving in prisons in Zambia.
39. Ms Maksym Demchenko, of Ukraine, called attention to the needs of people who inject drugs. She said the Ukrainian Network of People living with AIDS has managed to secure various government benefits. However, a sustainable response requires attention to the social drivers and root causes of HIV risk and vulnerability, she continued. Law enforcement officers, in particular, need to be sensitized to decrease harassment of people who use drugs, said Ms Demchenko. She called for strengthened harm reduction programmes and an integrated approach that links HIV prevention and treatment. She noted that recent political unrest in Ukraine had exacerbated the HIV challenges faced by people who inject drugs by interrupting access to services and increasing reports of violence against people who inject drugs, especially by law enforcement staff. Ms Demchenko advocated for treatment rather than punishment of people who inject drugs. She also highlighted the need to address hepatitis C among people who inject drugs.
40. Board participants welcomed the presentations and UNAIDS' engagement in social protection. The Hon. Fredrick Chilukutu, Deputy Commissioner for Prison from Zambia's Ministry of Home Affairs warmly commended the UNAIDS country office in Zambia for pioneering support for extending HIV workplace policies to prisons. He noted that today, prisoners are recognized as a key population most at risk of HIV, which has opened the way for development of more comprehensive HIV health services in prisons, including integrated HIV, TB and Hepatitis C, and post-release services. Brazil applauded Uruguay's Trans card program, and reported on Brazil's national plan for Lesbian, Gay, Bisexual and Transgender (LGBT) citizenship and rights, including a new policy that allows people to use their 'social names' on health cards, so that health care workers refer to them correctly. Another intervention stressed the importance of government recognition of social names.
41. The Asia and Pacific PCB NGOs also expressed appreciation for the progress in Uruguay and Brazil which recognizes and provides services for transgender people separate from those for men who have sex with men, but called for more leadership by transgender people. PCB NGOs North America also applauded the attentions to

the experiences of key populations at the Programme Coordinating Board, and called for more attention to the needs of indigenous peoples.

42. The role gender inequality plays in limiting progress with regards to the prevention of paediatric AIDS and access to HIV treatment for women including adolescents was highlighted. Pregnancy was highlighted as a period of heightened violence for women from intimate partners, requiring increased efforts to change gender norms to reduce vulnerability of women and girls to HIV. An intervention from UNODC lauded Zambia's high level commitment to address HIV in prisons and closed settings. UNODC further highlighted a number of countries that have invested in addressing HIV in prisons from Africa, Latin America and Europe including Ukraine.
43. The moderator, Ms Sozi, closed the discussion, noting that while social protection is the responsibility of governments, there are important roles for civil society and the private sector, and that greater investment in community efforts is needed.

CLOSING AND CONCLUSIONS OF THE 34th PROGRAMME COORDINATING BOARD THEMATIC SEGMENT

44. In the concluding remarks, Ms Mariangela Simão, Director, Rights Gender, Prevention and Community Mobilization at the UNAIDS Secretariat noted key themes from the thematic session: First, evidence that social protection programmes—in particular cash transfer—work, not only to reduce vulnerability and the impact of HIV but also to support treatment adherence and to reduce HIV risk, especially for women and girls, and that such programmes work better when provided with social support ('cash plus care'). Second, governments have a major role to play in social protection, and in making large institutions and social welfare systems HIV sensitive. Nevertheless the responsibilities of government should not exclude engagement of civil society organizations. Without community engagement, she said, we cannot end poverty, inequality or AIDS. Third, HIV-sensitive social protection is a good investment. It is good for families, and for the economy. Fourth, contrary to some assumptions, HIV-sensitive social protection is affordable in low and middle income countries as well as in high-income countries. Last but not least, HIV-sensitive social protection is about social justice, and the UN offers a good platform for pushing forward the joint agenda of social protection and social justice. Ms Simão closed by reminding the Programme Coordinating Board participants that even in countries that have a long way to go, "trend is not destiny. It does not matter where you are from; you make your own destiny."

KEY OPPORTUNITIES AND CHALLENGES

45. From the preparations of the thematic session, throughout the thematic day, a number of themes emerged from the speeches, panel presentations and interventions from Board Members and observers present.
46. Every country has some system of social protection which is often large and institutionalised and of national coverage. And every country has some form of an HIV epidemic. Joining together the end of AIDS, extreme poverty and inequality presents unprecedented opportunities for a re-invigorated AIDS response. Social protection can contribute to significant prevention of new HIV infections, enables effective HIV treatment scale up and helps protect the rights and dignity of everyone. Generating and sustaining political commitment towards ending AIDS, extreme poverty and inequality will be critical for a successful movement.

47. Social protection interventions, in particular cash transfer schemes, work for HIV prevention especially among young women. In the right circumstances, cash transfer strategies can yield 25 – 65 percent reductions in HIV risk behaviors and risk, as shown in East and Southern Africa. Cash transfer programmes work better when complemented by social support and 'care'. Rapidly scaling up these programmes is a tremendous opportunity that should be maximized. Scaling up these programmes for the AIDS response will require careful planning, collaboration and investment.
48. A research agenda that lays out the pathways to social inclusion, social protection and equitable economic growth in different geographic, political settings and HIV epidemic contexts is needed and will be an important step towards joint action on ending AIDS, extreme poverty and inequality. Social protection assessments that provide simple context specific evidence and analysis on the nexus of HIV, inequality and extreme poverty will be critical for a new approach in mainstreaming the AIDS response.
49. Just as the AIDS community in every country should become better informed about existing systems of social protection, the planners and implementers of social protection mechanisms need to be trained, motivated and held accountable for including key populations, people living with and those most at risk of HIV in their social protection programmes. Effective leadership, coordination, harmonization and accountability for results of the different social protection and HIV actors will be especially important.
50. With relatively small investments of HIV funds, large, national social protection policies and programmes can be made HIV sensitive—that is, responsive to the specific needs of people living with and at risk of HIV. It will be important to resolve questions on proportions of HIV budgets to be used for catalytic action on social protection, proportions of social protection budgets to be used for specific HIV programmes where they are required, and what kind of cross-sector co-financing arrangements should exist.
51. Governments are primarily responsible to ensure that no one is left behind in their social protection programmes. In a number of countries, government social protection services do not reach potential recipients, or if they reach, potential recipients can be sceptical about their intentions. This issue is especially acute for marginalized groups including prisoners and ex-prisoners, migrants, sex workers, people who use drugs, men who have sex with men, and transgender people. How governments ensure that these populations are reached is of critical importance.
52. Governments and development partners should invest in organizations and institutions of and led by people living with HIV, key populations and people most affected by HIV for strengthened partnerships to reach those in most need of HIV services and social protection. Governments should work with and invest in civil society networks to build mutually respectful relations to ensure that no one is left behind.
53. The planned UNGA high-level meeting on HIV/AIDS in 2016 offers a timely opportunity to report progress on the expansion of HIV-sensitive social protection in high-middle-and low-income countries around the world.

RECOMMENDATIONS

Based on the discussions from the thematic segment of the 34th Programme Coordinating Board meeting, the Board is invited to:

54. Take note with appreciation of the summary report of the Programme Coordinating Board thematic session on addressing the social and economic drivers of HIV through social protection.
55. Recognize the need to strengthen action to address the social and economic drivers of HIV in order to realize the goal of ending AIDS, and calls upon UNAIDS to connect, in the post-2015 agenda, HIV with the eradication of extreme poverty and inequality and the promotion of human rights, including the right to health, dignity and social protection.
56. Encourage the Joint Programme working collaboratively through its Social Protection Working Group and with other partners, to:
 - a. Facilitate country-level dialogues on ending AIDS, extreme poverty and inequality, and conduct HIV and social protection assessments to inform a new approach to mainstreaming HIV in different sectors, in order to meet the specific needs of people living with, most affected by and at risk of HIV;
 - b. Scale up social protection programmes that enhance HIV prevention, treatment, care and support, with particular focus on cash transfer programmes for young women in HIV high-prevalence countries;
 - c. Convene partners to articulate a research agenda that helps lay out the pathways to addressing the social and economic drivers of HIV and connecting the movements to ending AIDS, extreme poverty and inequality;
 - d. Build social protection literacy for people living with HIV, key populations, women's organizations, young people and broader civil society to increase access to social protection services;
 - e. Continue the strengthening and promotion of the Greater Involvement of People Living with HIV (GIPA) principles in social protection action including active participation of people living with HIV and other key affected populations in defining priorities and implementing programmes.

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