

HIV - Sensitive Social Protection

What does the evidence say?

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What does the evidence say?

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Executive summary

What is social protection and why is it important for HIV outcomes?

Over the past decade, there has been growing recognition of the importance of social protection to respond to a range of challenges faced by developing countries, including food insecurity, chronic poverty and the HIV pandemic.

HIV and AIDS can push people and households into poverty, in part by reducing household labour capacity and increasing medical expenses. In some cases, HIV-related stigma and discrimination marginalizes people living with HIV and households affected by the virus, and excludes them from essential services. Despite increased access to life-saving treatment, HIV and AIDS can increase individual and household vulnerabilities, hampering governments' efforts to meet the Millennium Development Goals.

In the face of rising HIV prevalence rates and the aftershocks of the recent economic crisis, few developing countries outside Latin America have national social protection systems or large-scale coverage. Social protection systems are especially limited in sub-Saharan Africa, with the notable exception of a few Southern African countries.

While many social protection schemes were not set up with HIV as a primary focus, their potential to contribute to a comprehensive HIV response is increasingly recognized. The UNAIDS business case on social protection,² which was a catalyst for the development of this paper, shows how HIV-sensitive social protection can reduce vulnerability to HIV infection, improve and extend the lives of people living with HIV, and support individuals and households. Under the Outcome Framework 2009–2011, (UNAIDS, 2009a) will focus its efforts on achieving results in nine priority areas; among these is the commitment to “enhance social protection for people affected by HIV”. Achieving social protection for people and households affected by HIV is a critical step towards the realization of Universal Access to prevention, treatment, care and support. The business case explains why this step is critical, what needs to be done to achieve it, and the role of UNAIDS in this endeavour.

Social protection measures are HIV-sensitive when they include people who are either at risk of HIV infection or susceptible to the consequences of HIV and AIDS. HIV-sensitive social protection can be grouped into three broad categories of interventions:

- ▶ *financial protection* through predictable transfers of cash, food, or other transfers for those affected by HIV and those who are most vulnerable;
- ▶ *access to affordable quality services*, including treatment, health and education services;
- ▶ *policies, legislation and regulation* to meet the needs and uphold the rights of the most vulnerable and excluded.

Ideally, a social protection strategy is comprehensive, with national coverage, and built on a sound understanding of the range of risks and vulnerabilities facing different population subgroups, particularly the poor and marginalized, at different stages of their lives. Understanding risk and vulnerabilities from an HIV perspective means understanding the epidemic stage; recognizing the drivers of the epidemic and different groups' exposure to

² UNAIDS outcome framework business case: enhancing social protection, 2010.

infection risk; and recognizing the importance of access to treatment and care. Based on this, a range of initiatives that are HIV-*sensitive* (as opposed to HIV-*exclusive*—which can be stigmatizing and inequitable) can be integrated into broader national social protection strategies.

What can social protection contribute to Universal Access?

While there is growing interest in HIV-sensitive social protection, it is important that policies and programming are backed by robust evidence. There is a wealth of evidence for some social protection instruments, such as cash transfers, which mitigate the impact of AIDS on vulnerable households and children. The evidence for the HIV-related impacts of other instruments is more limited.

An emerging evidence base shows the contribution of social protection to HIV prevention and treatment uptake and adherence. Studies are also showing the impact of social protection on related outcomes, such as access to primary health care and women's empowerment, from which it is possible to infer likely impacts on HIV. However, more operational research is required.

Social protection plays a critical role in helping people overcome the structural inequalities that drive the HIV epidemic and that serve as barriers to treatment, testing, schooling and other essential services. Social protection is particularly relevant to HIV because of its potential to address issues, such as gender inequality, stigma and discrimination, which exacerbate marginalization and vulnerability faced by key populations at higher risk of infection. The evidence also suggests that social protection may interrupt the cycle from being affected by AIDS to becoming vulnerable to HIV.

Social protection and HIV prevention

Social protection instruments such as social transfers, microcredit, social health protection and transformative laws, policies and regulation have the potential to prevent HIV directly or indirectly. Many studies show the effectiveness of cash and food transfers in increasing school enrolment and attendance, revealing their potential to expand access to the “social vaccine” of education against HIV infection. This is particularly important for adolescent girls and children orphaned by AIDS, who often have a greater risk of unsafe sex than their non-orphaned peers.

In a similar vein, programmes with demonstrated impacts on health service access, such as maternity care vouchers and the removal of user fees, have the potential to increase treatment of sexually transmitted infections, increase uptake of voluntary counselling and testing, and increase access to prevention of mother-to-child transmission services.

Social protection instruments targeted at girls and women have the potential to level the economic playing field, reduce gender inequality, and empower women to better negotiate their sexual relations and reduce their risk of HIV infection. Presently, few empirical studies have explored these causal pathways. The relevant instruments include cash transfers and microcredit programmes that provide small loans and often financial training. Empowering sex workers through access to economic assets, social mobilization and legislation can reduce HIV risk in this key population.

Social protection and treatment

There is evidence of the positive impact of social transfers for nutritional recovery of patients receiving HIV and tuberculosis treatment. People who start treatment in low-income countries often do so at very low CD4 counts, when pre-existing under-nutrition has often been compounded by wasting caused by HIV.

Food transfers can reduce under-nutrition in people living with HIV, although access to the right food (e.g. micronutrient rich, with a high energy density) is critical. While it is unclear how much food contributes to nutritional improvements versus the medication, under-nutrition is a predictor for mortality.

Cash transfer programmes in Uganda, and voluntary counselling and testing in Malawi have been successful in improving testing and treatment uptake and treatment outcomes. Availability of food can help people to better tolerate antiretroviral therapies, making food availability an important factor in adherence to treatment.

The range of social health protection measures that expand health-care access (e.g. social health insurance, vouchers, exemptions, fee abolition) are also relevant to treatment. Social health insurance covers some health-care expenses for participants, but largely fails to reduce financial barriers for those who need it the most: the ultra-poor.

Research on voucher and fee-exemption schemes show their potential for antiretroviral and other HIV-related health services. Voucher schemes are more effective when they cover transport costs along with medical expenses, and when providers are reimbursed for appointments covered with vouchers. Exemption schemes have a mixed record, particularly when they eliminate fees for the ultra-poor. Many experts (including those at the World Health Organization) advocate for free antiretroviral therapies as the only way to significantly increase access, noting the success in a number of countries piloting free HIV services.

While ensuring access to free and decentralized HIV services remove important barriers to access, other economic and social barriers, such as food and transport expenses and stigma may persist.

Social protection, care and support

The role of social protection for care and support—particularly to lessen the impact of AIDS—is better documented than for the other HIV outcomes considered in this paper. The main targets for impact mitigation are the ultra-poor and other vulnerable groups, such as members of labour-constrained households and children affected by AIDS. In addition, social protection can help to transform the prospects for those less poor, including AIDS-affected households with labour potential.

Many of the documented benefits of social transfer programmes address the vulnerabilities that AIDS exacerbates: reduced education and health-care access, household food insecurity, poverty and reliance on child labour. Combining transfer schemes with social work and child protective services can reduce exclusion errors and expand coverage to those commonly excluded.

Home-based care for people living with HIV and their caregivers can also play a role. Comprehensive home-based care can:

- ▶ provide health care for those marginalized due to poverty, HIV, or other stigmatized status;

- ▶ promote treatment adherence;
- ▶ provide food and economic support to members of affected households; and
- ▶ link clients and caregivers with legal support and livelihood opportunities.

Social protection to mitigate the impact of HIV and AIDS not only prevents deprivation, but it can also contribute to an enabling environment and transform individual prospects. An enabling environment is a supportive environment for people living with HIV and AIDS. Legislative, regulation and policy changes to reduce stigma and protect the rights of people living with HIV, widows and affected children are important components of care and support.

Livelihoods promotion, such as public works, income-generating activities and microcredit, can also play a role. Although specific HIV-related impacts are rarely measured, these schemes can increase households' ability to withstand shocks and reduce poverty. However, households grappling with the uncertainty and medical expenses related to HIV and AIDS may not always be appropriate targets for certain types of livelihood programmes in light of the risks associated with starting small businesses. Nevertheless, expanding antiretroviral therapy programmes may increase the relevance of livelihood approaches for people living with HIV and their households.

A key question for care and support is to determine whether ongoing social protection programmes reach AIDS-affected households. Anecdotal evidence on this varies, and further systematic research is needed.

Key populations at higher risk of HIV infection

As social protection is about reducing risk and vulnerability, it is important to address both the economic and social determinants. HIV-sensitive social protection is highly relevant to key populations, including sex workers, people who use drugs, men who have sex with men, and their families. Reducing the barriers they face in access to health, education and social services is a particular challenge. Yet, evidence on *how* to reduce discrimination, exclusion and poverty among key populations is extremely limited, particularly in sub-Saharan Africa.

Social protection can enable sex workers access to essential HIV-prevention and treatment services and legal protection, along with efforts to decriminalize sex work. Involving sex workers in the design, management and implementation of HIV-prevention activities heightens their effectiveness by empowering workers.

Evidence points to the importance of linking specific harm-reduction activities (like building demand for condom use in sex work) with social support, protection and services. Tackling gender and human rights issues, improving access to legal and economic services, building sex workers' social capital, and adding training and life skills education can increase the impact of public health approaches.

For men who have sex with men, socially protective legislation can contribute to HIV prevention, care and support by decriminalizing homosexuality. In India, advocates recently won a 10-year struggle to overturn the criminalization of homosexuality. While it is too early to see an impact, this legal change is likely to help more people in this group to access health and HIV services, which they may have previously avoided due to fear of prosecution. This can improve the treatment of sexually transmitted infections, promote condom use, increase uptake of voluntary counselling and testing, and other essential services for a key population.

Conclusion

The results of this review were shared with representatives of academic, donor, United Nations, nongovernment organizations and key population groups. This consultation led to agreement on the most relevant components of social protection in the context of HIV based on the main lessons from the evidence, as well as where more evidence is urgently needed. These gaps in the evidence are discussed in the final section of this paper.

Participants agreed that it is neither desirable nor feasible to set up parallel HIV-exclusive social protection programmes. However, there is potential for ensuring that planners adapt the scale up of national social protection programmes to HIV-related vulnerabilities in particular countries, and for a continuing dialogue between partners working on HIV and social protection. Ensuring that national social protection strategies are inclusive of those affected by, highly vulnerable to, and living with HIV is an essential component of a comprehensive HIV response.

Introduction

Why is HIV-sensitive social protection important?

During a family meeting in Pune (part of the International HIV/AIDS Alliance—India's CHAHA project), a woman discussed her recent experience with social welfare support. She has two children and is living with HIV, as is one of her children. She was recently widowed; her husband's family threw her out of the family home and seized the family ration card. Outreach workers helped the family access emergency shelter, HIV testing and treatment for the children, and other cash and food support. They also helped her access her national social welfare entitlements, in particular the widow's pension. However, when visiting the office to pick up her payment, the officer removed half as his "payment" for supporting her application. He also announced her HIV status to a waiting room full of people. Visibly distressed, she expressed how difficult it would be for her to attend this office and access her benefits again.

K. Iorpenda, International HIV/AIDS Alliance, personal communication, 2010

Social protection increases the resilience of households to shock and reduces barriers to essential services. When done well, it is based on a comprehensive assessment of risks and vulnerabilities, including those related to HIV and AIDS. A social protection strategy and its constituent programmes are designed to reduce, mitigate and help people cope with identified risks and vulnerabilities. Therefore, it has the potential to reduce the economic and social determinants of vulnerability to HIV and its consequences, as the many examples set out in this document show.

However, as illustrated by the Pune example, it cannot be assumed that social protection programmes are designed with HIV in mind; therefore, existing programmes may not adequately address the needs of people living with and affected by HIV. This paper looks at social protection as an opportunity to respond to the needs of vulnerable people living with and affected by HIV, as much as to other vulnerable populations. When a new programme is designed, HIV should be taken into account as one source of vulnerability, and existing programmes should be operationalized in an HIV-sensitive manner.

This paper summarizes the evidence on the appropriateness of different social protection instruments for promoting Universal Access to HIV prevention, treatment, care and support. This paper describes targeting considerations relevant to people and households affected by HIV,³ and proposes what can be achieved by linking social protection and HIV through further research.

The genesis of this paper was the recognition that the interaction between HIV and social protection was gaining increasing attention in the light of the UNAIDS business case on social protection (UNAIDS, 2010) among other things. However, there is a need to interrogate the evidence on the complex relationships between social protection and Universal Access outcomes, to understand what works in what contexts and the key evidence gaps.

Framing the paper

Social protection is about reducing poverty and marginalization. Although people do not need to be poor to be vulnerable to HIV infection, HIV and AIDS can push people into

3 For the purpose of this paper, the term "people and households affected by HIV" includes people infected with HIV and those susceptible to HIV infection.

poverty and marginalize those affected by or associated with the virus. The impact of HIV is felt most strongly at the individual and household levels. It hampers governments' efforts to reach Millennium Development Goals on poverty reduction, maternal and child health, as well as other areas.

Social protection is increasingly recognized as a key area for an integrated and comprehensive response to HIV and broader Millennium Development Goals. This raises two questions: what is social protection and how can social protection best strengthen HIV prevention, treatment, care and support?

Defining social protection

Although there are many definitions in circulation, the objective of "social protection" is broadly to reduce the economic and social vulnerability of all people, and to enhance the social status and rights of poor and marginalized people by providing social transfers, and ensuring access to basic essential services and equitable regulation, which can take many forms (Box 1). Social transfers are resources, either cash or in kind, which are transferred to vulnerable individuals or households. These transfers can be unconditional (e.g. social pensions or cash benefits) or conditional (e.g. given in exchange for work on public works programmes or attendance at school).

As this paper is concerned with social protection in low-income countries, it will focus largely on how social protection can improve the living conditions of people who are vulnerable and excluded in those countries. It will not spend any significant amount of time on the social protection needs of the employed middle and upper classes, which are often at least partially satisfied through public and private means.

Box 1 - Selected definitions of social protection

Social protection ...

"... is a collection of measures to improve or protect human capital, ranging from labour market interventions, publicly mandated unemployment or old-age insurance to targeted income support. Social protection interventions assist individuals, households and communities to better manage the income risks that leave people vulnerable" (Holzmann & Jorgensen, 1999)

"... is a set of transfers and services that help individuals and households confront risk and adversity (including emergencies) and ensure a minimum standard of dignity and well-being throughout the lifecycle" (UNICEF, 2008a)

"... describes all initiatives that provide income (cash) and/or consumption (food) transfers to the poor, protect the vulnerable against livelihood risks, and enhance the social status and rights of the excluded and marginalised people" (Devereux & Sabates-Wheeler, 2004)

Older debates on "social welfare" have focused mainly on "social assistance" to protect the poorest and most vulnerable from the welfare impacts of shocks and crises. Sometimes these efforts have tried to prevent crippling expenditures, such as those for health care or funerals, through "social insurance" and/or pooling of resources (i.e. usually to prevent the economic impacts of such events or needs, rather than to actually prevent them).

Although it is also about predictable and equitable social transfers to poor and marginalized people, "social protection" takes on a broader perspective and spectrum of programmes, services and policies to also include (or link to) promotive and transformative measures (Devereux & Sabates-Wheeler, 2004). In linking this to specific crises for human well-being such as HIV, which requires addressing complex needs of vulnerable and

marginalized people, a transformative social protection framework should describe types of strategies by their aims:

- ▶ Financial protection through assistance with targeted predictable “social transfers” (such as food or cash) to protect some minimum level of consumption for the very poor—referred to as “protective measures” or “social assistance”.
- ▶ Ensuring access to services, through spreading costs and reducing economic risks to the vulnerable through “social insurance, pooling of resources or public financing” (including for health care, education, contributory pensions, unemployment benefits, etc.). This can prevent major expenditures leading to deepening poverty and ensure access to public services. These are sometimes referred to as “preventive measures” (in an economic sense) or “social insurance”. Expanding social care, through home-based carers and social workers, is also included here as a way of linking those in need to available services.
- ▶ Strategies for transforming “structural”, regulatory or legal obstacles to empower marginalized people to participate more fully in development. Examples include addressing systemic discrimination—referred to as “transformative measures”, or “social justice”.

A fourth category, which can be related to social protection when targeted to the poor and effectively involves transfers (such as through subsidizing set up costs), is:

- ▶ More financially “promotive” strategies to “credit” or “training for income generation” for poor and marginalized people to promote productive livelihoods—referred to as “promotive measures”, linked to broader socioeconomic development.

There is still no consensus on the types of interventions covered by the concept of social protection, including in the context of HIV and AIDS. However, interventions appropriate to reduce vulnerability to HIV infection, to improve and extend the lives of people living with HIV, and to support those affected to mitigate the impacts of HIV include: transfers (such as cash or food); financial measures to ensure those poor and marginalized have access to essential services of treatment, health and education; and non-discriminatory access to financial services and resources (savings, insurance and credit). Strategies need to be tailored to specific contexts, groups and stages of the epidemic.

The first decade of social protection in developing countries has been dominated by (1) social assistance (protective social welfare-style transfers); the relative neglect of (2) social insurance (installing, predictable safety nets to ensure access and address vulnerability to major financial contingencies); and the almost total neglect of (3) social justice (interventions to address the socio-political conditions that contribute to marginalisation and structural vulnerabilities). Furthermore, the extent to which (4) livelihoods promotion programmes in social development (such as micro-finance or income-generating activities) qualify as social protection remains contested, on the basis that they are often short term and organized as projects. Most agree that social protection mechanisms should establish a floor below which people cannot fall, so they can participate in development programmes designed to put them on a pathway out of poverty. To the extent that these social protection mechanisms may be targeted to particularly vulnerable groups and effectively involve transfers (at least in the sense of set up costs), we include them in this paper as an extension of financial protection.

Linking social protection to HIV

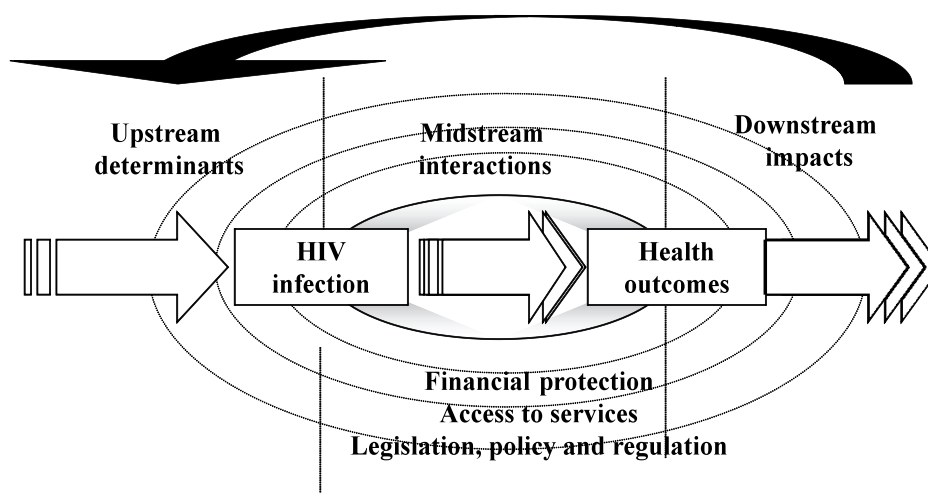
What potential benefits does social protection provide to prevent people from getting infected with HIV or to mitigate its impact? This discussion is bound to be fraught with a number of linguistic and conceptual challenges related to commonly used terms such as “preventive” and “vulnerability” in different fields. For example, in the livelihood and social protection discourse, the word “preventive” is typically used to refer to preventing economic shocks or deterioration in social protection, as opposed to HIV infection.

Terms related to different population groups in the HIV discourse have complex histories of evolution, and categories such as “care and support” have also shifted meanings—from concern with palliative and home-based care in the absence of antiretroviral therapies, to encompassing the earlier termed “impact mitigation”. Impact mitigation is now subsumed within care and support.(UNAIDS, 2010)

Similarly, “vulnerability” is a key word in the lexicon of HIV for those working in health, development, gender and child protection. It is often used in different—and partial—senses by those working in different sectors. From a health perspective, vulnerability is often seen as most relevant to the prevention of infection and treatment, while the social protection community has focused mainly on vulnerability as it relates to the potential social and economic impacts of HIV and AIDS. This may be a crude over-simplification, but it highlights a basic reason for difficulties in finding common languages across health and development.(Bloom et al., 2007; Edström, 2007)

Most definitions and theoretical constructions of vulnerability have tended to rely on passive and linear notions. A few writers have proposed the term “susceptibility” to refer to vulnerability in the sense of exposure, but this unhelpfully confounds the common sense of susceptibility as an embodied quality of individuals (lacking relative resistance) rather than a contextual relational state. A useful common sense definition is that “vulnerability here refers to exposure to contingencies and stress, and difficulty in coping with them”.(Chambers, 1989) As vulnerability is context-relative in terms of the chances of exposure, as well as consequences, and as contexts of disadvantage involve several dimensions relevant to social protection strategies, HIV responses and social protection strategies can be interrelated along the pathway of HIV, as in Figure 1.

Figure 1 Social protection approaches and AIDS responses along the pathway of HIV



Edstrom , 2010

For the purposes of this discussion, it is useful to link the two fields (HIV and social protection) by interrelating the three categories of the HIV response with the different types of social protection responses, grouped under pre-existing headings of the UNAIDS business case on social protection, with attention to the aims and the beneficiaries of each type. Table 1 maps this out with indicative examples.

Table 1 Linking social protection with Universal Access outcomes—indicative instruments and populations

	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
Financial protection Social assistance protection for very poor Livelihoods support for the poor and vulnerable	Transfers for the very poor to support HIV prevention Income generation or microcredit to reduce risk of exposure to HIV for poor key population groups	Transfers to poor PLHA for better HIV treatment access and adherence Economic empowerment for PLHA to prolong and improve life	Transfers to mitigate the impact of AIDS on individuals and households Income-generating activities, livelihood strengthening, microfinance for affected
Access to affordable quality services Social health protection for vulnerable	Social insurance to prevent risk of exposure to HIV (social security, public finance of reproductive health, maternal health and HIV prevention services, etc.)	Social health protection to ensure access to health care and to prevent erosion of savings	Preventive insurance measures appropriate for those affected (pension schemes, funeral clubs, etc.)
Laws, policy, regulation Social justice for the marginalized	Legal reform, policy process and protection regulation to reduce risk of exposure to HIV (decriminalization)	Protection of rights to health, treatment and work to improve life for people living with HIV and AIDS (antidiscrimination)	Legal protection for affected (property rights of widows and orphans, birth registration, etc.)

MH, maternal health; PLHA, people living with HIV; RA, reproductive health.

Methods

The literature that informs this paper comes from a range of fields. The review covers research on social protection and health, education, poverty, nutrition and child protection outcomes, and on HIV and AIDS, where available. Most of the literature and examples included in this review come from sub-Saharan Africa because this region has a high HIV burden and a low response capacity—meaning that the benefits of learning are maximized. Despite this, the results of the literature review are global and can be applied to other settings. Data are also drawn from a variety of epidemic settings (including areas experiencing concentrated epidemics, where this information is available).

Two types of evidence are required to understand and implement HIV-sensitive social protection: evidence of the impact of different interventions and evidence of programme

implementation. This paper seeks to summarize the former: the impact of the interventions that are most relevant to Universal Access outcomes. The paper closes with the most pressing operational issues that require further research.

We searched the peer-reviewed literature for published studies, as well as the grey literature for unpublished studies. We aimed to use information from randomized controlled trials, which are considered the gold standard for assessing the impact of interventions. However, few randomized controlled trials were available; therefore, most of the results come from research, operational research and programme evaluation with credible experimental designs, including baselines or comparison groups. Where evidence is anecdotal or taken from one small site, it is noted; we also attempt to clarify where evidence is contradictory. A quantitative analysis of the quality of the studies was beyond the scope of this review.

The paper's structure follows different social protection instruments and reflects the weight of the evidence. For each instrument, the particular impacts for HIV prevention, AIDS treatment, and care and support are considered. The evidence on care and support has been better covered elsewhere in the literature (e.g. JLICA, 2009), and is therefore only summarized in this paper. In the areas of prevention and treatment there was a need to dig deeper to draw out the evidence since these are newer areas for social protection. This means we had to extrapolate information from the existing literature, because there is, as yet, relatively little research on interventions for preventing HIV and treating AIDS in the social protection literature. Throughout the paper, we identify links between protective, preventive, promotive and transformative elements of social protection.

This paper is structured as follows:

- ▶ The first section summarizes the evidence relating to social protection instruments and HIV. This is organized into four main subsections
 - social transfers (also called social assistance), including cash and food;
 - relevant livelihood-building approaches, including public works, income-generating activities and microfinance;
 - social health protection, including social health insurance and home-based care;
 - transformative social protection approaches that use legislation, regulation and policies to achieve transformational aims.
- ▶ The second section assesses the literature on specific populations who have an increased risk of HIV exposure. This section also discusses children—specifically, early childhood development and child protection approaches.
- ▶ The third section summarizes what we know about different targeting approaches as relevant to people and households affected by HIV.
- ▶ Finally, the fourth section summarizes the major evidence gaps and priorities for research.

Readers should bear in mind the following points:

- ▶ This was not a complete, comprehensive global review; there may be evidence that was not found and that could affect the conclusions.
- ▶ Where HIV-specific outcomes were not measured, the analysis required a number of assumptions regarding their relevance to prevention, treatment, care and support. We attempt to explain these where appropriate.

- ▶ The boundaries of social protection are contested. Development professionals generally agree that social transfers are central to social protection, but there is less agreement about the other instruments surveyed here, as well as their categorization (e.g. we include public works programmes within livelihoods promotion, which some would debate). There are other instruments (e.g. humanitarian assistance) that some would place within social protection—which this paper does not cover.

We do not claim that this paper is the definitive word on social protection; instead, we seek to illuminate what might be considered HIV-sensitive social protection.

How social protection can prevent HIV infection, promote treatment, and strengthen care and support

Analysing different instruments makes it possible to draw general conclusions on the role of social protection in promoting Universal Access to HIV prevention, treatment, care and support.⁴

When seen through an HIV lens, the most obvious role for social protection is enabling individuals and households to withstand and recover from shocks associated with the prolonged illness and the possible death of a family member—often the household breadwinner. Additionally, while it is apparent that most social protection instruments have a greater impact on one or another Universal Access outcome, most instruments have an impact on multiple HIV and AIDS outcomes. For example, social transfers have benefits for care and support, as well as for treatment. Therefore, funders and programme designers should not view HIV-related planning, monitoring and evaluation as separate, discrete interventions, but make the most of potential linkages within national social protection strategies.

Evidence suggests that social protection has a particularly important role to play in interrupting the cycle from being a person affected by AIDS to becoming a person living with HIV. Poverty can exacerbate a person's vulnerability to HIV infection through a number of specific and complex pathways. For example, inequality clearly places people at risk. Similarly, research from a growing number of sub-Saharan countries shows that girls from AIDS-affected households are especially vulnerable to unsafe sex and other risk behaviours. (Birdthistle et al. 2009; Frega et al. 2010) Social protection helps to make incomes more regular, create livelihoods, diversify income sources and maintain school enrolment. In turn, this helps to reduce the factors (e.g. girls reliance on older men for income, transactional sex) that increase a person's risk of HIV infection. A research priority is building an evidence base that shows precisely how social protection can interrupt the cycle from being a person affected by AIDS to becoming a person living with HIV, by reducing risk factors among vulnerable groups.

Research suggests that the range of threats and impacts faced by people living with, and affected by, HIV can best be addressed through comprehensive social protection systems that include protective, preventive, promotive and transformative elements. For example, the impact of food transfers will be limited without actions to promote access to livelihoods; and targeted cash transfers for ultra-poor children may not reach those most marginalized—including those affected by HIV—without social workers or home health-care assistants to help them access their entitlements. (Vadapalli, 2009)

4 Comprehensive HIV prevention, treatment, care and support includes tailored HIV-prevention strategies, clinical care, adequate nutrition, psychological support, social and daily living support, involvement of people living with HIV and their families, and respect for human rights and legal needs (UNAIDS Terminology Guidelines 2010).

At the same time, the government ministries and public systems with responsibility for protecting the rights of the poorest are traditionally weak, under-capacitated and of limited political influence (Baingana et al., 2008). Social protection strategies must be realistic about what is achievable in the short and longer term in light of this challenge. Experience in different regions increasingly indicates the value of starting with simple social protection approaches in contexts with limited capacity (JLICA, 2009). However, the value of starting small must be balanced with the need for comprehensive approaches that progressively realize people's right to social protection, which can be facilitated through the development of comprehensive social protection strategies with phased introduction.

The reasons people enter and leave poverty change over an individual's and household's lifetime. Therefore, social protection programmes should target the relevant risks and vulnerabilities instead of targeting people. (Krishna, 2007) This is particularly pertinent to HIV: a person's risk exposure and vulnerability to HIV infection, and their need for care, support and treatment shift over time, as do their own abilities to mitigate and cope with these changing risks and vulnerabilities. It is critical that a social protection programme is comprehensive, and that people's access to different instruments is assessed regularly as their risk exposure, vulnerability and ability to mitigate and cope changes.

What the evidence says about social protection instruments and HIV

This section discusses the effectiveness of four main social protection instruments for minimizing the risk of HIV infection, promoting treatment, and enhancing care and support: social transfers (e.g. cash and food), livelihood building (e.g. public works, income-generating activities and microfinance), social health protection (e.g. social health insurance and home-based care) and transformative social protection (e.g. legislation, regulation and policies).

Social transfers and HIV

Social transfers, including cash, vouchers for specific goods or services, and in-kind transfers, most commonly food, are delivered to institutions, households or individuals on a periodic or regular (ideally predictable) basis. Transfers fulfil protective social protection aims for the ultra-poor (often the bottom income quintile or decile in a community) and those who are unable to meet their basic household needs. Transfers can also fulfil preventative social protection aims by smoothing income⁵ and consumption, and by preventing households from slipping further into poverty. (Devereux, 2001; Adato & Bassett, 2008)

The most obvious benefit of social transfers for HIV outcomes is providing care and support; that is, helping vulnerable households and individuals to withstand the economic impacts of AIDS. Social transfers can help to promote adherence to treatment, (Souteyrand et al., 2008; Emenyonu et al., 2010) although there is limited evidence about other Universal Access outcomes. Social transfers may also play a role in HIV prevention by reducing some of the factors that place people at risk of infection: school drop-out, migration, and girls' and women's social and economic inequality (e.g. grants for orphans and vulnerable children in Kenya). Cost data on cash and food transfers are available to inform decision-making on implementation and scale-up (e.g. cash transfers to vulnerable households in Malawi).

Education warrants a special mention in this section, because one of the most important HIV-related impacts of social transfers is enrolling and keeping children in school, particularly those who are most likely to drop out. In some settings, children affected by AIDS have lower rates of school enrolment and attendance; transfers schemes that include them can help ensure their right to education. The evidence shows that schooling can protect girls from HIV infection, as well as conferring other important health benefits, although the specific mechanisms are not clear. (Edström & Young, 2006) This is important, because girls are also at high risk of drop-out as they approach adolescence, which is the same time that their susceptibility to HIV infection dramatically increases. Social transfers have a clear effect on access to schooling for these groups (see Box 2 for an illustration). Complementary policy changes, such as free schooling, can reduce barriers for a far greater number of children than does targeted social transfers.

5 "Smoothing income" refers to making income more regular or reliable, and reducing the number of low or no income months.

Box 2 - Schooling counts—even more so when it is affordable

A simple study in Kenya showed the powerful protective function of schooling for sexual and reproductive health, aided by an intervention to reduce the costs of schooling. Researchers assessed the impact of providing secondary school students with school uniforms, comparing the effects with teaching the government's standard HIV curriculum and debates and essay writing on HIV prevention. The most effective approach to improve sexual and reproductive health was to provide students with free uniforms, which reduced dropout rates by 17% for boys and 14% for girls. This also reduced teenage childbearing and marriage among girls by 9% and 12%, respectively, at a rate of \$300 per pregnancy averted.(Duflo, 2006) This type of schooling support would have to be regular and predictable to fulfil social protection objectives.

Cash transfers

Cash transfers are regular, predictable payments (generally small) that are provided to specific population groups. Many cash transfer programmes are conditional for a behaviour, such as a child attending school for a certain number of days in a month, or attendance at a health clinic for infant and child growth monitoring and promotion. In contrast, voucher programs do not depend on a certain behaviour although their benefits are often conditional. For example, a voucher may cover specific health-care services, such as a safe delivery in a facility for a mother, or allow a choice of food from within a specified range of foods. The voucher may entitle the beneficiary to a fixed monetary equivalent of goods or to a predetermined quantity regardless of price.

A number of cash transfer programmes have been developed recently.(Adato & Bassett 2008) Many of these cash transfer programmes have solid monitoring and evaluation components to meet government and donor requirements, which provide a better and more visible evidence base than many of the other instruments. A few studies of cash transfers look specifically at HIV outcomes, but a wealth of studies, especially from Latin America and increasingly Southern Africa, look at health, education, nutrition and other impacts that are indirectly related to HIV. In-kind transfers, including voucher programmes, often have a similar function to cash.

Impact on HIV prevention

Conditional and unconditional cash transfers have many documented benefits, such as those specific to children (improved school attendance, decreased early marriage, etc), increased access to health care, and improved self-confidence and autonomy of women. In seven programmes in sub-Saharan Africa, cash transfers were spent mostly on food, followed by household expenditures (such as clothing, blankets, transportation), and education and health.(Adato & Bassett, 2008)

Benefits for children

In countries as diverse as Bangladesh, Brazil, Malawi and Mexico, cash transfers promote school attendance—often with a greater impact on girls and than boys.(Adato & Bassett, 2008) A study from Zomba, Malawi, showed that both conditional and unconditional cash transfers to girls, both in and out of school, improved school attendance and decreased early marriage, pregnancy and HIV infection rates among beneficiaries (see Box 3). Another ongoing study from South Africa is similarly assessing the impact of providing conditional cash transfers (conditional on their school attendance) to secondary school girls, along with community mobilization, to assess the impact on HIV-related outcomes.(Adato, 2010) The results from these two studies will help to show whether similar programmes can be used in other regions.

Other studies have had mixed results for the benefits of cash transfers in children. Mexico's *Oportunidades* (formerly *Progres*a) national poverty alleviation and conditional cash transfer programme found that the transfers did reduce the incidence of some adolescent risk behaviours, specifically smoking and drinking alcohol. However, cash transfers did not affect boys' and girls' decision to become sexually active, or whether to use a condom during their first sexual intercourse as well, or their most recent sexual intercourse. (Galarraga & Gertler, 2009)

Box 3 - The Zomba cash transfer experiment for adolescent girls

One of the few experiments from Africa that compares the relative benefits of conditional and non-conditional cash transfers for adolescent girls (using school attendance as the conditionality) substantially increased school attendance among beneficiaries who were currently enrolled in school or had dropped out at baseline. The intervention also led to a significant decline in early marriage, pregnancy and self-reported sexual activity among beneficiaries in both the conditional and non-conditional arms. Most importantly, preliminary findings indicate that HIV prevalence among "baseline schoolgirls" (beneficiaries who were enrolled in school at baseline) decreased by 60% compared to the control group, although there was no HIV effect among the "baseline dropouts" (girls who returned to school as a result of receiving cash transfers). Researchers found that the sexually active beneficiaries reduced their risky behaviour; they did not cease having sex, but rather with the cash in hand from the transfer, moved away from older partners to peer partners, who were less likely to be HIV-positive. The authors are currently investigating the relative roles of additional income and increased schooling leading to the large HIV effect.

While the schooling effects were the same in both groups, they did differ in one interesting respect: the girls receiving the conditional cash transfer had similar marriage rates to the control group, while child marriage was virtually eliminated for those in the non-conditional group. Researchers hypothesize that the pressure of the schooling requirement forced conditional families to make a decision about the most viable alternative—marriage—which may have seemed preferable in this context. (Baird et al., 2009; Baird et al., 2010).

Increased access to health care

Cash transfers and vouchers have a role in increasing health-care access, which is particularly pertinent to women and babies at risk of HIV infection, and for the care of HIV-positive children. (Coady et al., 2004; Lagarde et al., 2007) Cash transfers can reduce financial barriers to health care, demonstrated for maternity services particularly in Asia. (Borghi et al., 2006) Financial incentives can also improve adherence to tuberculosis treatment for low-income populations. (Marteau et al., 2009) These benefits may also extend to HIV prevention by increasing the uptake of treatments for sexually transmitted infections, voluntary counselling and testing access (see Box 4), and prevention of mother-to-child transmission. For example, vouchers that provide pregnant women with an assisted delivery in a health facility could permit access to prevention of mother-to-child transmission, even when the woman has not had access to antenatal services.

Box 4 - Even a small cash incentive can make a difference for voluntary counselling and testing uptake

Many people who are HIV-positive do not know their status, and expanding voluntary counselling and testing has been slower than hoped. Getting people into a testing centre is only half the battle—often, those tested do not return for their results. In a study from Malawi, nearly 3000 people were randomly assigned to receive a monetary incentive for collecting their HIV test results. Fewer than half of those who did not receive the incentive returned for their results. However, providing even a small incentive (about one tenth of a day's wage) increased that rate again by 50% (i.e. up to about 75% in total). (Thornton, 2006).

Cash transfers can reduce barriers that prevent people from accessing essential services, such as opportunity costs of accessing care. However, they must be accompanied by investments in the supply (e.g. in the quality and quantity of health and education) if they are to improve health and education in the long term.(Heinrich, 2006) This can mitigate the risk of health or education services deteriorating in the face of increased demand, as happened in Mexico and Bangladesh.(Slater, 2008) Improving the supply and quality of education and health services is particularly important for the success of conditional cash transfer programmes.

Improved self-confidence and autonomy

Finally, a handful of important studies show that cash transfers to women can increase their self-confidence, social standing and autonomy.(Gorman, 2004; Adato & Bassett, 2008) In turn, this can empower women to take more control of their sexual relationships, which can reduce their risk of HIV infection. Within six months of introducing Namibia's pilot Basic Income Grant programme, provided to all Namibians younger than 60 years in one area, female beneficiaries reported more control over their sexuality and increased economic independence from men.(BIG Coalition, 2008) Another ongoing study in Tanzania combines training in gender relationships, as well as other life skills, with a requirement of remaining free of sexually transmitted infection to receive a cash transfer, to reduce sexually transmitted infection rates (see Box 5).

Box 5 - Can gender training and a conditional cash transfer overcome the pull of unsafe sex?

In Tanzania, researchers for the Rewarding Sexually Transmitted Infection Prevention and Control in Tanzania (RESPECT) Project have tested the impact of randomly providing cash transfers—conditional in nature, using periodic negative curable sexually transmitted infection tests as the conditionality—to young adults 15 to 30 years old. Participants received education and training in basic financial literacy, life skills, gender relations, power inequities and couple communication. In the intervention group, one arm received a low-value conditional cash transfer, and one arm received a high-value conditional cash transfer. The control group did not receive any cash transfers. Participants testing positive for a sexually transmitted infection were treated and permitted to participate in the study after the infection was cured. After one year, results showed some impact on couples' joint decision-making about sex and condom use. Importantly, 9% of those who received the high-value conditional cash transfer were positive for one of the tested sexually transmitted infections compared with 12% in the control group, which the researchers describe as a 25% reduction in the incidence of those sexually transmitted infections; there was no such reduction among those in the group who received a low-value conditional cash transfer.(de Walque et al., 2010) Researchers describe this as a "proof-of-concept" study that needs wider testing of whether sexually transmitted infection test results are appropriate to use as a condition of transfer payments, and the impact of an incentive such as this on the spread of HIV. Given that inequality (especially gender inequality) fuels unsafe sex, these results are important for improving our understanding of how the cash incentive and gender-related training can protect young women.

Impact on AIDS treatment

The impact of cash transfers in reducing financial barriers to health care could also apply to treatment in light of the cost barriers to adherence, including payments for clinic visits and transportation as well as drugs. However, the documented evidence on the link between antiretroviral therapy and cash transfers is limited, and will be discussed further in the section on social health protection.

An important study using cash transfers to cover clinic transportation in a HIV treatment program in rural Uganda shows promising results. Researchers tested the hypothesis that providing patients with cash transfers to cover transportation costs would increase

antiretroviral therapy adherence and retention in care. The results of the randomized controlled trial showed better adherence scores in the intervention than the control group, leading the researchers to conclude that “Modest cash transfers of \$5–8 per month to defray the costs of transportation may be an important strategy to reduce costs and improve treatment outcomes in rural, resource-limited treatment settings”, (Emenyonu et al., 2010) revealing a link that warrants further investigation.

Impact on care and support

We have more evidence on the benefits of cash transfers for AIDS care and support than for the other Universal Access outcomes, in part because a number of pension programmes for the elderly have been developed over the last few years in Southern Africa, providing evidence on impact for beneficiaries and for children. (Gorman, 2004) Research shows the importance of this approach for mitigating the impacts of AIDS, which is especially relevant for the most vulnerable households unable to withstand shocks.

More research is needed to assess the impact of cash transfers on key populations in particular. Cash transfers provided as pensions for the elderly can be an important strategy for mitigating the impact of AIDS in countries where the large number of orphans and the large care burden of many grandparents have prompted governments to adopt national pension plans (see Box 6 for details).

Box 6 - A spotlight on pensions

Pensions for older people have demonstrated effects on beneficiaries’ mental health, social standing and livelihoods; the benefits extend beyond beneficiaries to improve household economies. (Gorman, 2004) Several countries in Southern Africa have national government-run pension schemes with broad coverage, including Botswana, Lesotho, Namibia, South Africa, Swaziland, as well as a pilot in Zambia.

While a number of forces led to the creation of these programmes, the unrelenting impacts of AIDS on poor households, which often leave older people and children living without a breadwinner, contributed. Income from pensions is used to meet basic needs; in a study of the pension schemes in Namibia and South Africa, only 28% of pensions were spent on pensioners themselves, underlining the population-wide impact of pensions. In South Africa, it is estimated that the social pension reduces the scale of older people’s poverty by 94% and the overall population’s poverty by 12.5%. In particular, pension income is spent primarily on food, schooling and health. (Devereux, 2001) In this study, people became better off when they hit pensioner age, and women’s self-reported health status improved.

In another study of the specific impact of South Africa’s pension scheme for households affected by AIDS, the study found that this scheme had the largest poverty-reducing effect of the four largest national transfer schemes (including the child support, disability and foster care grants). The study concluded that, in general, these grants bring many AIDS-affected households to the poverty level of non-affected households, although the study also illustrated the limitations of these national schemes as many of the poorest households are left out. (Booyson 2003).

The benefits outlined above for school attendance are relevant in light of the risk of non-attendance by children with sick and dying parents. Households receiving cash transfers are also more likely to seek health care for sick children, are more food secure, and more likely to invest in strategies that strengthen their livelihoods and household economies, which all help households to absorb the impacts of AIDS. (Yablonski, 2009) Additionally, cash transfers have documented benefits in reducing child labour in Brazil, a particular risk for AIDS-affected children in some settings. (Barrientos & DeJong, 2004)

For example, South Africa's Child Support Grant, when provided during the critical "window of opportunity" when a child is young, can have a significant impact on their growth. Children who were under the age of two when their household received the Child Support Grant, and received the benefit consistently for at least two thirds of their life until age three, significantly improved their height for age compared to those not receiving the Child Support Grant over this period. Beneficiary children had height-for-age z-scores⁶ 0.25 higher than children who only received benefits for 1% of their first three years of life.(Adato & Bassett, 2008)

Food transfers

The most common type of in-kind social transfer is food. In terms of evidence that is relevant to HIV, literature from a number of regions reports on the impact of school-based feeding on education and nutrition for children.(Bundy et al. 2009) and some evidence exists primarily from sub-Saharan Africa on the impact of food transfers on people living with AIDS, and orphans and vulnerable children.(Gillespie & Kadiyala 2005). We were unable to find clear evidence of the direct impact of food transfers on HIV prevention, although the potential link is explored below.

Impact on HIV prevention

Food transfers are most likely to help prevent HIV infection through their function of keeping vulnerable children in school. In so far as food transfers promote antiretroviral therapy adherence, it could be argued that this type of transfer also plays a role in reducing viral load through improving antiretroviral therapy uptake and adherence, which reduces the likelihood of HIV transmission.

School-based food transfers, commonly known as Food for Education,⁷ is primarily comprised of school feeding programmes and distribution of take-home rations. Food for Education targeting secondary school-aged children has greater potential relevance for HIV prevention, as older children are more likely to be at risk of unsafe sex than those in primary school.

An additional hypothesized route by which food transfers may promote HIV prevention is by reducing food insecurity, which in turn could reduce women's reliance on risky coping strategies (e.g. transactional or commercial sex) to feed their children.(Frega et al., 2010) This hypothesis is based on study results revealing the link between food insecurity and risky sexual behaviour. A study in Botswana and Swaziland showed that women reporting food insufficiency had 70% higher likelihood of inconsistent condom use with a non-primary partner than those not reporting food insufficiency, almost 50% higher likelihood of engaging in intergenerational sexual exchange, and were nearly twice as likely to engage in sexual exchange. A similar analysis for men showed 14% increased odds of inconsistent condom use, but no impact on the other behaviours.(Weiser et al., 2007) A smaller qualitative study in Uganda revealed similar behaviours.(Miller et al., 2010) The precise role of food transfers in reducing this type of risky behaviour warrants further exploration.

Although there is promising research on how social transfers can and might contribute to prevention, there is a need for more research on how social protection may reduce the lifetime risk of HIV infection. In other words, longitudinal research could explore if there is a lasting impact in relation to risk behaviours beyond the point at which the individual receives the transfer.

⁶ The z score for an item indicates how far and in what direction that item deviates from its distribution's mean, expressed in units of its distribution's standard deviation.

⁷ The World Food Programme no longer refers to "Food for Education" but to "school meals".

Impact on HIV treatment

Poor nutrition can play a role in hastening HIV disease progression in adults and children.(Fergusson et al., 2009) Good nutritional status should be achieved as early as possible because infections affect nutrient absorption and use, which makes nutritional status more difficult to correct during symptomatic infection.

Weight loss is common in HIV infection. It is caused by low dietary intake, malabsorption and altered metabolism. Regaining weight, particularly lean body mass (mainly muscle tissue), requires antiretroviral therapy, treatment of opportunistic infections, consumption of a balanced diet with all required nutrients, physical activity, mitigation of side effects of infection and medication (reduced appetite, nausea, diarrhea, vomiting) and, if necessary and possible, pharmacological treatment (appetite stimulants, growth hormone).(de Pee & Semba, 2010)

Studies have documented widespread micronutrient deficiencies among HIV-positive people, and several studies have assessed the impact of micronutrient supplements on HIV disease outcomes, such as mortality and CD4+ T cells (immune cells) count. However, the composition of supplements, patient characteristics and treatments varied widely across studies and the impact evidence is inconclusive.

Therefore, the World Health Organization currently recommends ensuring an intake of one recommended nutritional intake of micronutrients for people living with HIV, a level that is usually not reached by a majority of the population in low-income countries. It may be argued that one to two recommended nutritional intakes are required where micronutrient deficiencies are widely prevalent. Recommended intakes should be supplied by the habitual diet, including fortified foods and, where necessary, the basic diet should be augmented with home-fortification products or nutrient supplements.(de Pee & Semba, 2010)

Few studies in resource-limited settings have assessed the impact of specific food supplements on HIV infection outcome. The rationale for providing food supplements to people living with HIV themselves (i.e. not their household members, which would mitigate food insecurity and livelihood issues) varies from treating moderate to severe malnutrition in their own right to being an adjunct to antiretroviral therapy aimed at improving treatment outcome. Because mortality risk increases with a lower body mass index, also among people starting antiretroviral therapy, improving body mass index among moderate to severely malnourished people is important. Whether this requires provision of food supplements, and what kind might be supplied, depends on the food security situation of the household and the basic diet of the people receiving antiretroviral therapy. Importantly, caloric supplementation that leads beyond weight recovery and stabilization to weight gain will not in itself reduce the risk of disease progression.(Edström & Samuels, 2007)

From the limited evidence that is currently available from resource-limited settings, it appears that starting on antiretroviral therapy improves body mass index, and the provision of ready-to-use fortified spreads as well as fortified-blended food further increases body mass index in addition to antiretroviral therapy. While fortified-blended food seems to do so to a lesser extent than spreads, we still do not fully understand which product is most cost effective at different stages of recovery from malnutrition and of starting antiretroviral therapy. In addition, studies conducted to date have been too small to assess how much these interventions reduce mortality.(de Pee & Semba, 2010) It is worth noting that, in practice, the delivery of “food by prescription”⁸ for severely malnourished people living with HIV generally does not follow guidelines on the use of special therapeutic foods, which is likely to limit effectiveness.(Frega et al. 2010)

8 Food by prescription approaches integrate food and nutrition services into clinical HIV care and treatment services (<http://www.fantaproject.org>).

Once malnutrition has been treated and patients are well-established on antiretroviral therapy, the nutritional quality of the diet still needs to be ensured through dietary advice and possibly the provision of a complementary food supplement that provides specific high-quality nutrients. Such a complementary food supplement can range from a low-dose spread (45 g/d, such as Plumpy Doz) to a micronutrient powder, which provides only additional vitamins and minerals. Dietary quality is also important for preventing or mitigating long-term metabolic effects of antiretroviral therapy, such as dyslipidemia, insulin resistance and obesity.

In general terms, food transfers are shown to promote antiretroviral therapy adherence. (Gillespie & Kadiyala 2005, Cantrell et al 2008, Tirivayi et al. in press) In turn, treatment of HIV and opportunistic infections reduces malnutrition, which also relies upon the consumption of nutritious foods.

Impact on care and support

Providing food transfers to HIV-affected households is widely seen as an important way to mitigate the impact of the epidemic on vulnerable households. The quality of food transfers—in terms of micronutrient and energy content—is particularly important where a large number of beneficiaries in food insecure areas are living with HIV.

Food transfers can have impacts on household food security and in some cases, the nutrition of household members. (Adelman et al. 2008) However, studies also reveal the importance of looking at the intra-household food distribution by assessing the nutritional impact of transfers on all household members. It is not safe to assume that everyone is benefitting equally. There is evidence from some settings that orphaned children may be discriminated against by other children and caregivers in their foster households. Gender discrimination is also a consideration in intra-household food distribution, although this may be more of a concern in Asia than in other regions (J. Edstrom, Institute of Development Studies, Sussex, personal communication, 2010).

The other important dimension of food transfers relevant to care and support is feeding orphans and vulnerable children in school using Food for Education as described above. Benefits of Food for Education can be both educational and nutritional. Food for Education is shown to increase school attendance, cognition and educational achievement, especially when combined with nutritional measures such as de-worming and micronutrient fortification. (Kristjansson et al. 2007; Bundy et al., 2009)

The “alternative food for education programmes on child nutrition in northern Uganda” study compared the relative impacts of school feeding programmes and take-home rations. (Adelman et al. 2008) While both strategies had important nutritional benefits—for example, both improved the anaemia status of girls approaching puberty and in adolescence—the school feeding programmes had a larger impact on anthropometric status (height-for-age z-scores) of the preschooling-age siblings of students than the take-home rations. Researchers interpret this surprising result as indicating that some younger siblings accompanied students to school for feedings, and that the students benefitting from the school feeding programmes ate less at home, allowing their food to be redistributed to their siblings.

Take-home rations and school feeding programmes both have merits in this and many other studies. Hence, experts generally recommend a combined strategy: school feeding programmes for all students in areas in need plus more finely targeted take-home rations for children from especially vulnerable households, which may include orphans and vulnerable children. It is worth noting that in countries with low school enrolment, the poorest out-of-

school children will miss out on the benefits of Food for Education. In the context of AIDS, orphans and vulnerable children may still need transfers that reach them at home, including through home-based care providers as discussed below.

Livelihoods promotion for people affected by HIV

Activities that promote the livelihoods of the “working poor” are relevant to HIV-sensitive social protection, although there is some debate regarding the extent to which livelihoods are part of social protection. In any case, livelihoods promotion can fulfil promotional and transformative objectives. In HIV terms, livelihoods promotion has relevance for care and support of people living with HIV and members of their households, helping them to prepare for and sustain the possibility of a prolonged illness and potential death, sometimes of the main breadwinner. For HIV prevention, the transformative potential of livelihoods promotion may be to alter commercial sex workers’ vulnerability to infection, although the evidence is mixed, as addressed below.

This section covers public works, income generating activities, and microfinance, which all seek to promote livelihoods for the working poor. Importantly, the relevance for people and households affected by HIV may change over time, as their composition and health changes. Livelihoods promotion for people and households affected by AIDS are more relevant for the working poor than the labour-constrained ultra-poor, but as the status of individuals and households shifts, livelihoods approaches may become more or less relevant over time. Assumptions are often made about the labour potential of people living with HIV, which we need to revisit in the era of increased access to antiretroviral drugs.

Public works

Public works, also known as food or cash for work, refers to an approach where a government, donor agency, or nongovernment organization finances or implements a programme to create temporary jobs for workers. The intent of such programmes is to establish short-duration jobs for workers to increase their incomes and to develop public goods in the form of new infrastructure, improvements of existing infrastructure or delivery of services.

Public works programmes are part of a livelihoods approach because they seek to create assets and transfer skills along with predictable incomes; their documented benefits have much in common with social transfers. There is a solid evidence base on the general impacts of public works, but again, there is very little specific to HIV outcomes. It is worth noting that opinions are divided as to the applicability of public works programmes to an HIV response, as discussed below.

Impact on care and support

Public works programmes attract poor people of working age to low or unskilled paid labour, often for work on infrastructure projects, such as road construction, for which workers receive a wage either in cash or food. Public works programmes have demonstrated effects on household food security, households’ ability to weather shocks, and sometimes secondary employment benefits for workers if the project results in a construction that is useful for the community and requires maintenance, such as rural feeder roads. (Subbarao 2001)

There are valid questions about the relevance of public works programmes for people and households affected by HIV. Typically, public works programmes allow only one worker per

household. If a worker is ill with AIDS (or any other illness), there is a risk that the work—usually involving physical labour—could hasten the onset of more severe illness. Experience also shows the risk of posing additional burdens on women who are overworked by a large care burden, particularly if they are expected to work for wages that their families desperately need. (Slater 2008)

In summary, limited evidence indicates that in many cases public works are not the most appropriate social protection response for people living with HIV and affected households. However, increased access to antiretroviral therapy may be changing this, by increasing the productivity of people living with HIV and making public works more relevant.

There are ways to make public works programmes more HIV-sensitive, which would increase their usefulness for care and support outcomes. Establishing a household contract, which specifies an alternative worker to take the place of the designated one, is a way to mitigate the risk of the worker falling ill or being unable to work (see Box 7 for an illustration). An additional route to increasing the HIV sensitivity of public works is to expand the types of jobs that are considered eligible as “public works”. For example, South Africa includes home-based care as one of the options in their expanded national public works programme. Attracting people from HIV-affected households to work in home-based care, early childhood development and child welfare could have multiple benefits for a range of objectives. The World Bank is conducting a review of public work programmes, which could provide an opportunity to explore these benefits for people affected by AIDS in Africa.

Box 7 - Public works in Southern Africa—benefits for destitute children

Working in the heavily HIV-affected environment of South Africa, the Zibambele Public Works Programme, implemented by the KwaZulu Natal Department of Transport, proved flexible by adapting their programme to be sensitive to their environment.

The programme used community targeting to reach the poorest households, mostly female-headed and HIV-affected, either through illness and death or through housing orphans. Beneficiaries would traditionally be excluded from public works employment due to their limited labour capacity and the burden of domestic responsibilities. However, through their sensitive design, Zibambele was accessible to even severely labour-constrained households. The programme provided household contracts that permitted a replacement worker to take over in the event of illness or death of the worker, a part-time schedule and flexible hours.

Despite the low monthly income from low-intensity road maintenance activities, the programme had a significant impact on education and food consumption outcomes for children in participating households, compared to the baseline. The sustained nature of the employment over a long period contributed to its impact. (McCord 2005).

Income-generating activities

There is debate about the extent to which income-generating activities are part of social protection. However, they are included here because evidence suggests income-generating activities can economically empower people living with HIV and those in affected households, particularly in vulnerable and marginalized groups. Income-generating activities take many forms, and can include activities as diverse as small business promotion, cooperative undertakings, job creation schemes, sewing circles, credit and savings groups, and youth training programmes. Their common characteristic is that they affect the economic aspects of people’s lives through the use of economic tools. Income-generating activities have a moderate level of evidence to describe their impact, although the evidence for the impact of income-generating activities on specific HIV outcomes is limited.

Impact on HIV prevention

It seems logical that income-generating activities reduce the vulnerability of women and girls in AIDS-affected households by reducing their need to resort to risky coping strategies such as transactional sex or sex work that would increase their susceptibility to HIV infection. However, the specific pathway has not been researched and there is no evidence to support this claim.

Income-generating activities could possibly promote HIV prevention by transforming the life choices of sex workers. Advocates of the alternative livelihoods approach make the case that training sex workers for other, safer trades should be the priority.(UNAIDS 2009b) However, opinions are divided on the best approach to reducing HIV risks faced by sex workers.(Greenall, 2007) A balance must be struck between alternative livelihoods strategies and strategies that promote the rights of sex workers by protecting them from violence and abuse, increasing their access to essential services and promoting harm reduction. Importantly, the evidence of the effectiveness of targeting sex workers with income-generating activities to change their source of livelihood is not convincing: several studies show little impact on the transition from sex to other work as a result of participation in income-generating activities. Doupe 2007, Greenall 2007) Also concerning is the imposition of livelihood choices on sex workers. The rights of sex workers have not always been respected in schemes designed to change their source of livelihood, and as a result these schemes can be highly contentious. Nevertheless, where programmes seek to promote sex workers' rights through sex worker-led income-generating activities, such as in Sonagachi, India (discussed below), they can be more effective.

Impact on care and support

Income-generating activities can have benefits that may be relevant for people in poor AIDS-affected households with productive adults. They can deliver tangible outcomes such as the establishment of small businesses, increased incomes, and access to new goods and services, as well as secondary benefits of participation, such as acquiring new skills, empowerment, increased autonomy and expanded social capital. In poorer households, the effectiveness of income-generating activities is increased when smaller units (e.g. chickens) are provided, rather than larger assets (e.g. cows), because smaller units are more flexible and require less upkeep. However, there can also be risks associated with the lack of agricultural extension services to support beneficiaries (R. Yates, UNICEF, personal communication, 2010).

As a business model, income-generating activities are relatively complex, facing several risks to their success. This may make them less attractive to ill or poor people, who tend to be risk averse and more interested in reliable income flows through predictable social transfers.(World Bank 2009) Stigma is also a concern, and fear of discrimination could keep people living with HIV away.

Microfinance

A variation on income-generating activities is microfinance, including microcredit and savings, which has become a major force in development. There is a reasonable amount of evidence of the benefits of participation in microcredit and savings programmes, although it focuses on economic outcomes. There is little evidence specific to HIV-related outcomes.

Impact on HIV prevention

Microfinance improves the economic status of participants; it also has health-related and gender-related benefits.(Anderson et al. 2002) Benefits of microfinance that are relevant to HIV prevention include increased use of contraception (which indicates improved communication between couples), and increased empowerment, autonomy and self-confidence for women.(Goss & Mitten 2007) Box 8 describes a microfinance project from South Africa (the IMAGE project) that reduced the risk of intimate partner violence.

Box 8 - The IMAGE project in South Africa

Evidence from a randomized cluster trial indicates that a combination of microfinance, and gender and HIV education, reduced levels of physical and sexual violence in rural South African communities. The study found a 55% reduction in self-reported experiences of physical or sexual intimate partner violence in the past 12 months among participants receiving the intervention. IMAGE provides women with short-term business loans of up to US\$1300 (implemented through the Small Enterprise Foundation), operating on the premise that an increase in earning power will empower women to be more vocal at home, confronting unfaithful husbands about issues such as condom usage. People receiving loans are required to participate twice a week in workshops called Sisters for Life. These workshops provide a space in which women learn to communicate with their husbands about domestic violence, rape, the importance of using condoms and other issues. Other efforts to empower women through microfinance alone have mixed results on violence. Improved communication between couples about HIV increased uptake of voluntary counselling and testing, and reduced unprotected sex. The effect of the HIV education did not diffuse among non-involved community members as hoped (i.e. there was no diffusion effect).(Hargreaves et al. 2010).

Combining microfinance schemes with training and education can increase communication about HIV and increase the uptake of voluntary counselling and testing for HIV.(Barnes 2003) In Zimbabwe, female participants in CARE International's Integrated Savings and Lending Approach reportedly left sex work due to their participation.(Gandure 2006) Conversely, it is important to be aware of the risks associated with microfinance programmes; for example, those associated with a credit group in South Africa where social events—while good for strengthening participants' social capital—increased risky sexual behaviour among participants.(Slater 2004)

Some trials have focused on specific population groups—young people and sex workers—in the hope of having a demonstrable impact on HIV prevention. The Tap and Reposition Youth (TRY) project in Kenya educated young women about business development, savings and HIV, as well as providing them with savings accounts and contributions matched on family donations.(Erulkar et al. 2006) Participants increased their ability to insist on condom use and their ability to refuse sex, compared to a comparable control group. An important lesson from the TRY project is that the young women were less interested in business development and microcredit than they were in savings. This and other examples indicate that youth-focused approaches should emphasize savings education over business development. Again in Kenya, another study looked at the effectiveness of providing small loans, business training and HIV education to sex workers. The intervention reduced sexual risk behaviour among the borrowers through a combination of some leaving sex work and most reducing their number of clients, decreasing sexually transmitted infections by 50%. The income from their new businesses appeared to replace the income lost through reducing the number of clients. (Anderson et al., 2002)

The experiences described here demonstrate the value of integrated approaches. Education and training plus microfinance had a much greater impact than microfinance alone. Importantly, researchers note that this may be because the money brings participants through the door, providing a relatively captive audience for HIV education and training. In the IMAGE project, staff realized it was important to conduct the education before the loan distribution, otherwise the participants would leave after receiving their loans, missing the training component (J. Kim, UNDP, personal communication, 2010).

Impact on care and support

The literature on microfinance illustrates its potential for reducing poverty and enabling households to withstand shocks—both of which can help to mitigate the impact of AIDS. Evidence also shows that microfinance programmes can lessen the impact of AIDS on children. In terms of specific protections for orphans and vulnerable children, microcredit can reduce child labour, improve child nutrition, increase health promotion and improve schooling in some contexts (although not where enrolment is already high). (Pronyk, Hargreaves & Morduch 2007)

Some interventions work at the intersection of microfinance and AIDS impact mitigation. The SUUBI project in Uganda demonstrated the benefits of savings accounts and mentorships for orphans and vulnerable children, which also had some effect on their intent to engage in unsafe sexual behaviour—notably with a greater impact on boys than on girls. (Ssewamala et al. 2010) In Zimbabwe, Zambuko financial services dedicated a microfinance project to people affected by AIDS (this is described in Box 9).

Box 9 - In Zimbabwe, a microcredit organization benefits people affected by AIDS—and protects their own interests

The Zambuko Trust, a microfinance institution in Zimbabwe, developed tailored approaches for clients who are affected by AIDS. Their AIDS-sensitive approach helps them to minimize financial risks and includes a mandatory insurance fee to cover outstanding loans if a borrower dies, a mandatory savings requirement, and strict enforcement of additional guarantors for the loans. A study of the impact showed that credit allowed participants to improve their savings patterns, diversify their sources of income and retain more male children in school than a comparison group—also AIDS-affected—who were not microcredit clients. (Gillespie and Kadiyala 2005).

Implementing microfinance programmes

Once micro-finance approaches are established, they can be scaled up relatively easily and effectively. (Parker 2000) However, in settings with heavy HIV burdens, there may be risks brought on by the changing nature of client needs (especially the need for greater flexibility), and an increased default rate as participants are impoverished or die. Box 10 summarizes risk-management approaches for microfinance schemes targeted at people affected by HIV.

Box 10 - Approaches to making microcredit HIV-sensitive(Parker 2000)

- Develop lump sum and flexible savings products.
- Reduce requirements for compulsory savings and changing withdrawal policies to make it easier for people to access savings when they need them.
- Require clients to purchase insurance.
- Establish emergency loan products.
- Charge insurance fees to cover the death of a borrower, provide death insurance or debt wipe-out.
- Establish education trusts for minors.
- Provide preferential access to young people from AIDS-affected households.
- Allow an alternative household member to replace a sick one or loan co-guarantors.

While the demonstrated impacts of microfinance illustrate its relevance for HIV-sensitive social protection, staff must be mindful of the risk of further impoverishing AIDS-affected households because of loan repayment. As with other livelihoods approaches, microfinance has more relevance for the poor households with labour potential than for ultra-poor, labour-constrained households.

Integrating microfinance approaches with other important services is a popular approach that has varying degrees of effectiveness. Organizations have tried to link microfinance with social health insurance and life insurance, and to link with AIDS service organizations for AIDS-related education and training. Experience in sub-Saharan Africa suggests that collaborating with another organization to provide complementary services makes more sense than retraining microfinance staff to provide a new set of services.(Goss & Mitten 2007)

Social health protection, HIV and AIDS

Access to health care is a fundamental part of the right to health. For people living with a chronic disease such as HIV, access to basic health care is essential. The inability of poor people and households to absorb the high out-of-pocket payments for HIV-related medical expenses often leads them further into poverty or even destitution. For people living with HIV, health-related costs easily become catastrophic health expenditures, sometimes representing more than 20% of available income.(UNAIDS 2010)

Access to health care, rather than the delivery of health care itself, is usually seen as part of social protection. In terms of Universal Access goals, facilitating access to health care can advance treatment, care and support; it also has the potential to promote HIV prevention, although this link is not well established. There is evidence for the potential of social health protection to reduce financial barriers to health care for poor people in general, particularly for maternal and child health services, but little of this evidence is applied directly to HIV and AIDS. UNAIDS is currently conducting an in-depth review of the literature on this topic, including country-based modelling. This will shed light on real-world experience using social health insurance and other social health protection measures for AIDS-related services. It is important to note that barriers to health access are not always financial; for example, stigma and discrimination at community and health facility levels can be formidable barriers for people living with HIV.(GNP+ et al. 2007) While this section focuses on ways to reduce financial barriers, we also need to increase our understanding of the barriers to health care before developing interventions.

Financial barriers to health care

Ways of removing financial barriers to health care with the potential to promote Universal Access outcomes include abolishing fees, offering social health insurance, and providing vouchers and exemptions.

Abolishing user fees for publically available health care, either for specific services or specific population groups, is a common form of social health protection with demonstrated benefits, as discussed below. Social health insurance takes a variety of forms with a common aim: to protect individuals and families from financial hardship during periods of ill health and to deploy a combination of public, community and private financing for health. These schemes attempt to address the inaccessibility of private insurance in countries in which only a small percentage of the population is formally employed. (Box 11 describes an innovation for low-paid workers.) Mutual Health Organizations (*mutuelles*), also known as community-based health insurance schemes, are a popular form of social health insurance schemes in the poorest countries; these are contributory schemes financed by users. The number of *mutuelles* has increased significantly in places such as West and Central Africa, although the amount of the population covered remains less than 1%. (Rischewski 2009) While interest in various forms of social health insurance schemes is increasing, people have mixed views on their applicability to the poorest people—those who are least likely to be able to afford health services. Additionally, in poor countries with high HIV prevalence, community-based insurance schemes are unlikely to be viable from an economic perspective, because participant pools will never be sufficiently large to include enough people without HIV to cross-subsidize those living with HIV.

Other demand-side approaches to reducing financial barriers to health care include using vouchers for health services or exemptions for specific groups or particular services (e.g. maternal and child health services). (Souteyrand et al. 2008) It is important to note that other factors, such as the opportunity cost of accessing care, will still affect demand even when these measures make health services more affordable.

Box 11 - Risk pooling for low-income workers

PharmAccess, a Dutch foundation, developed a risk-pooling model for low-income workers. The model requires mandatory coverage for an entire workplace or community, facilitating broad-risk pooling for protection against a broad range of risks, including HIV/AIDS, malaria and tuberculosis. Using this model, PharmAccess has helped organize employment-based health insurance schemes in Kenya, Namibia, Nigeria, South Africa and Uganda. (Fultz 2010).

Countries with broad coverage of social health protection tend to use a combination of approaches, including social health insurance schemes, private insurance and public financing for exemptions. Thailand has managed to cover 96% of their population with a combination of health financing schemes, including insurance for the formally employed and social security coverage ensuring access to a network of dedicated providers for those falling outside formal insurance. (Joint NGO Briefing Group 2008) Ghana also combines approaches to cover more than half the population (see Box 12).

Box 12 - Ghana's national health insurance scheme

Ghana has achieved a higher level of coverage of health insurance than any other country in the region. More than half of their citizens are covered through a national health insurance scheme. Between 70% and 75% of the national health insurance scheme is tax financed through a 2.5% health insurance levy added to value-added tax (VAT). While this is an impressive achievement, the poorest do not benefit.(Yates 2004) One analysis estimated that 29% of the poorest Ghanaians are enrolled compared with 64% of the richest. Most (91%) poor households cite affordability as the main reason for not joining the scheme.(Marriott 2010) Other limitations of the scheme include rare coverage of high-cost treatments, including antiretroviral therapy; low-risk pooling and limited support and coordination between Ministry of Health systems.(Rischewski 2009) The government does provide some coverage of contributions for "indigents", recognizing that public support will always be required for those needing an extra bridge to access national or even community-based schemes.

Impact on HIV prevention

Social health insurance schemes and other demand-side financing mechanisms that increase access to health services can play a role in HIV prevention. Reducing financial barriers may encourage people to seek treatment for sexually transmitted infections, and increase their likelihood of participating in voluntary counselling and testing for HIV—thereby promoting HIV prevention objectives. However, we could not find evidence to support this.

Specific approaches to increase access are well documented in some regions. With greater integration of services into broader maternal and child health services with the aim of preventing mother-to-child transmission, the literature on increasing access for maternal health becomes pertinent to understanding how to promote access to decentralized HIV and AIDS, services such as treatment for sexually transmitted infections, voluntary counselling and testing and antiretroviral therapy, as discussed below. Community health insurance schemes have been effective in increasing the rates of assisted delivery for participating pregnant women in the Gambia and Rwanda (increasing rates of assisted delivery by 12% and 45%, respectively). These schemes generally exclude the ultra-poor but have clear benefits for the less poor.(Borghi et al., 2006)

Evidence suggests that providing free services, and vouchers and exemptions are more relevant for the ultra-poor than social health insurance schemes. Voucher schemes have effectively increased access to maternal and neonatal care in several countries in Asia.(Souteyrand et al. 2008) These experiences show the importance of covering transport costs, as well as actual medical expenses, which can be a major off-putting expense in many settings. Experience in Cambodia and Nepal show the benefits of covering transport costs; Cambodia's Health Equity Fund takes this concept one step further, providing coverage for food costs along with transport required by antenatal visits.(Bitran & Giedian 2003)

However, vouchers and exemption approaches do not always work. For example, in Kenya, providers are expected to absorb the costs of the visit covered by vouchers, and schemes are not as effective as those in countries where health systems compensate providers for earnings foregone by treating patients who "pay" with vouchers (this occurs in Cambodia, Indonesia and Thailand). Additionally, criteria defining who should be exempted from payments are not always clear and may depend on the highly subjective views of the provider, leading to significant errors of inclusion and exclusion.(Tabor 2005) Caution should be exercised to avoid other unintended risks of voucher programmes. For example, in Bangladesh, a voucher programme to increase safe deliveries provided higher value vouchers for caesareans correlated with a jump in the rate of caesareans. However, it is not clear whether the increased rate

reflected genuine need or whether unnecessary caesareans were done to increase benefits for the providers (L. Brown, World Food Programme, personal communication, 2010).

Ensuring a free public option for essential maternal and child health and HIV-related services can expand access while avoiding these challenges. In Ghana, exempting pregnant women from user fees reduced the maternal mortality rate. (Witter et al. 2007)

Impact on AIDS treatment

Across the world, only about 42% of people who need antiretroviral therapy have access. (UNAIDS 2010) With funding constraints and an ever-increasing number of people in need of treatment, social health protection may have a role in increasing access.

The World Health Organization and others call for the free provision of antiretroviral therapy as the only sure way to reach all of those in need. (Souteyrand et al. 2008) Some suggest fee abolition should be accompanied by prepayment schemes and risk pooling as ways to subsidize services for the poorest. (ILO 2007) There is a growing body of literature on the benefits of providing free antiretroviral therapies to eligible people, taken from programmes in Brazil and Senegal. Based on these examples, several other countries, including Benin, Congo, Ethiopia, Kenya, Nigeria and Tanzania, have adopted policies of universal free public sector access to antiretroviral therapy. In Benin, for example, the introduction of free HIV care in 2004 dramatically increased the uptake of voluntary counselling, HIV testing and antiretroviral therapy; similarly in Malawi, more women and younger people started antiretroviral therapy at an earlier stage of the disease when Lilongwe Central Hospital started a programme of free antiretroviral therapy distribution. (Souteyrand et al. 2008)

Social health insurance schemes do not usually cover AIDS treatment, limiting their effectiveness for promoting treatment. Some schemes also exclude people living with HIV, especially those from key populations, who may be viewed as too high risk. In 2006, China passed a state council decree to make this type of discrimination by private insurance companies illegal; however, enforcement remains a challenge. (Fultz 2010)

Other demand-side methods, such as vouchers and exemptions, may be more effective for promoting antiretroviral therapy, although the evidence is mixed. For example, pilot antiretroviral therapy projects in Cote d'Ivoire and Senegal failed to demonstrate the impact of exemptions for the poorest groups. In Senegal, applying for exemptions or reduced fees was a slow and bureaucratic process that lacked transparency and was expensive relative to the income generated. The response to patients facing financial difficulties was not sufficiently rapid to avoid interruptions in treatment. (Souteyrand et al. 2008)

Even free antiretroviral therapy is not guaranteed to increase coverage to all those in need. Providing free antiretroviral therapy could raise serious supply, capacity and funding challenges; additionally, governments have concerns about the impact of this policy on other essential health services and fostering long-term donor dependence. Countries that provide free antiretroviral therapy have uptake problems, likely due to real and opportunity costs (i.e. out-of-pocket costs, costs of lost labour time) of seeking treatment. Even where services are free, stigma, and other factors can prevent uptake of services. (Newman et al. 2007) A study from Ethiopia found that the most common reason for loss to follow-up is the use of alternative therapies (such as "holy water"). This is followed by a lack of support, nutritional problems, and transportation problems. (Seyoum et al. 2009) More evidence is needed on access barriers to shed light on different rates of antiretroviral therapy uptake in different settings, and whether investments in supply or demand will have the greatest impact.

Children living with HIV face specific barriers to treatment, which are particularly acute for those living in “skip generation” households, where often over-burdened, poor grandparents care for a large number of children. Results from a study in Uganda indicate that some members of skip generation households are less likely to adhere to antiretroviral therapy regimes compared with members of other households. Possible reasons are that older carers do not know how to take the drugs, cannot provide the necessary food to accompany the drugs, or simply cannot access the drugs. Children on antiretroviral therapies reported being turned away from drug distribution sites when they showed up alone, when older carers were unable to accompany them. (Samuels & Wells 2009)

Impact on care and support

As evident from the discussion above on HIV prevention, social health protection has an important role to play in mitigating the impacts of AIDS on affected households. This may reduce access to essential health care, especially when deaths leave elderly people and young children behind in skip generation households. Many health-financing experts emphasize the benefits of abolishing fees for essential health services. For example, when Uganda abolished health user fees for government health services, attendance by poor households immediately increased, sustained by accompanying investments in supply side improvements. (Yates et al. 2006) For ultra-poor households in low-income, high-burden countries, abolishing health user fees may be the best way to ensure access to essential child health and other services. In other countries with national health protection schemes, such as Thailand, the challenge may be to ensure that people affected by HIV are not discriminated against or excluded from national schemes, enabling their access to essential health services.

Social health insurance schemes can potentially play a role here in reducing financial barriers for the elderly and young children, although this benefit may be more evident in “better off” households, rather than in poorer households. (Joint NGO Briefing Group 2008) For example, a World Bank review of community-based health insurance schemes indicates that members of these schemes are less likely to need to borrow or sell their assets to cover health costs, and are less vulnerable to social pressure to contribute to the health costs of others. They cover an estimated 25–50% of health costs but again, in general, tend to exclude the ultra-poor. (Tabor 2005) Reasons that the poor are left out include unaffordability of required premium contributions, weak administrative capacity, fraud risks and a lack of awareness of the schemes. As mentioned above, exemptions for ultra-poor users rarely work well in practice.

Home-based care for people living with HIV

Home-based care for people living with HIV includes clinical, psychosocial, social and economic, legal and human rights services. While the specific contents of home-based care vary, it usually meets the social protection objective of protection for vulnerable people and households. Home-based care can also help to prevent destitution by providing food, and economic and legal support. The Universal Access objectives of home-based care primarily promote care and support, although there is increasing evidence of its relevance for treatment. (Budlender 2008; Senefeld et al. 2008) Comprehensive home-based care that reduces the vulnerability of affected household members could potentially play a role in HIV prevention as well, although this is not addressed in this paper due to lack of evidence. Similarly, there is little documented evidence for the impact of home-based care on levels of support for people living with HIV; most of the available literature is descriptive and does not provide evaluation or operational research results.

Providing home-based care is an essential complement to facility-based health services, although in many settings, home-based care programmes operate in the absence of links to health facilities and professional providers. The diversity of home-based care programming is wide in terms of activities, structure and goals of the providers.

Impact on AIDS treatment

As increasing numbers of people living with HIV are accessing antiretroviral therapy, the responsibilities of those who provide home-based care are shifting. Where antiretroviral therapy is available widely, the role of home-based care providers is changing from terminal to chronic disease management, requiring new knowledge and skills. Treatment adherence is becoming a major concern for providers, particularly with the push towards the virtual elimination of HIV transmission from mother to child. Adherence to antiretroviral therapy is primarily encouraged through education and counselling. The literature provides examples of promoting treatment adherence using technology. For example, people taking antiretroviral therapy can be given cell phones, which home-based care providers call to remind them to take their medications without requiring them to pick up, bypassing associated costs. (Senefeld et al. 2008)

A review of 21 home-based care programmes in Africa, Asia and Central America shows that most home-based care providers have received some training, which is particularly important because their roles include everything from providing a “good death” to chronic disease management. (Senefeld et al. 2008) However, another study covering programmes in Kenya, Malawi and Uganda found that up to one third of providers received no special training to carry out their duties. (Murray 2009) There is little documented evidence on the effectiveness of different approaches to home-based promotion of treatment adherence; however, it is clear that training providers to fulfil their changing roles is key.

Impact on care and support

As mentioned above, home-based care programmes provide a wide range of services. Descriptions of experience from several countries in Asia and sub-Saharan Africa show that home-based care programmes:

- ▶ improve pain management (in particular, the provision of oral morphine)
- ▶ improve the psycho-social well-being of patients and caregivers
- ▶ improve the quality of treatment by delivering care based on dignity and respect
- ▶ provide food, education and other support for people living with HIV, and children in affected households
- ▶ reduce stigma associated with HIV or with AIDS.

Home-based care programs may also assist with households’ economic status in two ways: by replacing the sometimes considerable sums spent on traditional healers, and by linking to livelihood opportunities in some settings. (Budlender 2010) In Cambodia, Khmer HIV/AIDS NGO Alliance (KHANA) and World Food Programme (WFP) found that a combined home-based care and orphans and vulnerable children intervention had numerous benefits. They found that providing food rations to people living with HIV and orphans and vulnerable children, along with home-based care services, is an appropriate approach to improve food

security and livelihoods—the principal aims of the programme. The group who received the combined intervention also had improved health, school enrolment and anthropometric status compared with the control communities, although it was not clear whether this could be attributed to the intervention. (Thwin 2006)

One of the challenges facing home-based care providers is the enormous number and scope of needs of members of AIDS-affected households, and providers' typically limited capacity to respond. Home-based care providers surveyed in Kenya, Malawi and Uganda inevitably invested some of their own (usually limited) resources. (Murray 2009) These were most often for non-medical needs among family members. The types of services providers delivered without external support included bringing food to households in need, providing support for affected children, as well as frequently covering their own transportation expenses. Box 13 describes an attempt to reduce the burden of care falling disproportionately on women in rural Zimbabwe.

Box 13 - Men as home-based care providers—a gender-based approach

In response to the impossible burden shouldered by women in rural Zimbabwe, Africare tested the feasibility of training men to serve as home-based care providers, linking care to notions of masculinity to sustain their involvement. Men participated as unpaid volunteers. An evaluation found that the men were willing to participate and provided much-needed care, and did not stick only to male clients as expected. However, they were not comfortable leaving their "comfort zone" in service provision, only undertaking tasks such as patient counselling, spiritual support and exercising the patient. They left nursing duties to women. Researchers propose that linking nursing functions with male norms, such as strength and empowerment, could help. They also recommend providing small payments for workers, which could be used as performance incentives to improve the quality of care. (Hall et al. 2006).

The balance of volunteer and paid staff in home-based care programmes varies, as does what providers are mandated and equipped to supply. Many home-based care services are provided by volunteers who do not make money from their work and are often impoverished themselves. Where volunteers and paid staff work side by side, tensions inevitably arise. (Murray et al. 2009) A major challenge for the provision of home-based care is adequate resourcing to enable some payment for providers, as well as supplies to cover the essential needs of the ill person and others in the household, especially children.

Providing home-based care is more effective for reducing stigma when the care is AIDS sensitive but not AIDS exclusive. That is, home-based care programmes should consider the needs of people and households affected by HIV and AIDS and adjust criteria to include these people (rather than simply targeting people living with HIV). Palliative care for AIDS does not differ from palliative care for other terminal illness, and in the era of expanding access to antiretroviral therapy, the shift to chronic disease management requires general skills that can be applied beyond the provision of antiretroviral therapy.

Implementing home-based care

Experience shows that home-based care is more effective when it is embedded within existing community-based HIV programmes. (Senefeld 2008) Effectiveness is also increased when home-based care is linked with other services through functioning referral systems. Links with health services are key, but legal, social, financial, nutritional and livelihood services are also important in mitigating the impact of AIDS.

Social protection plays a key role in linking the most vulnerable households to essential HIV-related services, which are best provided at the community level. However, people who provide home-based care point out that it is an underfunded and underaddressed part of the HIV response. The increasing attention to HIV-sensitive social protection can be an important opportunity to bring more attention, resources and professionalism to home-based care.

Legislation, policies, regulation and HIV

The social protection approaches described throughout this paper will have a limited impact without transformative approaches that change the legislative and cultural environment in which poor, vulnerable, and socially excluded people live. Hence, legislation, regulation and policies operating at different levels are key pillars of social protection, playing a role in promoting transformative objectives. Social protection legislation, regulation and policies have the potential to contribute to all the HIV outcomes addressed in this paper, although the evidence on their impact is extremely limited, making it difficult to assess their effectiveness. Selected examples are provided below to highlight the potential of work in this area to improve HIV-related outcomes.

Changes to the law

Changing laws can remove major barriers to essential health services for people living with HIV and AIDS-affected groups. Legal reform can even change the way in which services are provided, by altering the attitudes of health service providers. In turn, this can help to prevent HIV in key populations. A good example of how the law can reduce HIV susceptibility comes from India, where the sodomy laws were changed so it is no longer illegal for men to have sex with other men. This reform was a long time in coming: for 10 years, the negotiation was in and out of the courts (an effort led by the Lawyer's Collective). Fiji is undergoing a similar process. Meanwhile, in Uganda, there is a risk of overhauling the current punitive law with an even more draconian one (described in Box 14). While India's legal change is too recent to see a major impact, it is likely that men who were not willing to access essential health services because it would expose them to prosecution will now be able to seek care for sexually transmitted infections, voluntary counselling and training, and essential safer sex supplies, reducing their HIV risk. Changes in the law could also decrease stigma and discrimination towards men who have sex with men, decreasing their invisibility and possibly increasing service access (A. Doupe, World Health Organization, personal communication, 2010).

Box 14 - Social protection through legislation

The live debate about Uganda's Anti-Homosexuality Bill is a stark illustration of why legislation is an important piece of HIV-sensitive social protection. The Bill, which was introduced in October 2009, strengthens existing penalties against homosexuality, making same-sex relations punishable by prison or even death. In particular, it prescribes the death penalty for people who have previous convictions, are HIV-positive, or engage in same sex acts with people younger than 18 years. Among its many provisions, a person who fails to report within 24 hours the identity of anyone perceived to be a homosexual or who supports their human rights would be subject to up to three years in prison. These provisions could have immediately fatal consequences for some, and ultimately fatal consequences for others, as men who have sex with men are pushed even further away from essential health services. A Civil Society Coalition—an alliance between members of Uganda's civil society—is campaigning against the passing of this Bill. It appears the Bill may be withdrawn from parliament based on the recommendation of a review committee, although the committee still supports one component, which criminalizes the provision of services and funding to Uganda's lesbian, gay, bisexual, transgender and intersex community.

Legal assistance

Integrating legal assistance into HIV programming has the potential to address some of the structural forces making people vulnerable to HIV infection and its impact, along with providing essential health services. Research suggests that providing legal services can help to reduce some of the forces that render women vulnerable and pose barriers to HIV testing and disclosure, such as domestic violence, child custody concerns and access to resources. In South Africa, a model is being tested through the South Africa HIV/AIDS Antenatal Post-Test Support Study. (Canadian HIV/AIDS Legal Network 2007) Researchers are comparing the impact of providing voluntary counselling and testing, prevention of mother-to-child transmission initiatives, and legal services compared with voluntary counselling and HIV testing and prevention of mother-to-child transmission initiatives alone. In Zimbabwe, the Linkages for the Economic Advancement of the Disadvantaged's Legal Service Voucher Programme provides vouchers to poor clients of AIDS service organizations to give them access to legal services for will writing, guardianship assistance and maintenance claims. Lawyers, who were reimbursed by the project, had to compete to be part of the network receiving the vouchers, thereby improving the quality of services provided. More than half of the beneficiaries had redeemed their vouchers by the end of the first year of the pilot. (Gillespie & Kadiyala 2005) In South Africa, a committee of palliative care and legal service providers is integrating legal and human rights advocacy and services into hospices and palliative care programmes. These types of integrated approaches are relatively new and untested, but have the potential to improve care and support objectives, as well as HIV prevention.

In many regions, women who lose husbands are at risk of losing their property as well. This has stimulated the development of efforts to protect inheritance rights for widows and children, accelerated by the excess mortality from AIDS. While robust evaluations of these efforts are limited, approaches that provide legal and psychosocial support, including paralegal assistance, will-writing workshops and training widows to navigate legal processes, can help to empower widows to protect their property. Training village leaders, paralegals, and members of Land Boards and Tribunals can also help to enforce property protections, inheritance and legal rights. (GNP+ et al. 2007).

From a different perspective, work with injecting drugs users in the Ukraine shows how engaging the legal system can reduce the number of people who use these drugs and help those in need, rather than persecuting them. This increases opportunities to provide HIV-prevention interventions to injecting drug users. A study reported on civil society organizations that monitored police investigations, raised awareness with law enforcement officials and advocated with high level public officials to decrease the number of human rights abuses against injecting drug users. (Canadian HIV/AIDS Legal Network 2007).

Stigma-related barriers

A supportive legal and policy environment can go a long way towards protecting the rights of people living with HIV and changing the way in which they are viewed by service providers—particularly health-care workers. Stigma-related barriers to essential health services are among the most deadly; however, we do not know enough about the scope of their effect, nor about the most effective ways of reducing them.

A review of studies that used quantitative measures to assess HIV-related stigma summarized methods of measuring stigma. (Nyblade 2006) Studies that measured HIV-related stigma

in the general population were found to assess social distancing and support for coercive measures towards people living with HIV, as well as attitudes and values towards people living with HIV, such as responsibility, blame, shame and guilt. Another group of studies assessed the stigma experienced by people living with HIV, categorized as perceived stigma, experienced stigma and internalized stigma. The researcher concludes that there is a need for more refined measures, comprehensive data describing all key domains of HIV-related stigma and measurement in a wider range of contexts.

In a combined effort to address some of these gaps, Global Network of People living with HIV/AIDS (GNP+), International Community of Women with HIV/AIDS (ICW), International Planned Parenthood Federation (IPPF) and UNAIDS founded the international partnership, 'People Living with HIV Stigma Index',⁹ which seeks to collect data from around the world on this important yet underaddressed area. The partnership also seeks to understand the various forms that stigma and discrimination take, and their scope and impact. The index developed by the partnership was an initiative by and for people living with HIV, with national implementation driven by People Living with HIV Networks. It has been tested by networks in India, Kenya, Lesotho, South Africa, and Trinidad and Tobago. More than a dozen national partnerships led by people living with HIV have completed full roll-outs of the index, and data are currently being analysed to inform intervention programs and advocacy.

Bearing in mind the limitations of our understanding of stigma, a broad review of interventions shows that providing information, counselling, coping skills acquisition and contact with affected groups appear to reduce stigma and discrimination for people, as well as for those causing it. Most interventions combine information provision with another approach of those listed above; combined approaches are more effective than those providing information alone. (Vidanapathirana & Operario 2007)

Practical toolkits are one of the more common ways to tackle stigma. In settings as diverse as Tanzania and Vietnam, the use of toolkits decreased stigmatizing behaviour and attitudes in community and health-care settings. A review of the evidence also indicates the promise of programming that empowers people living with HIV through training in coping strategies and communication skills. Other nongovernment organizations focus on building support groups for people living with HIV, building their capacity to engage in governance processes, and implementing projects. (McGough 2010)

Stigma and fear of discrimination can keep people living with HIV away from livelihood programmes. A South African income-generating project provides one illustration of how this can be overcome. In this example, demonstrating the effectiveness of the income-generating approach early in the project's establishment attracted people who were initially hesitant to become involved—the early production of improved crops outweighed the fear of discrimination for participants living with HIV. (Swaans et al. 2009)

Workplace policies

Workplace policies on employee and employer rights and responsibilities have a potential role in HIV prevention, treatment, care and support. The International Labour Organization has been a leader in this area, working across regions to put antidiscrimination policies in place and increase access to workplace-based HIV-related education and services, including through employer-based health insurance. A review of their multi-country experience indicates their approach is having an impact. (ILO 2008) Benefits include improved attitudes towards

⁹ The People Living with HIV Stigma Index can be found at: <http://www.stigmaindex.org/>.

people living with HIV and awareness of HIV-related services. The review also suggests that participants increased their use of condom, although the reviewers note that the impact is hard to confirm because there was no comparison group. The Southern African Development Community has taken the workplace-based approach a step further and has implemented an HIV and AIDS in the Workplace Initiative, based on promoting the South African Development Community “Code of Conduct on HIV and Employment”.

The recently passed international labour standard on HIV and AIDS and the world of work should strengthen HIV prevention, treatment, care and support. (ILO 2010) This standard covers people in formal and informal employment, their families, job seekers, volunteers and laid-off workers in the public and private sectors. It contains provisions on antidiscrimination measures relating to social security schemes, occupational insurance schemes, and benefits such as health care, disability, death and survivors benefits. The standard emphasizes the importance of employment and income-generating activities for workers and people living with HIV.

Further information on the impact of workplace approaches is forthcoming. The ILO is completing a study to identify and classify social protection schemes provided around the world through private sector workplace structures that are of greatest importance to people affected by HIV in terms of HIV prevention, treatment, care and support, focusing primarily on employer-based health insurance. (Fultz 2010)

Populations at higher risk of HIV exposure, and children affected by AIDS

Most of the evidence provided in this paper is from the countries of sub-Saharan Africa. The social protection work in concentrated epidemics is most relevant to interventions targeting those at greatest risk of infection and transmission, described by UNAIDS as key populations at higher risk of HIV exposure. In concentrated epidemic settings, these populations include:

- ▶ sex workers
- ▶ people who use drugs
- ▶ transgender people
- ▶ men who have sex with men
- ▶ the families of these groups.

However, most of the data on core populations is primarily from developed countries. Gathering data from developing countries for these key groups is therefore a priority for future research.

This section summarizes the relevance of social protection measures on these key groups at higher risk of HIV infection. It is important to note that the diversity among these groups, and the fluid nature of the behaviours that place them at risk, can be overlooked easily. However, these factors cannot be ignored in targeting and programming. Additionally, many key populations live on the margins of societies, sometimes outside traditional households, without access to many of the benefits discussed in this paper. Reducing barriers to essential health, education and social services is a particular challenge for responding to HIV among key population groups. Finally, it is critical that programming approaches do not perpetuate the social norms that exclude people engaged in risky and often illegal behaviours.

Impact of social protection measures on sex workers

As mentioned in the livelihoods section above, work to reduce the HIV risk of sex workers has either used activities that promote alternative livelihood strategies, or activities that empower sex workers. Anecdotal evidence suggests that the latter is the most effective approach, although this has not been the subject of a meta-analysis. Helping sex workers to access essential HIV prevention, treatment, care and support services, and legal protections are the priorities, as well as efforts to decriminalize sex work. (UNAIDS 2009a) In doing so, it is critical to ensure that sex workers—as with other marginalized groups—participate in the development of programmes that are meant to be in their best interests.

Box 15 describes a ground-breaking project from India, which empowered sex workers by involving them in the design, management and implementation of HIV prevention activities. Tackling gender and human rights issues, improving access to legal services, building sex workers' social capital, and weaving in training and life skills education can heighten the impact of public health approaches.

Box 15 - An effective approach to empowering sex workers for protection: The Durbar Mahila Samanway Committee

In India, the Sonagachi Project, through the Durbar Mahila Samanway Committee, is an excellent example of the power of sex worker collectives changing the legislative and social environment as a way of reducing HIV and other risks. The Sonagachi project staff moved from a more traditional public health approach for HIV prevention to one that empowered sex workers, including activities to address gender issues, negotiation skills with clients, training and capacity building. This empowering approach, led by sex workers themselves, reduced rates of HIV transmission. Condom use in project areas has increased to up to 85% and HIV prevalence among sex workers decreased to 4% compared to rates of 50% reported in other sex work districts of India. The approach has been replicated in other sites in India and in Bangladesh.(Doupe 2007)

Relevant to the alternative livelihoods debate, one of the collective's priorities is to "rescue" children in sex work, usually trafficked into the trade, and training them for other livelihoods. They have been successful at increasing the average age of sex workers in the areas where they work and reducing the number of children in sex work through the use of self-regulatory boards.(Gayen 2006; Bandyopadhyay 2008) The collective has taken on other activities to empower the workers and protect and promote their children's rights, including the establishment of a successful credit cooperative, reducing their vulnerability to a range of threats including HIV.

Other examples in which sex worker collectives have mobilized to effectively promote their own and their children's rights and well-being include Durjoy in Bangladesh, which successfully campaigned to ensure children had access to school; Danaya So in Mali, which has an effective economic empowerment programme and runs a credit union; and Brazil's National Network of Sex Professionals, where sex workers lobbied the government to recognize sex work as an occupation and thereby open up the possibility for them to receive state pensions (R. Morgan Thomas, Global Network of Sex Work Projects, personal communication, 2010).

Experience demonstrates the importance of working with clients and other powerful figures who dictate the conditions of sex workers' experiences: brothel-owners, controllers and security personnel. There has been some success in working with these groups, local police and health workers to introduce codes of practice, which seek to reduce sex workers' potential risk through harm-reduction measures. Working with sex workers' regular sexual partners, as well as their professional clients, is often overlooked but also important.(Doupe 2007)

Policies requiring clients of sex workers to use condoms have had a major, well-documented effect on HIV prevalence in Thailand. Cambodia and Tamil Nadu, India, have adopted similar policies. Importantly, sex workers lose income as a result of these 100% condom promotion approaches, which therefore should be combined with microfinance and income-generating activities.

Impact of social protection measures on people who use drugs

What limited information we do have indicates that community-based outreach and risk or harm-reduction approaches through needle exchange, among other approaches, can reduce behaviours that increase exposure to HIV and significantly decrease HIV infection rates among people who use drugs.(Needle et al. 2005) These approaches should also include HIV treatment, care and support, and should be provided in a comprehensive manner that respects the human rights of participants.

HIV infection rates in Eastern Europe are increasing rapidly (particularly through injecting drug use), and a particular challenge in this region is the need to include the marginalized groups who are primarily affected. Young injecting drugs users (under 18 years) are particularly at risk of HIV infection because they are less likely to have access to harm-reduction services or HIV testing than older injecting drugs users. Those providing services also tend to stay away from young injecting drugs users for fear or legal or other repercussions. (UNICEF 2010)

Some effective programmes in this region focus on keeping children in the care of their families by improving the capacity of families in crisis to stay together through job skills training, parenting skills and home visitation. Also promising are “second chance” programmes specifically for children on the street—who are especially vulnerable to the multiple risks of drug use, coercive sex work and HIV infection—to enable them to rebuild their lives by reaching through networks of mobile outreach workers who provide food, counselling, shelter, education and case management.

Impact of social protection measures on men who have sex with men

Very few studies have been published on reducing HIV risk for men who have sex with men in developing countries, outside the legal issues described earlier in this paper. Men who have sex with men tend to be a higher priority for HIV programming in more concentrated epidemics, but it is also important that their needs and rights are addressed in more generalized situations as well. Despite their important role in transmission, men who have sex with men are not a priority in AIDS strategies in the Caribbean, sub-Saharan Africa or elsewhere. When men who have sex with men are considered within HIV agendas, they generally receive negative attention that fails to address their vulnerability and rights.

Even in the absence of laws criminalizing men who have sex with men, other factors obstruct their access to essential services, including health services. (GNP+ et al. 2007) For example, anal sexually transmitted infections often go untreated, with major implications for HIV susceptibility. Further research of the specific risk factors that men who have sex with men face, and how to address them, is paramount. Without this information, funding is unlikely for HIV prevention programmes that target this group.

Impact of social protection measures on transgender people

“Transgender” describes those people whose gender identity, expression or behaviour is not traditionally associated with their birth sex. Evidence drawn from a small number of studies suggests that transgender people have a high risk of HIV, particularly among sex workers: HIV prevalence rates in transgender sex workers have been found to be as high as 40% in Brazil and 21% in Uruguay. (GNP+ et al. 2007) Transgender people are also vulnerable to many risk factors, including limited access to education, health care and employment opportunities. Studies describe high rates of abuse, multiple sex partners, irregular condom use, injecting needle use and unprotected sex by male-to-female sex workers, which can lead to depression and ill health.

Transgender people may be unable to access treatment, care and support programmes for many reasons, including low socioeconomic status, fear of transgender status being revealed, and discrimination by health care and drug treatment workers and others. Targeted and sensitive HIV-prevention programmes, and appropriate care and support, are virtually nonexistent, despite the demand from transgender people and the concerning HIV statistics.

Pakistan has gone further than some other countries in identifying transgender people, or *hijras*, as a third sex, which can now be recorded on official documents such as passports. Ongoing qualitative research exploring their lived realities (de Lind van Wijngaarden et al., 2010) shows that *hijras* are usually driven out of their families and onto the streets where they often work as professional entertainers or sex workers. This research, which is commissioned by the National AIDS Control Programme, UNAIDS and UNICEF, is an important step in building the evidence base on the marginalization of transgender and other key populations. It lays the groundwork for policy and programming.

Impact of social protection on children

The impacts of AIDS on children are well documented. The Joint Learning Initiative on Children and AIDS¹⁰ has contributed to a growing body of evidence on effective responses for orphans and vulnerable children. (Schenk 2009) Most of this literature focuses on the heavily affected countries in East and Southern Africa, although there are important examples of success in Asia as well. The borders between social protection and orphans and vulnerable children activities are debatable. Clearly, there are significant overlaps, although until recently, orphans and vulnerable children programming has not been linked to social protection and vice versa. However, there is growing interest in child-sensitive social protection to ensure more effective scale up and cost-effective responses for those affected by AIDS. For example, the Joint Learning Initiative on Children and AIDS explored cash transfers as a potentially critical response for children affected by AIDS. A literature review of more than 300 papers found that cash transfers had significant benefits for children. (Adato & Bassett 2008) The Child-Sensitive Social Protection Framework acknowledges the importance of economic support to households (e.g. through social transfers), as well as the need for improved access to social care (family-based care, alternative care, etc.) to ensure the most vulnerable children are identified, protected from all forms of abuse and supported to access basic services. (UNICEF et al. 2009)

Orphans and vulnerable children responses are part of care and support for children affected by HIV, and are part of treatment in the case of paediatric AIDS. They may also play a role in promoting HIV prevention in light of the intergenerational transfer of vulnerability (e.g. by keeping children in school, thus reducing the incidence of hazardous child labour), although this is not well documented.

Early childhood development and HIV

Impact on care and support

Early childhood development programmes aim to:

- ▶ improve the survival, growth and development of young children
- ▶ minimize risks
- ▶ ameliorate the negative effects of risks.

¹⁰ The Joint Learning Initiative on Children and HIV/AIDS was a time-limited, independent alliance of researchers, implementers, policy-makers, activists and people living with HIV. The initiative mobilised research and discussion on children affected by HIV and AIDS. Work concluded in 2009.

Early childhood development programmes address some of the ways in which AIDS makes children vulnerable: intervening in early childhood has documented benefits for children's physical and cognitive growth, development and functioning; schooling outcomes; emotional and behavioural well-being; and economic outcomes. (Engle et al. 2009) Early childhood development programmes also address exclusion and marginalization that may arise for AIDS-affected children because of stigma and discrimination. These programmes also link children to essential health and nutrition services that they may otherwise miss because of their excluded status.

Early childhood development programmes are a priority for children affected by AIDS because they may be more likely to miss out on caregivers' time, sufficient food and nutrition, and health services than other children. These deprivations are especially harmful for children living with HIV. The impacts of deprivation are worse for younger children; however, intervening early with early childhood development programming can have a major, life-long impact. Early childhood development programming for AIDS-affected children should be integrated with psychosocial, health, nutrition and economic services for children and caretakers. The Joint Learning Initiative on Children and AIDS recommends combining programming with home-health visitors, who have had an impressive impact in developed countries but have not been used yet in developing countries. (Chandan & Richter 2009)

To be effective, early childhood development programmes need to work directly with caretakers and children, and to ensure sufficient training and supervision for staff. As mentioned above, including early childhood development staffing as a public works category is an untested concept but may have many benefits.

While the contribution of early childhood development programmes is primarily to AIDS care and support objectives, they may also help to prevent HIV. The developmental and growth benefits cited above may prepare children to perform better in school as they age. This may make it more likely that they remain in school and have greater self-confidence and better judgement ("life skills") as they become adolescents. Additionally, by providing childcare, early childhood development programming can free up women to work and girls to pursue their schooling, which again could reduce their HIV susceptibility. Again, these are hypotheses warranting further exploration.

Child protection and HIV

Child protection refers to a range of programming that aims to protect children from violence, exploitation and abuse. In social protection terms, child protection activities are typically protective in nature, ensuring a basic level of consumption for people and households, and providing a safety net to ensure basic human rights are upheld. Many programmes for orphans and vulnerable children fall within this category. Additionally, the limited evidence on alternative care for children without caregivers and birth registration is relevant here. These are all considered part of the care and support agenda in HIV terms. There is also a potential role for HIV prevention, although this is not documented.

Impact on care and support

Two areas of child protection work that can play an important role in mitigating the impact of AIDS are birth registration and alternative care. As more children lose parents or caregivers to AIDS, there is an increasing need to protect children's legal status and their care arrangements.

Birth certificates are often required to access benefits such as cash transfers and schooling, making them an essential social protection tool. A major campaign in Swaziland has shown that it is possible to register even the most marginalized of children. As a result of being registered, these children—many of whom would have been otherwise excluded—were able to access government educational support grants.(UNICEF 2008b)

Reforming alternative care (that is, finding alternative placements for children who cannot be cared for by their parents) is much more difficult to address. In Southern Africa, alternative care is unregulated, chaotic and often bad for children. As the numbers of children without caregivers increases, the number of orphanages increases, often without sufficient resources, regulation or supervision to ensure children's basic human rights.(UNICEF 2008b) In eastern Europe, HIV-affected children are relinquished into institutions at high rates due to poverty and stigma, including from health-care and social-care providers.(UNICEF 2010) Children raised in orphanages are also usually disadvantaged in terms of social skills and psychosocial well-being. Additionally, orphanages are expensive; on average, they cost 10 times more than community-based care.(Prywes et al. 2004) The United Nations *Guidelines for the alternative care of children* (BCN 2009) provides an opportunity to develop standards that are appropriate for different countries, and that are in the best interests of children.

Evidence—although limited—indicates that children tend to do better in family-like settings, known as family and community-based care.(BCN 2010) While the most appropriate type of care depends on the needs of the child, the society's traditional care practices and available resources, recommended options include:

- ▶ kinship care, in which children live with extended family members;
- ▶ foster care;
- ▶ well-supported child-headed households, where siblings can stay together with regular adult support.

Small family-style group homes may be an acceptable alternative when they are closely linked to the community, and are only used for children over five and for short-term placements.

The approach of programmes for orphans and vulnerable children varies across regions. In concentrated epidemics, reducing stigma so AIDS-affected children can attend school may be a priority. In contrast, covering school fees for the most vulnerable children may be the priority in generalized epidemics in the poorest countries. As with other community-based approaches, there is limited high-quality research identifying which programmes for orphans and vulnerable children are most effective.(Schenk 2009) UNICEF is commissioning studies that will help to further strengthen the evidence base, including a review of lessons learnt in scaling-up social protection in East and Southern Africa, and operational research exploring how community childcare mechanisms can be used to improve access to paediatric treatment and the prevention of mother-to-child transmission (e.g. through links with neighbourhood care points in Swaziland).

Examples of successful programs include the following)

- ▶ Structured community care coalitions in Uganda and Zambia have mobilized and empowered community organizations to care for orphans and vulnerable children and chronically ill people, as well as working with faith leaders to encourage faith-based organizations to support these vulnerable groups. The model increased the number of

beneficiary children with adequate food access and sleeping under a bednet. However, the needs of orphans and vulnerable children far outstripped the community coalitions' capacity to respond, especially in areas with increasing food insecurity. (Schenk 2009)

- ▶ In Uganda, succession planning with HIV-positive parents has increased the number of parents who identify a successor guardian and who have disclosed their HIV status to their children. Succession planning can include counselling on disclosure, will writing, assistance with school fees and income generation. (Gilborn 2003)
- ▶ In Tanzania, the child-led Vijana Simama Imara provides material support, HIV education and counselling, self-defence training, agricultural training and recreational activities. This programme provides psychosocial and socioeconomic benefits, pointing to the important role that child participation can play. (Schenk 2009)

Implementing child protection programmes

Child protection activities for children affected by AIDS are usually aimed at orphans and vulnerable children. According to most countries' definitions, this includes children vulnerable due to a range of causes, including HIV. Experience shows that programmes for orphans and vulnerable children must be AIDS sensitive but not AIDS exclusive to be effective. There are many harmful examples of singling out "AIDS orphans" for exclusive benefits rather than targeting children in greatest need of assistance regardless of the cause. (Baingana et al. 2008)

Child protection and programmes for orphans and vulnerable children must also be sensitive to gender. Boys and girls face different vulnerabilities, especially as they reach adolescence, and need different approaches that take account of this. Evidence from a number of sub-Saharan countries reveals that adolescent girls orphaned by AIDS are more likely to be sexually active than non-orphaned peers; the impact also differs if they lost their mothers, fathers or both parents. (Birdthistle 2009) Boy orphans may also be at risk. For example, in livestock or pastoralist areas, such as in Lesotho, orphaned boys may be more likely than boys from the household caring for the orphan to be taken out of school to tend the herd (L. Brown, World Food Programme, personal communication, 2010). By being gender sensitive, programmes for orphans and vulnerable children have the potential to break the cycle of HIV susceptibility, interrupting the intergenerational transfer of ill health for a particularly vulnerable group.

Other programming lessons must be taken into account to improve impact. Programmes for orphans and vulnerable children are more successful where they use local resources and leadership structures. At the same time, formal management structures are necessary for success. Finally, programming has more of an impact when it responds to immediate, locally defined needs, rather than donor driven ones. (Schenk 2009)

Who should benefit: lessons on targeting

Targeting issues are key design considerations for HIV-sensitive social protection. Anecdotal evidence suggests that people affected by HIV, including those who are HIV-positive, are often excluded from social protection programmes because of stigma, social marginalization or other factors.

This section summarizes what we know about different targeting approaches being relevant to people and households affected by HIV. Much of the evidence comes from targeting cash transfer programmes, but is applicable more broadly.

What we know about targeting social protection

The following common types of targeting approaches are used on their own or in combination:

- ▶ means testing: using predefined measures of wealth (proxies) to assess household income level;
- ▶ geographical: reaching everyone in a particular defined geographical area based on poverty, food insecurity or HIV prevalence;
- ▶ community-based: a group of community members identifies those most in need using locally agreed criteria;
- ▶ categorical: reaching everyone in a clearly defined group (pensions for the elderly are the most common form of categorically targeted benefit);
- ▶ self-targeting: participants in need make themselves available for benefits, as is used in public works programmes.

No targeting method is perfect; their strengths and weaknesses vary. None can completely avoid errors of inclusion (where benefits reach those unintended for them) or exclusion (where those who are supposed to receive benefits are left out). Planners may be willing to tolerate more inclusion errors (“leakage”) than exclusion errors, and tradeoffs between these types of errors are inevitable. A major review of cash transfer targeting approaches conducted by the World Bank found that most targeting reached more of the poorest than would random allocation. (Coady et al. 2004) The review found that approaches using proxy means testing, community-based selection of beneficiaries and categorical targeting of children worked better at reaching the poorest than categorical targeting the elderly and self-selection based on consumption.¹¹

11 “Self-selection relies on the poor to opt into program participation and the non-poor to opt out based on the type of service or good provided. Subsidies applied to goods consumed largely or disproportionately by the poor, like kerosene or broken rice, are examples. Public works programs that offer below market wages set a costless screen against leakage since better-off households are unlikely to work for lower wages.” (J. Van Domelen, *Reaching the poor and vulnerable: targeting strategies for social funds and other community-driven programs*. Washington DC, World Bank; World Bank Discussion Paper No. 711) P6

Reaching those most in need

The increasing interest in HIV-sensitive social protection is partially fuelled by the perception that people affected by HIV are often overlooked in social protection programmes. Because of the effects of AIDS on households (e.g. if the caregiver is ill they can give less attention to children, thus experiencing stigma and discrimination), people living with HIV and households affected by AIDS may be disproportionately excluded. People who use drugs, sex workers, transgender people, men who have sex with men and other people who have a higher risk because of criminalized behaviour are even less likely to be able to access their entitlements because of the additional legal barriers.(GNP+ et al. 2007)

People are also excluded from social protection programmes because they may not know that programmes exist, they lack the documents required to access the benefit (e.g. birth certificates), or they are unable to access the benefit due to real costs and opportunity costs (e.g. missed income while accessing the benefit).(Scherr 2009) In addition, “leakage” to higher income groups is a concern with categorical and universal approaches.

Integrated approaches are needed to minimize vulnerable groups from being excluded. Combining social work and legal services with cash transfer dispersal has potential to extend benefits to those who could be potentially excluded, although there are few experiences with this type of integration. Chile’s national social protection system—*Solidario*—shows the potential of combining conditional cash transfers with social services directly assisting beneficiary families (see Box 16). The Isibindi model in South Africa mobilizes trained child and youth care workers from the community to respond holistically to vulnerable children and their families. Through regular home visits, care workers help in different ways to ensure that children receive the necessary support to remain in their community and with their families. This support may include assisting families to secure social security or disability grants or accompanying them to health services and government offices (R. Yates, UNICEF, personal communication, 2010).

Box 16 - Chile *Solidario*

Chile *Solidario*, designed in 2002, is often cited as the best example of a comprehensive national social protection system,(Palma & Urzua 2006) For the first 24 months, beneficiary families receive help from a social worker and decreasing amounts of money. After this initial phase, beneficiaries receive a bonus and are eligible for more subsidies from the state and preferential access to social assistance programmes.

Chile *Solidario* includes skills development; work assistance; social security; services for vulnerable children and families, such as school loans; programmes for at-risk children and domestic violence survivors; and family support visits by social workers, who play a key role in linking participants to services.(Palma & Urzua 2006)

Developing programmes that are HIV-sensitive not HIV-exclusive

The HIV exclusion challenge should not automatically lead to a raft of new HIV-specific social protection programming. Instead, social protection programmes should be HIV-sensitive but not HIV-exclusive, meaning that they should include those affected by, and living with, HIV. HIV-sensitive targeting criteria are needed to strike a balance between equity, scale, feasibility, affordability and effectiveness. This is true everywhere, but particularly where AIDS has transformed societies.

General principles of “good targeting practice” can help to ensure that people affected by HIV are included where they are in need, such as the cash transfer programmes in Malawi and Zambia, described in Box 17. Experiences in Malawi and Zambia indicate that cash transfers that are targeted through community-based mechanisms can effectively reach households affected by AIDS—even those households that are not targeted specifically. Targeting criteria should be context specific, sensitive and flexible. The level of poverty, type of HIV epidemic and degree of community cohesiveness should be taken into account when choosing the most effective method of targeting. (GTZ 2009) Cash transfer programmes from a number of regions have shown that providing transfers to women does more to expand the benefits to household members, especially children, than providing cash transfers to men. (Adato & Bassett 2008)

Box 17 - Reaching those in need in Kalomo and Mchinji

Two pilot projects in Southern Africa—in Mchinji, Malawi, and Kalomo District, Zambia—assessed the impact of community-based targeting of ultra-poor and labour-constrained households with unconditional cash transfers. A recent evaluation of the Mchinji project showed that the scheme was able to reach the elderly, children and orphans, with demonstrated benefits for child and adult health, school enrolment and hunger in beneficiary households compared to a comparison group (notwithstanding some concerns about the comparability of the reference group). (Miller et al. 2008)

The projects used economic targeting criteria, in conjunction with surrogate measures of the impact of AIDS—including high-dependency ratios (households were considered labour constrained if they had a dependency ratio greater than three). An analysis by UNICEF found that these projects reached approximately 80% of HIV-affected households that required social assistance. (UNICEF 2007)

The authors (UNICEF 2007) conclude that to be HIV-sensitive in high-burden settings, cash transfers schemes should have effective targeting procedures to minimize exclusion errors; provide transfers regularly, reliably and at a level sufficient to meet the most basic needs of all household members; link beneficiaries to health and social services, such as antiretroviral therapy, home-based care and psychosocial counselling; and are complemented by productivity and employment-oriented schemes that target ultra-poor households with adult members who are fit for work as part of a comprehensive social protection strategy.

It is worth noting that these schemes experience continuous tension between affordability and the need for systems, technology, staffing and resources necessary for successful implementation; and that they have not managed to expand from small-scale operations to the expanded scale so desperately needed in Malawi and Zambia.

The system should allow for regular reassessments of eligibility as the vulnerability of people and households shifts over time, depending on factors such as labour potential, asset base and health of the main breadwinner. For example, this becomes a critical consideration where households with several children rely on income from a grandparents’ pension—the household’s security must be ensured when grandparents die and this income is lost.

While the above considerations are important to help make programming HIV sensitive, some suggest that there may be one case where HIV exclusive targeting makes sense: social transfers for people on ART to help promote adherence; for example, to cover transport costs and help meet nutritional requirements. Antiretroviral therapy will fail, and investment will be lost, without adequate nutrition and regular access to health services. (de Pee & Semba 2009) This is also true for other diseases that require long-term monitoring and treatment (e.g. tuberculosis or cancer). In the case of antiretroviral therapy, the Uganda study described in the cash transfer section demonstrates the potential of providing a small amount of additional funds to promote adherence. (Emenyonu et al. 2010) However, this

approach risks violating equity concerns, leading others to recommend targeting transfers to the “ultra-poor” (identified using one of the methods described above), including those on antiretroviral therapy, only when they are eligible using poverty criteria.(Slater 2008) In low and concentrated epidemic settings, it will be particularly important to balance poverty-based targeting with targeting that identifies the most vulnerable people at heightened risk of HIV infection, as well as people disproportionately affected by the impact of the epidemic (e.g. people using drugs, mobile populations, sex workers).

Programme designers must strike the right balance between locally appropriate targeting approaches, where beneficiaries are regularly monitored, and the need to keep programmes simple and feasible where capacity is limited. In some cases, there may be value in starting small. Some Latin American countries have used cash transfers for a limited population to lay the groundwork for more comprehensive approaches (J. Elder, UNICEF, personal communication, 2009). Experience shows how capacitating the ministry responsible for the implementation of a particular programme—such as a social welfare ministry, which is often weak—to deliver cash transfers can attract further resources to enable them to expand operations. Similarly, the success of a cash transfer programme can build political commitment to social protection, which can lead to more comprehensive approaches and governments that are more accountable to their poorest citizens.

Recognizing the vulnerabilities of key groups

Focusing on poverty considerations alone is not sufficient to make social protection HIV-sensitive. HIV-sensitive social protection must also take account of the specific HIV-linked vulnerabilities of particular population groups. Many of the reasons that people are susceptible to HIV infection relate to social exclusion, marginalization and stigma associated with particular behaviours, rather than to poverty. As this paper has shown, in addition to reducing poverty and its impacts, social protection can play a role in managing risk, reducing social vulnerabilities and building resilience.

UNAIDS urges planners to “know their epidemic”; similarly, understanding the drivers of the spread and progression of HIV is essential for designing appropriate social protection programmes that include those affected by HIV. In generalized epidemics, broadly targeted approaches may make the most sense, while in concentrated epidemics, more targeted approaches are likely to be required to reach key populations at risk of HIV infection. However, when targeting interventions at particular groups, particular attention must be paid to stigma. Operational research looking at targeting in different epidemic contexts that takes account of social and economic vulnerability is limited, pointing to a major evidence gap.

Conclusion: do we know enough about HIV-sensitive social protection?

This final section summarizes the most pressing gaps in the evidence on HIV-sensitive social protection, based on the literature review.

Gaps in the evidence for the impact of social protection programmes

Many social protection instruments are supported by an evidence base on health, education and other child and social outcomes, from which it may be possible to infer HIV-related impacts. However, this paper demonstrates how few of the studies categorically link results directly to HIV. This does not imply that the social protection instruments are not HIV-sensitive. Many of these programmes, when operating in areas of high HIV prevalence, likely benefit HIV and households affected by AIDS, but this is not widely documented, because monitoring and evaluation systems are not often in place to assess these impacts. As noted, the impacts of different social protection instruments on AIDS-related care and support are better documented than for prevention and treatment.

Expanding social protection research to include HIV prevention

The first research priority is to build the evidence on how different social protection instruments affect HIV prevention, knowledge and behaviour. This research should consider gender issues, focusing on the particular vulnerabilities of girls, women and key populations. On a related note, further research is needed on how to break the cycle of AIDS-affected to HIV-infected. Research is also needed on the role of social protection throughout people's lives; for example, for the youngest HIV-positive children and those affected by HIV (early childhood development, nutrition, care and protection); adolescents at risk of early sexual debut; through to HIV-positive adults and those affected by HIV, and elderly care givers looking after vulnerable children. This could be explored using longitudinal research that follows individuals to trace the causal pathways from economic strengthening or asset transfer to a reduction in risky behaviour.

Harm-reduction approaches, which are often used to target people who use drugs or sex workers, could be applied more widely. Several studies indicate that girls and women adopt a harm-reduction approach for their sexual behaviour (e.g. the girls targeted in the Zomba cash transfer programme and the sex workers reached through the Kenya project). In each case, beneficiaries did not stop having sex, but they changed how they had sex and with whom (decreasing frequency, having sex with peer boyfriends rather than older men) to reduce their risk. In both cases, it appears that the influx of cash replaced the money or goods formerly received from sexual partners, reducing their risk in the process of changing their patterns of sexual partnering. Similar harm reduction approaches may be achieved by reducing food insufficiency through food assistance, either in kind or as vouchers. Research testing this hypothesis in a range of settings could yield important results.

Defining social protection's contribution to AIDS treatment

The links between social protection and AIDS treatment are barely explored in the literature, leaving a number of important questions unanswered. As an increasing number of countries roll out free antiretroviral therapies, research to understand the other economic and social

barriers to treatment becomes increasingly important. Social protection may help to reduce some of these barriers. With the growing commitment to the virtual elimination of mother-to-child transmission, understanding and responding to access barriers, including through HIV-sensitive social protection, is likely to be an area of growing interest. In this respect, there is the need to support operational research on how different combinations of cash, social care and stigma reduction initiatives can help expand access. In addition, there is more to learn from systematically applying the lessons learnt from the maternal health and other fields to AIDS treatment; for example, testing the most effective models of fee exemption for AIDS care. Finally, there may be untapped potential within social health insurance schemes to cover antiretroviral therapy or related treatment costs, possibly combined with public subsidies for those who cannot afford premiums. UNAIDS is currently conducting an in-depth review of the literature on this topic, including country-based modelling. This will shed light on real-world experience using social health insurance and other social health protection measures for AIDS-related services.

Evaluating the effect of livelihoods approaches

As more people living with HIV live active lives on treatment, there is more to learn about the utility of livelihoods approaches, especially microfinance, for people and households affected by HIV. Again, there is a need to learn from programmes with a graduated approach to social protection, including those combining social assistance and livelihoods support, to better understand the ways to support populations with different levels of productive capacity.

Of particular interest is the extent to which including early childhood development and home-based care staffing within public works programmes could benefit AIDS-affected populations. If attractive to women (and men) from AIDS-affected households, this could potentially play a role in protecting children, advancing care and support objectives, and generating income for households in need. South Africa's experience with making home-based care part of their public works programme should be closely monitored for lessons that could be tested elsewhere.

Targeting key populations at highest risk

Another under-researched but important area is how to use social protection programming to promote HIV prevention, treatment, care and support for key populations. The evidence is mostly limited to the developed world, with some potential relevance to other regions. The almost total lack of evidence on effective ways to use social protection approaches to reach men who have sex with men in developing countries is notable, particularly since many are married to women and at high risk of getting and transmitting HIV. The evidence on the impact of transformative approaches for sex workers is limited to only a few sites, and there is much more to learn about people who use drugs as well. In summary, we need to know much more about the role that HIV-sensitive social protection can play in reducing the vulnerability of populations at high risk, and their families—both in preventing infection and mitigating impact, as well as protecting and promoting human rights. Another priority is exploring the lessons learnt from developed country experiences relevant to low-income settings.

Gaps in the evidence for implementing social protection programmes

Two types of evidence are required to assess the effect of social protection activities: evidence on programme impact, and evidence on operational lessons to inform implementation and scale-up. Evidence for the latter highlights the need for comprehensive social protection systems that link different instruments, and connect to complementary services and sectors. An important operational question is how “comprehensive” a social protection approach must be to promote Universal Access outcomes.

Identifying the right package of support

Further research is needed on the optimal packages of social protection measures for Universal Access outcomes. Debate is often focused on cash versus food, or conditional versus unconditional transfers. However, we still need to understand what is the most appropriate combination of transfers (i.e. food and cash vouchers) and programmes to strengthen economies, improve access and minimize social exclusion. This requires further research in different settings. Ongoing research in the Southern Africa Children and AIDS Regional Initiative is an opportunity to address some of these issues.

Understanding the political economy of HIV-sensitive social protection

Assessing the current state of social protection programming is outside the scope of this paper. A systematic literature review is needed of the contents, coverage and impact of social protection programming in the context of HIV. Central to this research are questions of political commitment, capacity of social welfare or other lead ministries, and the nature of donor support (e.g. the room within governments’ HIV and social protection budgets to expand HIV-sensitive social protection). Building on the few studies that have assessed the political economic of social protection (e.g. McCord 2009), and ensuring HIV is considered within such studies, is a priority for further research.

There are concerns about the financial capacity to provide social protection, particularly in low-income contexts. Research on the cost-effectiveness of different instruments is limited, however there is some evidence available for cash transfers which has been better analysed than other instruments. More cost-effectiveness data are urgently needed to inform discussions with finance and economic planning ministries on where investments are likely to yield the greatest returns for Universal Access, as well as Millennium Development Goal outcomes.

Concerns about fiscal space point to the need to look carefully at the risks of inclusion and exclusion errors within different schemes, and to identify what is most accessible to the ultra-poor. For example, planners need to consider that income level and the ability to take on economic risk will determine whether individuals are likely to take up transformational livelihood activities and contribute to social health insurance schemes.

Identifying the best way of targeting key populations at higher risk

There are many unanswered questions about effective targeting. Further research is needed to find the right balance between reaching poor, excluded and HIV-affected people. This could be done by collecting data from programmes that are already in place.

A key issue is whether targeting based on economic criteria alone is sufficient to be HIV-sensitive, and whether this can help overcome the social exclusion faced by widows, orphans

and key populations. We also need to identify the best proxy indicators for HIV affectedness and vulnerability to help determine who needs HIV-sensitive social protection and which instruments are appropriate. For example, in the epidemic context of Southern Africa, high numbers of orphans and households headed by the elderly correlate to high rates of HIV; further research is needed to define the best proxy indicators in different epidemic contexts.

Specifying the targeting question further, there is a great deal to learn about the reach and impact of cash transfer programmes for AIDS-affected households. Some research is being done in small areas; for example, Free State Province in South Africa, (Booyson 2003) Kalomo, Zambia, and Mchinji, Malawi (Schubert 2007, Miller et al. 2008). Save the Children UK and UNICEF have designed a longitudinal multi-country study exploring operational challenges to scaling up cash transfers, including different targeting approaches, which should take AIDS' impact into account. (Yablonski 2009) Answering this question would require a complex study design; however, in light of the popularity and impact of cash transfer programming, such results could be significant for those seeking effective ways to mitigate the impact of AIDS on households.

Making the most of the evidence

Finally, we have opportunities to learn from existing and planned social protection programmes. In particular, more programme evaluation is required, because regular monitoring and solid evaluation is critical to scaling up (although it is expensive to do well). Programmes need more consistent baselines and more rigorous evaluation design. Qualitative research that sheds light on people's lived experiences of HIV-related risk and vulnerability will help to expand the availability of quantitative monitoring data on the HIV-related impacts of social protection programming. Monitoring, evaluation and research needs must be balanced with pressure to provide resources to beneficiaries, requiring donors to be flexible about acceptable levels of overheads for implementation, monitoring and evaluation, and research.

The challenge does not end with new studies, operational research, or improved monitoring and evaluation. As with any research agenda, particularly one as urgent as this, evidence must be maximized for its policy relevance, timeliness and accessibility to potential users. Even where there is evidence, it is often not used to inform programming. In light of fiscal constraints, the recent economic crisis and the ever growing number of people in need of HIV prevention, treatment, care and support, we must do more than ever to interrogate existing programmes, target new research, and ensure evidence reaches decision-makers, especially governments in the "global south", to expand and scale up social protection measures that are HIV-sensitive.

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