



HIV-SENSITIVE SOCIAL PROTECTION:

STATE OF THE EVIDENCE 2012 IN SUB-SAHARAN AFRICA

unicef 

Economic
Policy
Research
Institute

HIV-SENSITIVE SOCIAL PROTECTION: STATE OF THE EVIDENCE 2012 IN SUB-SAHARAN AFRICA

10 July 2012

Elizabeth Miller, Economic Policy Research Institute
Michael Samson, Economic Policy Research Institute

Commissioned by UNICEF



Economic
Policy
Research
Institute

ACKNOWLEDGEMENTS

The authors are grateful to the many respondents with whom we have consulted in UNICEF and other UNAIDS partner organisations who have contributed their time and intellectual engagement to this project. We are particularly grateful to the HIV/AIDS team and the Social Protection team at UNICEF Headquarters for their tireless support and most helpful comments on previous drafts. This paper was reviewed and amended after a participatory meeting with government, civil society, UN and academic stakeholders held in Johannesburg in March 2012. We would like to thank all of those who provided inputs at the meeting to discuss the evidence and conceptual framework and who provided comments on this draft.

Miller, Elizabeth and Michael Samson (2012) "HIV-sensitive Social Protection: State of the Evidence 2012 in sub-Saharan Africa. Commissioned by UNICEF and produced by the Economic Policy Research Institute, Cape Town.

This working paper was made possible with support from the United Nations Children Fund (UNICEF) and is a product of Economic Policy Research Institute with input from UNICEF staff. The findings, interpretations and conclusions expressed in the working paper do not necessarily reflect the views of UNICEF or its Board or Executive Directors.

TABLE OF CONTENTS

ACRONYMS	3
EXECUTIVE SUMMARY	4
Introduction	4
The reach of HIV-sensitive social protection	4
Achieving core impacts	5
Prevention	5
Treatment	6
Social and economic care and support	6
Comprehensive approaches	7
Expanding and sustaining HIV-sensitive social protection	7
Conclusions about evidence gaps and recommendations	7
The reach of HIV-sensitive social protection	8
Achieving core impacts	8
Comprehensive approaches	8
Expanding and sustaining HIV-sensitive social protection	9
1. INTRODUCTION	10
Figure 1. The HIV and AIDS Investment Framework	11
1.1 Key definitions	12
Figure 2. Examples of social protection interventions that mitigate the impact of HIV/AIDS on vulnerable households	13
1.2 Methodology	14
2. DEMAND-DRIVEN EVIDENCE BASE ANALYSIS FRAMEWORK	16
Figure 3. A demand-driven perspective on evidence	16
Figure 4. A conceptual framework for HIV-sensitive social protection operational evidence	17
Figure 5. Impact of social protection in improving HIV prevention, treatment, care and support outcomes	18
Figure 6. Linkages between HIV-sensitive social protection and core HIV and AIDS outcomes	19
3. EVIDENCE GAP ANALYSIS: THE REACH OF HIV-SENSITIVE SOCIAL PROTECTION	21
3.1 Key research questions: Programme reach	21
3.2 Evidence from the State of the Evidence 2010: Programme reach	22
3.3 New and emerging evidence: Programme reach	23
3.4 Gaps in the evidence: Programme reach	25
4. EVIDENCE GAP ANALYSIS: ACHIEVING CORE HIV/AIDS IMPACTS	27
4.1 Key research questions: Core HIV/AIDS impacts	27
4.2 Prevention	28
4.2.1 Evidence from the State of the Evidence 2010: Prevention outcomes	28
4.2.2 New and emerging evidence: Prevention outcomes	28
Figure 7. Outcomes from the Zomba, Malawi CCT study	29
4.2.3 Gaps in the evidence: Prevention outcomes	33
4.3 Treatment	34
4.3.1 Evidence from the State of the Evidence 2010: Treatment outcomes	34
4.3.2 New and emerging evidence: Treatment outcomes	35
4.3.3 Gaps in the evidence: Treatment Outcomes	38
4.4 Economic and social care and support	39
4.4.1 Evidence from the State of the Evidence 2010: Economic and social care and support	39
4.4.2 New and Emerging Evidence: Economic and social care and support	40
4.4.3 Gaps in the evidence: Economic and social care and support	43

5. EVIDENCE GAP ANALYSIS: COMPREHENSIVE APPROACHES	44
5.1 Evidence from the State of the Evidence 2010: Comprehensive approaches.....	44
5.2 New and emerging evidence: Comprehensive approaches	44
Figure 8. The development planning approach to social protection.....	46
5.3.Gaps in the evidence: Comprehensive approaches	48
6. EVIDENCE GAP ANALYSIS: EXPANDING AND SUSTAINING HIV-SENSITIVE SOCIAL PROTECTION	49
Figure 9. Economy, efficiency and effectiveness in a value-for-money approach.....	49
6.1 Evidence from the State of the Evidence 2010: Expanding and sustaining HIV-sensitive social protection	50
6.2 New and emerging evidence: Expanding and sustaining HIV-sensitive social protection.....	50
6.3 Gaps in the evidence: Expanding and sustaining HIV-sensitive social protection	51
7. CONCLUSIONS.....	53
The reach of HIV-sensitive social protection	53
Achieving core impacts.....	53
Comprehensive approaches	54
Expanding and sustaining HIV-sensitive social protection.....	55
WORKS CITED	56
ANNEX I: CONSULTATION RECORD.....	61
ANNEX II: ONGOING AND UPCOMING HIV-SENSITIVE SOCIAL PROTECTION RESEARCH	62
ANNEX III: COUNTRY CONSULTATION INSTRUMENT	66

ACRONYMS

AIDS	acquired immune deficiency syndrome
ARVs	antiretroviral drugs
ART	antiretroviral therapy
AusAID	Australian Government Overseas Aid Program
CARI	Children and AIDS Regional Initiative
CT	cash transfer
CCT	conditional cash transfer
COPE	In Care of Nigeria's Poor
DFID	Department for International Development (UK)
DHS	Demographic and health survey
EPRI	Economic Policy Research Institute
FAO	Food and Agricultural Organization of the United Nations
HIV	human immunodeficiency virus
ILO	International Labour Organization
IMAGE	Intervention with Microfinance for AIDS and Gender Equity
JSY	Janani Suraksha Yojana
LEAP	Livelihood Empowerment Against Poverty
MDA	ministries, departments and agencies
MDG	Millennium Development Goals
MIS	management information systems
MTCT	mother-to-child transmission
NAP	National Action Plan
NGO	nongovernmental organisation
OVC	orphans and vulnerable children
PHS	physical health summaries
PMTCT	prevention of mother-to-child transmission people living with HIV/AIDS
PTSD	post-traumatic stress disorder
RESPECT	Rewarding STI Prevention and Control in Tanzania
SCT	social cash transfer
SMS	short message service
STI	sexually transmitted infection
UCT	unconditional cash transfer
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UNICEF ESARO	UNICEF Eastern and Southern Africa Regional Office
UNICEF WCARO	UNICEF Western and Central Africa Regional Office
USAID	United States Agency for International Aid
VCT	voluntary counseling and testing
WFP	World Food Programme
WHO	World Health Organization

EXECUTIVE SUMMARY

Introduction

Over the past two decades policy-makers and other stakeholders have increasingly recognised the importance of social protection in tackling poverty, achieving progress towards the Millennium Development Goals and supporting development frameworks for pro-poor and inclusive economic growth. As the HIV epidemic continues, social protection is also now being recognised for its capacity to address HIV-related vulnerabilities. Social protection has the potential to play a key role in reducing an individual's chance of becoming infected with HIV, improving treatment access and adherence, and reducing the likelihood that HIV will have a damaging effect on individuals, households and communities. However, social protection will only support vital HIV objectives if social protection instruments are appropriately designed and effectively implemented. *The State of the Evidence 2012 aims to build on existing reviews of the evidence, particularly Temin (2010), and provide an evidence base to support the development and implementation of social protection instruments that can effectively reach these HIV objectives.* This analysis will also inform planned country-level operational research in sub-Saharan Africa being supported by UNAIDS co-sponsors.

A conceptual framework based on demand-driven evidence analysis underpins this report, encompassing four steps in the development of effective HIV-sensitive social protection policy and programmes. The first step is ensuring that the intervention reaches groups that are more susceptible to HIV infection and vulnerable to the consequences of the disease. The second step involves achieving HIV impacts, which can be divided into the three core Universal Access Outcomes: (i) prevention, (ii) treatment and (iii) social and economic care and support. The third step enhances impacts by building complementary linkages and shifts emphasis to more comprehensive approaches. The fourth step reflects the critical priority that HIV-sensitive social protection programmes are expanded and sustained, so that they can scale up and continue to reach the vulnerable and have a positive impact on key HIV and socio-economic outcomes. The process, from one sequential step to the next, is driven by the *design and implementation* of effective policies and programmes.

The HIV/AIDS Investment Framework (Schwartländer, B. et al., 2011) proposes a new approach to managing national and international responses, and emphasizes the importance of social protection as a development synergy for

achieving HIV outcomes. The Investment Framework's focus on evidence-informed design, inter-sectoral linkages and quantified economic returns based on costed strategies informs this paper's conceptual framework. This paper's review and analysis of existing evidence aims to illuminate the relevant dimensions of social protection as an HIV response as well as inform global and country-level HIV investments.

The reach of HIV-sensitive social protection

A key policy consideration is how to ensure that vulnerable HIV affected populations are reached through social protection interventions. Temin (2010) recommends integrated approaches that can minimise the exclusion of vulnerable groups, as in the case of the Isibindi model in South Africa, which trains child and youth care workers to provide a holistic response in their home visits. *She concludes that HIV-inclusive, rather than HIV-exclusive, social policies are more feasible and may better reach the households most in need.* Schubert (2007) shows that Malawi and Zambia's schemes are successful in reaching HIV-affected households, as roughly 70 per cent fall into this category. However, he also finds that focusing on poverty considerations alone is not sufficient to make social protection HIV-sensitive; rather programme designers must "know their epidemic" and take account of the specific HIV-linked risks and vulnerabilities of particular population groups.

Considering gender within HIV-sensitive social protection is also critical. In an examination of the relationship between cash transfers and HIV prevention, Lutz and Small (forthcoming) conclude that an understanding of AIDS as a disease of inequality, both economic and gendered, implies that targeting women and girls for certain social protection interventions in specific contexts may be the most effective strategy. In India UNDP is focusing on extending the reach of state-run social protection programmes to people living with HIV, especially women and girls, given their heightened social and economic vulnerability. In an analysis of a social cash transfer in Zambia, Schüring (2011) identifies appropriate eligibility criteria that do not focus exclusively on HIV-affected households, and therefore may be less stigmatising than tying the transfer to the HIV-status of household members.

Consideration of how HIV-specific or inclusive social protection interventions should be is another key consideration. An analysis of social protection in Nigeria in the context of high HIV prevalence similarly concluded that, although HIV can be one factor contributing to inequality and social exclusion, social protection should not focus on targeting HIV specifically, but rather poor and vulnerable people in general. Similarly, targeting exclusively on orphaning status in the context of HIV has come under increasing scrutiny. Analysing data from 60 nationally representative household surveys from 36 countries, Akwara et al. (2010) found that orphanhood and co-residence with a chronically ill or HIV-positive adult are not universally robust measures of child vulnerability across national and epidemic contexts. The study calls for more multivalent approaches to determining vulnerability, including a greater focus on household income levels, when determining who are the most vulnerable children. Handa and Stewart (2008) provide further evidence against narrowly targeted programmes

Achieving core impacts

Prevention

Temin (2010) documents an emerging evidence base demonstrating that social cash transfers, food transfers, social health protection, and transformative laws, policies and regulation as well as other broader poverty income generating activities and microcredit, have the potential to prevent HIV directly and/or indirectly. There is a relatively strong body of evidence demonstrating the effectiveness of cash and in-kind transfers (food, uniforms) in increasing school enrolment and attendance, revealing social protection's potential to expand access to the "social vaccine" of education, preventing HIV infection. Temin hypothesises that income-generating activities and microcredit can also reduce the vulnerability of women and girls in AIDS-affected households. Although income-generating activities and microcredit are not social protection, they can be linked to social protection programming. These programmes can empower women, increasing their ability to insist on condom use and refuse sex, as well as reducing their need to resort to risky coping strategies (such as transactional sex) that would increase their susceptibility to HIV infection. Temin notes that many social protection programmes were not designed with the specific objective of impacting HIV outcomes, so therefore there is no HIV-specific impact evidence to support this pathway, or the impacts of maternity care vouchers and the removal of user fees on voluntary counselling and testing or access to prevention of mother-to-child transmission (PMTCT) services. However, there is evidence of impact in the broader health sector, from which it may be possible to infer likely impacts on HIV outcomes.

Since Temin (2010), new evidence has emerged showing more precisely how social protection can address upstream structural drivers of HIV-risk. Specific factors that contribute to vulnerability to HIV risk include poverty, gender inequality, and lack of educational attainment. A growing body of evidence suggests that poverty on its own is not a driver of HIV-risk, but instead interacts with a range of other factors including mobility, social and economic inequalities and social capital, which can converge in a potent way for certain demographic groups, particularly young women in southern Africa.¹ Social protection can play a potentially valuable role in mitigating these risk factors. Social protection programmes can also increase the uptake of critical preventive health services, such as PMTCT treatment and counselling. Lutz and Small (forthcoming) review existing evidence to assess the advantages and disadvantages, both known and inferred, of using cash transfers as a tool for HIV prevention. Their review of the conceptual links between the structural factors of HIV risk (including inequality/poverty, education and gender), as well as proximal factors and proxies for HIV risk, suggests that cash transfers might be effective for HIV prevention.

Evaluation of a randomised control trial in Zomba, Malawi found that recipients of an unconditional monthly cash transfer had a lower prevalence of HIV infection than women in the control group, who received no cash transfer, with evidence further supported by changes in self-reported sexual behaviour. Furthermore, the treatment effects did not differ significantly between unconditional and conditional cash transfer treatment groups, suggesting that the cash was the factor contributing to lower HIV infection rates, perhaps due to higher rates of school attendance in both treatment groups compared to the control group. A study in rural Tanzania found a significant reduction in sexually transmitted infection (STI) prevalence for the treatment group that was eligible for \$20 payments, but no such reduction was found for the group receiving a lesser \$10 payment. Findings of linkages among both conditional and unconditional cash transfer programmes, school attendance and risk factors in Pakistan, Bangladesh, Mexico, and South Africa suggest possible impacts in terms of reduced vulnerability to HIV. A randomised controlled trial in rural eastern Zimbabwe found a more direct link, with comprehensive support to keep orphan adolescent girls in school reducing HIV risk.

An emerging evidence base—with evidence from El Salvador's Comunidades Solidarias Rurales cash transfer programme and India's Janani Suraksha Yojana scheme, a programme that incentivizes women to deliver their babies in a government or accredited private health facility, indicates that social protection programmes can

1 Kim, J., Pronyk, P., Barnett, T., and Watts, C. (2008), Exploring the role of economic empowerment in HIV prevention

reduce social and financial barriers of access and thus increase the uptake of critical prevention health services, such as PMTCT treatment and counselling, thereby contributing to HIV prevention.

Treatment

Temin (2010) documents evidence of the positive impact of a variety of social protection instruments – including social cash transfers, food transfers, social health protection, vouchers and fee exemption schemes on HIV/AIDS treatment. Social transfers and food transfers can play an important role in the nutritional recovery of patients receiving HIV treatment, as well as improving testing and treatment uptake. In a study from Malawi, a randomly assigned small monetary incentive (one tenth of a day's wage) led to a 50 per cent increase in people returning to collect their HIV results. Social health protection (affordable health insurance or government-funded health services that protect against the economic losses and social distresses that can result from ill health) as well as measures that expand health-care access (vouchers, exemptions, fee abolition) can increase access to health services and treatment. Cash transfers to cover clinic transportation costs in rural Uganda (\$5-8 per month) led to better treatment adherence.

More recent studies have further contributed to the body of evidence on barriers to treatment. In Zambia, a qualitative study suggests that the reasons for non-uptake of treatment in these circumstances include issues related to local cultural frameworks (e.g., illness ideology, unfamiliarity with chronic disease management), mental and behavioural health (e.g., managing depression or interpersonal challenges), stigma, and competing motivating factors of different cultures (e.g., values of church or marriage). A qualitative study in Maharashtra, India reported patients' barriers to antiretroviral therapy (ART) adherence and follow-up including financial barriers, social norms of attending family rituals and fulfilling social obligations, self-perceived stigma and attitude towards medication, long waiting periods and insufficient counselling. Ongoing analysis being supported by UNICEF and others on demand and supply bottlenecks will also help inform the design of appropriate social protection and other responses.

Social and economic care and support

Temin (2010) finds a larger amount of literature in relation to the impact of social protection on the care and support of HIV-affected households and children than the evidence for prevention and treatment outcomes. *Households receiving cash transfers are 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. Home-based care programmes also strengthen households' economic status in two ways: by replacing the cost of traditional healers, and by linking to livelihood opportunities and life-saving health and nutrition services in some settings. An important concern is ensuring that people affected by HIV are not discriminated against or excluded from social health protection schemes, such as being excluded from health insurance. Public works programmes must be carefully designed to be sensitive to the challenges that may accompany HIV, such as medical expenses, the heavy care burden that women may already be bearing, and in some cases responsive to labour deficits at the household level. With the expansion of antiretroviral therapy programmes, livelihood programmes are likely to become more important as a response for HIV affected households; however there is limited evidence to date on the impact of livelihood programmes on a range of HIV outcomes.²

Newer evidence includes a study of the Malawi social cash transfer programme which examined how people living with HIV/AIDS (PLWHA) used transfers to aid in the support of themselves and their families, finding broadly positive household-level impacts on health, food security, and economic wellbeing, as well as being better able to send children to school. The Kwa Wazee Project in rural Tanzania provided a pension to grandmothers in a region with very high HIV prevalence and a growing number of orphans dependent upon grandmothers. A participatory qualitative evaluation found a positive impact on school attendance and progress, child-reported increases in time to play, study, read and talk with friends, and nutritional improvements. Similarly, a qualitative study of a community-based cash transfer to support orphans in Western Kenya found it to be a promising means of supporting orphans and carers in terms of food security and social capital. Evaluations of Zambia's social cash transfer provide evidence of a "cash plus", interventions that combine cash transfers with other services, such as home base care, that can mitigate both the social and economic effects of HIV on a household.

There is growing interest on how to ensure social protection can be complemented by other services to maximise impact on HIV-affected children and households. Two areas of child protection work that can play an important role in mitigating the impact of AIDS are birth registration and alternative care. Successfully implemented programmes include structured community

² This is an area of future focus for the From Protection to Promotion Initiative (<http://www.fao.org/economic/PtoP/en/>) a collaborative effort looking at the role of cash transfer programmes in fostering broad-based economic development in sub-Saharan Africa

care coalitions in Uganda and Zambia, succession planning with HIV-positive parents in Uganda, and the child-led Vijana Simama Imara programme in Tanzania. Early childhood development programmes can also address some ways in which AIDS makes children vulnerable and provide important linkages to health and social protection services.

Comprehensive approaches

Development partners increasingly recognise that social protection strategies need to be comprehensive, enabling a range of HIV-sensitive initiatives to be integrated into broader national social protection strategies that achieve both HIV and AIDS objectives and broader human development goals. When executed effectively, comprehensive linkages can contribute to the *transformational* potential of social protection, protecting socially vulnerable groups against discrimination and abuse, changing public attitudes and behavior, and enhancing social equity. Temin (2010) shows the limits of evidence in this regard, particularly in respect of required operational evidence linking different instruments to complementary services and sectors. A critical operational question is how 'comprehensive' a social protection approach must be to promote Universal Access outcomes.

Since 2010 the concept of "comprehensive" social protection has expanded further. Increasingly, developing countries such as Bangladesh, Cambodia, Indonesia, South Africa, Tanzania, Thailand, Uganda and others are adopting development planning approaches to social protection, aiming to maximise the potential impact of both intra- and inter-sectoral linkages. The broader development planning approach seeks to ensure better integration and linkages between different parts of the social protection system, as well as better linkages between social protection programmes and systems with broader sectoral responses (health, education, etc.) to ensure greater development impacts. The HIV/AIDS Investment Framework conceptualises complementarities in two ways: (1) Context-specific critical enablers including both social enablers as well as programme enablers are in many cases social protection instruments; and (2) The alignment of HIV/AIDS activities with national development objectives, which involves inter-sectoral planning and the rationalisation of investments across sectors, can strengthen HIV and AIDS-related impacts.

Expanding and sustaining HIV-sensitive social protection

Temin (2010) briefly addresses expanding and sustaining HIV-sensitive social protection programming in her discussion of the political economy of HIV-sensitive social protection. She recognises the concerns among governments and development partners about the fiscal capacity to finance social protection, especially for low-income countries. Citing McCord (2009), she recommends that HIV-sensitive social protection be considered in similar future studies of the political economy of social protection. In terms of the question of investment returns, Temin recognises that relatively better evidence for cash transfers exists, but highlights the urgent need for more cost-effectiveness data supporting decision-making on the optimal mix of instruments and the required scale of investment. This data could 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. Governments require credible and rigorous analysis of appropriate financing strategies for expanding existing social protection programmes, or developing new ones, in order to progressively strengthen universal access to social protection and maximise impacts in terms of prevention, treatment, care and support. The formulation of an HIV/AIDS investment framework (Schwartländer, B. et al., 2011) represents an important innovation, recognising that despite impressive progress to date, "universal access to prevention, treatment, care, and support for HIV/AIDS is not available worldwide, and is unlikely to be achieved with the present pace of change and with the present approaches to investment." *The paper argues "a targeted strategic investment programme driven by the latest evidence is needed to produce substantial and lasting effects on the HIV/AIDS epidemic and make the most of investment in the response."* The investment framework models costed interventions and aims to monitor progress in order to optimise the investment mix in response to documented results (or the lack thereof).

Conclusions about evidence gaps and recommendations

Building an effective evidence base for HIV-sensitive social protection requires more concrete research on the hypothesised relationships between interventions and HIV outcomes, which is then translated into action with new evidence-informed programming. *Embedding operational research – the search for knowledge on strategies, interventions or tools that can enhance the performance of programmes in which the research is being*

conducted – within these programmes can demonstrate progress towards strategic objectives, improve on-going programme performance, strengthen the global evidence base and reinforce political will for scale-up and sustainability.

The reach of HIV-sensitive social protection

Policy-makers consistently express demand for evidence on whether poor, HIV-affected, and vulnerable populations are being reached through social protection programmes, or, if not, what barriers and bottlenecks do they face in accessing services. Operational research looking at targeting in different epidemic contexts that takes account of social and economic vulnerability is also limited, pointing to a major evidence gap. This is particularly important in low and concentrated epidemics where stigma and discrimination may be more extreme and key affected populations such as sex workers, same-sex partners or drug users may have challenges accessing their entitlements, whether this is to health insurance or a social transfer. There is also a strong need for operational research that can guide policymakers on targeting decisions and the management of data relating to programme coverage, exclusion error and inclusion error.

Achieving core impacts

This research also highlights important gaps in the evidence base policy-makers need, in terms of the impact of type (for instance, nutrition supplementation or cash transfers), unconditional and conditional designs, benefit size, time frame, and differential impacts on men and women. More direct evidence of the link between interventions and HIV prevalence is required. In addition, little is understood of the actual causal pathways driving the identified impact—and this may require further qualitative analysis. Clearer evidence supporting the choice of most appropriate instruments (and mix of instruments) is also required.

While the evidence base examining why people living with HIV fail to adhere to treatment is growing, more evidence is needed on access barriers, to shed light on different rates of antiretroviral therapy uptake in different settings, and how outcomes will be maximized when both demand and supply interventions are considered. Specifically, more research looking at differences across the rural/urban divide, different epidemic contexts, and differences across age groups (for example, one emerging issue is that adolescents have much poorer adherence rates to treatment than adults) would strengthen the evidence base. *The most critical gap in the evidence relating to treatment is the lack of studies that look at treatment access and adherence as a specific outcome*

of social protection programming. There is evidence to support indirect linkages, but a lack of studies looking specifically at social protection and treatment access and adherence.

While there is a stronger evidence base for care and support than for prevention and treatment, significant gaps remain. *There is a strong demand for guidance on programme design, so that social protection can most efficiently achieve the desired care and support outcomes.* For example, there is a need for more formal frameworks to guide the development of social protection that strengthens the transformative dimensions, particularly in terms of reducing stigma and discrimination. There is also demand for more evidence on the implementation of case management alongside social protection interventions. Specifically, there is a gap in evidence on how case management can improve the targeting of transfers, reducing both exclusion and inclusion error. Much remains to be learned about the role of delivery structures in ensuring access to transfers and programmes.

Social protection yields interrelated and often mutually reinforcing impacts that cut across prevention, treatment, care and support, many of which are under-researched. An important research priority is building a robust evidence base that shows precisely how social protection can 1) reduce risk factors within vulnerable groups, 2) interrupt the cycle from being a person affected by AIDS to becoming a person living with HIV, 3) support treatment adherence, and 4) improve care and support, mitigating the negative effects of HIV on individuals, households and communities.

Further research is also needed on the optimal packages of social protection measures for Universal Access outcomes. As emphasised in Temin (2010), social protection debates are often focused on cash versus food, or conditional versus unconditional transfers. However, we also need to understand how different social protection programmes can be combined to reinforce and optimise Universal Access outcomes. This requires further research in different settings, where studies have the power to discern the different effects of different components of a combination intervention.

Comprehensive approaches

The application of the development planning framework to HIV-sensitive social protection is a relatively new approach, and requires a more comprehensive methodology for mobilising evidence. While the efficacy of specific design elements or the impact of individual programme interventions can be tested with rigorous trials, the optimal combination of multi-sectoral strategies requires

different analytical tools. The increased use of systematic reviews and meta-analyses may provide valuable evidence. The interest expressed by a number of UNAIDS co-sponsors and other development partners in pursuing evidence building in this area offers promise of future progress.

Expanding and sustaining HIV-sensitive social protection

One major area for further work is integrating the conceptual framework represented by the HIV/AIDS investment framework with the emerging evidence on the economic and larger returns to social protection. This step can complete a “virtuous circle” with which appropriate interventions reach the appropriate constituencies, achieve core and comprehensive impacts, and generate the social, economic and political returns that support their expansion and sustainability—further propelling the cycle forward.

The emerging evidence base documented in this report highlights the important role that appropriately designed and effectively implemented HIV-sensitive social protection programmes can serve in achieving critical downstream HIV and AIDS outcomes with positive impacts on children. While there is less rigorous evidence regarding the contribution of the upstream policy environment, there is no reason to believe that the role of well-articulated policies and comprehensive strategies is any less important. While the multi-dimensional complexity of developmental HIV-sensitive social protection strategies makes quantitative impact assessments challenging, promising directions like the Investment Framework, the use of participatory approaches and the emerging tendency for national governments to integrate social protection within a development planning approach suggest this evidence gap can be progressively addressed.

1. INTRODUCTION

Over the past two decades policy-makers, practitioners, governments and international development partners have increasingly recognised the importance of social protection in tackling poverty, achieving progress towards the Millennium Development Goals and supporting development frameworks for pro-poor and inclusive economic growth. Governments and development partners in many low- and middle-income countries have successfully implemented social protection programmes that reduce income poverty, support human capital development, improve livelihoods and promote better living standards. An emerging evidence base in developing countries is documenting the impact of social protection on poverty, nutrition, education, health and other critical outcomes. Social protection received increased attention during the recent finance, food, and fuel crisis, when it was recognised as an important mechanism for countering individual, household and community vulnerabilities. As the HIV epidemic continues, social protection is also now being recognised for its potential to address HIV-related vulnerabilities.

Social protection has the potential to play a key role in reducing an individual's chance of becoming infected with HIV (susceptibility) and reducing the likelihood that HIV will have a damaging effect on individuals, households and communities (vulnerability). Social protection can work alongside efforts to expand access to HIV prevention, treatment, care and support, ensuring access for those who are the most difficult to reach. However, social protection will only support vital HIV objectives if social protection instruments are appropriately designed and effectively implemented. Governments and donors often face constraints in mobilising the political will, delivery capacity or resources necessary to implement programmes that will effectively reinforce HIV prevention, treatment, care and support efforts.

The State of the Evidence 2012 aims to provide an evidence base to support the development and implementation of social protection instruments that can effectively reach these HIV objectives. It builds upon Miriam Temin's 2010 state of the evidence, *HIV-sensitive social protection: What does the evidence say?* Temin's literature review, commissioned by UNICEF with inputs from UN co-sponsors and the Institute of Development Studies, provides an in-depth examination of how social protection can contribute to core HIV outcomes (prevention, treatment, and care and support), how social protection can impact key affected groups, the targeting of

social protection programmes, and gaps in the evidence for the impact and implementation of social protection programmes. *What Does the Evidence Say?* provides the starting point for the State of the Evidence 2012.

The State of the Evidence 2012 has been informed by a growing body of work undertaken by UNAIDS co-sponsors and members of the UNAIDS Social Protection, Care and Support Working Group who are exploring the synergies and linkages between social protection and HIV. As part of this work UNAIDS co-sponsors developed an expanded business case on enhancing social protection –the catalyst for the 2010 State of the Evidence- and published the *HIV and social protection guidance note* in 2011. HIV-sensitive social protection is also a key theme in the UNICEF-published paper *Taking evidence to impact: Making a difference for vulnerable children living in a world with HIV and AIDS*, from 2011.

A critical contribution to this literature is the new UNAIDS-developed investment framework, *Towards an improved investment approach for an effective response to HIV/AIDS* (Schwartländer, B. et al., 2011). It proposes a strategic investment framework that is intended to support better management of national and international HIV/AIDS responses than exists with the present system. The framework, illustrated below, proposes three categories of investment, consisting of six basic programmatic activities, interventions that create an enabling environment to achieve maximum effectiveness, and programmatic efforts in other health and development sectors related to HIV/AIDS. While the investment framework does not specifically focus on social protection, it represents an important shift to focusing on investment in the HIV response, and the returns that can be generated by efficient investment. It also indicates the need to identify evidence-based interventions that can accelerate prevention, treatment and care and support outcomes. Within the framework social protection is identified as a key development synergy. To take the goals of the Investment Framework forward we need to further unpack how social protection programmes can directly and indirectly improve HIV outcomes.

This paper also incorporates the findings of several regional studies commissioned after the UNAIDS social protection business case was finalised in mid-2010. This includes a review of UNICEF-supported HIV- and child-sensitive social protection by the Institute of Development Studies in East and Southern Africa, a mapping in South Asia/East Asia/Pacific on child- and HIV-sensitive

Investment Framework

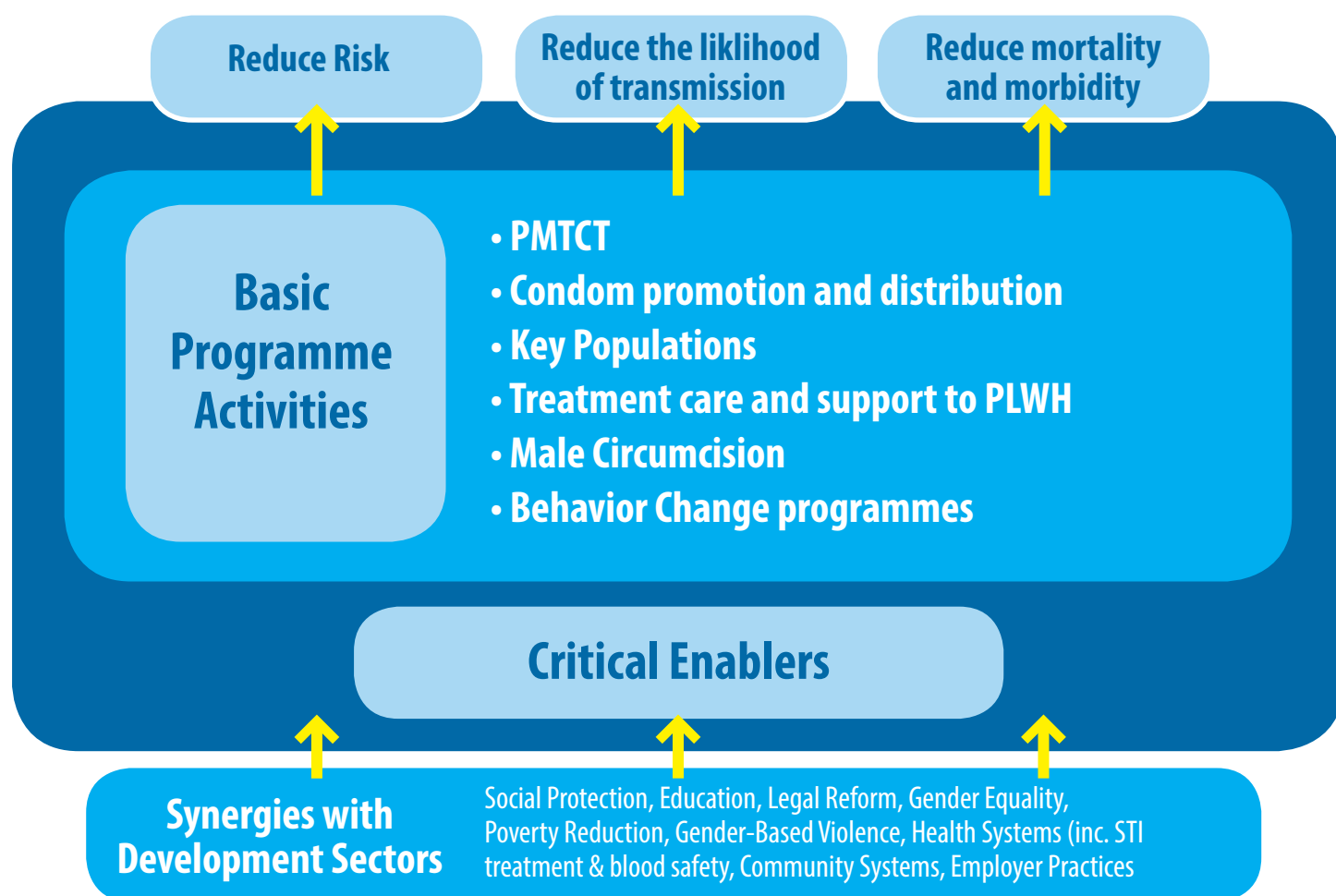


Figure 1. The HIV and AIDS Investment Framework

SOURCE: Schwartländer, B. et al. (2011), Towards an improved investment approach for an effective response to HIV/AIDS

social protection by the Economic Intelligence Unit, and a series of studies by the UNICEF West and Central Africa Office regarding social policy, HIV and child protection programming.

The *State of the Evidence 2012* aims to identify key evidence for HIV-sensitive social protection and translate findings into recommendations for effectively designed and implemented policies and interventions. It will identify gaps in the evidence base that need to be addressed in order for policymakers and stakeholders to more effectively advocate, design, implement, monitor and evaluate appropriate HIV-sensitive social protection policies and interventions. The gap analysis will support subsequent country level operational research on HIV-sensitive social protection that is planned under the joint UNICEF-EPRI *Building the Evidence* initiative. This research recognises that many countries with high HIV prevalence already have social protection programming, though with a great

deal of variability in terms of programme objectives, who the programmes reach and what services they provide. Therefore, this work does not view HIV-sensitive social protection as starting from “square one”. As concluded in Temin (2010), it is neither desirable nor feasible to create parallel, HIV-exclusive social protection programmes. Rather, this research aims to provide a resource for countries with existing programmes to further develop, modify, and create linkages that will make them more HIV-sensitive. It will guide the scale-up of national programmes so that they adapt to HIV-related vulnerabilities, without exacerbating these vulnerabilities, and promote increased collaboration and communication between policymakers focused on HIV/AIDS and those working on social protection policies and programmes. It will also serve as a resource for countries developing social protection and health strategies, and initiating new programming in these areas. The overarching goal of this operational research serves to support evidence-based

social protection policy and programming that is comprehensive, nationally led, and built on a sound understanding of the range of risks and vulnerabilities facing households affected by HIV/AIDS.

The geographic focus of the State of the Evidence 2012 is sub-Saharan Africa. Of the estimated 33.3 million adults and children living with HIV, 22.5 million live in sub-Saharan Africa.³ Approximately 70 per cent of adults and children newly infected with HIV in 2009 live in this region.⁴ Because sub-Saharan Africa has a high HIV burden and low response capacity, the benefits of learning can be maximised. The consultations that have informed this research have primarily been with sub-Saharan UNICEF country and regional offices, African-based researchers and practitioners, and international development partners. As a result, the following chapters will draw largely from studies and policy documents focused on the sub-Saharan African context. However, this paper references relevant studies from the other regions, particularly Latin America and South Asia. HIV-sensitive social protection offers the potential to achieve HIV outcomes across a range of geographic contexts, and it is possible that the scope of this operational research initiative will be expanded to a global scale in subsequent phases.

1.1 Key definitions

UNAIDS has identified a commitment to “enhance social protection for people affected by HIV” as one of its 10 priority areas, a critical step towards the realisation of universal access to prevention, treatment, care and support. Throughout this paper, the term ‘HIV’ is used when referring to both HIV and AIDS, in line with UNAIDS’ terminology guidelines. The term ‘AIDS’ is used when this advanced state of the HIV infection is specifically being referenced. There is a range of definitions for social protection, although the most often referenced definitions share common ground. For the purposes of this paper we will use UNICEF’s definition of social protection:

Thus, social protection extends beyond cash transfer programmes, and includes health and education fee waivers and subsidies, income support for the elderly (pensions), in-kind transfers, public works programmes, social insurance, child protection and legislation that ensures non-discrimination and equity in vulnerable populations’ rights and access to these services. This comprehensive approach to social protection has great potential to improve the lives of people living with and affected by HIV. The pathways that lead to HIV vulnerability are complex, with many interrelated structural and

UNICEF defines social protection as the set of public and private policies and programmes aimed at preventing, reducing and eliminating economic and social vulnerabilities to poverty and deprivation.

Four key components include:

- Social transfers
- Programmes to ensure economic and social access to services
- Social support and care services
- Legislation and policies to ensure equity and non-discrimination in children’s and families’ access to services and employment/livelihoods

SOURCE: UNICEF (2012), Social protection strategic framework

proximal factors. The multidimensional nature of social protection, and its potential to reduce/eliminate economic and social vulnerabilities, is well suited to the multidimensional nature of HIV-related vulnerabilities, and its complex effects on individuals, households and communities.

UNICEF’s definition and approach builds on a valuable framework for understanding the multidimensional nature of social protection provided by Devereux and Sabates-Wheeler (2004) in their work on transformative social protection. Devereux and Sabates-Wheeler define social protection as

all public and private initiatives that provide income or consumption transfers to the poor, protect the vulnerable against livelihood risks, and enhance the social status and rights of the marginalised; with the overall objective of reducing the economic and social vulnerability of poor, vulnerable and marginalised groups.⁵

In this conceptual framework, social protection protects at-risk and vulnerable groups (in both development and relief contexts) and prevents asset depletion and destitution as the result of shocks. But it also sets out to promote human development, asset accumulation and economic self-sufficiency and to transform the lives of vulnerable individuals by addressing social equity and exclusion. This transformative aspect has the potential to address many of the structural inequities, including income inequalities and stigma, which ultimately drive the HIV epidemic.

Social protection measures can be considered HIV-sensitive when they include people who are either at risk of HIV infection or sensitive to the consequences of HIV and AIDS, needing particular support in accessing

³ UNAIDS (2010), UNAIDS report on the global epidemic

⁴ Ibid.

⁵ Devereux, S. and Sabates-Wheeler, R. (2004), Transformative social protection

	Protective	Preventative	Promotional	Transformative
Intervention	Direct feeding programmes for PLWHA	Cash transfer to vulnerable households (inclusive of households affected by HIV)	Livelihoods programme that include PLWHA	Legislation protecting PLWHA from workplace discrimination
Linkage to HIV/AIDS	Secures basic consumption needs for PLWHA; nutrition is critical for the success of ART	Reduces fluctuations in income that could lead PLWHA to negative coping mechanisms	Provides means for PLWHA to generate income and assets	Transforms institutions and relationships to recognize the rights of a potentially marginalized and stigmatized group

Figure 2. Examples of social protection interventions that mitigate the impact of HIV/AIDS on vulnerable households

treatment or care and support.⁶ Such measures can reduce vulnerability to HIV infection (prevention), improve and extend the lives of people living with HIV (treatment), and support individuals and households (care and support).⁷ 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.

Although many social protection programmes were not set up with HIV as a primary focus, especially in lower prevalence contexts, their potential to contribute to a comprehensive HIV response has been increasingly recognised. Figure 2 shows examples of a range of HIV-sensitive social protection interventions and the ways in which they can lead to prevention, treatment and care and support outcomes. As it illustrates, social protection can provide a comprehensive set of tools to address not only economic vulnerabilities, but also social vulnerabilities (and their interaction). Multiple interventions can be combined in “cash plus” programmes, in which cash

transfers lie within comprehensive national social protection programmes. Effective “cash plus” programmes have the potential to tackle the underlying structural drivers of the epidemic, remove barriers for accessing HIV-specific services, reduce stigma while fostering independence, and mitigate the negative impacts of the epidemic on affected households. The “cash plus” approach is important, because behavioural strategies are essential but not sufficient components of comprehensive HIV prevention, and “behavioural strategies themselves need to be combinations of approaches at multiple levels of influence.”⁸

As mentioned in the introduction, the concepts of *susceptibility* and *vulnerability* are crucial to understanding the link between social protection and HIV. Susceptibility refers to an individual’s chance of becoming infected with HIV, while vulnerability refers to the likelihood that HIV will have damaging effects on individuals, households and communities. A comprehensive approach to social protection with protective, preventive, promotive and transformative objectives can address the drivers of both susceptibility and vulnerability.⁹ A comprehensive approach can also help to ensure that efforts to achieve Universal Access will reach the most vulnerable and hard-to-reach population groups. Existing evidence on these relationships – as well as gaps in the evidence base – will be examined in the following chapter.

6 UNAIDS (2010), Expanded business case: Enhancing social protection

7 Ibid

8 Coates, T.J., Richter, L., and Caceres, C. (2008), Behavioural strategies to reduce HIV transmission: how to make them work better

9 Ibid.

A note on terminology

This paper brings together the spheres of both health and social policy. These two disciplines can use the same terminology in different ways, potentially leading to confusion. One important example is the concept of vulnerability. From a social policy (and more specific, social protection) approach, vulnerability refers to a broad concept of social and economic vulnerabilities to poverty, exclusion, shocks and loss of assets/income. In contrast, those working in health and HIV use the term vulnerability in relation to factors that make individuals, families or communities either at higher risk of infection (susceptibility) or -in the area of mitigation- less likely to cope with the social and economic consequences of illness and death.

1.2 Methodology

This paper was written as part of a larger operational research programme launched by UNICEF, to explore the extent to which national social protection programmes are responding to the needs of individuals and households affected by HIV and AIDS. This research will inform policy guidance on how social protection interventions can become more HIV sensitive and contribute to HIV prevention, treatment, care and support outcomes. This paper was one of several early project deliverables, which set the groundwork for the country-focused work in the main phase of research. The main phase of research will include secondary analysis of country-level datasets, micro-simulation modeling to determine the extent to which social protection programmes are HIV-sensitive, and research protocols supporting country-led qualitative research on HIV-sensitive social protection. The research findings will then be synthesized and communicated through policy guidance notes on HIV-sensitive social protection topics and the building of communities of practice to support lesson learning and dialogue at the national and country level.

This paper was written as an update to Miriam Temin's 2010 review of HIV-sensitive social protection, commissioned by UNICEF and UNAIDS. It summarizes her key findings and presents new relevant research. Miriam Temin's paper was organized by different social protection instruments and then looked at the implications of each instrument for different vulnerable groups. The State of the Evidence 2012 was conceptualized in a different way. Rather than organize the evidence by instrument, this paper organizes it using a conceptual framework following four different areas of evidence. This framework is described in greater detail in Chapter 2.

Key documents were identified for the review by covering several topics in HIV/AIDS health literature (prevention, treatment, care and support, mitigation) and social

protection literature that together comprise HIV-sensitive social protection. A wide range of terms were included in searches because HIV-sensitive social protection is an emerging field, and because there are few studies that look explicitly at the HIV/AIDS-related impacts of social protection interventions. The focus was on randomised controlled trials (RCTs), rigorous observational studies and qualitative studies. We searched PubMed for papers published in peer-reviewed journals since 2010. We also searched other online academic indexes. Search terms included combinations of the terms "social protection", "HIV", "AIDS", "cash transfers", "social cash transfers", "conditional cash transfer", "HIV-sensitive", "mitigation", "contingency management", "prevention", "treatment", "care and support", "antiretroviral therapy (ART)", "behavior", "pension", and "health insurance." Additional studies and papers were identified through contacts, meetings and the March meeting on HIV-sensitive social protection in Johannesburg, South Africa.

The goal was to review new and emerging research relevant to HIV-sensitive social protection and identify salient findings, linkages, and gaps in knowledge. Several recent important studies emerged, including the following randomised trials and rigorous programme evaluations that dealt specifically with HIV/AIDS and social protection:

- Baird, S. et al. (2012), Effect of a cash transfer programme for schooling on prevalence of HIV and herpes simplex type 2 in Malawi: a cluster randomised trial
- de Walque, D. Nathan, R. et al. (2012), Incentivising safe sex: a randomised trial of conditional cash transfers for HIV and sexually transmitted infection prevention in rural Tanzania
- Hallfors, D. et al. (2011), Supporting adolescent orphan girls to stay in school as HIV risk prevention: Evidence from a randomised controlled trial in Zimbabwe

- Miller, C. and Tsoka, M.G. (2012), ARVs and cash too: caring and supporting people living with HIV/AIDS with the Malawi Social Cash Transfer
- Packel, L. et al. (2012) Sexual behavior change intentions and actions in the context of a randomized trial of a conditional cash transfer for HIV prevention in Tanzania
- Schüring, E. (2011), Cashing in: How cash transfers shore up Zambian households affected by HIV

The paper builds upon a number of key policy documents and reviews published by UNICEF, UNAIDS and other development partners since 2010. Key global sources include:

- UNAIDS (2010), Expanded business case: Enhancing social protection
- UNAIDS (2011), HIV and social protection guidance note
- UNICEF (2011), Taking evidence to impact: making a difference for vulnerable children living in a world with HIV and AIDS

This paper also incorporates the findings of several regional studies commissioned after the UNAIDS social protection business case was finalised in mid-2010. The regional studies include:

- Economist Intelligence Unit (2011), Mapping of social protection measures for children affected by AIDS in Asia-Pacific
- Roelen, K. et al. (2011), Lessons from the Children and AIDS Regional Initiative (CARI): Child- and HIV-sensitive social protection in Eastern and Southern Africa
- UNICEF (2009), Strengthening social protection for children: West and Central Africa

A draft of this paper was reviewed and amended after a participatory meeting with government, civil society, UN and academic stakeholders held in Johannesburg in March 2012. The meeting provided a valuable opportunity to discuss the evidence and conceptual framework, and the paper was validated and accepted by development partners.

2. DEMAND-DRIVEN EVIDENCE BASE ANALYSIS FRAMEWORK

This paper, and the broader research initiative that it supports, adopts a “demand-driven” approach to building and analysing the evidence base on HIV-sensitive social protection. “Demand-driven” evidence aims to identify and answer the questions that policymakers, practitioners and stakeholders are asking. Answering these questions is critical for operational research in the field of HIV-sensitive social protection, where there is strong demand for guidance regarding the design, implementation, monitoring and evaluation of programmes. As shown in Figure 3, supply-side and demand-side evidence are two areas that overlap to form the existing operational evidence base. Evidence that has been produced by academics and researchers that meet policymakers’ and practitioners’ need for evidence to inform their policies and programmes falls in the overlapping area, the operational evidence base. The evidence gap arises when policymakers and practitioners need evidence (for example, on delivery mechanisms or programme targeting), but robust evidence has not yet been produced. Our focus will be on adding to the existing operational evidence base from the demand-side, lessening the evidence gap. The adoption of a demand-driven approach for this paper does not discount the value of research that is not directly driven by policymakers’ and practitioners’ questions. However, for the purposes of the *State of the Evidence 2012* it provides a valuable framework for evaluating current evidence and evidence gaps.

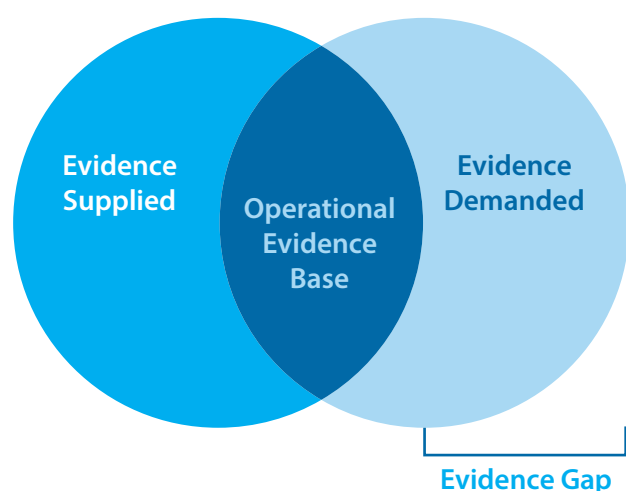


Figure 3. A demand-driven perspective on evidence

The starting point for a demand-driven analysis of the evidence is the question:

What evidence do policy-makers and key stakeholders (including those in UNICEF and partner UNAIDS co-sponsors) need to know in order to more effectively advocate, design, implement, monitor and evaluate appropriate social protection policies and interventions that tackle the challenges of HIV and AIDS?

Our methodology for answering the question of “what do we need to know?” includes a review of the existing literature and consultations with researchers, policymakers, practitioners and other stakeholders (a summary of these consultations can be found in the Annex). Consultations have included UNICEF headquarters, regional and country offices, other UN and partner organisations and research institutes. Particular focus has been given to consultations with in-country offices, where there is valuable expertise to be leveraged regarding the challenges of designing and implementing effective HIV/AIDS-related social policy. Following Temin (2010) we will identify two key components of the required evidence: 1) what kinds of social protection policy interventions are most effective in achieving the desired impacts on HIV outcomes, and 2) how can these interventions be designed and implemented more effectively? The research review will then address a second key question:

What evidence exists that enables policy-makers and key stakeholders to more effectively design, implement, monitor, evaluate and advocate for appropriate social protection policies and interventions that tackle the challenges of HIV and AIDS?

Addressing this question will involve synthesis of Temin’s (2010) findings, to leverage this critical work on the evidence base. It will also involve a comprehensive review of evidence at the nexus of HIV and social protection that has emerged since 2010, as well as a summary of ongoing research initiatives that will contribute to this body of evidence in the future. This step is important because

policies and programming need to be backed by robust evidence. While there is a wealth of information on certain social protection instruments, such as cash transfers, the evidence for other instruments and their impact on HIV is more limited. A comparison of the results from these two steps of work will help address the third critical question:

What are the gaps in the evidence base that need to be addressed in order to better enable policy-makers and key stakeholders to more effectively advocate, design, implement, monitor and evaluate appropriate social protection policies and interventions that tackle the challenges of HIV and AIDS?

The gap analysis represents the main application of the evidence framework, providing guidance and prioritisation for future research. While there is evidence for some social protection instruments, particularly cash transfers and their role in mitigating the impact of HIV/AIDS on vulnerable households and children, evidence on linkages to prevention and treatment is more limited.

UNAIDS' business case (2010) commits to action the development of "an evidence-informed, coherent approach to HIV-sensitive social protection among UNAIDS and its partners on what combination of mechanisms best contributes to:

- Reducing susceptibility to HIV infection among vulnerable groups.
- Promoting uptake and adherence to treatment, care and support across the life cycle.
- Mitigating the impact of HIV on individuals, households and communities.
- Monitoring and evaluating the quality and coverage of protection, care and support for people, households and communities affected by HIV, in order to fill serious data gaps."

This commitment represents a key "policy demand" driving this report's analysis of the evidence base. The commitment also reflects a key demand from policy-makers across the developing world, addressing two core questions: (1) How can social protection interventions reach those who need them? (2) How can these interventions best achieve the impacts for which they are designed and implemented?

The demand-driven gap analysis will be applied to the large body of research at the nexus of HIV and social protection. A conceptual framework (see figure below) has been developed to organise the gap analysis. The framework encompasses four critical steps in the development of effective HIV-sensitive policy and programmes. The process, from one chronological step to the next, is driven by the *design* and *implementation* of the programme. The design and implementation of a programme act as levers that drive the cycle and determine a programme's effectiveness at each step.

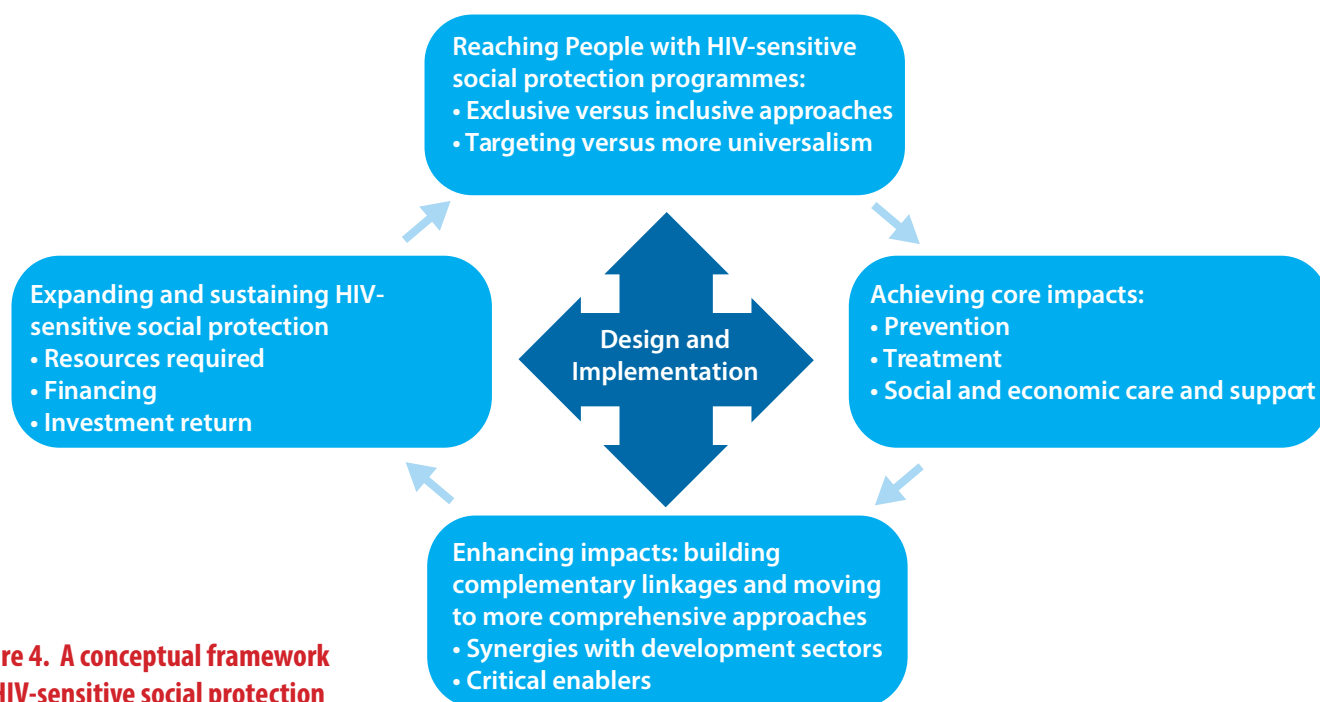


Figure 4. A conceptual framework for HIV-sensitive social protection operational evidence

The critical first step is ensuring that the intervention reaches groups that are more susceptible and vulnerable to HIV. This step is covered in the first part of the evidence gap analysis (in Chapter 3). In an HIV-inclusive approach the use of HIV-sensitive inclusion criteria helps to ensure the targeting of programmes to reach the most vulnerable households, including those directly affected by HIV. In contrast, HIV-exclusive programmes solely target people or households affected by HIV. Reach is a question of both targeting and programme implementation because a programme must be effectively implemented to reach its intended targets, often the most remote, marginalised or “invisible” individuals in communities. As more programmes mitigate the impact of HIV on households, become more HIV-inclusive than exclusive, and, in many cases, target more on the basis of poverty than HIV-related variables (such as orphaning), a key research question will be to ascertain whether the households and children least resilient to the impact of HIV are being reached effectively. This key topic will be discussed further in the first section of the evidence gap analysis (Chapter 3).

The second step is achieving HIV impacts, which can be divided into the three core Universal Access Outcomes as described in the UNAIDS Investment Framework, *HIV and social protection guidance note* (2011) and the Extended Business Case (2010):

- Prevention
- Treatment
- Social and economic care and support

Impact mitigation (lessening the negative effects of HIV/AIDS) falls under the category of social and economic care and support. Impact mitigation covers a wide range

of areas that can ultimately be affected by HIV/AIDS in the household or community, including health, education, participation in the labour force, nutrition, abuse and neglect. The impacts that a social protection programme achieves will vary depending on the type of intervention and the population it reaches (Step 1).

A variety of sub-impacts fall under these three broad “umbrella” impact categories (prevention, treatment, and social and economic care and support), including risk mitigation, livelihoods improvement, greater economic security, improved nutrition, access to healthcare and education, and reduced stigma and discrimination. Impacts can be direct or indirect. For example, providing free access to prevention of mother-to-child transmission (PMTCT) services may increase uptake of services and thus reduce vertical HIV transmission. A recent randomised control trial in Zomba, Malawi found a link between cash transfers and reduced HIV risk in girls and young women (ages 13-22). The link was attributed to multiple mechanisms, including changes in sexual behaviour and networks among the beneficiaries (older age of sexual debut, fewer partners, less sexual activity, and younger male partners, who are less likely to have HIV). The second part (chapter 4) of the evidence gap analysis will examine the Zomba intervention more closely, as well as other new evidence relating to achieving the three core outcomes.

For the purposes of structuring this paper, the impacts of social protection on HIV/AIDS have been divided into three broad categories. However, it is important to understand social protection as having many interrelated and often mutually reinforcing impacts. The diagram below from UNICEF’s report *Taking evidence to impact* (2011) illustrates the complexity of these impacts and the pathways through which social protection can lead to HIV prevention, treatment, care and support outcomes.

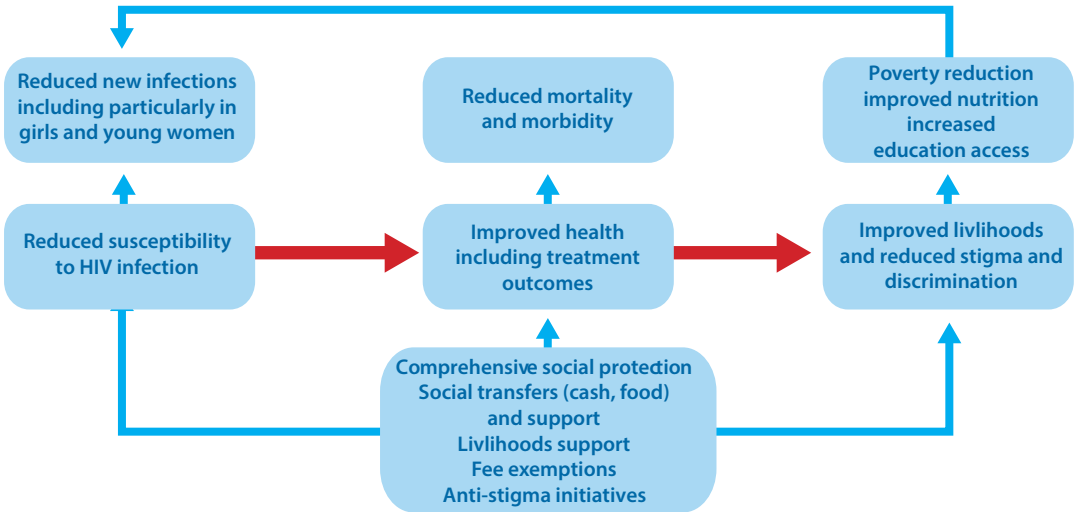


Figure 5. Impact of social protection in improving HIV prevention, treatment, care and support outcomes

SOURCE: UNICEF (2011), *Taking evidence to impact*, adapted from Edstrom, J., (2010), UNAIDS/UNICEF/IDS workshop on Social Protection, HIV and AIDS

There is currently a lack of in-depth pathway mapping that visualises the specific pathways through which social protection can ultimately impact HIV/AIDS. Figure 6 (below) represents an initial attempt to map out these complex but critical relationships. It illustrates social protection’s potential to affect HIV/AIDS prevention, treatment and care and support through multiple interrelated and mutually reinforcing pathways. The left side of the diagram shows broad areas in which social protection programmes have well-documented impacts: greater gender equality, more economic security, better food security and nutrition, access to healthcare, access to education/higher educational attainment, and reduced stigma and discrimination. On the far right of the diagram are the 3 core HIV/AIDS impact areas: prevention, treatment, and social and economic care and support. The intervening steps trace the complex pathways by which social protection programming can achieve these impacts.

A top research priority is building a robust evidence base that shows precisely how social protection can 1) reduce risk factors within vulnerable groups, including interrupting the cycle from being a person affected by AIDS to becoming a person living with HIV, 2) support treatment adherence, and 3) improve care and support, mitigating the negative effects of HIV on individuals, households and communities. Further research is needed on the optimal packages of social protection measures for Universal Access outcomes. As emphasised in Temin (2010), social protection debates are often focused on cash versus food, or conditional versus unconditional transfers. However, we also need to understand how different social protection programmes can be combined to reinforce and optimise Universal Access outcomes. This requires further research in different settings, where studies have the power to discern the different effects of different components of a combination intervention.

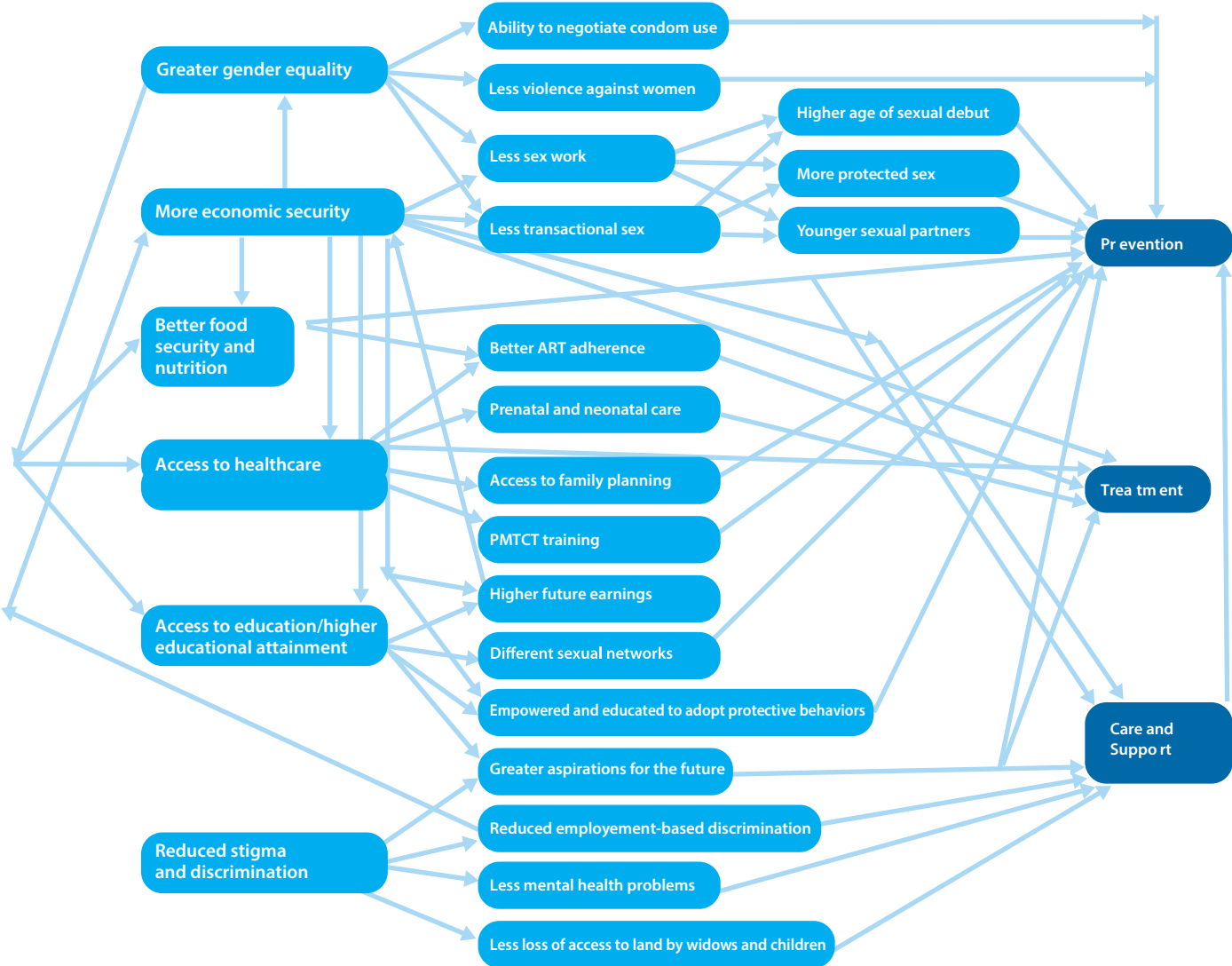


Figure 6. Linkages between HIV-sensitive social protection and core HIV and AIDS outcomes

Returning to the conceptual framework (figure 4), the third step in the process is enhancing impacts by building complementary linkages and moving to more comprehensive approaches. These synergies, when designed and implemented effectively, can strengthen an intervention's impact on individuals, households and communities. For example, investments to improve adolescent girls education – as well as having multiple benefits in terms of literacy, gender empowerment and higher future income potential – have also been shown to be a 'social vaccine' for reducing HIV incidence through changing sexual networks and lower age of sexual partners. Synergies, linkages and critical enablers will be discussed further in the third part (chapter 5) of the evidence gap analysis.

The fourth step in the cycle reflects the critical priority that HIV-sensitive social protection programmes are expanded and sustained, so that they can scale-up and continue to reach the vulnerable and have a positive impact on key HIV and socio-economic outcomes. Expanding and sustaining an intervention will depend on capacity, political will, and –perhaps most importantly– a strong financial and human resource base and commitment to funding and capacity building. Affordability is crucial for sustaining any intervention, and it ultimately will depend on the design and implementation of the intervention driving cost-effective impacts. For example, the administration of conditionalities or multi-step targeting processes (such as using community-level targeting) can entail higher administration costs. Savings cannot come at the expense of programme impact and rigor, but it is crucial that support is provided in identifying sustainable financing options. Evidence on programmes' cost-effectiveness is a crucial area for future focus, and UNAIDS' business case (2010) identifies it as a major short-term focus "to generate evidence, including on cost-effectiveness" that will enable the identification of which interventions have the most effective impact on HIV.

The State of the Evidence 2012 aims to consolidate existing evidence and identify critical evidence gaps, in order to identify the top priorities to pursue within an environment of limited financing and competing development concerns. The fourth part (chapter 6) of the evidence gap analysis will explore this critical topic at greater length.

3. EVIDENCE GAP ANALYSIS: THE REACH OF HIV-SENSITIVE SOCIAL PROTECTION

The evidence gap analysis will follow the conceptual framework outlined in the previous section, with four sections:

- Reaching people with HIV-sensitive social protection programmes
- Achieving core impacts
- Enhancing impacts
- Expanding and sustaining HIV-sensitive social protection

Each section will begin with an operational framework that identifies and structures the key questions that the evidence base must address. These key questions emanate from the literature review and consultations with key stakeholders. While they are not exhaustive, they provide a valuable framework to compare to the existing evidence. Each framework will be followed by a synthesis of the existing evidence, as presented in Temin (2010), with the addition of new research produced since 2010. Each section will then conclude with an identification of the critical evidence gaps, resulting from a comparison of “what we need to know” with “what we know”.

The following section of the paper will analyse evidence regarding populations that are more vulnerable to HIV, how well social protection programmes are reaching vulnerable HIV-affected individuals and households, and how HIV-sensitive programming can be designed to better reach the vulnerable. “Reaching” people with a programme ultimately requires questions of exclusive versus inclusive approaches (as defined in the Introduction). Moving to more inclusive approaches, based on a wider set of social and economic vulnerabilities, is important for effectively reaching both children affected by HIV and children vulnerable to HIV risk. More inclusive approaches can also reduce stigma and discrimination.

The following section will address vulnerable populations, targeting programming to be inclusive of these populations, and key design elements for effectively reaching the vulnerable.

3.1 Key research questions: Programme reach

The topic of programme reach for HIV-sensitive social protection encompasses a number of key questions which have been raised by a number of development partners working in this field, including:

- What evidence is available on who is most vulnerable (to HIV infection and the effects of HIV) in the context of the HIV response and what can be done to help them, and how strong is the evidence?
- Who make up the core vulnerable populations in developing countries?
- How far are households vulnerable to HIV and HIV-affected households being reached by existing social protection programmes?
 - What are the questions that need to be added to existing surveys to gain an understanding of whether vulnerable HIV-affected households are being reached?
 - Given the difficulty of determining HIV status in surveys, what variables can be successfully used as proxies?
- For countries that are implementing or modifying management and information systems (MIS), how do they set up databases and systems to quantify the programmes’ reach to HIV-affected households, and provide more information on the people who are reached?
- What are the barriers faced by HIV-affected individuals and households in accessing social protection programmes for which they are eligible?
- What types and combinations of social protection instruments and interventions are most effective for reaching HIV-affected households?
- What are the core design elements necessary for a social protection intervention to effectively reach vulnerable HIV-affected households?
 - What types of social protection initiatives are relevant for different groups living in different epidemic contexts – does HIV-sensitive social protection look different in a concentrated as opposed to a generalised epidemic?

- How can technological innovations such as mobile phones be used to more effectively reach vulnerable HIV-affected households?
- What targeting criteria should be used in different epidemic contexts to ensure social protection programmes are HIV-sensitive?
- Are there examples of where HIV-specific targeting might be warranted, e.g. as behavioural incentive? What are the longer-term implications?

3.2 Evidence from the State of the Evidence 2010: Programme reach

Much of the programmatic debate about programme reach has emerged from programmes to support children affected by AIDS and concerns as to whether external assistance programmes were reaching those in need. Temin also emphasises the vulnerability of children, a result of the intergenerational transfer of vulnerability and the impact of stigma, abuse, and orphaning, among other factors. However, harmful examples of targeting “AIDS orphans” have been well documented.¹⁰ As a result, benefits should be targeted to children in greatest need of assistance, regardless of the cause.

In sub-Saharan Africa the HIV epidemic is largely driven by youth, and married couples are often at higher risk. However, Temin also identifies key populations at higher risk of HIV infection, and the implications for designing and targeting inclusive social protection programming. The non-exhaustive list of vulnerable groups includes:

- Sex workers
- People who use drugs
- Transgender people
- Men who have sex with men
- Families of the aforementioned groups.

Temin summarises the relevance of social protection measures on these key groups at higher risk of HIV infection. Temin notes that reducing the barriers that members of these groups face in access to health, education and social services is a particular challenge. Improving access to these areas is critical for increasing the treatment of sexually transmitted infections, promote condom use, increase uptake of voluntary counselling and testing, and other essential services for vulnerable populations.

10 Baingana, F. et al. (2008), The implementation gap in services for children affected by HIV/AIDS: supporting families and communities in caring for and protecting vulnerable children

Temin notes that stigma and fear of discrimination can be significant barriers to people living with HIV accessing programmes. 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).¹¹

Based on its review of the evidence, the 2010 State of the Evidence makes several targeting and programme design recommendations. Integrated approaches can minimise the exclusion of vulnerable groups, as in the case of the Isibindi model in South Africa, which trains child and youth care community outreach workers to assist families in securing grants and accompanying them to health services. It also recommends that the system allow for regular reassessments of eligibility as the vulnerability of people and households shifts over time, such as when several children rely on income from a grandparent’s pension and the grandparent dies.

It concludes that HIV-inclusive, rather than HIV-exclusive, social policies are more feasible and may better reach the households most in need. General principles of “good targeting practice” can help to ensure that people affected by HIV are included. HIV-sensitive targeting criteria are needed to strike a balance between equity, scale, feasibility, affordability and effectiveness. For example, Schubert (2007) analysed participant households in Malawi and Zambia’s social cash transfer schemes, which both determine eligibility based on the dependency ratio and poverty status of households, and concluded that they were effective in reaching HIV-affected households, as roughly 70 per cent fell into this category even though they were not explicitly targeted.¹² However, Temin (2010) also states that focusing on poverty considerations alone is not sufficient to make social protection HIV-sensitive; rather programme designers must “know their epidemic” and take account of the specific HIV-linked risks and vulnerabilities of particular population groups.

11 Sherr, L. et al. (2009), Examining ways in which contact opportunities associated with transfers might help identify vulnerable households and link the with social welfare services: a systematic review of the literature

12 Schubert, B. (2007) The impact of social cash transfers on children affected by HIV and AIDS: Evidence from Zambia, Malawi and South Africa

3.3 New and emerging evidence: Programme reach

In sub-Saharan Africa the HIV/AIDS epidemic has shaped the design and targeting of many social protection programmes, resulting in several programmes that emphasize the ultra-poor, the labour-constrained, and/or caring for orphans and vulnerable children (OVC).¹³ A 2012 World Bank report on cash transfers provides valuable documentation of existing cash transfers that target individuals living in HIV-affected households, including Burkina Faso's pilot conditional cash transfer and cash transfer (CCT-CT) programme, Kenya's Cash Transfer for Orphans and Vulnerable Children (CT for OVC), Lesotho's Child Grants Programme, and Senegal's Conditional Cash Transfer for Orphans and Vulnerable Children.¹⁴ All of these programmes reach a significant number of AIDS-affected households, but none operate at scale. In South Africa the Child Support Grant (CSG), initiated in 1998, reaches nearly 11 million children, more than half of all children in the country. The CSG is targeted to primary caregivers of children under age 18 living below the poverty line, contributing to the cost of child rearing in very poor households. Namibia and South Africa, two middle-income countries, provide a disability grant, separate from other transfers, that reaches adults affected by AIDS who are no longer able to work.¹⁵ In countries such as Malawi and Zambia, transfers for extremely poor people living with disabilities are part of broader transfer programmes targeting households that are unable to participate in the labour force.¹⁶ In Zambia, the motivation for the programme came from the increasing number of households affected by HIV/AIDS that lacked a household head capable of benefitting from work-based programmes or microcredit.¹⁷ All of the aforementioned programmes reach households affected by HIV and are described in greater detail in the 2012 World Bank report.

Several recent studies and policy papers have contributed to our understanding of how to design and implement HIV-sensitive social protection programmes that will successfully reach the most vulnerable children and households. In an examination of the relationship between cash transfers and HIV prevention, Lutz and Small (forthcoming) conclude that an understanding of AIDS as a disease of inequality, both economic and gendered, may mean that targeting women and girls is the most effective strategy in particular contexts,

often including programmes delivering cash transfers. Targeting that maintains or increases inequalities may be less effective, or even counterproductive. Furthermore, targeting certain marginalised groups, such as AIDS orphans or people living with HIV, could make public information that people would prefer to remain private, and could reinforce social divides. The following section will examine recent evidence that can further inform decisions regarding targeting and inclusion.

In India UNDP is focusing on extending the reach of state-run social protection programmes to people living with HIV, especially women and girls, given their heightened vulnerability.¹⁸ As a result, 35 government schemes have been amended to respond to the needs of people living with HIV, including:

- Removal of an HIV exclusion clause from the special health insurance scheme of the Ministry of Labour for informal sector workers;
- Removal of age criterion so that HIV positive widows can access the widow pension scheme provided by the Department of Women and Child Development;
- Supporting legal aid clinics for people living with HIV to improve access to HIV and other services;
- Provision of transport allowances for people living with HIV who are unable to afford their travel costs, to both support access to HIV treatment and improve adherence to HIV treatment.¹⁹

In the case of the widow pension scheme, the pension card served as an identity card, facilitating linkages with a bank, self-help groups and the community.²⁰ In Orissa, India, a local NGO facilitated the process of availing the scheme to people living with HIV/AIDS (PLWHA), improving the reach of the pension.²¹ Other states in India have implemented or are considering implementing similar pension reforms for PLWHA. Across India there are multiple social protection programmes that provide opportunities for expansion to include people affected by HIV. These are important strategies for including vulnerable HIV-affected households in pre-existing programmes. This approach is potentially more cost-efficient than the development of parallel programmes targeted exclusively to HIV-affected individuals and households, while also addressing underlying issues of stigma and social exclusion. However in many cases community and household level facilitation by community level health workers, social welfare officers, or networks of people living with HIV have been instrumental in linking HIV-affected families to grants to which they are eligible.

13 Davis, B., Gaarder, M., Handa, S. and Yablonski, J. (2012) Evaluating the impact of cash transfer programmes in sub-Saharan Africa: an introduction to the special issue

14 Garcia, M. and Moore, C. M. T. (2012), The cash dividend: the rise of cash transfer programs in Sub-Saharan Africa

15 Ibid.

16 Ibid

17 Ibid.

18 UNAIDS (2011), HIV and social protection guidance note

19 Ibid.

20 Lutz, B. (2012), Experiences from HIV-sensitive social protection

21 Ibid.

In an analysis of a social cash transfer in Zambia, Schüring (2011) enumerates several potential appropriate eligibility criteria that characterise HIV-affected households, such as “generation-gap households” or “households headed by children”.²² These categories do not focus exclusively on HIV-affected households, and therefore may be less stigmatising than tying the transfer to the HIV-status of household members. The specific HIV-sensitive targeting criteria that were adopted in the Zambia social cash transfer programme were:

1. Destitute: The household is hungry, malnourished and/or begging, lacks shelter and adequate clothing and might not survive without external support. Furthermore, it means the household has no regular source of substantive income (business in town, rental income, regular support from relatives) and no valuable assets to help cope.
2. Incapacitated: The household does not have enough fit members to care for dependents (more than three dependents for every fit member, a dependency ratio of 3). Members of the Community Welfare Assistance Committee determine whether members are unfit. This designation usually includes those who are under 19 or over 64, or 19-64 and chronically sick, as well as those who are disabled or still going to school.²³

An analysis of social protection in Nigeria in the context of a region with high HIV incidence came to similar recommendations for programme targeting.²⁴ It concluded that although HIV can be one criterion related to inequality and social exclusion, social protection should not focus on targeting HIV specifically, but poor and vulnerable people in general.²⁵ Nigeria’s COPE (In Care of Nigeria’s Poor) conditional cash transfer (CCT) scheme currently targets according to broader vulnerability criteria, including poor female- and elderly- headed households with young children, households where the household head is disabled, and households headed by PLWHA and other vulnerable groups. In order to ensure that people living with HIV/AIDS are supported, the analysis recommends that programmes consider linking HIV-related service uptake to a social protection transfer and improve coordination with agencies mandated to address HIV-related issues.²⁶

In Zimbabwe the National Action Plan for Orphans and Vulnerable Children (NAP for OVC) defines a child as any

person below 18 years of age and defines orphans as children whose parents have died. However, it provides no single definition of vulnerability. Instead, it allows stakeholders at community level, including, nongovernmental, faith-based and community-based organisations to identify children they consider to be the most vulnerable within their respective communities. A review of NAP I for OVC found this approach to be effectively reaching the most vulnerable children; Zimbabwe is now building on this success the NAP Phase II 2011-2015, shifting towards a child-sensitive social protection programme with an emphasis on cash transfers and community case management, aiming to reach more than 80,000 households.

In Kenya, the Cash Transfer for Orphans and Vulnerable Children (known as the CT for OVC) began as a pre-pilot in 2004, with a targeting method that has been refined from the pre-pilot stage. Targeting is first done geographically, with the selection of programme districts on the basis of both poverty and HIV/AIDS levels.²⁷ The districts are ranked according to the number of extremely poor households with OVC in the district. The criteria for final selection into the programme are poverty-based, depending on the number of households below the poverty line.²⁸ Community-level committees then select the individual households eligible for the transfers.

Ghana’s Livelihood Empowerment Against Poverty (LEAP) cash transfer programme was built on the experience of a UNICEF-supported Department of Social Welfare (DSW) programme that covered the national health insurance premium costs for OVC in 20 districts with high HIV/AIDS prevalence rates.²⁹ LEAP continues to target caregivers of OVC, many of whom have been orphaned as a result of AIDS. OVC were initially defined as children who were infected or affected by HIV/AIDS, but the concept has now been broadened to include other categories of extremely vulnerable children. The programme has also been expanded to destitute older people and persons with severe disabilities. As of May 2009, LEAP had benefited approximately 26,200 households, with 131,000 individual beneficiaries, in 74 districts (out of 178 districts nationally). Ghana also has relatively high coverage by its National Health Insurance Scheme (NHIS), reaching approximately 54 per cent of the population at the end of 2008.³⁰ While the NHIS is not explicitly pro-poor, the proportion of marginalized groups covered by exemptions has increased. One challenge for reaching individuals affected by HIV/AIDS who are in need of social protection programming

22 Schüring, E. (2011), *Cashing in: How cash transfers shore up Zambian households affected by HIV*

23 Ibid.

24 Samuels, F. Blake, C. and Akinrimisi, B. (2012), *HIV vulnerabilities and the potential for strengthening social protection responses in the context of HIV in Nigeria*

25 Ibid.

26 Ibid.

27 World Bank (2009), *Project appraisal document for a cash transfer for orphans and vulnerable children project*

28 Garcia, M. and Moore, C. M. T. (2012), *The cash dividend: the rise of cash transfer programs in Sub-Saharan Africa*

29 Jones, N. Ahadzle, W. and Doh, D. (2009), *Social protection and children: opportunities and challenges in Ghana*

30 Ibid.

is that they may not identify themselves because of the stigma associated with HIV/AIDS. In response to this challenge, Senegal developed a conditional cash transfer for OVC that relies on local organizations that are already in contact with them, capitalizing upon local knowledge.³¹ These organizations include district-level social service delivery organizations and associations for PLWHA.³² The programme targets children aged 2-18 affected by HIV/AIDS, children living in households affected by HIV/AIDS, and other poor orphans who need schooling or vocational training or who are at risk of dropping out of school.

Pensions in particular have been shown to be an important instrument for reaching vulnerable individuals affected by HIV, specifically in countries with a large number of orphans.³³ In countries such as Lesotho, South Africa and Botswana, in households in which one or both parents have died of AIDS a heavy burden of care for orphans falls on grandparents, creating a large number of “skip-generation” households. For example, in Lesotho, 60 percent of households receiving the social pension include young children, many of who are orphaned by HIV/AIDS.³⁴

There is a growing body of evidence indicating that targeting programmes specifically to “AIDS orphans” is not the best practice for reaching the children who are most vulnerable. Analysing data from 60 nationally representative household surveys from 36 countries, Akwara et al. (2010) found that orphanhood and co-residence with a chronically ill or HIV-positive adult are not universally robust measures of child vulnerability across national and epidemic contexts. For several indicators of vulnerability (wasting, early sexual debut, and to a lesser extent, school attendance), there were few statistically significant differences between orphans and non-orphans or children living with chronically ill or HIV-positive adults and children not living with chronically ill or HIV-positive adults.³⁵ These findings indicate that vulnerability is more complex than simply orphanhood, and that household wealth tends to be a better predictor of child vulnerability.³⁶ Social protection programmes that are context-specific and recognise the multiple dimensions of vulnerability will more successfully reach the children who are most vulnerable, including those affected by HIV. Furthermore, targeting social protection specifically to orphans can potentially have unintended effects. For

example, in Botswana orphans are sometimes said to be considered ‘assets’ for accessing food vouchers through the OVC support programme.³⁷ There is no rigorous evidence to support these concerns, and more research is required to determine if transfers that incentivise foster care have negative side-effects. However, social protection interventions that specifically target orphans or may increase the number of children in foster care should be implemented with strong monitoring systems.

Handa and Stewart (2008) provide further evidence against narrowly targeted programmes that focus on orphans or HIV-positive persons. Using data from four countries – Malawi, Mozambique, Uganda and Zambia – and micro-simulation modelling, they determined that the proportional gain in per capita consumption and schooling, as well as reduction in the poverty gap, is maximised when social transfers target the poorest households with children, rather than households with orphans.³⁸ They conclude that – to the extent that vulnerability is directly correlated with extreme poverty – cash transfers that target ultra poor households with children will have the greatest impact on vulnerable children in the region. This is because orphans are not necessarily clustered in the poorest households.

Overall, evidence suggests that the HIV/AIDS crisis has led to increased demand for existing social protection programming. In Namibia, coverage of the Child Maintenance and Foster Care Grants increased 10 times over from 2003 to the end of 2008.³⁹ The World Bank (2009) attributes this increase to the rapid growth of the OVC population, which is attributable to the HIV/AIDS epidemic.⁴⁰ Similarly, South Africa has seen significant grant uptake over the past decade (although this is also due to the expansion of benefits to cover additional groups, increases in grant values and wider awareness of the grant system).

3.4 Gaps in the evidence: Programme reach

It is critical to know whether vulnerable key affected populations are being reached through social protection programmes. If the vulnerable are not being reached, we need to know what barriers they face in accessing services.

31 Garcia, M. and Moore, C. M. T. (2012), The cash dividend: the rise of cash transfer programs in Sub-Saharan Africa

32 Ibid.

33 DFID (2011), Cash transfers evidence paper

34 National University of Lesotho (2006), cited in Samson et al. (2007), The social and economic impact of cash transfers

35 Akwara, P. A. et al. (2010), Who is the vulnerable child? Using survey data to identify children at risk in the era of HIV and AIDS

36 Ibid.

37 Roelen, K. et al. (2011), Lessons from the Children and AIDS Regional Initiative (CARI): Child- and HIV- sensitive social protection in Eastern and Southern Africa

38 Handa, S. and Stewart, S. (2008), Reaching OVC through cash transfers in Sub-Saharan Africa: Simulation results from alternative targeting schemes

39 Garcia, M. and Moore, C. M. T. (2012), The cash dividend: the rise of cash transfer programs in Sub-Saharan Africa

40 Ibid.

The evidence synthesised above identifies a limited number of interventions that have reached key vulnerable populations. In particular, there is strong evidence supporting HIV-inclusive, rather than HIV-exclusive approaches, as well as strong evidence indicating that targeting AIDS orphans is not the most effective way to reach children who are truly the most vulnerable.

While there is a growing evidence base looking at child vulnerability, the data on core at-risk populations (men who have sex with men, drug users, and sex workers) comes primarily from developed countries. Gathering data on these key groups, and children within these groups, from developing country contexts is therefore a priority for future research.

Operational research looking at targeting in different epidemic contexts that takes account of social and economic vulnerability is also limited, pointing to a major evidence gap. This is particularly important in low and concentrated epidemics where stigma and discrimination may be more extreme and key affected populations such as sex workers or drug users may have challenges accessing social protection programming, whether it is health insurance or a social transfer.

There is a strong need for operational research that can guide policymakers on targeting decisions and the management of data relating to programme coverage, exclusion error and inclusion error. Specifically, there is demand for a guide on how to implement management and information systems (MIS) that can quantify the reach of social protection programmes and the extent to which they are reaching HIV-affected households. There is also demand for a guide on the types of questions that can be added to programme evaluations and surveys in order to gain an understanding of whether vulnerable, HIV-affected households are being reached by social protection programmes, as well as whether affected households are able to access treatment. There is evidence that determining HIV status in surveys is difficult, and it is often under-reported; as a result, guidance on variables that can be successfully used as proxies (for example, whether a family member has been repeatedly ill over the past 30 days) would benefit programme monitors and evaluators. At the same time, with the increasing prevalence of non-communicable diseases (diabetes, cancers, cardiovascular diseases and chronic lung diseases), it may be difficult to identify households affected by HIV through proxy measures.

4. EVIDENCE GAP ANALYSIS: ACHIEVING CORE HIV/AIDS IMPACTS

The following section of the paper will analyse the evidence base as it relates to achieving core impacts in preventing HIV infections, improving treatment access and adherence to reduce AIDS-related morbidity, and mitigating the impact of HIV and AIDS on vulnerable households through comprehensive care and support. These three categories come from Universal Access, a global commitment to scale-up access to HIV prevention, treatment and care and support.⁴¹ These elements are also reflected in the HIV and AIDS investment framework, with policy-makers, practitioners, governments and international development partners expressing growing interest in the potential for social protection to achieve Universal Access and other developmental goals.

As a result, it is critical that we have a robust evidence base to guide the design and implementation of social protection programming. Therefore this section will be the most extensive component of the evidence gap analysis. It begins with an operational framework posing key questions from an operational research perspective. This is followed by three sections that look at the existing evidence and resulting evidence gaps for each of the three core impact areas: prevention, treatment, and care and support.

4.1 Key research questions: Core HIV/AIDS impacts

A number of key research questions remain for better understanding the impact of HIV-sensitive social protection on key HIV/AIDS outcomes, including:

- How can social protection impact core HIV/AIDS outcomes: prevention, treatment and care and support?
 - How can social protection affect the causal factors for HIV-infection, preventing HIV transmission and ultimately reducing HIV incidence?
 - What are the specific pathways by which social protection interventions (such as household targeted cash transfers or cash incentives targeted at individuals) can prevent HIV transmission?

- How do these prevention impacts differ across different vulnerable populations (e.g. girls and young women)?
- How can social protection contribute to better access and adherence to HIV treatment, including prevention of mother-to-child transmission (PMTCT) and paediatric AIDS outcomes?
 - How can social protection reduce social barriers, such as stigma, which may prevent men and women accessing available services?
- How can social protection contribute to care and support for HIV-affected households and children?
- What are the core design elements necessary for a social protection intervention to effectively achieve HIV-related impacts?
 - What is the relationship between benefit level, frequency and duration and core HIV-related impacts?
 - Does the relationship between design elements (e.g. level, frequency, duration or type of transfer) and HIV-related impacts differ by gender?
- What combinations of food/cash/vouchers/social insurance/other social services are warranted for different types of HIV affected and infected populations? What are the most cost-effective in terms of HIV outcomes?
- How do we ensure that social protection programmes do not result in negative unintended consequences?
- How can participatory planning contribute to better social protection outcomes for HIV affected individuals and households?

⁴¹ enshrined in the 2006 UN Political Declaration and led by countries worldwide with support from UNAIDS and other development partners

4.2 Prevention

4.2.1 Evidence from the State of the Evidence 2010: Prevention outcomes

Temin (2010) documents an emerging evidence base that shows the contribution of social protection to HIV prevention. Research from a growing number of sub-Saharan countries show that girls living in AIDS-affected households are especially vulnerable to unsafe sex and other behaviours that increase their risk of contracting HIV.⁴² Temin concludes that evidence suggests that social protection can have a particularly important role in interrupting this cycle, preventing a person affected by AIDS from becoming a person living with HIV. However, Temin notes that prevention is a relatively new area for social protection. As a result, information had to be extrapolated from the existing literature because there is currently limited research specific to social protection and HIV prevention.

The 2010 review is organised by instrument, and examines each instrument's potential linkages to HIV prevention. Temin finds that social cash transfers, food transfers, income generating activities, microcredit, social health insurance, and transformative laws, policies and regulation have the potential to prevent HIV directly and/or indirectly. There is a relatively strong body of evidence demonstrating the effectiveness of cash and in-kind transfers (food, uniforms) in increasing school enrolment and attendance, revealing social protection's potential to expand access to the "social vaccine" of education, preventing HIV infection. By increasing young women's (or other vulnerable groups, like sex workers) self-confidence, social standing and autonomy, social protection can have a transformative effect, empowering women to protect themselves from HIV in their sexual relationships.

Temin hypothesises that income-generating activities and microcredit can also reduce the vulnerability of women and girls in AIDS-affected households by empowering them, increasing their ability to insist on condom use and refuse sex. These programmes could also reduce their need to resort to risky coping strategies (such as transactional sex) that would increase their susceptibility to HIV infection. However, Temin notes that there has been no research to support this specific pathway. While livelihoods programmes and microcredit do not fall under our definition of social protection, these programmes can be linked to other social protection instruments for a more effective overall response.

Social protection 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 (PMTCT) services. Temin extrapolates from evidence in Asia showing that voucher schemes have effectively increased access to maternal and neonatal care, but again notes that while this pathway is logical there is no HIV-specific evidence.

Care and support responses that reach orphans and vulnerable children may also play a role in HIV prevention, considering the intergenerational transfer of vulnerability. For example, care and support programmes that allow children to stay in school increase their future income potential and can empower them, leaving them less susceptible to HIV risk factors. Again, Temin notes that this pathway has not yet been well documented.

4.2.2 New and emerging evidence: Prevention outcomes

In order for social protection to prevent the transmission of HIV/AIDS it must affect the upstream determinants of infection. Since the publication of the 2010 review, more evidence has emerged showing more clearly how social protection can address upstream structural drivers of HIV-risk. Specific upstream factors that contribute to vulnerability to HIV risk include poverty, gender inequality and educational attainment. The results of several recent randomised controlled studies suggest that the financial security provided by social protection could affect sexual behaviours, and that the promotion of economic empowerment and sustainable livelihoods could play a key role in the reduction of HIV risk.⁴³ Social protection programmes can also increase the uptake of critical prevention health services, such as PMTCT treatment and counselling.

There is some emerging evidence linking food insecurity with HIV risk, and the potential for food and nutritional supplements to contribute to HIV prevention efforts. Observational studies suggest that food insecurity is associated with increased HIV transmission risk behaviors.⁴⁴ For example, in an HIV-endemic community in Uganda it was found that food insecurity led to increased sexual vulnerability among women, who were often compelled to engage in transactional sex or remain in

42 Birdthistle, I. et al. (2009), Is education the link between orphanhood and HIV/HSV-2 risk among female adolescents in urban Zimbabwe?, and Frega, R. Duffy, F. and Grede, N. (2010), Food insecurity in the context of HIV and AIDS

43 Kim, J., Pronyk, P., Barnett, T., and Watts, C. (2008), Exploring the role of economic empowerment in HIV prevention

44 Anema et. al. (2009), Food insecurity and HIV/AIDS: Current knowledge, gaps, and research priorities

violent or abusive relationships due to their reliance on men to provide food for themselves and their children.⁴⁵ Recently researchers have looked at linkages between food insecurity and sexual risk with the aim of supporting the integration of food and HIV/AIDS programming activities where possible.⁴⁶ In addition to understanding how social protection affects food security and related HIV risk, there is a need for greater understanding of how social protection (through reducing malnutrition) can reduce susceptibility to HIV infection⁴⁷

An important contribution to the literature on social protection and HIV prevention is *Cash Transfers: What do we know and where do we go?* (Lutz and Small, forthcoming). This paper reviews existing evidence to understand the advantages and disadvantages, both known and inferred, of using cash transfers as a tool for HIV prevention. It emphasises the complex relationship between poverty, inequality and HIV risk. At a global level, poverty is associated with HIV risk (poor countries have higher HIV incidence), but at an individual level wealth remains associated with increased HIV risk.⁴⁸Overall, AIDS is increasingly seen as a disease of inequality and of economic and social transition, but poverty can lead to increased HIV risk, such as in cases where poverty leads to transactional sex as a means of meeting material needs. Therefore, poverty on its own is not a driver of the HIV epidemic, but rather has a multidimensional role interacting with a range of other factors including mobility, social and economic inequalities and social capital, which can converge in a potent way for certain demographic groups, particularly

young women in southern Africa.⁴⁹ There is very strong evidence that cash transfers can result in sizeable reductions in national poverty, with modest decreases in the poverty headcount and strong decreases in the severity of poverty (e.g. the poverty gap). There is also some evidence that cash transfers can lead to reductions in national inequality, as shown in Brazil, Mexico and Chile.⁵⁰ Given that inequality, rather than poverty, appears more closely associated with HIV risk, the inequality reductions attributable to cash transfers may lead to lower HIV risk.⁵¹ However, the linkage is inferred, as no studies have explicitly examined this relationship.

The intersection of cash transfers and HIV in particular has received significant media coverage in recent years (for example, a study of a conditional cash transfer in Zomba, Malawi made it into the *Economist* and the *Financial Times*). A new analysis of the Zomba programme, published in *The Lancet*, found in a randomised control trial that women aged 13-22 years who received an unconditional monthly cash transfer (UCT) had a lower prevalence of HIV infection than women in the control group, who received no cash transfer.⁵² These effects are supported by changes in self-reported sexual behaviour, as illustrated in the diagram below. Furthermore, the treatment effects did not differ significantly between the UCT and conditional cash transfer group (where receipt of the transfer was conditional on school attendance), suggesting that the cash was the factor contributing to lower HIV infection rates.

45 Miller, C. L. et al. (2011), Food insecurity and sexual risk in an HIV endemic community in Uganda
46 Ibid.
47 Seume-Fosso. E. et al. (2004), HIV/AIDS: A guide for nutritional care and support
48 Lutz, B. and Small, S. (forthcoming), Cash transfers and HIV prevention: What do we know and where should we go?
49 Kim, J., Pronyk, P., Barnett, T.,and Watts, C. (2008), Exploring the role of economic empowerment in HIV prevention
50 Lutz, B. and Small, S. (forthcoming), Cash transfers and HIV prevention: What do we know and where should we go?
51 Ibid.
52 Baird, S. et al. (2012), Effect of a cash transfer programme for schooling on prevalence of HIV and herpes simplex type 2 in Malawi: a cluster randomised trial

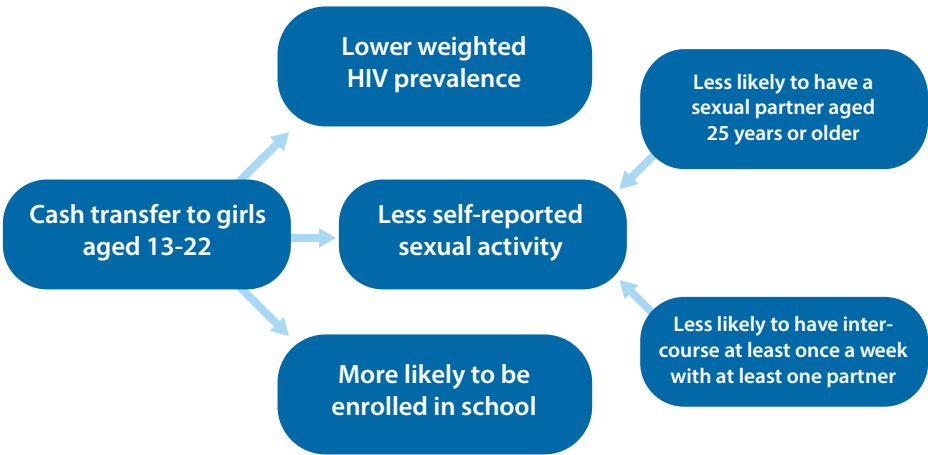


Figure 7. Outcomes from the Zomba, Malawi CCT study

SOURCE: Baird, S. et al. (2012), Effect of a cash transfer programme for schooling on prevalence of HIV and herpes simplex type 2 in Malawi: a cluster randomised trial

The linkages between educational attainment and lower individual risk of HIV-infection are well documented⁵³ and several recent studies have further contributed to this body of evidence. The 2012 analysis of the Zomba study again found that both the CCT and UCT recipients had statistically higher rates of school attendance and lower rates of HIV prevalence.⁵⁴ A World Bank study in Pakistan found that a female-targeted cash transfer, conditional on school attendance, increased the enrolment of eligible girls, and that the positive impacts persisted over time.⁵⁵ The study also found suggestive evidence that participating girls delay marriage and have fewer births by the time they are 19 years old. In Bangladesh the Female Secondary School Stipend programme required participant girls to remain unmarried through secondary school. While HIV was not tracked in this study, an evaluation found a wide range of positive impacts on girls' lives, including increase in age at marriage, greater birth spacing, positive attitude to smaller family size, and higher employment and earning levels.⁵⁶ A study of the *Oportunidades* conditional cash transfer in Mexico (which is conditioned on school attendance) also found that for adolescent females, the conditional cash transfers reduce the likelihood of expecting to be married by age 21 and have children before age 20.⁵⁷ These findings could translate into lower vulnerability to HIV in certain contexts, if marriage and pregnancy are viewed as (imperfect) proxies for sexual intercourse.

A more direct link between educational attainment and reduced HIV vulnerability was found in a randomised controlled trial in rural eastern Zimbabwe, which tested whether comprehensive support to keep orphan adolescent girls in school could reduce HIV risk.⁵⁸ The combination intervention included a daily feeding programme, receipt of school fees and uniforms, and a school-based helper to monitor attendance and resolve problems.⁵⁹ The intervention reduced school dropout by 82 per cent and marriage by 63 per cent after 2 years. Compared with control participants, the intervention group reported better future expectations, more equitable gender attitudes, and more concerns about the consequences of

sex – all promising impacts that could potentially reduce HIV risk.⁶⁰

Globally young women aged 15-24 are most vulnerable to HIV, with infection rates twice as high as in young men and accounting for 22 per cent of all new HIV infections.⁶¹ In sub-Saharan Africa more women than men are living with HIV (59 per cent), and young women aged 15-24 are as much as eight times more likely than men to be living with HIV.⁶² This is hypothesised to be the result of upstream determinants that lead to gender inequality. Risk pathways are both direct and indirect, and gender inequities overlap and interact with many other structural factors (e.g., economic inequalities, laws, policies and social norms) to reinforce HIV risk.⁶³ The Zomba, Malawi study found that a cash transfer targeted to women reduced HIV infection, suggesting that financially empowering school-age girls and their families can have substantial effects on their sexual and reproductive health.⁶⁴

The Intervention with Microfinance for AIDS and Gender Equity (IMAGE) study is another randomised trial of a structural intervention to prevent HIV in women with a biological outcome. However, as noted by Temin (2010), the IMAGE study found that the combination of a microfinance programme with a sexuality education and HIV training curriculum had no effect on HIV incidence.⁶⁵ More positive outcomes were found with female empowerment and household communication about HIV/AIDS; women reported greater self-confidence and autonomy in decision-making, challenging gender norms and collective action than other women, while younger participants were more likely to use condoms in non-spousal relationships and have gone for HIV testing.⁶⁶ However, IMAGE and other earlier microfinance-based interventions (such as Tap and Reposition Youth in Kenya) suggest that addressing HIV risk through microfinance may be better achieved as a result of partnerships with well-established microfinance programmes and working with diverse age groups, rather than specifically tailoring novel interventions to align directly with HIV prevention-related goals.⁶⁷

60 Ibid.

61 UNAIDS (2010), Fact Sheet: Women, girls, gender equality and HIV

62 Ibid.

63 Lutz, B. and Small, S. (forthcoming), Cash transfers and HIV prevention: What do we know and where should we go?

64 The treatment group, which received the cash transfer, had a statistically significant lower rate of HIV infection (as tested at the conclusion of the intervention), as compared to the control group, which did not receive a cash transfer. See Baird, S. et al. (2012), Effect of a cash transfer programme for schooling on prevalence of HIV and herpes simplex type 2 in Malawi: a cluster randomised trial

65 Pronyk, P.M. et al. (2006), Effect of a structural intervention for the prevention of intimate partner violence and HIV in rural South Africa: results of a cluster randomised trial (IMAGE)

66 Ibid.

67 Kim, J., Pronyk, P., Barnett, T., and Watts, C. (2008), Exploring the role of economic empowerment in HIV prevention

53 Hargreaves, J.R. et al. (2008), Systematic review exploring time-trends in the association between educational attainment and risk of HIV infection in sub-Saharan Africa

54 Ibid.

55 Alam, A., Baez, J. E., and Del Carpio, X. V. (2011), Does cash for school influence young women's behavior in the longer term? Evidence from Pakistan

56 Mahmud, S. (2003), Female secondary school stipend program in Bangladesh: A critical assessment

57 Galárraga, O. and Gertler, P. (2009), Cash and a brighter future: the effect of conditional transfers on adolescent risk behaviors: Evidence from urban Mexico

58 Hallfors, D. et al. (2011) Supporting adolescent orphan girls to stay in school as HIV risk prevention: Evidence from a randomised controlled trial in Zimbabwe

59 Ibid.

Transactional sex can reduce women's ability to negotiate condom use, result in a higher number of sexual partners, or make them at greater risk of violence, thereby increasing vulnerability and HIV risk. Transactional sex is exchanging sex for money, goods, or services; commercial sex work might be thought of as one end of a continuum of sexual relationships that feature a transactional component.⁶⁸ In order for social protection to interrupt this pathway, we must first have an understanding of the drivers behind transactional sex. There is a growing body of literature on this area. Wamoyi et al. (2010) completed an ethnography of young women's motivations and negotiations for transactional sex in rural northern Tanzania. Motivations were largely financial, including escaping intense poverty, seeking beauty products or accumulating business capital. The paper hypothesises four ways in which transactional sex increases the risk of HIV transmission: 1) the motivation of receiving material goods encouraged sexual activity that may not have otherwise occurred if women had other sources of income or means of acquiring goods, 2) it provides a dynamic for partner change, 3) more affluent men are considered more desirable, but given the current distribution of HIV they are also more likely to be infected since they can have multiple partners and change them frequently, and 4) it creates a further barrier to condom use.⁶⁹ The authors suggest that alternative income-generating schemes may reduce the transactional sex that is motivated by poverty, as well as potentially empowering women who continue to engage in transactional sex to resist high risk sexual partners or unprotected sex, although deep cultural change is also needed. An analysis of transactional sex as a response to risk in Western Kenya found that women who engage in transactional sex substantially increase their supply of risky, better compensated sex to cope with unexpected health shocks, particularly the illness of another household member.⁷⁰ These behavioural responses entail significant health risks for these women and their partners, and suggest that these women are unable to cope with risk through other consumption smoothing mechanisms.⁷¹ Social protection that provides women with economic security and protects against health shocks can therefore have an important role in preventing risky transactional sex.

An additional important area for research is whether AIDS-affected youth are at increased risk of transactional sex. Cluver et al. (2011) find that youth in AIDS-affected families are at higher risk of transactional sex, which

68 Robinson, J. and Yeh, E. (2011), Transactional sex as a response to risk in western Kenya

69 Wamoyi, J. et al. (2011), Transactional sex amongst young people in rural northern Tanzania: an ethnography of young women's motivations and negotiation

70 Robinson, J. and Yeh, E. (2011), Transactional sex as a response to risk in western Kenya

71 Ibid.

is partly due to increased food insecurity and abuse in AIDS-affected families.⁷² In a four-year longitudinal study in South Africa, Cluver et al. found that the combination of familial AIDS, food insecurity and abuse raised transactional sex risk among girls (aged 15 to 24) dramatically, from 1 per cent to 57 per cent.⁷³ To combat the risk of transactional sex, family and poverty risk factors for youth must be addressed. Social protection can play a potentially effective role in reducing intervening variables (like food insecurity) that have been shown to affect risky sexual behaviour. But overall the relationship between social protection and transactional sex remains poorly understood, and is a critical area for future research.

There is also a growing body of quantitative evidence on using cash transfers as a behavioural incentive for HIV prevention, as documented in a 2010 GTZ discussion note.⁷⁴ Packel et al. (2012) analysed the RESPECT (Rewarding STI Prevention and Control in Tanzania) trial in rural Tanzania, a randomised controlled trial with a cash transfer contingent upon testing negative for a set of curable sexually transmitted infections (STIs).⁷⁵ The theory behind these behavioural interventions, such as the RESPECT trial, is that the conditional cash transfer intervention would raise the perceived "price" of risky sexual behaviours, since risky behaviours could lead to not receiving a proximate financial reward. Packel et al. (2012) find two important implications from their results; 1) those at higher risk are more likely to change than those reporting lower levels of risk, and 2) since there is some supporting evidence that new and unexpected opportunities (e.g. free STI testing, or a cash transfer) can be associated with overall change, more attention should be focused on creating such opportunities for those who are at risk.⁷⁶

The RESPECT trial in rural Tanzania tested for risky sexual behaviour repeatedly over short time intervals, finding a significant (25 per cent) reduction in STI prevalence for the treatment group that was eligible for \$20 payments.⁷⁷ No such reduction was found for the group receiving a lesser \$10 payment. The RESPECT trial suggests that using cash transfers to incentivise safer sexual practices is a potentially promising new tool in HIV prevention, and that curable STIs can be a non-stigmatizing proxy for HIV. The

72 Cluver, L. et al. (2011d), Transactional sex amongst AIDS-orphaned and AIDS-affected adolescents predicted by abuse and extreme poverty

73 Ibid.

74 Schäfer, M. (2010), Using conditional cash transfers to control sexually transmitted infections and HIV

75 Packel, L. et al. (2012), Sexual behavior change intentions and actions in the context of a randomized trial of a conditional cash transfer for HIV prevention in Tanzania

76 Ibid.

77 deWalque et al. (2012), Incentivising safe sex: a randomised trial of conditional cash transfers for HIV and sexually transmitted infection prevention in rural Tanzania

difference in outcomes between the Malawi and Tanzania studies illustrates the critical importance of cash transfer design and implementation, particularly in regards to timeframe and the value of the transfer.

In their evaluation of a conditional cash transfer program in rural Malawi, which offered financial incentives to men and women to maintain their HIV status for approximately one year, Kohler and Thornton (2011) found no effect on HIV status. However, there were some interesting gender differences; men who received the cash transfer were 8.5 percentage points *more* likely to engage in risky sex (in comparison, women were 7.5 percentage points *less* likely to engage in risky sex).⁷⁸ The reason for this is unknown, though the authors hypothesise that the men use the transfer to purchase risky sex, the increase in income was a signal to women that the men were HIV-negative, or that the men spent the money on items that increased their level of attraction.⁷⁹ This finding has not been collaborated in other studies, but additional investigation into the men and women's different responses to cash transfers is warranted.

A key question is how effective financial incentives can be combined with comprehensive sex education and access to reproductive health commodities such as condoms to reduce risk factors and new infections. A new systematic review of HIV prevention programmes for young people in sub-Saharan Africa documents a wide range of sex and HIV education interventions in schools and communities.⁸⁰ However, many of the programmes did not have a significant impact on reported sexual risk behaviours. For example the community-based MEMA kwa Vijana trial in Tanzania provided in-school sexual and reproductive health education, youth-friendly sexual and reproductive health services, and condom promotion and distribution. A follow-up study published in 2010 found clear and consistent beneficial impact on knowledge, but no significant impact on reported attitudes to sexual risk, reported pregnancies or other reported sexual behaviours.⁸¹ Given the evidence of positive impacts for cash transfers, an area for future research is pairing cash transfers with youth educational programmes (like MEMA kwa Vijana) to potentially achieve greater impacts.

An emerging evidence base indicates that social protection programmes can increase the uptake of critical prevention health services, such as PMTCT treatment and counselling, thereby contributing to HIV prevention.

78 Kohler, H.P. and Thornton, R. (2011), Conditional cash transfers and HIV/AIDS prevention: Unconditionally promising?

79 Ibid.

80 Mavedzenge, S.N., Doyle, A. and Ross, D. (2010), HIV prevention in young people in sub-Saharan Africa: A systematic review

81 Doyle, A.M. et al. (2010), Long-term biological and behavioural impact of an adolescent sexual health intervention in Tanzania: Follow-up survey of the community-based MEMA kwaVijana trial

A study of El Salvador's CCT programme *Comunidades Solidarias Rurales* found robust impacts on outcomes at time of birth (skilled attendance and birth in facility), while no impacts were found on health-seeking behaviour pre- and post-birth (prenatal and postnatal care).⁸² However, given the extremely low prevalence of HIV in El Salvador, and the possible role of supply-side constraints, these results cannot be applied to the sub-Saharan Africa context. A more applicable study by Limet al. (2010) analysed data from Indian household surveys to assess the effect of the Janani Suraksha Yojana (JSY) conditional cash transfer scheme on antenatal care, in-facility births, and perinatal, neonatal and maternal deaths. In the JSY scheme women are eligible for a cash transfer (variable by region) if they deliver their baby in a government or accredited private health facility. While implementation of the programme has been variable, it was found to have a significant effect on increasing antenatal care and in-facility births.⁸³ A national programme in Nepal similarly provides cash incentives to women conditional on them giving birth in a health facility. Evaluation of the programme found a modest positive effect on the utilisation of maternity services, with women who had heard of the programme before childbirth being 4.2 percentage points (17 per cent) more likely to deliver with a skilled attendant.⁸⁴ The treatment effect was positively associated with the size of the benefit offered by the programme, as well as the quality of care in facilities.⁸⁵ Overall there is limited evidence on whether these conditional cash transfers work in low-income countries, particularly when implemented at-scale. No comparable studies have been done with CCTs linked to PMTCT services, which could be a potentially effective means to increase PMTCT uptake. Improving access and adherence to PMTCT services could have significant prevention outcomes in countries like Ghana, where mother-to-child transmission (MTCT) accounts for an estimated 15 per cent of new infections.⁸⁶

A systematic review showed that policy-level support and empowerment strategies for sex workers in resource-poor settings could improve acceptability, adherence, and coverage of HIV-prevention programmes.⁸⁷ Legislative

82 deBrauw, A. and Peterman, A. (2011), Can conditional cash transfers improve maternal health and birth outcomes?: Evidence from El Salvador's *Comunidades Solidarias Rurales*

83 Lim, S. S. et al. (2010), India's Janani Suraksha Yojana, a conditional cash transfer programme to increase births in health facilities: an impact evaluation

84 Powell-Jackson, T. and Hanson, K. (2012), Financial incentives for maternal health: Impact of a national programme in Nepal

85 Ibid.

86 Jones, N. Ahadzie, W. and Doh, D. (2009), Social protection and children: opportunities and challenges in Ghana

87 Shahmanesh, M., Patel, V., Mabey, D., and Cowan, F. (2008), Effectiveness of interventions for the prevention of HIV and other sexually transmitted infections in female sex workers in resource poor setting: a systematic review

reforms, reducing stigma and discrimination, and enhancing social capital are important structural interventions for a range of populations (such as sex workers or men who have sex with men), and can potentially play an important role in prevention.⁸⁸

4.2.3 Gaps in the evidence: Prevention outcomes

Overall, further research is needed to guide the replication and scale-up of promising programmes, and to document how different interventions differently affect patterns and pathways of risk. Addressing HIV risk through food security and nutrition programmes is an area where integrated approaches are currently being developed, and where robust evaluation is needed to demonstrate their impact. Further research must also take into account equity of food distribution within the household, as women may be less food secure than men as a result of unequal household food allocation, a situation that may be exacerbated by their lack of control over decisions related to food production, consumption and sale.⁸⁹ Food insecurity could contribute to higher HIV-risk amongst women, but further research is needed to illuminate these risk pathways.

The Zomba, Malawi study is one of the most critical pieces of evidence on HIV-sensitive social protection, because it looks at HIV prevalence as a biological outcome. While the study demonstrates that cash transfers to young girls can lead to lower HIV prevalence, it also points to several important gaps in our knowledge of HIV-sensitive cash transfers. It found several areas in which the treatment groups (receiving the conditional and unconditional cash transfers) differed from the control group (which received no cash) in statistically significant ways after the intervention. As shown in Figure 7, the treatment groups were more likely to be enrolled in school, had less self-reported sexual activity and –notably– had a lower HIV prevalence. However, much remains to be learned about how these different outcomes interact and/or reinforce each other. While the intervention’s income effect is a clear part of the pathway to lower HIV risk, the schooling effect is less clear. Are young girls who receive the transfers more likely to have younger sexual partners because they are in school, and have a different peer network, or because the cash may improve their economic security and lessen their likelihood of turning to transactional sex? Qualitative research could shed light on how money for school or unconditional cash transfers affects young girls as agents of their own sexual decision-making.

In the Zomba study the comparison between the unconditional and conditional cash transfer groups was of smaller treatment groups and therefore it has less statistical power to detect effects for each of these intervention groups. There is no other evidence on how CCTs and UCTs may differently impact HIV outcomes. As noted by Medlin and de Walque (2008) in a World Bank policy research working paper, there remain questions about the importance of conditionality to the effectiveness of such programmes, and little work has been done towards in-depth examination of the conditionality requirement.⁹⁰ For HIV prevention, the role of conditionalities is a critical piece of information that is needed to assess whether cash transfer programmes can be effective at reducing risky sexual behaviour.

A second area for future research is the impact of the transfer amount, a critical decision in programme design that could potentially affect programme impact. Conditional cash transfers have often relied on formulas to compensate participants on the opportunity costs of complying with programme requirements, such as antenatal care visits. However, if cash transfers are used as a tool to encourage safer sexual practices and discourage risky ones, the purpose of the incentive is to not only compensate for opportunity costs, but to affect an individual’s decision-making process.⁹¹ More research is needed on the relationship between the magnitude of rewards and the impacts on different target behaviours, by randomly assigning different size payments to individual participants, as was done in the study of learning HIV status in Malawi (Thornton, 2008).

A third area is the frequency of the intervention. Even if the size of the transfer is small, recent behavioural economics research suggests that individuals’ choices are not time-consistent, and therefore regular reminders related to sexual health could impact individuals’ decisions related to sexual risk.⁹² A fourth critical issue is that more guidance is needed for the complexities of implementing cash transfers on a larger scale. While UCTs are less complex than CCTs since there are no conditionalities to implement and monitor, both involve significant administrative capacity to expand beyond trials and operate at-scale.

A fifth area that deserves further research is differences in programme impact for men and women, given the increased HIV-vulnerability of women in sub-Saharan Africa, as well as political acceptability of targeting

88 Gupta, G.R., Parkhurst, J.O., Ogden, J.A., Aggleton, P., and Mahal, A. (2008), Structural approaches to HIV prevention

89 Kim, J., Pronyk, P., Barnett, T., and Watts, C. (2008), Exploring the role of economic empowerment in HIV prevention

90 Medlin, C. and de Walque, D. (2008), Potential applications of conditional cash transfers for prevention of sexually transmitted infections and HIV in sub-Saharan Africa

91 Ibid.

92 Della Vigna, S. (2009), Psychology and economics: evidence from the field

adolescent girls alone in the scaling up of cash transfers to incentivise girls to stay at school. The question of differential programme impacts on men and women is a research question that applies to all social protection interventions, not just cash transfers. A sixth gap in the evidence base is studies linking conditional cash transfers to health services, particularly PMTCT services. A seventh important gap is examining the longer-term effects of these programmes. While the Zomba, Malawi study showed lower HIV prevalence at the conclusion of the study, we do not know its longer term-effects on the girls' schooling, decision-making, and HIV-risk. One hypothesis is that the transfers merely postponed infection amongst the intervention group, and upon the study's conclusion the girls could be at the same risk as their peers who had not received the cash. Furthermore, their risk could be higher if participants respond to the economic shock of losing the cash transfer by turning to risky behaviours such as transactional sex. There is currently no evidence to support either hypothesis, but these longer-term effects are an important area for future research. More broadly, more research is needed into what specific behaviours can be incentivized. Finally, the role of structural interventions that address cultural norms, gender and economic inequalities, migrant labour, and other factors underlying individual behaviour (e.g. transactional sex) is a substantial area of exploration.⁹³

Overall, there is a paucity of data on the direct effect of social protection interventions on both HIV prevalence and incidence. Much of the evidence requires inference to draw a linkage between the social protection intervention and a sexual health or HIV outcome. There is strong demand for efficacy trials that examine HIV infection as the outcome, so as to more directly ascertain what social protection programming effectively leads to reduced risk of HIV infection. Difficulties in measurement of HIV prevalence combined with the well-documented problems in the self-reporting of sexual behaviour pose significant obstacles to obtaining evidence on social protection programming's impact on HIV prevention. However, assessing the impact of programmes on the uptake of programmes like HIV testing, PMTCT and treatment can potentially be useful both alone and as a proxy for effect on HIV incidence.⁹⁴

93 Padian, N. S. et al. (2011), HIV prevention transformed: the new prevention research agenda

94 Ibid.

4.3 Treatment

4.3.1 Evidence from the State of the Evidence 2010: Treatment outcomes

Temin (2010) documents evidence of the positive impact of a variety of social protection instruments –including social cash transfers, food transfers, social health protection, vouchers and fee exemption schemes– on HIV/AIDS treatment. Temin discusses how treatment is affecting home-based care, as increasing numbers of people living with HIV are accessing ART and the role of home-based care providers is changing from terminal to chronic disease management. As a result treatment adherence is becoming an increasingly important area for policymakers, particularly with the push toward the elimination of MTCT and keeping adults and children on life-long treatment. Little documented evidence exists on the varying impacts of different approaches to home-based promotion of treatment adherence; however, it is clear that training providers to fulfil their changing roles strengthens effectiveness. There may also be an important role for technology. For example, people taking antiretroviral therapy can be given mobile phones, which home-based care providers call to remind them to take their medication.

Social transfers and food transfers can play an important role in the nutritional recovery of patients receiving HIV treatment, as well as improving testing and treatment uptake. Temin (2010) finds that in general terms, food transfers are shown to promote antiretroviral therapy adherence, helping people to better tolerate antiretroviral therapies.⁹⁵ People who start treatment in low-income countries often do so at very low CD4 counts, when wasting has often compounded pre-existing under-nutrition or malnutrition. Temin notes that several studies have assessed the impact of micronutrient supplements on HIV disease outcomes, such as mortality and CD4+ T cells (immune cells) count.⁹⁶ However, the composition of supplements, patient characteristics and treatments varied widely across studies, and as a result the impact evidence is inconclusive. While it is unclear how much food contributes to nutritional improvements (versus how much the medication contributes), under-nutrition is a predictor for mortality. Poor nutrition can play a role in hastening HIV disease progression in adults and children.⁹⁷ Food transfers can reduce under-nutrition in people living with HIV, although access to the right food

95 Gillespie, S. and Kadiyala, S. (2008), HIV/AIDS, food and nutrition security: from evidence to action, Cantrell, R.A. et al. (2008), A pilot study of food supplementation to improve adherence to antiretroviral therapy among food-insecure adults in Lusaka, Zambia

96 such as Fawzi, W. W. et al. (2004), A randomized trial of multivitamin supplements and HIV disease progression and mortality

97 Fergusson, P. et al. (2009), Nutritional recovery in HIV-infected and HIV-uninfected children with severe acute malnutrition

(micronutrient rich, with a high energy density) is critical.

Examining the limited evidence from resource-limited settings, Temin finds that starting on antiretroviral therapy improves body mass index, and the provision of fortified foods further increases body mass index in addition to antiretroviral therapy. While fortified-blended food seems to do so to a lesser extent than spreads, Temin notes that we still do not fully understand which product is most cost effective at different stages of malnutrition recovery and antiretroviral therapy (ART). In addition, studies conducted to date have been too small to assess how much these interventions reduce mortality.⁹⁸ It is worth noting that, in practice, the delivery of “food by prescription” 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.⁹⁹

Temin notes that there is evidence of social transfers having a positive impact on the nutritional recovery of patients receiving HIV and tuberculosis treatment¹⁰⁰, but the documented evidence on the link between antiretroviral therapy and cash transfers is limited. There is potentially a role for cash incentives in increasing uptake of voluntary counselling and testing, an important first step in promoting access to treatment and prevention services. In a study from Malawi, a randomly assigned small monetary incentive (one tenth of a day’s wage) led to a 50 per cent increase in people returning to collect their HIV results.¹⁰¹

Social health protection as well as measures that expand health-care access (vouchers, exemptions, fee abolition) can increase access to health services and treatment. Temin emphasises the importance of these measures given social health insurance’s failure to reduce financial barriers (such as payments for clinic visits and transportation, as well as medication) for the ultra-poor and most vulnerable. Furthermore, social health insurance schemes do not usually cover AIDS treatment, limiting their effectiveness for promoting treatment. Voucher and fee-exemption schemes have potential for increasing access to ART and other HIV-related health services, particularly if they cover transport costs along with medical expenses, and when providers are reimbursed for appointments covered with vouchers. Temin highlights an important study using cash transfers to cover clinic transportation in rural Uganda, which found that modest cash transfers of \$5-8 per month to defray the costs of transportation

led to better treatment adherence.¹⁰² Exemption schemes have a mixed record; 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.¹⁰³ The World Health Organization (WHO) and others call for the free provision of antiretroviral therapy as the only sure way to reach all of those in need. However, Temin notes that while ensuring access to free and decentralised HIV services can improve treatment adherence, other barriers, such as stigma or lack of support, may persist.

4.3.2 New and emerging evidence: Treatment outcomes

As noted in Temin (2010) the documented evidence on the link between social protection and treatment is limited. Social protection can potentially facilitate access to treatment both directly and indirectly. Examples of direct linkages include cash transfers or vouchers for transportation, food and nutrition assistance, reduction in stigma and discrimination in medical service delivery, the abolition of user fees, and health insurance reforms. Indirectly, social protection can create or free-up resources (such as time and money) that can then be put towards the costs associated with treatment adherence.¹⁰⁴ For example, a disability grant can provide the funds necessary for transport to the local clinic. Social protection can also mitigate the impact of AIDS on a household, which can then make treatment adherence more likely.

There is a growing body of evidence examining reasons patients fail to adhere to their treatment. The question of *why* patients are not fulfilling their treatment is critical to the design and implementation of effective interventions. Looking at West Africa, and health services more broadly, analysis of demographic and health surveys (DHS) for nine countries in the region found that the main obstacles expressed by women in accessing health services are finding the money for treatment (55.8 per cent), distance to health facilities (39.5 per cent) and having to take transport to reach health services (37.4 per cent).¹⁰⁵ *From access to adherence: The challenges of antiretroviral treatment* (2006) makes an important contribution to research at the nexus of social policy and HIV/AIDS. It incorporates country studies (Botswana, Tanzania and Uganda) and approaches ART adherence from an operational

102 Emenyonu, N. et al. (2010), Cash transfers to cover clinic transportation costs improve adherence and retention in care in a HIV treatment program in rural Uganda

103 Souteyrand, Y.P. et al. (2008), Free care at the point of service delivery: a key component for reaching universal access to HIV/AIDS treatment in developing countries

104 Lutz, B. (2012), Experiences from HIV-sensitive social protection

105 UNICEF (2009), Maternal and child health: the social protection dividend (West and Central Africa)

98 de Pee, S. and Semba, R. (2009), Nutrition and HIV infection

99 Frega, R., Duffy, F., and Grede, N. (2010), Food insecurity in the context of HIV and AIDS

100 Marteau, T., Ashcroft, R., and Oliver, A. (2009), Using financial incentives to achieve healthy behavior

101 Thornton, R.L. (2008), The demand for, and impact of, learning HIV status

perspective. The study's qualitative research identified several specific demand-side constraints to optimal treatment adherence¹⁰⁶:

- Transport costs
- Registration and user fees
- Waiting times
- Hunger
- Stigma
- Side effects
- Lack of counselling

More recent studies have further contributed to the body of evidence on barriers to treatment. In Zambia, despite model scale-up programmes and intensive community work, there remains a significant HIV positive population that rejects HIV care programmes and/or ART. A qualitative study suggests that the reasons for non-uptake of treatment in these circumstances include issues related to local cultural frameworks (e.g., illness ideology, unfamiliarity with chronic disease management), mental and behavioural health (e.g., managing depression or interpersonal challenges), stigma, and competing motivating factors of different cultures (e.g., values of church or marriage).¹⁰⁷ A qualitative study in Maharashtra, India reported patients' barriers to ART adherence and follow-up, corroborating Hardon et al. (2006), including financial barriers, social norms of attending family rituals and fulfilling social obligations, self-perceived stigma and attitude towards medication, long waiting periods and insufficient counselling.¹⁰⁸ Barriers can differ in rural and urban areas. A study of over 1200 ART patients in South Africa, where services in the public sector are free at the point of use, found that while a decentralised model of service provided access to ARTs in remote areas, affordability barriers were significantly higher in rural than urban settings.¹⁰⁹ In one of the four sites studied 50 per cent of respondents incurred catastrophic healthcare expenditure, and 36 per cent borrowed money to cover these expenses.

These studies can contribute to a bottleneck analysis of HIV treatment, identifying key barriers to access and adherence that can then be addressed through social protection programming. For example, social cash transfers can address financial barriers, allowing patients to

afford transport to their local clinic. Anti-discrimination legislation that protects PLWHAs' rights to health, treatment and work can address issues of stigma that may prevent some patients from adhering to their antiretroviral (ARV) regimen.

The increasingly widespread free provision of treatment is a critical step in increasing poor and vulnerable people's access to treatment, as there is a growing consensus that the removal of user fees can have significant positive impact on service utilisation, especially by the poor.¹¹⁰ However, even with free treatment available, many patients fail to adhere adequately. "Contingency management" is the treatment adherence term for programmes that reinforce and reward appropriate behaviours, resulting in behavioural change. Like conditional cash transfers, contingency management relies on a conditionality to elicit certain behaviours, but while traditional CCT programmes require a "simple" behavioural response (e.g. attending a health clinic), contingency management requires a "complex" change (e.g. abstaining from a behaviour that may be desirable in the short-run, but in the long-run is detrimental to one's health).¹¹¹ There is a growing body of relevant research in this field. Simoni et al. (2008) provide a valuable literature review, summarizing the existing evidence on behavioural interventions to promote ART adherence.¹¹² However, Simoni et al. (2008) note that although adherence interventions may be successful in experimental trials, they may not be feasible or adaptable at the larger-scale given resource limitations at clinics and in community-based settings.¹¹³ A clinical trial in the United States found that vouchers contingent upon timely medication use (regulated using electronic medication caps) amongst methadone patients resulted in significant mean adherence differences between the voucher and comparison groups.¹¹⁴ Although the study was done in the United States, the effectiveness of using vouchers with a high-risk group (drug-users) may have applicability to high-risk groups in other parts of the world.

Technology, specifically mobile phones, may play a valuable role in contingency management. A randomised control trial tested the efficacy of short message service (SMS) reminders on adherence to ART among patients attending a rural clinic in Kenya and found that 53 per cent of participants receiving weekly SMS reminders

110 UNICEF (2009), Maternal and child health: the social protection dividends (West and Central Africa)

111 Medlin, C. and de Walque, D. (2008), Potential applications of conditional cash transfers for prevention of sexually transmitted infections and HIV in sub-Saharan Africa

112 Simoni, J. M. et al. (2008), Strategies for promoting adherence to antiretroviral therapy: A review of the literature

113 Ibid.

114 Sorensen, J.L. et al. (2007), Voucher reinforcement improves medication adherence in HIV-positive methadone patients: A randomized trial

106 Hardon, A. et al. (2006), From access to adherence: the challenges of antiretroviral treatment: Studies from Botswana, Tanzania and Uganda

107 Murray, L.K. et al. (2009), Barriers to acceptance and adherence of antiretroviral therapy in urban Zambian women: a qualitative study

108 Joglekar, N. et al. (2011), Barriers to ART adherence and follow ups among patients attending ART centres in Maharashtra, India

109 Cleary, S. M. et al. (2012), Unequal access to ART: exploratory results from rural and urban case studies of ART use

achieved adherence of at least 90 per cent during the 48 weeks of the study, compared with 40 per cent of participants in the control group.¹¹⁵ Participants were also significantly less likely to experience treatment interruptions exceeding 48 hours during the 48-week follow-up period than participants in the control group. The WelTel randomised clinical trial in Kenya also found that weekly SMS messages significantly improved ART adherence and rates of viral suppression among patients initiating ART, as compared with the control individuals.¹¹⁶ These studies suggest that SMS reminders may be an important tool for improving treatment adherence in resource-limited settings.

There is a growing body of evidence linking social cash transfers to improved health outcomes, more broadly. The Bomi social cash transfer pilot in Liberia provided an average transfer of \$25 USD per month to households that were both in “extreme poverty” and labour constrained.¹¹⁷ A 2012 evaluation found that the transfer recipients were more likely than comparison respondents to seek health-care when sick (57 per cent vs. 27 per cent, $p < .001$) in November 2011, compared to November 2010 before the transfer programme was launched.¹¹⁸ Furthermore, when sick, respondents sought care for 97 per cent of intervention children versus 77 per cent of comparison children ($p < .001$).¹¹⁹ While this study did not look at ART specifically, it shows a linkage between cash transfers and seeking health services. A pilot social cash transfer in Zambia was designed to be the “missing link” between free health and social services (including ART) and different HIV interventions.¹²⁰ Committees administer the transfers at the grassroots level, and members of the committees have been trained to provide beneficiaries with counselling and vital information about HIV treatment. In Ghana, the most frequent answers regarding how the first LEAP cash transfer had been spent included payment of national health insurance premiums.¹²¹ However, a robust impact evaluation is necessary to determine the extent to which this social protection programming has improved health and more specifically, treatment outcomes.

115 Pop-Eleches, C. et al. (2011), Mobile phone technologies improve adherence to antiretroviral treatment in a resource-limited setting: a randomized controlled trial of text message reminders

116 Lester, R.T. et al. (2010), Effects of a mobile phone short message service on antiretroviral treatment adherence in Kenya (WelTel Kenya1): A randomised trial

117 Defined as having no adult between the ages of 19 and 64, or the adult is not able to work because he or she is chronically ill, disabled, or caring for more than three children, disabled or elderly people

118 Miller, C. and Themba, Z. et al. (2012), External evaluation of the Bomi Social Cash Transfer pilot

119 Ibid.

120 Schüring, E. (2011), Cashing in: How cash transfers shore up Zambian households affected by HIV

121 Jones, N. Ahadzie, W. and Doh, D. (2009), Social protection and children: opportunities and challenges in Ghana

Several recent studies examine the impact of specific social protection interventions on antiretroviral therapy. In an evaluation of the Malawi social cash transfer many respondents reported improved healthcare and ability to access ARVs.¹²² One respondent stated

*Since I have started to receive this cash transfer I am able to receive the ARV at hospital... I am able to buy medicine or use the money for transport to receive ARV tablets. [Female, 30]*¹²³

In South Africa a disability grant provides financial assistance to people who are deemed ‘disabled’ and therefore unable to seek or sustain employment. The purpose of the disability grant for HIV-infected persons is to provide support to individuals until they are healthy enough to re-enter the labour force and support themselves. A study of the disability grant and ART adherence found that disability grants had significant implications for household income, and access to basic nutrition; this in turn affected the participants’ ability to adhere to their treatment.¹²⁴

There is anecdotal concern that an unintended consequence of disability grants that are conditioned on patients’ CD4 counts is that patients will not adhere to their treatment, so as to remain eligible for the grant. At the time of Paoli et al.’s 2010 study, a general rule in South Africa was that an individual with a CD4 count of ≤ 200 , which is roughly associated with clinical Stage 4 AIDS, met the clinical criteria for receiving a disability grant. However, their study found that it was not a common strategy to compromise one’s health in order to qualify for the disability grant.¹²⁵

For households affected by HIV, cash transfers can support livelihoods, enable access to education and improve nutrition, all of which improve the effectiveness of ART. However, as noted in DFID’s *Cash transfers evidence paper* (2011), these relationships are not saying that cash transfers are the best intervention to reach each of these objectives, in terms of rates of return, in all circumstances. However, these treatment impacts must be considered when considering investment options and in programme design, appraisal and evaluation.¹²⁶

122 Miller, C. and Tsoka, M.G. (2012) ARVs and cash too: caring and supporting people living with HIV/AIDS with the Malawi Social Cash Transfer

123 Ibid.

124 de Paoli, M.M., Grønningsæter, A.B., and Mills, E. (2010), HIV/AIDS, the disability grant and ARV adherence: Summary report

125 There suggestions that other PLWHAs (i.e. not the participants but people they knew) ‘adjusted’ their treatment regimens in an attempt to qualify for renewal of their grants by bringing down their CD4 counts without seriously jeopardising their health.

126 DFID (2011), Cash transfers evidence paper

An important area of increasing focus is nutritional and food support and their potential impact on treatment outcomes. Several key messages are emerging from the literature. One is that there is a vicious cycle between food insecurity/malnutrition and HIV, including treatment outcomes.¹²⁷ Second, food and nutrition interventions have been found to support HIV treatment outcomes through two levers; 1) nutritional stabilization/recovery, and 2) access to treatment (both retention in care and treatment adherence). The existing evidence –as well as gaps in the evidence and future research priorities– are identified in Anema et. al. (2009), *Food insecurity and HIV/AIDS: Current knowledge, gaps, and research priorities*. Among individuals receiving antiretroviral therapy (ART), food insecurity is associated with decreased ART adherence, reduced baseline CD4 cell count, incomplete virologic suppression, and decreased survival.¹²⁸ For example, a pilot study of food supplementation to improve adherence to ART among food-insecure adults in Lusaka, Zambia found that food-insecure patients that receive nutritional support are 1.5 times more likely to reach satisfactory adherence levels than patients without nutritional support.¹²⁹ This study suggests that providing food assistance to food-insecure patients initiating ART is feasible and may improve adherence to medication. Thus, food security interventions have the potential to improve the health and quality of life among those infected.

Weiser et al. (2012) make an important contribution to the literature with the only longitudinal study to date that looks at the association between food security, morbidity, clinic visits and hospitalization. Looking at individuals from the Uganda AIDS Rural Treatment Outcomes cohort, the study found that severe food insecurity was associated with worse Medical Outcomes Study-HIV Physical Health Summaries (PHS), opportunistic infections, and increased hospitalizations.¹³⁰ Based on the negative impact of food insecurity on morbidity and patterns of healthcare utilization among HIV-infected individuals, the study recommends that policies and programs that address food insecurity should be a critical component of HIV treatment programs worldwide.¹³¹

4.3.3 Gaps in the evidence: Treatment Outcomes

Improving HIV/AIDS treatment outcomes is critical, given the high risk of treatment failure (at least 95 per cent levels of adherence are required to prevent treatment failure) and the potential for the generation of an ARV-resistant virus.¹³² Furthermore, there remains a large HIV+ population that is eligible for ART but rejects HIV care programmes and/or ART in particular, despite low cost and/or good access to treatment.

There is a growing evidence base examining why people living with AIDS fail to adhere to treatment. This is valuable, as it can inform the types of social protection programmes that are developed. But 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. Specifically, more research looking at differences across the rural/urban divide and in different geographic regions would strengthen the evidence base. While there is a significant amount of research on the prevalence and determinants of adherence to ART among adults and children in Africa, the research that is focused specifically on adolescents remains largely focused on patients in the United States, with little on adolescents in sub-Saharan Africa or the developing world more broadly. Specifically, more information is needed on what factors determine the uptake of treatment for infected children.

For the relationship between food and nutritional support, Anema et al. (2009) identify the need for longitudinal research applying validated measurement tools in order to better understand the mechanisms through which food insecurity adversely affects HIV treatment (as well as transmission and care). To better inform policymakers, research should compare the effectiveness of different cash transfer, food assistance and livelihoods strategies. There is need for more longitudinal studies examining the benefits of food and nutritional supplements for ART patients. This relationship would be valuably informed by a large randomised study of the clinical benefits of food supplementation to ART patients. It is also important to highlight a point made in Gillespie and Kadiyala's (2005) extensive review of over 150 papers relating HIV/AIDS and food and nutrition security. While they acknowledge that the "cumulative results of these studies help us to build up a picture of dynamics and impact", the more we learn about interactions and responses, the more clear it is how context-specific many of them are.¹³³ Future generation of evidence, and the use of this evidence to inform policy, must address the importance of context-specificity.

127 See Gillespie, A. and Kadiyala, S. (2005), HIV/AIDS and food and nutrition security: From evidence to action

128 Anema et. al. (2009), *Food insecurity and HIV/AIDS: Current knowledge, gaps, and research priorities*

129 Cantrell, R.A. et al. (2008), A pilot study of food supplementation to improve adherence to antiretroviral therapy among food-insecure adults in Lusaka, Zambia

130 Weiser, S.D. et al. (2012), Food insecurity is associated with morbidity and patterns of healthcare utilization among HIV-infected individuals in a resource-poor setting

131 Ibid.

132 Hardon, A. et al. (2006), From access to adherence: the challenges of antiretroviral treatment: Studies from Botswana, Tanzania and Uganda

133 Gillespie, A. and Kadiyala, S. (2005), HIV/AIDS and food and nutrition security: From evidence to action

The most critical overarching gap in the evidence relating to treatment is the lack of studies that look at treatment as a specific outcome of social protection programming. As with the evidence regarding prevention, there is evidence to support indirect linkages, but a lack of studies looking specifically at social protection and ART. Regarding cash transfers, a key research question is what components of the programmes, or combination thereof, are important in achieving the ensuing improvement in health or treatment outcomes? There are a variety of pathways through which cash transfers could lead to improved treatment outcomes. The cash could be used to pay for transport to a clinic, to buy food that makes it easier for the patient to adhere to ART, or could more broadly lead to more hope for the future and, as a result, better treatment adherence. For example, evaluation of the Malawi Social Cash Transfer Scheme found that participants experienced greater hope, wellness and optimism for the future, as well as reduced number and severity of illnesses and greater access to health services.¹³⁴ Understanding the role of such factors in influencing treatment outcomes is critical for developing more effective HIV-sensitive social protection programmes.

4.4 Economic and social care and support

4.4.1 Evidence from the State of the Evidence 2010: Economic and social care and support

Temin's 2010 literature review examines the role of social protection in care and support more extensively than the previous two outcomes (prevention and treatment), the result of a stronger evidence base for this topic. In this paper, "economic and social care and support" encompasses the concepts of care, support and mitigation. Economic and social care and support includes protecting the health and human capital development of individuals and households affected by AIDS. The results of AIDS include increased dependency ratios within households, a high burden of care that often falls to young carers, and a growing number of orphans and vulnerable children. These negative consequences of the AIDS epidemic can be mitigated through effective economic and social care and support. Social protection is a key means of providing this social and economic care and support. There is a well-documented evidence base for social transfers' role in addressing the vulnerabilities that HIV/AIDS exacerbate. Households receiving cash transfers are 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.

Providing food transfers to HIV-affected households is

widely seen as an important way to mitigate the impact of the epidemic on vulnerable households. Temin (2010) notes that weight loss is common in HIV infection, a result of low dietary intake, mal-absorption and altered metabolism. Food transfers can mitigate these negative effects of HIV. As noted in the discussion of food transfers and HIV treatment, the quality of food transfers (high micronutrient and energy content) is critical when the food transfers are reaching beneficiaries who are living with HIV.

Food transfers can have impacts on household food security and in some cases, the nutrition of household members.¹³⁵ However, studies also reveal the importance of looking at the intra-household food distribution; it is not safe to assume that resources are allocated equally. Temin notes that there is some evidence that orphans may be discriminated against in foster settings, and that gender discrimination may affect intra-household food allocation.

The other important dimension of food transfers relevant to care and support is school feeding programmes for orphans and vulnerable children. School feeding has been shown to increase school attendance, cognition and educational achievement, especially when combined with nutritional measures such as de-worming and micronutrient fortification.¹³⁶ There may also be positive spillover effects on other members of the household when food is redistributed to younger children who are not yet receiving food in school.¹³⁷ Thus, food transfers can improve educational attainment, which in-turn has been shown to lessen HIV vulnerability. Temin emphasizes that in countries with low school enrolment, the poorest out-of-school children will miss out on the benefits of school feeding programmes. 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.

Home-based care for people living with HIV and their caregivers can also play an important role in care and support, through the following pathways enumerated by Temin (2010):

- Providing health care for those marginalised due to poverty, HIV, or other stigmatised status
- Promoting treatment adherence
- Providing food and economic support to members of affected households
- Linking clients and caregivers with legal support and livelihood opportunities.

135 Adelman, S. et al. (2008), The impact of alternative food for education programs on child nutrition in northern Uganda

136 Kristjansson, B.P.M. et al. (2007), School feeding for improving the physical and psychosocial health of disadvantaged students, Bundy, D. et al. (2009), Rethinking school feeding: social safety nets, child development, and the education sector

137 Ibid.

Home-based care programmes may also assist with households' economic status in two ways: by replacing the cost of traditional healers, and by linking to livelihood opportunities in some settings.¹³⁸ Temin recommends that home-based care programmes consider the needs of people and households affected by HIV and AIDS and adjust criteria to include these people, rather than targeting people living with HIV.

Social health protection also has an important role to play in mitigating the impacts of AIDS on affected households. Temin concludes that 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. An important concern is ensuring that people affected by HIV are not discriminated against or excluded from social health schemes.

Livelihoods promotion, such as public works, income-generating activities and microcredit, can also play a role in mitigating the effects of HIV/AIDS. Although specific HIV-related impacts are rarely measured, these schemes can increase households' ability to withstand shocks and reduce poverty.¹³⁹ 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.¹⁴⁰ However, livelihoods programmes must be carefully designed to be sensitive to the challenges that may accompany HIV, such as medical expenses, the heavy care burden that women may already be bearing, and responsive to declining health.¹⁴¹ Limited evidence indicates that in many cases livelihoods interventions are not the most appropriate social protection response for people living with HIV and affected households, but the expansion of antiretroviral therapy programmes may increase their relevance.

As Temin emphasises, the impacts of AIDS on children are well documented and there is growing interest in child-sensitive social protection to ensure more effective scale-up and cost-effective responses for those affected by AIDS. Child protection refers to a range of programming that aims to protect children from violence, exploitation and abuse. Two areas of child protection work that can play an important role in mitigating the impact of AIDS are birth registration and alternative care. Birth registration enables children to access government grants, schooling and other benefits. Reforming alternative care (finding alternative placements for children who cannot be cared for by their

parents) is more difficult to address. Evidence—although limited—indicates that children tend to do better in family-like settings, known as family and community-based care, which includes kinship care, foster care, and well-supported child-headed households.¹⁴² As with other community-based approaches, there is limited high-quality research identifying which programmes are most effective, although Temin enumerates several successfully implemented programmes, including structured community care coalitions in Uganda and Zambia, succession planning with HIV-positive parents in Uganda, and the child-led Vijana Simama Imara programme in Tanzania.

Early childhood development programmes can address some 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.¹⁴³ They can also address exclusion and marginalization that may result from the stigma of HIV, and provide an opportunity for linkages to essential health and nutrition services. Temin hypothesises that these programmes may then have a cyclical effect, contributing to HIV prevention by reducing risk factors.

Temin makes several "good practice" recommendations for child protection and programmes for OVC's including:

- Not targeting solely based on orphanhood
- Not targeting solely based on HIV status
- Gender sensitivity
- Use of local resources and leadership structures, combined with formal management systems
- Ensuring that programmes response to immediate, locally-defined needs rather than donor agendas.

4.4.2 New and Emerging Evidence: Economic and social care and support

Since the publication of Temin (2010) there has been further research done relating to social protection and care and support. UNDP-sponsored studies in five countries (Cambodia, China, India, Indonesia and Viet Nam) demonstrated the impact of AIDS at the household level. The surveys (conducted 2004-2010 using matched case-control methodology) found several key AIDS impacts at the household level, including negative economic impacts (income, poverty, employment and asset ownership), negative impacts on coping mechanisms (savings, debt, asset liquidation) and negative impacts on food

138 Budlender, D. (2010), Compensation for contributions: report on interviews with volunteer caregivers in six countries

139 Subbarao, K. (2001), Systemic shocks and social protection: Role and effectiveness of public works programs

140 Pronyk, P., Hargreaves, J.R., and Morduch, L. (2007), Microfinance programs and better health: prospects for sub-Saharan Africa

141 McCord, A. (2005), Public works in the context of HIV/AIDS

142 Better Care Network (2010), Guidelines for the alternative care of children (formerly UN Guidelines for the appropriate use and conditions of alternative care for children)

143 Engle, P.L. et al. (2009), Strategies to avoid the loss of developmental potential in more than 200 million children in the developing world

security.¹⁴⁴ Additionally, the surveys found an increase in health spending, at the expense of education, negative impacts on education (attendance, drop-out rates), and high levels of stigma and discrimination.¹⁴⁵

A study exploring social protection and related programming in Nigeria illuminated the impact of HIV on households in a context of a concentrated epidemic. Households affected by HIV and AIDS experience declining levels of income, agricultural production and family assets, while simultaneously having greater numbers of widows, orphans and elderly- and child-headed households.¹⁴⁶ High numbers of OVC have led to an increase in dependency ratios and large household sizes: 90 per cent of poor households in Nigeria have 20 or more individuals. Meanwhile, disinheritance and the loss of property affect women and OVC disproportionately. Coping strategies vary, but can include:

begging, trading, doing hard work to survive, cleaning of the compound and clothes for people, to survive. The children are also made to go out to hawk ... they give children out to work, they give children as slaves for money ... [they engage in] sex for money' (adolescents' focus group discussion, Lagos)¹⁴⁷

Several recent studies from the Young Carers Project in South Africa are shedding light on the health and educational impacts for children living in AIDS-affected households. In the first known study of educational impacts for children in AIDS-affected, other-sick and healthy homes in Africa, researchers identified three major impact themes: missing or dropping out of school to care for sick adults, hunger at school due to household-level poverty, and concentration problems due to worrying about the sick person.¹⁴⁸ Researchers found that children in AIDS-affected homes were at higher risk of all negative school outcomes than children in other-sick or healthy homes.¹⁴⁹ This result was found independently of age, gender, household size, caregiver type and amount of time spent in care work. Children in AIDS-affected households are vulnerable to long-term negative psychological impacts. In the first large-scale longitudinal study of the psychological impacts of having an AIDS-sick caregiver, children with an AIDS-sick caregiver were found to score significantly higher on measures of depression, anxiety and post-traumatic stress than children living with an other-sick or healthy caregiver, even after 4

years.¹⁵⁰ Psychological distress in youth living with AIDS-sick caregivers was as high as in AIDS-orphaned youth, while children who were AIDS-orphaned and living with an AIDS-sick carer (dual-affected) had the highest risk of psychological distress.¹⁵¹ Children in AIDS-affected households are also more likely to be abused. Furthermore, children living in AIDS-affected households are at heightened risk for infectious diseases such as colds, the flu, worms, pneumonia, bronchitis, and diarrhea, as well as tuberculosis, regardless of vertical HIV transmission.¹⁵² These findings underscore the importance of children in AIDS-affected households having good access to health services and psychosocial care.

Economic and social care and support is crucial because the ability of informal safety nets to protect individuals and families has weakened considerably in the face of the HIV/AIDS crisis.¹⁵³ As noted in UNICEF (2009), traditional solidarity mechanisms are of limited value when a shock affects an entire community, as in the case of natural disasters or, in some communities, HIV/AIDS.¹⁵⁴ Certain groups such as orphans and vulnerable children (OVC) have been especially vulnerable to these changes, which was increasingly recognized during the drought and food security crisis that hit southern Africa in 2002 and 2003 and overwhelmed the capacity of informal safety net systems.¹⁵⁵ UNICEF has developed a comprehensive framework for assistance to OVCs in which they identify social transfers as an important component of an overall care and support package.

Social protection has emerged as a response to this crisis. A 2012 World Bank report summarizes a range of cash transfer programmes that have been developed at least partially in response. For example, Kenya's Cash Transfer for Orphans and Vulnerable Children (OVC) Project was created to systematically support Kenya's OVC and to prevent their institutionalization, while Swaziland's Old Age Grant was begun to address the growing vulnerability of poor elderly Swazis given the deteriorating of informal support systems.¹⁵⁶ Mozambique initially targeted its Food Subsidy Program (Programa de Subsídio de Alimentos) to urban residents, whom they believed lacked the informal safety nets available to rural Mozambicans,

150 Cluver, L. (2011), Children of the AIDS pandemic, and Cluver, L., Orkin, M., Boyes, M., Gardner, F. (2011c), Persisting mental health problems among AIDS-orphaned children in South Africa

151 Cluver, L. (2011), Children of the AIDS pandemic

152 Cluver, L. et al. (2011b) Infectious disease and TB co-occurrence amongst children with AIDS-affected caregivers

153 Garcia, M. and Moore, C. M. T. (2012), The cash dividend: the rise of cash transfer programs in Sub-Saharan Africa

154 UNICEF (2009), Strengthening social protection for children: West and Central Africa

155 Garcia, M. and Moore, C. M. T. (2012), The cash dividend: the rise of cash transfer programs in Sub-Saharan Africa

156 Ibid.

144 Lutz, B. (2012), Experiences from HIV-sensitive social protection

145 Ibid.

146 Samuels, F. Blake, C. and Akinrimisi, B. (2012), HIV vulnerabilities and the potential for strengthening social protection responses in the context of HIV in Nigeria

147 Ibid.

148 Cluver, L. et al. (2011a), Educational shortfalls among 'Young Carers' in the South African AIDS Epidemic

149 Ibid.

but the subsequent expansion of the programme to rural areas indicates a recognition that traditional safety nets are also insufficient in rural areas.¹⁵⁷

Zambia's Social Safety Net Project is an example of a social transfer programme for poor households, including those affected by AIDS, which has mitigation outcomes. The transfers target households that have not received help from other labour-based or microcredit programmes. UNICEF piloted a psychosocial counselling module through the community welfare assistance committees, which select and attend to beneficiary households.¹⁵⁸ The module aims to support, in particular, children and other family members who have experienced a loss or other problems within the household or community. The inclusion of counselling is important, given the persistence of mental health problems amongst AIDS-orphaned children.¹⁵⁹ The Ministry plans to include in any future national SCT scheme training for community committees in HIV management, psychosocial counselling and sessions on nutrition and health-related matters, so that information can be passed along to beneficiaries.¹⁶⁰ These services may be offered on payment days, since beneficiary households collect their transfers at a central location. The Zambia SCT provides a valuable example of a "cash plus" intervention that can mitigate both the social and economic effects of HIV on a household.

A study of the Malawi social cash transfer examined how PLWHA used transfers to aid in the support of themselves and their families. The qualitative interviews found that prior to the transfer recipients lived in destitution, lacking food and basic necessities, were often sick, and had little support from friends or family members.¹⁶¹ After receipt of the transfer, the majority of respondents reported positive impacts on health, food security, and economic well being, as well as being better able to send children to school.¹⁶² Thus, the social transfer often supported the wellbeing of the entire household, rather than solely the PLWHA.

The Kwa Wazee Project in rural Tanzania provided a pension to grandmothers in a region with very high HIV prevalence and a growing number of orphans dependent upon grandmothers. A participatory evaluation among beneficiaries found a positive impact on school attendance and progress, mainly because children had

school materials and uniforms, which eliminated stigma, and because they had kerosene for lamps, allowing them to study at night.¹⁶³ Children reported more time to play, study, read and talk with friends, and their body mass index improved. A qualitative study of a community-based cash transfer to support orphans in Western Kenya found it to be a promising means of supporting orphans and carers.¹⁶⁴ Findings suggest that the programme not only increased food availability, but also enhanced social capital. Participating caregivers felt empowered due to the support, focus and acknowledgement they had been given through the programme.¹⁶⁵ The role of intra-household allocation of resources may have an impact on how orphan-targeted programmes affect different members of the household, but this topic remains complex and under-researched. Richter (2010) provides an in-depth analysis of cash transfer programmes and their potential as an AIDS response, emphasising the need for them to be both conceptualised and implemented within a broader framework of social protection, socioeconomic development and human rights.¹⁶⁶

Social protection interventions can provide a valuable contact point for stigma and discrimination reduction efforts. Kenya's CT for OVC is administered at the district level by OVC subcommittees, local OVC committees, and volunteer children officers, who have a range of responsibilities including determining eligible households, programme enrolment and transfer disbursement. An additional responsibility is sensitizing communities to the situation of OVC and people living with HIV/AIDS.¹⁶⁷ However, there has not yet been an impact evaluation that examines the programme's effect on stigma.

Integrating child-sensitive social protection with child protection can also enhance the impact of programmes on vulnerable children. This is critical as children living with an AIDS-sick caregiver are more likely to be the victims of abuse as well as suffer from persistent mental health problems like post-traumatic stress disorder (PTSD).¹⁶⁸ In Malawi the linkages between HIV, child vulnerability, and the potential positive impact of child protection are shaping the ongoing (as of 2012) development of a national child protection system.¹⁶⁹ Such a

163 Hoffmann, S. et al. (2008), Salt, soap and shoes for school: The impact of pensions on the lives of older people and grandchildren in the KwaZee project in Tanzania's Kagera region

164 Skovdal, M. et al. (2008), Community-based capital cash transfer to support orphans in Western Kenya: a consumer perspective

165 Ibid.

166 Richter, L. (2010), Social cash transfers to support children and families affected by HIV/AIDS

167 Garcia, M. and Moore, C. M. T. (2012), The cash dividend: the rise of cash transfer programs in Sub-Saharan Africa

168 Cluver, L., Orkin, M., Boyes, M., Gardner, F. (2011c), Persisting mental health problems among AIDS-orphaned children in South Africa

169 Attenborough, J. (2012), Investing in Malawi's National Child Protection System to support national social protection goals

157 Ibid.

158 Schüring, E. (2011), Cashing in: How cash transfers shore up Zambian households affected by HIV

159 Cluver, L. et al. (2011c), Persisting mental health problems among AIDS-orphaned children in South Africa

160 Ibid.

161 Miller, C. and Tsoka, M.G. (2012), ARVs and cash too: caring and supporting people living with HIV/AIDS with the Malawi Social Cash Transfer

162 Ibid.

system could then facilitate improved outcomes from Malawi's social cash transfer program, through transformative legislation, case management, and capacity building within the social welfare workforce.¹⁷⁰

Several comprehensive policy guidance documents have been published since the 2010 literature review. *Care and support: the forgotten pillar of the HIV response* provides a comprehensive review of what "care and support" encompasses and the nature of current care and support programming and its impacts, as well as how care and support relate to prevention and treatment, the other Universal Access pillars.¹⁷¹ *HIV-sensitive social protection for impact mitigation in Asia and the Pacific* (2011) summarises the outcomes and critical elements of an UNDP-organised regional conference. It highlights how social protection reduces people's vulnerability to socio-economic risks and impoverishment, protects them from shocks (e.g. an HIV-related death), and can transform economic and social relations in ways that can strengthen PLWHA's longer-term prospects. Impact mitigation is also a core component of the Expanded Business Case, illustrating its recognised importance amongst policymakers and development partners.

4.4.3 Gaps in the evidence: Economic and social care and support

While there is stronger evidence for social protection's linkages to care and support than for the previous two outcomes (prevention and treatment), significant gaps remain. There is a strong demand for guidance on programme design, so that social protection can most efficiently achieve the desired care and support outcomes. For example, there is a need for more formal frameworks to guide the development of instruments that deliver on social protection's promotive and transformative dimensions, including strengthening the economic resilience of HIV affected households, guaranteeing access to HIV-related and other social services and reducing HIV-related stigma and discrimination.

There is also demand for more evidence on the implementation of case management alongside social protection interventions. Specifically, there is a gap in evidence on how case management can improve the targeting of transfers, reducing both exclusion and inclusion error.

There is a growing evidence base regarding social cash transfers, but there is a need for more evidence on other social protection interventions. This would help policymakers to determine what type of social transfers are

most appropriate for different HIV mitigation responses. It would also help them to determine the optimal combination of cash and social care for addressing the economic and social vulnerabilities of households affected by HIV. Research needs to address the growing role of ART; with increasing access to treatment more PLWHA can be supported through social protection programmes that promote production as well as consumption.

While there is anecdotal evidence of foster grants creating unintended consequences, there is no robust evidence. Given the tendency in some countries to design social protection programmes pre-emptively to counter perceived perverse incentives, policy-makers require robust evidence examining if foster grants or other social transfers create incentives for household formation choices that are not in the interests of HIV-affected children. There is also a need for more rigorous monitoring systems and impact evaluations that focus on potential unintended consequences of social protection interventions, in order to ensure social protection programmes do no harm. An important gap in the evidence on care and support is how social protection can keep children within the family environment and reduce reliance on institutional care. As stated in the synthesis of existing research, there is evidence that children do much better when they are kept in kinship settings, but there is a lack of operational guidance on how to take these findings and translate them into policy that will better protect vulnerable children.

Lastly, a crucial gap is evidence showing the impact of social protection interventions on stigma and discrimination. This outcome has not been a focus in the HIV and social protection studies described thus far. This may be a particularly difficult, though important, area for social protection to address because longitudinal studies have not shown any compelling evidence that even ARVs have had a major effect on HIV stigma. However, given the persistence of stigma and discrimination, these are critical areas for consideration and study.

Across the three core impact areas (prevention, treatment, and social and economic care and support) there is strong demand for cost-benefit analysis tools that has not been met. Policymakers and practitioners need strengthened cost-benefit analysis for effective comparison across different instrument and design options. These tools would account for programme costs and benefits across the three impact areas. While no such tool exists yet, research on the frontier issues identified throughout this paper's "evidence gap" sections would contribute towards improved cost-benefit analysis.

170 Ibid.

171 Care and Support Working Group (2011), *Care and support: the forgotten pillar of the HIV response*

5. EVIDENCE GAP ANALYSIS: COMPREHENSIVE APPROACHES

5.1 Evidence from the State of the Evidence 2010: Comprehensive approaches

Temin (2010) recognises that “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 marginalised, at different stages of their lives,” enabling a range of HIV-sensitive initiatives to be integrated into broader national social protection strategies. As defined by UNAIDS, 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.¹⁷² Temin pushes the idea of “integrated and comprehensive” further, recognising linkages between social protection and other social policy priorities and referring to a response to both HIV and broader Millennium Development Goals.

Temin (2010) identifies several examples of building synergies to increase the comprehensive impact of HIV-sensitive social protection, including:

- Combining cash transfer schemes with social work and child protective services
- Providing comprehensive home-based care for people living with HIV and their caregivers
- Linking specific risk-reduction activities (like building demand for condom use in sex work) with social support, protection and services

Combining transfer schemes with social work and child protective services capitalises on the contact opportunities that arise from the transfers to help identify vulnerable households and link them with social welfare services. Linking risk-reduction activities can reduce exclusion errors and expand coverage to those commonly excluded.

When executed effectively, these linkages can contribute to the transformational potential of social protection. A comprehensive social protection system includes protective, preventive, promotive and transformational elements, as discussed in Chapter 2. For example, targeted

cash transfers for ultra-poor children may not reach those most marginalised— including those affected by HIV— without social workers or home health-care assistants to help them access their entitlements.¹⁷³ Legislative, regulation and policy changes to reduce stigma and protect the rights of PLWHA, widows and affected children create an enabling and supportive environment, increasing the impact of any one component of a HIV-sensitive intervention.

Temin recognises the limits of evidence in this regard. The existing operational evidence highlights the need for comprehensive social protection systems that link different instruments, and connect to complementary services and sectors. A critical operational question is how ‘comprehensive’ a social protection approach must be to promote Universal Access outcomes.

5.2 New and emerging evidence: Comprehensive approaches

The concept of “comprehensive” continues to be expanded further. As noted in a UNICEF regional report commissioned by the West and Central region, an integrated approach means developing comprehensive national social protection strategies, as well as comprehensive HIV strategies, rather than adopting a piecemeal approach.¹⁷⁴ Overall there is a new emphasis on the contribution of social protection programmes towards larger sectoral objectives and the degree of complementarities between interventions. As UNICEF (2009) emphasizes, these integrated approaches require capacity building, especially in ministries that are responsible for a range of social protection and complementary programming and services.¹⁷⁵ An effective social protection system that is HIV-sensitive, ensuring that programmes reach those affected by HIV and contribute to positive core outcomes, must be built on strong linkages between different government ministries, as well as development partners (both local NGOs and international development partners) if they are involved. As identified in an analysis of the social protection dividends of maternal and child health, cross-ministerial coordination is a major,

173 Vadapalli, A. (2009), Barriers and challenge in accessing social transfers and role of social welfare services in improving targeting efficiency: A study of conditional cash transfers

174 UNICEF (2009), Strengthening social protection for children: West and Central Africa

175 Ibid.

172 UNAIDS Terminology Guidelines 2011

but necessary, challenge to developing effective comprehensive approaches.¹⁷⁶ Countries like Malawi, which as of May 2012 is developing a national child social protection system and finalising a national social support policy, present a valuable opportunity to ensure that a comprehensive, HIV-sensitive approach guides future policy and programming.¹⁷⁷

The Kenya National AIDS Strategic Plan III (KNASP III), covering the period 2009/10 to 2012/13, is an example of an integrated approach to HIV/AIDS and related social policy. KNASP III is based on four linked pillars that operate as an integrated programme.¹⁷⁸ First, the Health Sector HIV Service Delivery Pillar ensures that “ministries responsible for health play a key role in delivering Universal Access to prevention, care and support services.” It coordinates all health sector partners’ HIV programmes under one framework. Secondly, the Sectoral Mainstreaming of HIV Pillar addresses adapting sectoral policy and practice to take into account susceptibility to HIV transmission and vulnerability to the impacts of AIDS. The overall goal for this pillar is to achieve comprehensive integration of HIV prevention, treatment and socio-economic protection interventions in all areas of the public and private sectors, as well as civil society, in a harmonised and aligned manner. Thirdly, the Community-based HIV Programmes Pillar “enhances community engagement and capacity towards Universal Access and strengthens social transformation into an HIV competent society.” This pillar includes community-based social protection programmes, such as cash transfers. Lastly, the Governance and Strategic Information Pillar focuses on “leadership and coordination so that all stakeholders operate within a fully harmonised and aligned results framework that is linked to full accountability for results at all levels.” Across the four pillars, a key crosscutting focus is on the most-at-risk and vulnerable populations. This strategic plan represents an important commitment to an integrated, cross-cutting, and mainstreamed approach to HIV/AIDS, bringing together health, social policy, community programming and governance.

Increasingly, developing countries such as Bangladesh, Cambodia, Indonesia, South Africa, Tanzania, Thailand, Uganda and others are adopting development planning approaches to social protection, aiming to maximise the potential impact of both intra- and inter-sectoral linkages. The development planning approach is in

part a response to inter-sectoral pressures: along with the demand for HIV-sensitive social protection emerges pressure for gender-sensitive social protection (Holmes and Jones, 2010), child-sensitive social protection (Joint statement on advancing child-sensitive social protection, 2009), broader health-sensitive social protection (Chatham House, 2012), climate-sensitive social protection (Davies, Oswald and Mitchell, 2009) and others. The development planning approach aims to integrate the sensitivities, incorporating priorities without fragmenting interventions.

The development planning framework incorporates integrated systems approaches to social protection, building on models developed in Brazil, Chile and South Africa. UNICEF (2012) lays out the rationale for integrated approaches to social protection, highlighting both the roles of systems and a multi-sectoral focus, with the associated benefits in terms of efficiency, sustainability and developmental multiplier benefits. The development planning framework goes one step further, incorporating social protection as a priority cross-cutting sector within the national social and economic policy planning process, with the aim of maximising intra-sectoral and inter-sectoral synergies.

The diagram below illustrates the logic of the development planning approach. The strategies and objectives depicted are only indicative (in order to represent the model in a simple figure)—Uganda’s matrix, for example, includes hundreds of instruments and dozens of objectives.

176 UNICEF (2009), Child and maternal health: the social protection dividends (West and Central Africa)

177 Attenborough, J. (2012), Investing in Malawi’s National Child Protection System to support national social protection goals

178 National AIDS Control Council (NACC) (2009), Kenya national AIDS strategic plan 2009/10 – 2012/13: Delivering on Universal Access to Services (KNASP III)

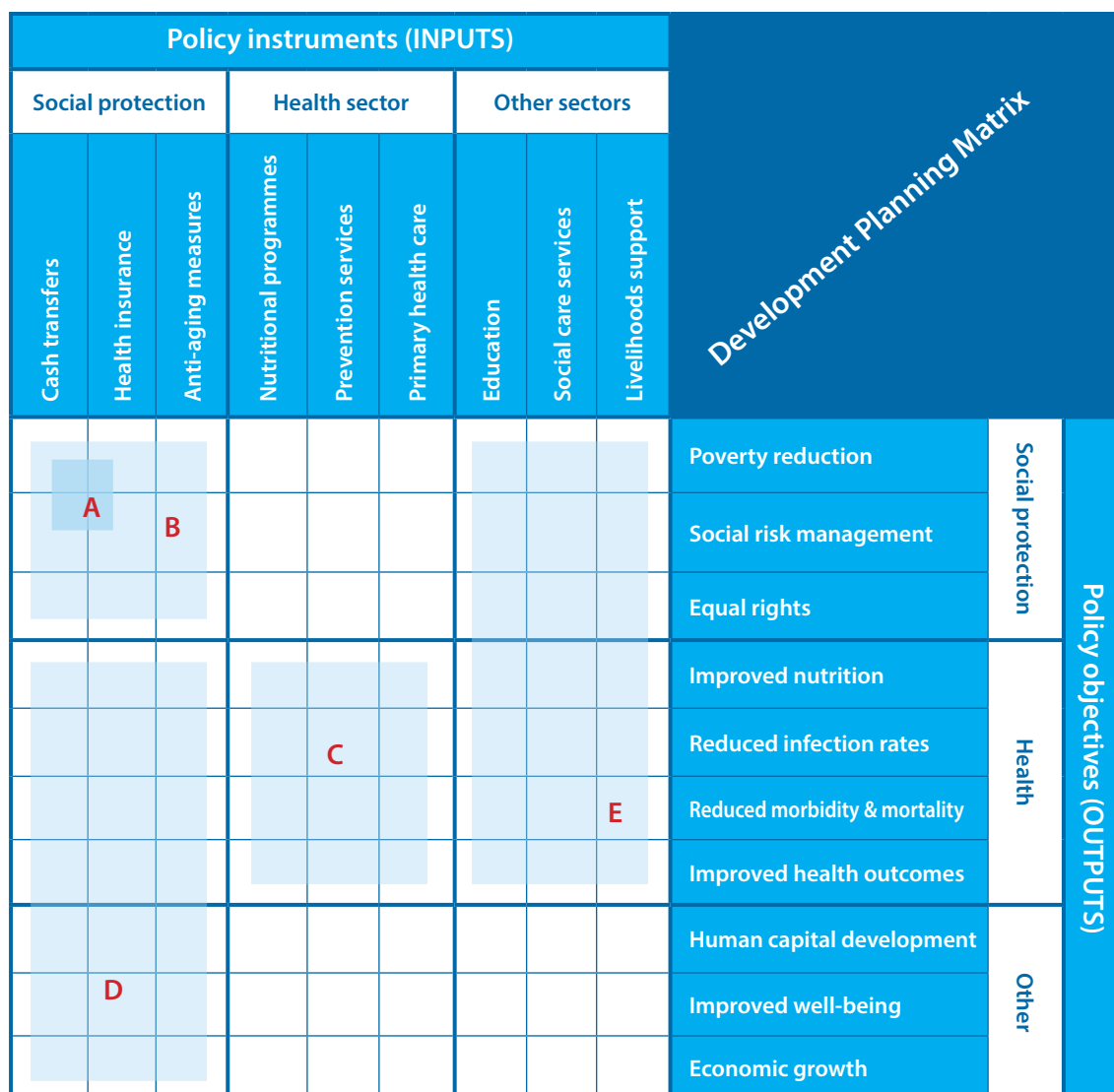


Figure 8. The development planning approach to social protection

The approach incorporates the conventional interpretation of comprehensive. For example, in the diagram above, the box labelled “A” highlights intra-sectoral social protection linkages between cash transfers and social health insurance, which reinforce each other’s objectives in terms of reducing poverty and helping households manage the risks they face. Cash both directly reduces income poverty and helps enable households to pay the premiums for social insurance programmes, which in turn helps protect households against the catastrophic health shocks that overwhelm the limited capacity of cash transfers to fight poverty. Cash also reduces the economic vulnerability of women, reducing risks of HIV infection. The larger box labelled “B” expands these intra-sectoral linkages to include anti-stigma measures. For example, stigma creates barriers to accessing social protection programmes and intensifies the worst impacts of poverty and HIV/AIDS. Policy instruments that tackle

stigma increase the effectiveness of complementary social protection programmes while directly improving important social outcomes. The box labelled “C” likewise highlights the complex positive relationships (“synergies”) among nutrition, prevention and primary care instruments (as well as many other relevant health policy instruments not depicted in the matrix). Across all sectors, the development planning approach aims to coordinate instruments in order to maximise joint impacts.

The box labelled “D” represents intra-sectoral linkages: the extent to which social protection instruments generate spillover impacts in other sectors. In particular, extensive evidence documents the positive relationship between social protection investments and improved health outcomes, particularly in terms of people affected by HIV and AIDS. The potential for these inter-sectoral linkages motivates the case for HIV-sensitive social protection.

Inter-sectoral linkages go further: social protection improves access to other social services (including education and care services) and strengthens human capital and other associated impacts. Social protection also reinforces pro-poor and inclusive economic growth.

Similarly, the box labelled “E” represents intra-sectoral linkages: the extent to which other sectors’ instruments generate spillover impacts in the social protection and health sectors. Investing responses to increase the supply and quality of education and health, for example, are critical interventions to be supported in tandem with measures to address demand-side constraints. Education demonstrates effective impact in helping to prevent HIV infection, along with a range of other developmental impacts. The effectiveness of HIV-sensitive social protection is most completely conceptualised within a development planning framework.

The HIV/AIDS investment framework conceptualises complementarities in two ways. First, as discussed above, complementary strategies require context-specific critical enablers including both social enablers as well as programme enablers. The activities the framework defines as social enablers—“...stigma reduction, advocacy to protect human rights, and monitoring of the equity and quality of programme access...”—fall within the definition of transformative social protection. Likewise, the programme enablers include incentives for programme participation and methods to strengthen adherence—objectives of piloted HIV-sensitive social protection initiatives.¹⁷⁹ Second, the investment framework identifies the importance of “synergies with other development sectors,” including social protection. The framework recognises that the alignment of HIV/AIDS activities with national development objectives, involving inter-sectoral planning and the rationalisation of investments across sectors, can strengthen impacts.¹⁸⁰

The comprehensive approach aims to ensure that interventions integrate important social protection components (such as cash and food transfers, social care, health access and public works) with other sectoral interventions so that the totality of impact is greater than sum of parts. Consistency across systems improves efficiency—social protection that provides cash transfers to pay user fees for vital services utilises an instrument prone to targeting errors to try to ameliorate another imperfect public instrument. A comprehensive approach aims to more structurally resolve the underlying problems. This requires both a broader understanding of the wider social policy context as well as the monitoring of wider development impacts.

For example, how does a cash transfer programme established to reduce poverty and promote human capital development generate spill-over benefits in terms of HIV prevention and other health outcomes?

As emphasized by Kim et al. (2008), development plans, as well as economic development plans more specifically, must pass an “AIDS impact assessment”; given the range of factors known to interact with poverty and increase HIV risk, development plans must be viewed with an “HIV lens” in order to determine whether they may inadvertently increase HIV risk, and if so, whether measures can be taken to reduce this risk.¹⁸¹ This “HIV lens” is comparable to the “environmental impact assessment” than many governments require for private and public sector development projects. This comprehensive approach has the potential to impact the broader contextual factors that go beyond individual programmes and policies, and can maximise the impacts of interventions through cross-cutting and reinforcing gains.

Social protection programmes can capitalize on potential synergies with existing successful supply-side programmes. For example, Senegal provided an unconditional cash transfer that used some of the systems already developed in the successful Nutrition Enhancement Program in order to lessen the programming burden on the cash transfer, and targeted areas that have already received extensive support for maternal and children’s health.¹⁸² In Ghana the Livelihood Empowerment Against Poverty (LEAP) programme provides cash transfers specifically targeting caregivers of OVC (in particular AIDS-related orphans and children with disabilities), persons with severe disabilities (with no productive capacity) and elderly people with no other means of subsistence support.¹⁸³ It links beneficiaries (a planned enrolment of 164,000 households by 2013) to free national health insurance, as well as other complementary services.¹⁸⁴ Since LEAP is targeted to districts with high HIV/AIDS prevalence, it provides an opportunity to reach vulnerable children and ensure that they benefit from both the cash transfer and free health insurance registration. A “Common Targeting Mechanism” is currently being implemented in Ghana, providing indicators to identify potential beneficiaries for pro-poor initiatives, as a key operational element of the programme’s integration across different sectors. It is intended to improve the efficiency and coordination of the government’s social protection programming. However, inter-sectoral linkages and synergies within

181 Kim, J., Pronyk, P., Barnett, T., and Watts, C. (2008), Exploring the role of economic empowerment in HIV prevention

182 Garcia, M. and Moore, C. M. T. (2012), The cash dividend: the rise of cash transfer programs in Sub-Saharan Africa

183 UNICEF (2009), Strengthening social protection for children: West and Central Africa

184 Ibid.

179 Schwartländer, B. et al. (2011), Towards an improved investment approach for an effective response to HIV/AIDS

180 Schwartländer, B. et al. (2011), Towards an improved investment approach for an effective response to HIV/AIDS

and across ministries, departments and agencies (MDAs) remains a challenge in Ghana.¹⁸⁵ Ministries as diverse as the Ministry of Health, Ministry of Women's and Children's Affairs, the Ghana AIDS Commission, Ministry of Local Government Rural Development and Environment, and the district assemblies all have roles to play in effective HIV/AIDS programming.

Comprehensive responses can address constraints that may cause some available services to be underused. For example, Eritrea's results-based CCT (conditional upon completing a certain number of medical check-ups) recognised that a major obstacle to women giving birth in medical facilities is a lack of timely transportation. In addition to providing traditional cash transfers to women, the programme raises awareness among transport providers and awards vouchers to individuals who transport women to health facilities to deliver their children.¹⁸⁶ Programmes can also adopt a more comprehensive approach by having graduated levels of programming. The Malawi graduated safety net model is a valuable example. It provides different interventions for households that are labour constrained and those that are more able to engage in economic activity.

While social protection – and in particular, cash transfers – can help the poor overcome demand-side (cost) barrier to accessing critical services like PMTCT care or ARV therapy, they cannot resolve supply-side problems with service delivery (e.g. the training of public health professionals), a caveat highlighted in DFID's 2011 review of cash transfer programmes.¹⁸⁷ For example, in the Malawi study where individuals were randomly assigned monetary incentives to learn their HIV status after testing, the location of VCT centres (where results were collected) was randomised. It was found that the distance needed to travel for the results was a significant factor in the take-up rate.¹⁸⁸ Therefore, it is critical that cash transfers and other social protection programming are complemented by other ongoing sectoral strategies.

5.3. Gaps in the evidence: Comprehensive approaches

The application of the development planning framework to HIV-sensitive social protection is relatively new approach, and requires a more comprehensive methodology for mobilising evidence. While the efficacy of

specific design elements or the impact of individual programme interventions can be tested with rigorous trials, the optimal combination of multi-sectoral strategies requires different analytical tools. The increased use of systematic reviews and meta-analyses may provide valuable evidence. The interest expressed by UNICEF, UNDP and WFP in pursuing evidence building in this area offers promise of future progress.

The biggest gap identified in consultations with policy-makers and researchers is the extent to which more comprehensive approaches to social protection can generate social and economic returns, and how these returns can be maximized. Interventions that aim to prevent the transmission of HIV can generate strong positive returns, but how much greater are these returns if the investments are co-ordinated with social protection and education interventions? The rate of return to investments aiming to achieve HIV and AIDS outcomes cannot be determined independently of the level of investments in social protection and other sectors. Independent investments in cash transfer programmes may yield important poverty reduction impacts, but weaker outcomes in the health sector. Integrated approaches require more considerable investments, but may generate much more substantial returns. In the absence of quantitative evidence and credible modelling approaches, these questions are only promising, not definitive.

Other key questions include:

- How can participatory planning identify critical demand and supply side bottlenecks and identify potential linkages and contribute to better social protection outcomes for HIV affected households?
- How do you build support for social protection interventions across a range of sectors that provide services that are critical for vulnerable HIV-affected households?
- How can contact opportunities that arise from social protection interventions be utilised to identify and support HIV-affected households and children?
- What are some examples of successful, cost-effective linkages to social protection programming?
- What is the evidence of 'transformational' nature of social protection on households affected by HIV and AIDS, particularly for socially marginalised groups?
- How do you implement HIV-sensitive social protection in a manner that addresses stigma and discrimination of vulnerable people and households?

185 Ibid.

186 Ayala Consulting (2009) cited in Garcia, M. and Moore, C. M. T. (2012), The cash dividend: the rise of cash transfer programs in Sub-Saharan Africa

187 DFID (2011), Cash transfers evidence paper

188 Thornton, R.L. (2008), The demand for, and impact of, learning HIV status

6. EVIDENCE GAP ANALYSIS: EXPANDING AND SUSTAINING HIV-SENSITIVE SOCIAL PROTECTION

When facing social protection choices, policy-makers are concerned with questions of cost, affordability, financing, sustainability, accountability and returns to investment. Particularly in low-income countries, policy-makers face constrained fiscal resources and limited financing options. The prospects of making initial commitments (perhaps with uncertain costs) that cannot be sustained raise the social, economic and political risks. Increasingly, government officials and development partners are focusing on returns to investment, sometimes couched in terms of value-for-money.

For example, DFID's value-for-money framework (Figure 9) conceptualises an approach to evaluating the cost effectiveness of an HIV-sensitive social protection strategy, and represents a key "policy demand" for this kind of operational research.¹⁸⁹ The diagram below illustrates the key linkages. Cost effectiveness first requires an economical approach to deploying the required interventions. This might be measured as the average cost to deliver benefits to eligible households. Efficiency requires an appropriate design and implementation model to achieve the key outputs, and the combination of monitoring results and attuning the intervention mix aims to ensure effectiveness. Generating both core and comprehensive impacts

and achieving this result economically and efficiently represents cost-effectiveness—that is, value-for-money.

This focus can expand opportunities to scale up HIV-sensitive social protection. Officials in the social sectors often aim to broaden the reach of key interventions but are constrained by finance ministries that may view these instruments as "government consumption". Clear and credible costing exercises linked to rigorous investment analyses can provide persuasive evidence that positively influences finance and planning ministries. While a development calculator alone does not give all the answers and define the approach to adopt, it is an important tool for building government support. Other considerations, such as path dependency, local preferences and acceptability, and local capacities will also affect the choice of an approach and specific social protection instruments. Ultimately the sustainability of social protection programmes is an issue of political economy; political will is a critical factor in explaining fiscal commitments to social protection. The recognition of the pro-poor growth impact of HIV-sensitive social protection, as well as its social (social cohesion) and political (support from the electorate) returns, can expand the political constituency for this agenda.

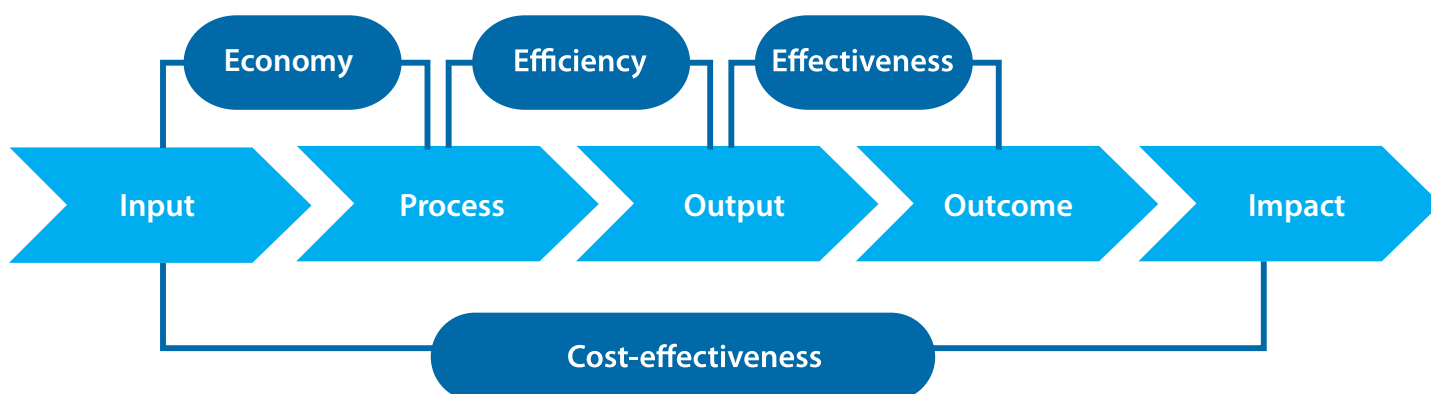


Figure 9. Economy, efficiency and effectiveness in a value-for-money approach

SOURCE: DFID (2011), DFID's Approach to Value for Money (VfM)

6.1 Evidence from the State of the Evidence 2010: Expanding and sustaining HIV-sensitive social protection

Temin (2010) briefly addresses expanding and sustaining HIV-sensitive social protection programming in her discussion of the political economy of HIV-sensitive social protection. She recognises the concerns among governments and development partners about the fiscal capacity to finance social protection, especially for low-income countries. Citing McCord (2009), she recommends that HIV-sensitive social protection be considered in similar future studies of the political economy of social protection.¹⁹⁰ In terms of the question of investment returns, Temin recognises that relatively better evidence for cash transfers exists, but highlights the urgent need for more cost-effectiveness data. This data could 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.

Temin's analysis also explores expanding social protection programming as it relates to a comprehensive approach. She refers to experience that building capacity for a social welfare ministry (or other agency responsible for implementing a social protection programme) can attract resources to further expand operations. The resulting success can build political commitment to social protection, strengthening more comprehensive approaches and greater government accountability to the poorest citizens.

6.2 New and emerging evidence: Expanding and sustaining HIV-sensitive social protection

The formulation of an HIV/AIDS investment framework represents an important innovation, recognising that despite impressive progress to date, "universal access to prevention, treatment, care, and support for HIV/AIDS is not available worldwide, and is unlikely to be achieved with the present pace of change and with the present approaches to investment."¹⁹¹ The Lancet article accompanying the Investment Framework argues "a targeted strategic investment programme driven by the latest evidence is needed to produce substantial and lasting effects on the HIV/AIDS epidemic and make the most

of investment in the response."¹⁹² The investment framework models costed interventions and aims to monitor progress in order to optimise the investment mix in response to documented results (or the lack thereof).

Similarly, the social protection sector increasingly recognises the need for costed approaches that quantify investment returns. There is some on-going work in this area. Cambodia's Ministry of Planning with support from UNICEF has initiated a study of the rates of return on social protection programmes, recognising the critical evidence gap in this area. The FAO is implementing a DFID-funded study to better understand the economic returns to social protection. AusAID has supported evaluations that aim to understand better the economic pathways out of poverty that result from social protection programmes in Bangladesh, Cambodia and Pacific Island Countries. A joint ILO-UNICEF initiative has led the way in costing social protection programmes globally, developing (and helping countries to implement) a costing tool¹⁹³, and DFID has supported regional costing initiatives.

A critical component to sustaining and expanding HIV-sensitive social protection programming is building political support for schemes, and securing government and donor commitment. Several Latin American cash transfer programmes have been evaluated rigorously, with positive findings regarding increases in food consumption, school enrolment, and healthcare, and decreases in stunting, child labour, and illness rates. This evidence, which has been widely circulated, has been crucial to building political support and ultimately led to the programmes' expansion. More examples of the impact of HIV-sensitive social protection are needed to provide evidence of a broader impact both within and outside of the health sector. This will help convince donors to invest in HIV-sensitive social protection as an integral and worthwhile strategy towards achieving MDG targets. In particular, operational research demonstrating a positive impact on maternal and child health services would be of great value, given the international community's focus on PMTCT.

A number of ongoing and upcoming rigorous impact evaluations of social protection programmes in African countries (see Annex II) will strengthen the evidence base on the broader impacts of these programmes. The findings will help to address the current evidence gaps in this area.

190 McCord, A. (2009), Accelerating action on social protection: Regional scoping assessment DFID of southern Africa

191 Schwartländer, B. et al. (2011), Towards an improved investment approach for an effective response to HIV/AIDS

192 Ibid.

193 The ILO's Social Protection Costing Tool, developed in 2011, can be accessed at <http://www.socialprotectionfloor-gateway.org/24.htm>

Richter (2010) acknowledges the fear that exists that cash transfer programmes and funds could be “hijacked” by unscrupulous political leaders. To ensure programme success, Richter advocates for these interventions to be built as part of a “rights-based developmental system of social protection”, rather than introduced in isolation.¹⁹⁴ When the transfers are rights-based, recipients are holders of rights, eligibility and allocation are more transparent, and there are legal ramifications for illegal exclusion or corruption. This can help to ensure the longer-run success of the programme.

UNICEF (2009) recommends specific actions to sustain emerging social protection initiatives, including

- Assistance in the scale-up and refinement of social protection programmes where they exist
- Support for the operationalization of national social protection strategies where these have been prepared or adopted
- Encouragement and support to help translate the general commitments to social protection that appear in many strategy papers into social protection strategies and costed implementation plans for eventual programme design, operationalization, monitoring and evaluation.¹⁹⁵

Overall, it is critical that government capacity is developed over time, so that national governments can implement and monitor programmes at the national and district levels over the short-, medium- and long-terms. An example of government increasingly taking ownership of social protection programming is the CT for OVC in Kenya. The Government of Kenya, with technical and financial assistance from UNICEF, designed and began implementing the pilot CT for OVC in 2004. After a successful demonstration period, the CT-OVC was formally approved by Cabinet, was integrated into the national budget, and is now currently managed by the Children’s Department of the Ministry of Gender, Children and Social Development (MGCSD), Government of Kenya. Funding is provided by the Government of Kenya and development partners (including UNICEF, the World Bank and DFID), but the Government of Kenya has increased its share of the funding.

It is critical that broader country-level policies support and sustain the impact of individual programmes, as there are limitations to what individual interventions can achieve. Kim et al. (2008) conclude that the impact of scaling-up or replicating successful pilots is often constrained

by “a lack of realistic engagement with broader policies and structures that can curtail or expand their scope.”¹⁹⁶ Therefore, for social protection programmes to successfully be sustained and expanded they must be supported by country-level policies and domestic legislation.

6.3 Gaps in the evidence: Expanding and sustaining HIV-sensitive social protection

The introduction of the investment framework represents a starting point, raising key questions that have largely been unanswered up to now. One major area for further work is integrating the conceptual framework represented by the HIV/AIDS investment framework with the emerging evidence on the economic and larger returns to social protection. This step can complete a “virtuous circle” with which appropriate interventions reach the appropriate constituencies, achieve core and comprehensive impacts, and generate the social, economic and political returns that support their expansion and sustainability—further propelling the cycle forward.

Consultations with development partners found that demand was heaviest for a “toolkit” that would allow them to evaluate HIV-sensitive programmes “bang-for-the-buck”, so that resources can be most efficiently allocated. Existing studies of cash transfers for HIV prevention have not explicitly or rigorously tracked costs; while the direct cost of the incentive is known, other design and implementation costs are not. The ideal evidence base would be able to quantify returns on investment for different HIV-sensitive social protection instruments. There is a relatively broad spectrum of return on investment analysis, and it may be that useful quantitative analysis is impossible, in which case it would be valuable to qualitatively identify which aspects of intervention design can have the greatest return. Greater evidence on programme impact would align social protection with an increased global focus on results-based financing programmes, which reward the delivery of an agreed upon *outcome*, *output*, or *impact* upon verification of that delivery, as opposed to simply directly financing *inputs* to a program. An increased focus on the results of HIV-sensitive social protection would therefore be a step towards consolidating political (and financial) support.

194 Richter, L. (2010), Social cash transfers to support children and families affected by HIV/AIDS

195 UNICEF (2009), Strengthening social protection for children: West and Central Africa

196 Kim, J., Pronyk, P., Barnett, T., and Watts, C. (2008), Exploring the role of economic empowerment in HIV prevention

UNICEF country offices and policy-makers have expressed demand for more methodological decision-making tools for comparing costs and benefits, which support the identification of optimal instruments. The gap analysis identifies the following questions for further research:

- What aspects of countries political landscape are favourable to successful scale up of HIV- sensitive social protection?
- How can the impact of social protection on HIV outcomes be quantified without underplaying contributions to other developmental outcomes?
- What types of social systems (e.g. social assistance, social insurance) need to be in place to successfully scale up HIV-sensitive social protection?
- How can technological innovations such as mobile phones be used to scale up economic strengthening of HIV affected households?

7. CONCLUSIONS

The analysis presented in this report suggests that building an effective evidence base for HIV-sensitive social protection requires more specific research on the hypothesised relationships between interventions and HIV outcomes, which is then translated into action with new evidence-informed programming. Embedding operational research – the search for knowledge on strategies, interventions or tools that can enhance the performance of programmes in which the research is being conducted¹⁹⁷ – within these programmes can support the achievement of four objectives of evidence-building:

1. Demonstrate progress towards the strategic goals of the policies, programmes and other interventions,
2. Improve ongoing programme performance through operational evaluations,
3. Strengthen the social protection evidence base to address common challenges across countries, and
4. Reinforce political will for programme expansion and sustainability.

More effective methods of moving from pilot projects and randomised controlled trials to national rights-based programmes are also necessary. For example, the Zomba, Malawi study offers intriguing results regarding the potential of cash transfers to keep girls in school and reduce risky sexual behaviour. However, it raises critical questions about the potential consequences of a large-scale initiative modelled after the Zomba trial. Moving from small trials to larger-scale programmes requires a careful assessment of contextual factors, a gendered understanding, and communication with communities. Increasingly, integrated qualitative-quantitative impact assessments are proving helpful in both providing evidence of programme effectiveness as well as the information required about implementation issues and causal pathways that facilitates moving to national scale.

The reach of HIV-sensitive social protection

Policy-makers, practitioners and other stakeholders consulted during the inception stage of this project have

consistently expressed demand for evidence on whether key populations at higher risk and other specific vulnerable groups, including children affected by AIDS, are being reached through social protection programmes, or, if not, what barriers do they face in accessing services. This report documents a growing evidence base documenting research on how social protection addresses child vulnerability. However, the data on key populations at higher risk (such as sex workers, injecting drug users, and men who have sex with men) comes primarily from developed countries. This report highlights the priority of mobilising more thorough and credible evidence concerning these key populations from developing country contexts. Another major evidence gap is the lack of operational research analysing targeting in different epidemic contexts, particularly evidence that takes account of social and economic vulnerability. This is particularly important in low and concentrated epidemics where stigma and discrimination may be more extreme and key populations such as sex workers or injecting drug users may have challenges accessing their entitlements, whether this is to health insurance or a social transfer.

This report also identifies a significant requirement for operational research that can guide policymakers on targeting decisions and the management of data relating to programme coverage, specifically in terms of the analysis and management of exclusion error and inclusion error. In particular, there is demand for guidance on how to implement a management information system (MIS) that can quantify the reach of social protection programmes, and the extent to which they are reaching HIV-affected households. There is also demand for guidance on the types of questions that can be added to programme evaluations and surveys in order to gain an understanding of whether vulnerable, HIV-affected households are being reached.

Achieving core impacts

This report highlights important gaps in the evidence base policy-makers require to strengthen prevention impacts resulting from HIV-sensitive social protection. Major evidence gaps include answers regarding the relative impact of unconditional and conditional designs, the optimal benefit size, the required time frames associated with programme duration and time-to-impact, and the differential impacts of interventions on men and women.

¹⁹⁷ Zacariah, R. et al. (2011), The HIV/AIDS epidemic in sub-Saharan Africa: thinking ahead on programmatic tasks and related operational research

More direct evidence of the link between interventions and HIV prevalence is also required. In addition, little is understood of the actual transmission mechanisms driving the identified impacts—and this may require further qualitative analysis. Clearer evidence supporting the choice of most appropriate instruments is also required.

While the evidence base examining why people living with AIDS fail to access or adhere to treatment is growing, 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-side responses will have the greatest impact. Specifically, more research looking at differences across the rural/urban divide, or in different geographic regions, would strengthen the evidence base. The most critical gap in the evidence relating to treatment is the lack of studies that look at treatment as a specific outcome of social protection programming. There is evidence to support indirect linkages, but a lack of studies looking specifically at social protection and ART, as well as health-related outcomes such as access to PMCT for pregnant women.

While there is a stronger evidence base for social and economic care and support than for prevention and treatment, significant gaps remain. There is a strong demand for guidance on programme design, so that social protection can most efficiently achieve the desired care and support outcomes. For example, there is a need for more formal frameworks to guide the development of social protection that strengthens the transformative dimensions, particularly in terms of reducing stigma and discrimination. There is also demand for more evidence on the implementation of case management approaches alongside social protection interventions. Specifically, there is a gap in evidence on how case management can improve the targeting of transfers, reducing both exclusion and inclusion error.

Several key stakeholders have commented that while the growing evidence base regarding social cash transfers provides useful evidence, there is an unmet need for more evidence on other social protection interventions. This would help policymakers to determine what types of social protection interventions are most appropriate for different HIV mitigation responses. A better evidence base would also help policy-makers determine the optimal mix of cash and social care for addressing the economic and social vulnerabilities of households affected by HIV, as well as other potential combinations of social protection instruments. Research needs to address the growing role of ART; with increasing access to treatment more PLWHA can be supported through social protection programmes that promote more sustaining livelihoods as well as protecting consumption.

There is a need for more rigorous monitoring systems, which can identify if there are unintended consequences resulting from social protection interventions that may undermine positive impacts. Qualitative evaluations of impact can trace key linkages and help identify causal pathways. Another important gap in the evidence on care and support is how social protection can keep children within the family environment and reduce reliance on institutional care. As stated in the synthesis of existing research, there is evidence that children do much better when they are kept in kinship settings and that it is often poverty rather than lack of kin that drives children into institutions, but there is a lack of operational guidance on the role of social protection in strengthening the resilience of households to enable more secure placements of children and how to take these findings and translate them into policy that will better protect vulnerable children.

Social protection yields interrelated and often mutually reinforcing impacts that cut across prevention, treatment, care and support, many of which are under-researched. An important research priority is building a robust evidence base that shows precisely how social protection can 1) reduce risk factors within vulnerable groups, 2) support treatment adherence, and 3) improve care and support, mitigating the negative effects of HIV on individuals, households and communities.

Further research is also needed on the optimal packages of social protection measures for Universal Access outcomes. As emphasised in Temin (2010), social protection debates are often focused on cash versus food, or conditional versus unconditional transfers. This report analyses a wealth of evidence on cash transfers, but finds significant gaps for most other instruments. More evidence is required on instruments other than cash transfers. Further research is also required to better understand how different social protection programmes can be combined to reinforce and optimise Universal Access outcomes. This requires further research in different settings, where studies have the power to discern the different effects of different components of a combination intervention, or where qualitative research can contribute to an understanding of the different components.

Comprehensive approaches

This report highlights how comprehensive and integrated approaches effectively address the multiple vulnerabilities faced by people affected by HIV and AIDs. Moreover, it shows how the application of the development planning framework to HIV-sensitive social protection is a relatively new approach, and policy-makers require a more comprehensive methodology for mobilising

evidence. While the efficacy of specific design elements or the impact of individual programme interventions on coverage or core impacts can be tested with rigorous trials, the optimal combination of multi-sectoral strategies requires different analytical tools. The increased use of systematic reviews and meta-analyses may provide valuable evidence. The interest expressed by UNAIDS and other partners in pursuing evidence building in this area offers promise of future progress.

Expanding and sustaining HIV-sensitive social protection

Consultations with stakeholders have found substantial demand for evidence and perhaps a “toolkit” that would allow them to evaluate HIV-sensitive programmes’ cost-effectiveness, so that resources can be most efficiently allocated. Existing studies of cash transfers for HIV prevention usually have not explicitly or rigorously tracked costs. While the direct cost of the benefits can usually be calculated, other costs related to implementation—particularly the subtle costs of targeting—are not easily quantified. A more constructive evidence base would be able to quantify returns on investment for different HIV-sensitive social protection instruments, depending on the context in which the programme is implemented. An appropriate mix of quantitative and qualitative analysis may most effectively illuminate the choices for policy-makers, particularly given the difficulty in quantifying many of the associated costs. Greater evidence on programme impact would align social protection with an increased global focus on results-based financing programmes, which reward the delivery of an agreed upon *outcome*, *output*, or *impact* upon verification of that delivery, as opposed to simply directly financing *inputs* to a program. An increased focus on the results of HIV-sensitive social protection would therefore be a step towards consolidating political (and financial) support and strengthening the sustainability of these programmes. Increasing political support will also require paying more attention to the political economy aspects of social protection, for example, looking at existing programmes and their approaches, and their socio-cultural acceptability. This step goes beyond the reach of a development calculator, but is critical for sustaining and expanding programmes.

While gaps exist in evidence about the difficult-to-quantify returns from complex multi-sectoral approaches, the recent introduction of the HIV/AIDS investment framework represents a starting point, raising key questions that have largely been unanswered up to now. One major area for further work is integrating the conceptual framework represented by the HIV/AIDS investment framework with the emerging evidence on the economic

and larger returns to social protection. This step can complete a “virtuous circle” with which appropriate interventions reach the appropriate constituencies, achieve core and comprehensive impacts, and generate the social, economic and political returns that support their expansion and sustainability—further propelling the cycle forward.

Following the finalisation of this report and further consultations with key stakeholders, EPRI and UNICEF will work with a discrete number of countries in sub-Saharan Africa to further refine and prioritise these operational research questions at a country level in order to take forward more country-led analysis. Using both existing quantitative data and the opportunity to develop more qualitative analysis on causal pathways, EPRI, working with UNICEF and national researchers, will support countries in tackling operational research questions related to HIV-sensitive social protection which can strengthen the country-level evidence base, inform more effective programming and contribute to global evidence and guidance.

WORKS CITED

Adelman, S. et al. (2008), The impact of alternative food for education programs on child nutrition in northern Uganda. Washington D.C., International Food Policy Research Institute and the World Bank.

Akwara, P. A. et al. (2010), Who is the vulnerable child? Using survey data to identify children at risk in the era of HIV and AIDS. *AIDS Care*, 22(9): 1066-1085

Alam, A., Baez, J. E., and Del Carpio, X. V. (2011), Does cash for school influence young women's behavior in the longer term? Evidence from Pakistan. Washington D.C., The World Bank Independent Evaluation Group, Public Sector Unit.

Anema et. al. (2009), Food insecurity and HIV/AIDS: Current knowledge, gaps, and research priorities. *Current HIV/AIDS Reports*, 6(4): 224-231.

Attenborough, J. (2012), Investing in Malawi's National Child Protection System to support national social protection goals. UNICEF Malawi.

Baingana, F. et al. (2008), The implementation gap in services for children affected by HIV/AIDS: supporting families and communities in caring for and protecting vulnerable children. Joint Learning Initiative on Children and HIV/AIDS.

Baird, S. et al. (2012), Effect of a cash transfer programme for schooling on prevalence of HIV and herpes simplex type 2 in Malawi: a cluster randomised trial. *The Lancet*, 379(9823): 1320-1329.

Better Care Network (2010), Guidelines for the alternative care of children (formerly UN guidelines for the appropriate use and conditions of alternative care for children). Better Care Network.

Birdthistle, I. et al. (2009), Is education the link between orphanhood and HIV/HSV-2 risk among female adolescents in urban Zimbabwe?. *Social Science & Media*, 68(10): 1810-1818.

Budlender, D. (2010), Compensation for contributions: report on interviews with volunteer caregivers in six countries. New York, The Huairou Commission.

Bundy, D. et al. (2009), Rethinking school feeding: social safety nets, child development, and the education sector. Washington D.C., The World Food Programme and World Bank Directions in Development.

Cantrell, R.A., Sinkala, M., Megazinni, K. et al. (2008), A pilot study of food supplementation to improve adherence to antiretroviral therapy among food-insecure adults in Lusaka, Zambia. *Journal of Acquired Immune Deficiency Syndrome*, 49: 190-195.

Care and Support Working Group (2011), Care and support: the forgotten pillar of the HIV response. UK Consortium on AIDS and International Development.

Chatham House (2012), Social protection interventions for tuberculosis control: the impact, the challenges and the way forward. Symposium, 15 -17 February 2012. Hosted by the London School of Hygiene and Tropical Medicine. London, UK, Chatham House.

Cleary, S. M. et al. (2012), Unequal access to ART: exploratory results from rural and urban case studies of ART use. *Sexually Transmitted Infections*, 88: 141-146.

Cluver, L. (2011), Children of the AIDS pandemic. *Nature*, 474: 27-29.

Cluver, L., Operario, D., Lane, T. and Kganakga, M. (2011a), Educational shortfalls among 'Young Carers' in the South African AIDS Epidemic. *Journal of Adolescent Research*, Online first publication.

Cluver, L., Orkin, M., Kuo, C., Moshabela, M., and Kganakga, M. (2011b), Infectious disease and TB co-occurrence amongst children with AIDS-affected caregivers. South African AIDS Conference V, Durban, 2011.

Cluver, L., Orkin, M., Gardner, F., and Boyes, M.E. (2011c), Persisting mental health problems among AIDS-orphaned children in South Africa. *Journal of Child Psychology and Psychiatry*, 53(4): 363-70.

Cluver, L., Orkin, M., Boyes, M.E., Gardner, F., and Meinck, F. (2011d), Transactional sex amongst AIDS-orphaned and AIDS-affected adolescents predicted by abuse and extreme poverty. *JAIDS*, 58(3): 336-343.

Coates, T.J., Richter, L., and Caceres, C. (2008), Behavioural strategies to reduce HIV transmission: how to make them work better. *Lancet*, 372: 669-84.

- Davies, M., Oswald, K. and Mitchell, T. (2009), Climate change adaptation, disaster risk reduction and social protection. In *Promoting pro-poor growth: Social protection*. Paris, Organisation for Economic Co-operation and Development (OECD).
- Davis, B., Gaarder, M., Handa, S. and Yablonski, J. (2012), Evaluating the impact of cash transfer programmes in sub-Saharan Africa: an introduction to the special issue. *Journal of Development Effectiveness*, 4(1): 1-8.
- Della Vigna, S. (2009), Psychology and economics: evidence from the field. *Journal of Economic Literature*, 47: 315-72.
- Devereux, S. and Sabates-Wheeler, R. (2004), Transformative social protection. Brighton, Sussex, Institute of Development Studies (IDS Working Paper 232).
- deBrauw, A. and Peterman, A. (2011), Can conditional cash transfers improve maternal health and birth outcomes?: Evidence from El Salvador's Comunidades Solidarias Rurales. Washington D.C., International Food Policy Research Institute.
- de Paoli, M.M., Grønningsæter, A.B., and Mills, E. (2010), HIV/AIDS, the disability grant and ARV adherence: Summary report. Oslo, Norway, Fafo.
- de Pee, S. and Semba, R. (2009), Nutrition and HIV infection (draft). Washington D.C., World Food Programme (Background Paper for WFP).
- deWalque, D. Nathan, R. et al. (2012), Incentivising safe sex: a randomised trial of conditional cash transfers for HIV and sexually transmitted infection prevention in rural Tanzania. *British Medical Journal Open*, 2: e000747 doi:10.1136/bmjopen-2011-000747.
- DFID (2011), Cash transfers evidence paper. London, UK, DFID Policy Division.
- DFID (2011), DFID's approach to value for money (VfM). London, UK, Department for International Development (DFID).
- Doyle, A.M. et al. (2010), Long-term biological and behavioural impact of an adolescent sexual health intervention in Tanzania: Follow-up survey of the community-based MEMA kwaVijana trial. *Public Library of Science Medicine*, 7(6): e1000287 doi:10.1371/journal.pmed.1000287.
- Economist Intelligence Unit (2011), Mapping of social protection measures for children affected by AIDS in Asia-Pacific. Commissioned by UNICEF Asia-Pacific Shared Services Centre, Regional Offices for East Asia and Pacific and South Asia
- Emenyonu, N. et al. (2010), Cash transfers to cover clinic transportation costs improve adherence and retention in care in a HIV treatment program in rural Uganda. In *Association of antiretroviral therapy adherence and health care costs* (ed.), Mbarara, Uganda.
- Engle, P.L. et al. (2009), Strategies to avoid the loss of developmental potential in more than 200 million children in the developing world. *Lancet*, 369(9557): 229-242.
- Fawzi, W.W., Msamanga, G.I., and Spiegelman, D. et al. (2004), A randomized trial of multivitamin supplements and HIV disease progression and mortality. *New England Journal of Medicine*. 2004;351:23-32
- Fergusson, P. et al. (2009), Nutritional recovery in HIV-infected and HIV-uninfected children with severe acute malnutrition. *Archives of Disease in Childhood*, 94: 512-516.
- Frega, R., Duffy, F. and Grede, N. (2010), Food insecurity in the context of HIV and AIDS. *Social Science & Medicine*, 68(10): 1810-1818.
- Galárraga, O. and Gertler, P. L. (2009). Cash and a brighter future: the effect of conditional transfers on adolescent risk behaviors: Evidence from urban Mexico (working paper). Paper from 7th World Congress on Health Economics, Beijing, July 2009, Harmonizing Health and Economics.
- Garcia, M. and Moore, C. M. T. (2012), The cash dividend: the rise of cash transfer programs in Sub-Saharan Africa. Washington D.C., World Bank.
- Gillespie, S. and Kadiyala, S. (2005), HIV/AIDS, food and nutrition security: from evidence to action. Washington D.C., International Food Policy Research Institute (Food Policy Review 7).
- Gupta, G.R., Parkhurst, J.O., Ogden, J.A., Aggleton, P., and Mahal, A. (2008), Structural approaches to HIV prevention. *Lancet*, 372: 764-75.
- Hallfors, D. et al. (2011), Supporting adolescent orphan girls to stay in school as HIV risk prevention: Evidence from a randomised controlled trial in Zimbabwe. *American Journal of Public Health*, 101(6): 1082-1088.
- Handa, S. and Stewart, S. (2008), Reaching OVC through cash transfers in Sub-Saharan Africa: Simulation results from alternative targeting schemes. (Working Paper) Nairobi, Kenya, UNICEF ESARO Social Policy and Social Protection Section.
- Hardon, A. et al. (2006), From access to adherence: the challenges of antiretroviral treatment: Studies from Botswana, Tanzania and Uganda. Geneva, Switzerland, World Health Organization.

Hargreaves, J.R. et al. (2008), Systematic review exploring time-trends in the association between educational attainment and risk of HIV infection in sub-Saharan Africa. *AIDS*, 22: 403-414.

Hoffmann, S. et al. (2008), Salt, soap and shoes for school: The impact of pensions on the lives of older people and grandchildren in the KwaZee project in Tanzania's Kagera region. HelpAge International, Regional Psychosocial Support Initiative (REPSSI), Swiss Agency for Development and Cooperation (SDC), and World Vision International.

Holmes, R. and Jones, N. (2010), How to design and implement gender-sensitive social protection programmes: a toolkit. London, U.K., Overseas Development Institute (ODI).

Joglekar, N. et al. (2011), Barriers to ART adherence and follow ups among patients attending ART centres in Maharashtra, India. *Indian Journal of Medical Research*, 134: 954-959.

Joint statement on advancing child-sensitive social protection (2009). DFID, HelpAge International, Hope & Homes for Children, Institute of Development Studies, International Labour Organization, Overseas Development Institute, Save the Children UK, UNDP, UNICEF and the World Bank.

Jones, N. Ahadzie, W. and Doh, D. (2009), Social protection and children: opportunities and challenges in Ghana. Accra and London, UNICEF Ghana and Overseas Development Institute (ODI).

Kim, J., Pronyk, P., Barnett, T., and Watts, C. (2008), Exploring the role of economic empowerment in HIV prevention. *AIDS*, 22(suppl 4): S57-71.

Kohler, H.P. and Thornton, R. (2011), Conditional cash transfers and HIV/AIDS prevention: Unconditionally promising? *World Bank Economic Review*, doi: 10.1093/wber/lhr041.

Kristjansson, B.P.M. et al. (2007), School feeding for improving the physical and psychosocial health of disadvantaged students. *The Cochrane Library* 2009, 1.

Lester, R.T. et al. (2010), Effects of a mobile phone short message service on antiretroviral treatment adherence in Kenya (WelTel Kenya1): A randomised trial. *The Lancet*, 376(9755): 1838-1845.

Lim, S. S. et al. (2010), India's JananiSurakshaYojana, a conditional cash transfer programme to increase births in health facilities: an impact evaluation. *The Lancet*, 375: 2009-23.

Lutz, B. (2012), Experiences from HIV-sensitive social protection. Social protection interventions for tuberculosis control: the impact, the challenges and the way forward. Symposium, 15 -17 February 2012. Hosted by the London School of Hygiene and Tropical Medicine. London, UK, Chatham House.

Lutz, B. and Small, S. (forthcoming), Cash transfers and HIV prevention: What do we know and where should we go? New York, United Nations Development Programme.

Mahmud, S. (2003), Female secondary school stipend program in Bangladesh: A critical assessment. Bangladesh Institute of Development Studies.

Marteau, T., Ashcroft, R., and Oliver, A. (2009), Using financial incentives to achieve healthy behavior. *British Medical Journal*, 338:b1415

Mavedzenge, S.N., Doyle, A. and Ross, D. (2010), HIV prevention in young people in sub-Saharan Africa: A systematic review. Infectious Disease Epidemiology Unit, Department of Epidemiology and Population Health, London School of Hygiene and Tropical Medicine.

McCord, A. (2005), Public works in the context of HIV/AIDS. Cape Town, Southern Africa Labour and Development Research Unit (SALDRU), School of Economics, University of Cape Town.

McCord, A. (2009), Accelerating action on social protection: Regional scoping assessment DFID of southern Africa. Presentation of draft findings. London, UK, Overseas Development Institute.

Medlin, C. and de Walque, D. (2008), Potential applications of conditional cash transfers for prevention of sexually transmitted infections and HIV in sub-Saharan Africa. Washington D.C., World Bank (Policy Research Working Paper No. 4673).

Miller, C. (2012), Social protection, cash transfers and health in Africa. Social protection interventions for tuberculosis control: the impact, the challenges and the way forward. Symposium, 15 -17 February 2012. Hosted by the London School of Hygiene and Tropical Medicine. London, UK, Chatham House.

Miller, C. and Tsoka, M.G. (2012), ARVs and cash too: caring and supporting people living with HIV/AIDS with the Malawi Social Cash Transfer. *Tropical Medicine and International Health*, 17(2): 204-210.

Miller, C. and Themba, Z. et al. (2012), External evaluation of the Bomi Social Cash Transfer Pilot. Boston University Center for Global Health and Development (CGHD).

Miller, C. L. et al. (2011), Food insecurity and sexual risk in an HIV endemic community in Uganda. *AIDS Behavior*, 15: 1512–1519.

Murray, L.K. et al. (2009), Barriers to acceptance and adherence of anti-retroviral therapy in urban Zambian women: a qualitative study. *AIDS Care*, 21(1): 78.

National AIDS Control Council (NACC) (2009), Kenya national AIDS strategic plan 2009/10 – 2012/13: Delivering on Universal Access to Services (KNASP III). Nairobi, Kenya.

Packel, L. et al. (2012) Sexual behavior change intentions and actions in the context of a randomized trial of a conditional cash transfer for HIV prevention in Tanzania. Washington D.C., World Bank (Policy Research Working Paper 5997).

Padian, N. S. et al. (2011), HIV prevention transformed: the new prevention research agenda. *Lancet*, 378: 269–78.

Pop-Eleches, C. et al. (2011), Mobile phone technologies improve adherence to antiretroviral treatment in a resource-limited setting: a randomized controlled trial of text message reminders. *AIDS*, 25(6): 825–34.

Powell-Jackson, T. and Hanson, K. (2012), Financial incentives for maternal health: Impact of a national programme in Nepal. *Journal of Health Economics*, 31(1): 271–284.

Pronyk, P.M. et al. (2006), Effect of a structural intervention for the prevention of intimate partner violence and HIV in rural South Africa: results of a cluster randomised trial (IMAGE). *Lancet*, 368: 1973–83.

Pronyk, P. M., Hargreaves, J.R., and Morduch, L. (2007), Microfinance programs and better health: prospects for sub-Saharan Africa. *Journal of the American Medical Association*, 298(16): 1925–1927.

Richter, L. (2010), Social cash transfers to support children and families affected by HIV/AIDS. *Vulnerable Children and Youth Studies*, 5(S1): 81–91.

Robinson, J. and Yeh, E. (2011), Transactional Sex as a Response to Risk in Western Kenya. *American Economic Journal: Applied Economics*, 3(1): 35–64.

Roelen, K. et al. (2011), Lessons from the Children and AIDS Regional Initiative (CARI): Child- and HIV-sensitive social protection in Eastern and Southern Africa. Brighton, Sussex, Centre for Social Protection, Institute of Development Studies.

Samson, M. et al. (2007), The social and economic impact of cash transfers. Cape Town, South Africa. Economic Policy Research Institute.

Samuels, F. Blake, C. and Akinrimisi, B. (2012), HIV vulnerabilities and the potential for strengthening social protection responses in the context of HIV in Nigeria. London, UK, Overseas Development Institute.

Schäfer, M. (2010), Using conditional cash transfers to control sexually transmitted infections and HIV. Discussion papers on social protection. Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ).

Schüring, E. (2011), Cashing in: How cash transfers shore up Zambian households affected by HIV. Gesellschaft für Internationale Zusammenarbeit (GIZ).

Schwartländer, B. et al. (2011), Towards an improved investment approach for an effective response to HIV/AIDS. *Lancet*, 77: 2031–41.

Schubert, B. (2007), The impact of social cash transfers on children affected by HIV and AIDS: Evidence from Zambia, Malawi and South Africa. UNICEF ESARO.

Seume-Fosso, E. (2004), HIV/AIDS: A guide for nutritional care and support. 2nd Edition. Washington D.C., Food and Nutrition Technical Assistance Project, Academy for Educational Development.

Shahmanesh, M., Patel, V., Mabey, D., and Cowan, F. (2008), Effectiveness of interventions for the prevention of HIV and other sexually transmitted infections in female sex workers in resource poor setting: a systematic review. *Tropical Medicine & International Health*, 13: 659–79.

Sherr, L. et al. (2009), Examining ways in which contact opportunities associated with transfers might help identify vulnerable households and link the with social welfare services: a systematic review of the literature. London, Royal Free and University College Medical School, University College London.

Simoni, J. M. et al. (2008), Strategies for promoting adherence to anti-retroviral therapy: A review of the literature. *Current Infectious Disease Reports*, 10(6): 515–521.

Skovdal, M. et al. (2008), Community-based capital cash transfer to support orphans in Western Kenya: a consumer perspective. *Vulnerable Children and Youth Studies*, 3(1): 1–15.

Sorensen, J.L. et al. (2007), Voucher reinforcement improves medication adherence in HIV-positive methadone patients: A randomized trial. *Drug and Alcohol Dependency*, 88(1): 54–63.

Souteyrand, Y.P. et al. (2008), Free care at the point of service delivery: a key component for reaching universal access to HIV/AIDS treatment in developing countries. *AIDS*, 22(Suppl. 1): S161–S168.

Subbarao, K. (2001), Systemic shocks and social protection: Role and effectiveness of public works programs. Washington D.C., World Bank (Social Protection Discussion Paper Series No. 0302).

Temin, Miriam (2010), HIV-Sensitive Social Protection: What does the evidence say?, Geneva, Switzerland, UNAIDS and UNICEF.

Thornton, R.L. (2008), The demand for, and impact of, learning HIV status. *American Economic Review*, 98(5): 1829-1863.

UNAIDS (2010), Expanded business case: Enhancing social protection. Geneva, Switzerland, Social Protection Working Group, UNAIDS.

UNAIDS (2010), Fact Sheet: Women, girls, gender equality and HIV. Geneva, Switzerland, UNAIDS.

UNAIDS Terminology Guidelines 2011 (2011), Geneva, Switzerland, UNAIDS.

UNAIDS (2010), UNAIDS report on the global epidemic. Geneva, Switzerland, UNAIDS.

UNAIDS (2011), HIV and social protection guidance note. Geneva, Switzerland, UNAIDS.

UNICEF (2009), Maternal and child health: the social protection dividend (West and Central Africa). UNICEF Regional Office for West and Central Africa.

UNICEF (2009), Strengthening social protection for children: West and Central Africa. UNICEF Regional Office for West and Central Africa.

UNICEF(2011), Taking evidence to impact: making a difference for vulnerable children living in a world with HIV and AIDS.

UNICEF (2012), Integrated social protection systems: Enhancing equity for children.

UNICEF (2012), Integrated Social Protection Systems: Enhancing equity for children. Social protection strategic framework. Written by Natalia Winder and JennYablonski in the Social and Economic Policy Analysis Unit, New York, UNICEF.

Vadapalli, A. (2009), Barriers and challenge in accessing social transfers and role of social welfare services in improving targeting efficiency: A study of conditional cash transfers. *Vulnerable Children and Youth Studies*, 4(Suppl. 1).

Wamoyi, J. et al. (2011), Transactional sex amongst young people in rural northern Tanzania: an ethnography of young women's motivations and negotiation. *Reproductive Health*, 7(2): 1-18.

Weiser, S.D. et al. (2012), Food insecurity is associated with morbidity and patterns of healthcare utilization among HIV-infected individuals in a resource-poor setting. *AIDS*, 26(1): 67-75.

World Bank (2009), Project appraisal document for a cash transfer for orphans and vulnerable children project. Washington, DC., World Bank.

Zacariah, R. et al. (2011), The HIV/AIDS epidemic in sub-Saharan Africa: thinking ahead on programmatic tasks and related operational research. *Journal of the International AIDS Society*, 14(Suppl. 1): S7.

ANNEX I: CONSULTATION RECORD

Name	Organization/ Affiliation	Country	Date
Alviar, C.	UNICEF	Ghana	28/2/12, 27/4/12
Bachman, G., Sandison, S. and Castor, D.	USAID	N/A	2/2/12
Bosworth, J.	UNICEF	Kenya	10/4/12, 10/5/12
Cluver, L.	Oxford University	South Africa	26/2/12
Davis, B.	FAO	N/A	16/2/12
Elder, J. and Stanciole, A.	World Bank	N/A	2/2/12
Farooq, M.	UNICEF	Lesotho	15/3/12, 3/5/12
Grede, N.	WFP	N/A	14/3/12
Huijbregts, M. and Chowdhury, S.	UNICEF	Mozambique	6/3/12
Kalanda, B.	UNICEF	Sierra Leone	28/2/12
Karim, Q. A.	CAPRISA	South Africa	19/3/12
Laryea-Adjei, George	UNICEF	South Africa	20/3/12, 26/4/12
Mafico, M. and Nxumalo, F.	UNICEF	Swaziland	21/3/12
Maksud, N., Fenn, T., Fajth, G. and Lawson-McDowall, J.	UNICEF ESARO	N/A	1/2/12
Sammon, E. and Rumble, L.	UNICEF	Zimbabwe	10/5/12
Spadafora, T. R., Warren, K., Grant, B., Shawa, S. and Mon, A. A.	UNICEF	Malawi	15/3/12, 25/4/12
Stirbu, M. and Kaboré, C. N.	UNICEF WCARO	N/A	20/1/12
Tsague, L. and Moller, J.	UNICEF	Zambia	19/3/12
Visani, S., Felix, C. and Munyuzangabo, T.	UNICEF	Côte d'Ivoire	29/2/12
Webb, D. and Lutz, B.	UNDP	N/A	13/3/12

ANNEX II: ONGOING AND UPCOMING HIV-SENSITIVE SOCIAL PROTECTION RESEARCH

Project	Description	Countries	Agency/Sponsor
Economic growth and risk reduction in Malawi's social cash transfer scheme	Research will investigate the economic impact of the Government of Malawi's Social Cash Transfer (SCT) programme on target households and the local community, focusing on two key areas: 1) whether SCTs can promote economic growth, and 2) the role of SCTs in both mitigating the impact of AIDS and reducing the risk of HIV.	Malawi	International Initiative for Impact Evaluation (3ie)
Estimating the effectiveness of a food supplementation intervention integrated into an AIDS care and treatment program	This quasi-experimental study aims to evaluate the impact of household food rations on clinical, socioeconomic and behavioural outcomes. It will employ propensity matching methods with difference-in-difference estimations to examine changes that occur as a result of food assistance to evaluate the impact of food supplementation on: a) HIV progression, medical, nutritional and quality of life, high risk behaviour, labour productivity and food security outcomes of PLWHIV, and b) socioeconomic, health, and nutritional outcomes at the household level including food security, household dietary diversity, household expenditures, intra-household labour reallocation, assets and savings, indebtedness, perceived well-being, mental health and child growth.	Uganda	International Initiative for Impact Evaluation (3ie), the AIDS Support Organization (TASO), The Regional Network on AIDS, Livelihoods and Food Security (RENEWAL) coordinated by IFPRI, and WFP
The growth and protection impacts of Zimbabwe's Social Cash Transfer (SCT) Programme	Evaluation will assess the impact of SCTs, a major programme component of the National Action Plan for Orphans and Vulnerable Children (NAP II) 2011-2015, and its accompanying pooled funding mechanism (the Child Protection Fund). It will focus on HIV risk (sexual activity, condom use, transactional and forced sex, and partner characteristics), as well as child protection (psycho-social status, age at marriage and age at first pregnancy, and physical abuse, particularly violence against women), and human capital (school enrollment, attainment, repetition, labour force participation, and physical health). In addition, it will investigate the SCT's economic impact on both target households and the local community.	Zimbabwe	International Initiative for Impact Evaluation (3ie)

Project	Description	Countries	Agency/Sponsor
HPTN 068: Effects of cash transfer for the prevention of HIV in young South African women	A phase III, randomised, controlled factorial design study to determine whether providing cash transfers to young women and their household, conditional on school attendance, reduces young women's risk of acquiring HIV. The overall goal of the CCT intervention is to reduce structural barriers to education with the goal of increasing school attendance of young women, hereby decreasing their HIV risk.	Bushbuckridge, South Africa	Carolina Population Center
Intervention with Micro-finance for AIDS and Gender Equity (IMAGE)	Randomized control trial to evaluate the effects of a combined microfinance and participatory health training intervention on levels of intimate partner violence and HIV risk behaviours over two years. Currently working on a scale-up of the programme and possible replication in other country contexts.	South Africa	London School of Hygiene and Tropical Medicine, University of the Witwatersrand School of Public Health, Small Enterprise Foundation (SEF)
Iringa Combination Prevention Research Trial	Large combination prevention research trial will include biomedical, behavioural, and structural interventions. Structural intervention is being designed now, prospectively an unconditional cash transfer to adolescent girls (and their families). May undertake additional operational and impact research focused exclusively on the UCT component, depending on resources available and possible interactions with the broader combination prevention research	Tanzania	USAID
Operational research focused on an OVC cash transfer and complementary livelihoods interventions	USAID is considering operational research to explore the differential and combined impacts of an OVC-focused cash transfer and complementary livelihoods intervention (e.g., savings), hoping to build off of existing efforts (such as the government's CT-OVC scheme and the APHIA projects funded by USAID)	Kenya	USAID
Reducing HIV in adolescents (RHIVA)	A proof of concept cluster randomised controlled trial to evaluate the impact of a cash incentivised prevention intervention to reduce HIV infection in high school learners in rural KwaZulu-Natal, South Africa. There are two behavioural interventions: a cash incentive (paid to learners for reaching pre-determined milestones) and a life skills curriculum.	KwaZulu-Natal, South Africa	Centre for the AIDS Programme of Research in South Africa (CAPRISA) and UNAIDS

Project	Description	Countries	Agency/Sponsor
Research project on how food and nutrition can facilitate access to HIV care and support services	Research project examining 1) to what extent HIV care and support interventions are currently provided as complements to food and nutrition activities, and 2) how food nutrition delivery mechanisms can support non-food related HIV care and support interventions	Possibly Ethiopia, Malawi, Mozambique, Swaziland, Zimbabwe	World Food Programme
RESPECT Study: Evaluating Conditional Transfers for HIV/STI Prevention in Tanzania	Evaluation of cash payments to adults to avoid unsafe sex and prevent STIs such as chlamydia, gonorrhoea, trichomonas, mycoplasma genitalium, and syphilis.	Tanzania	World Bank
Safety nets and HIV/AIDS in Botswana, Namibia and Swaziland	Assessment of the impact of HIV/AIDS on existing formal safety nets and how formal safety nets could better respond	Botswana, Namibia, Swaziland	World Bank
Schooling, Income and HIV Risk (SIHR) in Malawi: Understanding the long term impacts of a schooling conditional cash transfer program	SIHR is a randomised evaluation of a CCT program in Malawi designed to address several research gaps by focusing on sub-Saharan Africa, comparing the effectiveness of conditional vs. unconditional cash transfers, and having a longer-term timeframe. It will also examine final outcomes (rather than measures of utilization) in terms of learning, labour market and HIV and STD risk. To examine long-term impacts, the study will return to the field in 2012 – four years after baseline and two years after the completion of the program – and collect evidence on outcomes including labour market participation.	Malawi	International Initiative for Impact Evaluation (3ie), George Washington University, World Bank University of California, San Diego University of Malawi
Transfer Project evaluation of impact of cash on adolescent risk: Four-year follow-up round of the Kenya CT-OVC evaluation	The objectives of the study are to examine the medium term impacts of the programme on household economic activity and welfare, and the transition of OVC into young adulthood. Information was collected on approximately 2400 young people ages 15-25 on schooling, psycho-social status, hope, marriage, pregnancy, sexual activity, partner characteristics, friends, time preference and future expectations. Survey tracks household residents aged 15–25 and captures information on schooling, psycho-social status, hope, marriage, pregnancy, sexual activity, partner characteristics, friends, time preference and future expectations. Initial findings show that cash transfers have reduced incidence of forced sex and numbers of sexual partners, with schooling as the main protective factor.	Kenya	Transfer Project, UNC, GoK, Research Solutions Africa and FAO, and funded by the U.S. National Institute of Health

Project	Description	Countries	Agency/Sponsor
Transfer Project evaluation of vulnerability grant in Zambia	The Transfer Project, based at UNC, is supporting Zambia in the evaluation of the vulnerability grant and working with AIR consultants to develop a dedicated OVC module looking at OVC behaviour and risk taking. Recently launched, it includes a module specifically designed to measure sexual activity among OVCs.	Zambia	Transfer Project

ANNEX III: COUNTRY CONSULTATION INSTRUMENT

Summary Instrument for Country Consultations

Goal of country consultations: to understand different country perspectives on priority issues and evidence gaps for HIV-sensitive social protection research, as well as existing and ongoing programmes, research, and data in this area.

Proposed Meeting Agenda

1. Introduction of project and meeting participants
2. Discussion questions
3. Questions from country participants

Documents to be provided by EPRI to consultation participants

- Terms of Reference including Scope of Work
- Project introduction document, including annexes:
 - Criteria for country selection (1 page word document)
 - Timeframe for project (Gantt chart)
- This “Instrument for Country Consultations” document
- Initial bibliography

Introduction of meeting participants and research team members

Introduction of project:

Scope of work

- Purpose: support generation of evidence and policy guidance in relation to HIV-sensitive social protection
- Goal: to improve quality and relevance of social protection and HIV research in Sub-Saharan Africa

Time frame

- Currently in inception phase: 4-month inception phase January – end April 2012.
- Main phase of the project: May 2012 – April 2013

Key discussion questions for country consultations

- Are you aware of existing or emerging research in your country that links social protection with HIV and AIDS?
- What are the priority questions and areas for which evidence can illuminate better policy and practice with HIV-sensitive social protection?
- Discussion of our focal country criteria and explanation of our requirements
- Main discussion questions for country-level consultation: ongoing work and resources
 - Are there ongoing social protection interventions?
 - Are there HIV and AIDS linkages with these social protection interventions?
 - Are there existing or ongoing evaluations of these interventions
 - Does UNICEF have access to the data from these evaluations?
 - Are there other relevant data sets that can be made available
 - Other relevant issues with respect to country participation
- Emerging research questions: country perspective