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SOCIAL PROTECTION: ADVANCING THE RESPONSE TO HIV

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Social protection refers to public and private initiatives that provide cash or in-kind transfers to people in resource limited settings, protect against livelihood risks and enhance the social status and rights of marginalized groups, with the overall objective of reducing their economic and social vulnerability. Social protection goes far beyond cash and in-kind transfers, encompassing economic, health insurance and employment assistance to reduce inequality, exclusion and barriers to accessing HIV prevention, treatment, care and support services.

Introduction

Social protection is recognized as a critical enabler of the AIDS response. It has the power to address the social economic drivers of the AIDS epidemic, reduce HIV risk behaviour, break down barriers to the access of HIV services and make HIV programmes more effective.

For the first time, there is a consensus that the tools now exist to end the AIDS epidemic as a public threat by 2030. To accelerate progress towards that goal, new Fast-Track targets for 2020 have been established to do the following:

- Ensure 90% of people living with HIV know their HIV status, 90% of people who know their HIV positive status are accessing treatment and 90% of people on HIV treatment have suppressed viral loads.
- Reduce new HIV infections to fewer than 500 000.
- Achieve zero AIDS-related discrimination.

These targets aim to transform into concrete milestones and end points the UNAIDS vision of zero new HIV infections, zero discrimination and zero AIDS related deaths.

The Fast-Track approach seeks to scale up proven programmes for populations left behind in key countries and locations. Particular efforts are required in 35 countries (15 of which are in eastern and southern Africa) that account for 90% of all new HIV infections worldwide. The proven programmes include HIV treatment, which dramatically extends the lifespan of people living with HIV and effectively prevents HIV transmission by suppressing their viral load, but they also go beyond medicines to include condom programming, behaviour change, voluntary medical male circumcision and other programmes that have demonstrated their capacity to lower HIV infections in key populations. Those programmes are dramatically enhanced and other programmes strengthened when combined with social and structural approaches, including social protection (1).

In the face of competing priorities and limited resources, the AIDS response must exploit synergies for identifying fiscal space, cross-sectoral financing and co-programming of HIV and social protection programmes. Combining HIV and social protection programmes offers opportunities to tap into new resource streams and increases the potential for the AIDS response to reach more people, especially those left behind by the current provision of HIV services. HIV and social protection integration also promote the recognition and protection of the rights of people living with and most affected by HIV.

The 10 case studies presented in this document clearly demonstrate that social protection works for HIV prevention, treatment, care and support. In particular, they show how social protection benefits the AIDS response through increased access to HIV services for all people including the most marginalized and excluded in society.* The studies also demonstrate that carefully constructed and well-managed social protection programmes have the power to support people who are hardest to reach.

The case studies reflect the great diversity in the scope and focus of activities that occur under the umbrella of social protection. Some are **HIV-relevant social protection** programmes that focus on the general public, while still addressing the needs of people who are living with (or are affected by) HIV. Under this category, there are case studies from Kenya (where a cash transfer programme is contributing to protecting adolescents from HIV), India (which has been increasing access to social protection for people affected by HIV), and the United Republic of Tanzania (where social protection for older people and their dependents has been strengthened). Examples of programmes of this type also come from Thailand (where the health insurance scheme has been expanded to cover non-Thai residents) and Uruguay (where an affirmative action programme for transgender people has been introduced).

Other social protection programmes aim for **social transformation** by addressing societal attitudes, policy and legal reforms to protect the rights of people living with HIV, women and key populations. A programme for sex workers in Kenya is a powerful example of social transformation in action.

There also are **HIV-specific social protection** programmes that focus exclusively on HIV and people living with HIV. One example is the case study from Honduras, where the national AIDS response has been strengthened to better meet the needs of vulnerable children and children orphaned by HIV. From North America, there is a profile of The Committee for Accessible AIDS Treatment in Canada and a study from the United States of America of a low-threshold harm reduction housing programme for people who use drugs and are living with HIV. Finally, a case study from countries in eastern Europe and central Asia profiles the impact of programmes that provide free HIV services, incentives for desirable behavioural and HIV outcomes and nutritional support programmes that have been deployed to support people living with HIV or those undergoing treatment for tuberculosis (TB).

Clearly, social protection has a key role to play in addressing the social inequalities and economic drivers of the HIV epidemic, and in sustaining an effective and rights-based approach for the AIDS response. Much can be learned from the experiences of the profiled countries that can help inform and inspire greater social protection around the world for the most vulnerable in society—and the most vulnerable to HIV.

* Key populations are groups of people who are more likely to be exposed to HIV or to transmit it, and whose engagement is critical to a successful HIV response. In all countries, key populations include people living with HIV. In most settings, men who have sex with men, transgender people, people who inject drugs, and sex workers and their clients are at higher risk of exposure to HIV than other groups, but each country should define the specific populations that are key to their epidemic and response based on the epidemiological and social context.

HIV-RELEVANT SOCIAL PROTECTION FOR ORPHANS AND OTHER VULNERABLE CHILDREN

Kenya: cash transfers for orphans and other vulnerable children

Background

Cash transfers as a means of HIV prevention are attracting increasing interest in Africa, and the evidence base supporting such programmes is growing. Many large-scale, unconditional cash transfer programmes that focus on poverty alleviation and family support across eastern and southern Africa are showing impressive results in terms of HIV outcomes, risk mitigation, HIV prevention and increased access and adherence to treatment for HIV and TB. In addition, several projects in the region have provided proof that conditional and unconditional cash transfers can delay sexual debut and reduce the incidence of HIV and sexually transmitted infections among young women.

Conditional cash transfers require recipients to undertake specific actions, such as sending their children to school or having their children receiving a certain number of immunizations. Unconditional cash transfers, however, do not require recipients to undertake particular activities. However two most recent cash transfer studies from South Africa-CAPRISA 007 and HPTN 068-failed to show an effect on HIV incidence in spite of showing a 30% reduction of HSV2 (a marker of sexual activity) and highlighting the HIV protective role of education. In the HPTN 068 study, the girls who attended fewer than 80% of classes were three times more likely to become infected with HIV than their peers who attended more than 80% of classes. (2)

One such programme is Kenya Cash Transfer for Orphans and Vulnerable Children, a large-scale unconditional government social protection programme that engages ultra poor, labour-constrained households and contributes to reducing the HIV behavioural risk among young people (both male and female) aged 15–25. It is Kenya’s largest social protection programme. A household is considered ultra poor if it is unable to meet the most basic needs, including food and essential non-food items (such as soap and clothing). A household is labour-constrained if the ratio of household members “fit to work” to “not fit to work” is more than 3.

Eligibility for the program is based on poverty and having at least one orphan or vulnerable child. Families are provided a flat monthly allowance of approximately US\$ 23, which is paid directly to the caregiver. There are no punitive conditions attached to the transfer, although caregivers are informed that the money is for the care and support of children.

Approach

The programme is considered to be a form of HIV-sensitive social protection, as its focus is households and children affected by HIV and other vulnerabilities, and it has been shown to have an impact on HIV outcomes. These outcomes include a reduction in sexual debut and improved mental health of young people, which is an important factor when it comes to them adopting and practicing behaviours that protect against HIV.

Reach of the programme

The programme currently reaches 150 380 households that have at least one orphan or vulnerable child below the age of 18. The primary focus of the programme is to address household poverty and vulnerability, and to support households with the care of orphans. This helps to keep them in school and ensure their access to health care and other social services.

Impact of the programme

With funding from the National Institute of Mental Health, researchers from the University of North Carolina at Chapel Hill collected data from study households in 2011. This included a special module on sexual behaviour and mental health administered directly to a maximum of three household residents aged 15–25 (2). The study found that among the young people surveyed, those who were in the programme group were 23% less likely to have experienced sexual debut than peers in households that were not receiving the cash transfer.

In particular, the study found that among those who had sex, young people in households that received cash transfers were 11 percentage points less likely to have had three or more unprotected sex acts in the previous three months. Young women who had their sexual debut were 7 percentage points less likely to have had more than two sexual partners in the previous 12 months. Furthermore, the programme had an important impact on the mental health of young people: young people in families that received the transfer were 15 percentage points less likely to suffer from depressive symptoms and 19 percentage points more likely to score above the median on the Hope scale, an indicator of agency and self-efficacy. Finally, young women in households that received cash transfers were 5 percentage points less likely to have ever been pregnant (compared to young women in households that did not receive cash transfers).

The effects occurred because young people—especially women in households that received cash transfers—were able to attain higher schooling, which in turn boosted their life chances by facilitating a safe and healthy transition into adulthood.

Since the programme is unconditional, implementation is easier than for conditional cash transfers. Implementation and administrative processes are not encumbered with efforts to monitor and enforce compliance with conditions. Furthermore, since it has a similar design and approach to many other national cash transfer programmes used in Africa, the results can be generalized across the continent.

Financing and management

The Kenya Cash Transfer for Orphans and Vulnerable Children programme is managed and implemented by the Department of Children Services of the Ministry of Labour, Social Security and Services. The budget is generated by general tax revenues (32%), development loans (39%) and foreign aid donations (29%). Major partners include the United Nations Children's Fund (UNICEF), the Food and Agriculture Organization of the United Nations,

the United Kingdom of Great Britain and Northern Ireland's Department for International Development, the World Bank, the University of North Carolina and Save the Children.

The Government of Kenya is financing an expansion of the programme that will allow it to reach over 300 000 households. It also is moving towards an integrated National Safety Net Programme that will feature the Kenya Cash Transfer for Orphans and Vulnerable Children as one component. Overall coordination of the program is provided by the Social Protection Secretariat within the Ministry of Labour, Social Security and Services.

Further information

The Kenya Cash Transfer Program for Orphans and Vulnerable Children (CT-OVC). In: The Transfer Project [website]. UNC Carolina Population Centre (<http://www.cpc.unc.edu/projects/transfer/countries/kenya>, accessed 7 October 2015).

HIV-RELEVANT SOCIAL PROTECTION FOR PEOPLE LIVING WITH HIV

India: increasing access to social protection for people affected by HIV

Background

The HIV epidemic in India is concentrated in key populations, particularly female sex workers, people who inject drugs, men who have sex with men, transgender people and migrants. Although the estimated number of people living with HIV is high at 2.1 million (4), advocacy for inclusive policies and programmes for people living with HIV in India has been a challenge due to the low HIV prevalence: adult prevalence rate is greater than 1% only in approximately one-third of the country's 606 districts, and it is concentrated among key populations that are social excluded and do not command high-level political commitment and attention.

The national response to HIV and related issues cannot be seen in isolation, especially in the light of the Government of India's 12th Five-Year Plan, which focuses on inclusion, integration and sustainable growth. This focus makes a strong case for increased public investment for HIV responses in the country and the need to optimize resources through integration and collaboration between government ministries. In this scenario, social protection becomes a key policy tool to help communities become resilient to social economic shocks and income fluctuation.

Approach

A three-pronged strategy was implemented to deliver social protection programmes for people affected by HIV in India. It was based on the HIV-specific and HIV-sensitive modification of existing social protection schemes and programmes. The modifications were:

- Already existing social protection schemes that provide pensions, free medical care, food subsidies, educational scholarships and other benefits to vulnerable people (including widows) were modified to add special services or service provisions relevant to people living with HIV.
- The specific needs of people living with HIV (including access to HIV treatment, food and nutrition support, and livelihood strengthening) were highlighted in existing social protection schemes. The channels were developed for people living with HIV to access these services without stigma and discrimination including removing the need to disclose HIV status.
- People living with HIV were included in existing social protection schemes. Certain existing social protection schemes did not require major modification in order to make them HIV-sensitive; all they required was the inclusion of people living with HIV in the list of intended beneficiaries.

Reach of the programme

Through ongoing advocacy at the national and state level, different categories of schemes have been modified or initiated. These include access to health, HIV treatment, food and nutrition,

social security, livelihood, housing, legal aid and grievance redress. On the directive of the State Council on AIDS, 35 states and central schemes were amended, and as of December 2013, more than 600 000 people living with HIV were benefiting from these schemes.

One example of this is the Indira Gandhi National Widow Pension in the state of Rajasthan, which was modified to include all widowed women aged 18 and older (instead of only widows aged 40 and older). This revision enabled coverage for younger widows, including those living with HIV. Furthermore, while widowed women with a male child older than 25 were not given this benefit in the original scheme, this condition was withdrawn in the case of women widowed by HIV, making them eligible to receive a lifelong pension. In total, there are more than 18 000 widowed women living with HIV in the state who are now receiving widow pensions as if 2013.

Many states have followed this example: by 2013, approximately 24 850 women had benefited in states that featured modified widow pension schemes. Moreover, states have increasingly been covering transportation costs for HIV treatment for people living with HIV: in 2013, more than 213 000 people benefited from this programme (up from 31 000 people in 2010).

Impact of the programme

The modification of existing social protection schemes has enabled them to reach 600 000 individuals, with 52% benefiting from at least one social protection scheme by the end of 2013. The total value of applications logged for benefits was US\$ 15 million. In the case of the Indira Gandhi National Widow Pension Scheme, these changes have mitigated the impact of HIV at the household level by giving pensions to women widowed by HIV, but other changes have provided additional benefits, such as food coupons, housing, scholarships and medical aid, as well as soft loans for enterprises, education and other livelihood options.

In addition, there were many non-financial benefits. For example, 33% of beneficiaries obtained a national identity card for the first time. The national identity cards conferred citizenship and entitlements to social services to a population that was not recognised officially, opening the door for entitlement. The social protection agenda also has been mainstreamed to approximately 45 nongovernmental organizations (NGOs) and community-based organizations working with key populations at higher risk of HIV, and approximately 10 government departments have been made more sensitive to social protection issues related to HIV.

Financing and management

The major partners in efforts to modify existing social protection in India are civil society, the Department of AIDS Control, key government ministries and the United Nations Development Programme (UNDP). Through the Department of AIDS Control, the sustainability and scale-up of the model has been made feasible, and current annual work plans of all state AIDS control agencies include a budget component for social protection.

Lessons learned and recommendations

Identification of HIV as a chronic disease and special provisions within mainstream social protection schemes helped people living with HIV access benefits that were previously meant only for an intended beneficiary group. Similarly, granting them conditional below poverty line status has helped people living with HIV gain inclusion into subsidized food schemes.

Routing benefit schemes through the integrated HIV counselling and testing, as well as the antiretroviral therapy centres, has helped to reach people living with HIV and provide a comfortable environment with less stigma and discrimination. Meanwhile, routing schemes through the legal aid clinic have helped address legal issues and hasten application procedures.

Positive people's networks, NGOs and state AIDS control societies have been the force behind the uptake of social protection schemes by people living with HIV. Other stakeholders—such as state ministries and departments, district administrations and local government institutions—also have played a facilitative role through their commitment and cooperation.

Several factors were noted to be obstacles to the uptake of schemes and their effectiveness. Procedural issues—such as restrictive eligibility criteria, cumbersome application procedures, delays in the receipt of benefits and opportunity costs—have constrained people living with HIV from participating in a scheme or have affected the realization of benefits available to them. Governance issues—like undue delay, leakages in resource flows and a lack of quality in services—have further exacerbated restrictions in accessing social protection schemes. Similarly, HIV-related stigma and discrimination impacted utilization of social protection services, and the lack of sufficient data (specifically gender-disaggregated data) has made analysis of utilization patterns of social protection schemes difficult.

Further information

Innovative approaches—HIV-sensitive social protection in India. Bangkok: UNDP, 2014: (http://www.asia-pacific.undp.org/content/rbap/en/home/library/hiv_aids/innovative-approaches---hiv-sensitive-social-protection-in-india.html, accessed 29 May 2015)

HIV-RELEVANT SOCIAL PROTECTION FOR OLDER ADULTS AND THEIR DEPENDENTS

The United Republic of Tanzania: Kwa Wazee—social protection of older people and their dependents in the context of HIV

Background

Kagera is located in the United Republic of Tanzania, near the borders with Uganda and Rwanda. One of the first areas in sub-Saharan Africa to be severely affected by the AIDS epidemic, it had a particularly high prevalence of HIV and high numbers of AIDS-related deaths. It took many years to realize that one of the consequences of the AIDS epidemic was a livelihood crisis that affected the whole family. It took even longer to realize that older people often were the most vulnerable members of the family. This was not only due to their greatly increased role as main caregivers for orphaned children, but because of the rapid erosion of their traditional support system.

Kwa Wazee, a small private NGO, was set up at the end of 2003. A 2008 survey by Kwa Wazee among 108 randomly selected participants aged 60 and over revealed that they had raised an average of six children, and that an average of three children were still alive. Few children, however, were in a position to support the older generation; in fact, many of the surviving children had migrated to the towns or lived in poverty.

Approach

Kwa Wazee focuses on HIV-related social protection. Starting on a small scale, Kwa Wazee provided support to a limited number of older people and their dependents through social pensions and child support. Kwa Wazee also filled a role as a learning laboratory in the field of ultra poor older people and skipped generation households, an area that had been neglected in the literature to date. Over the years, Kwa Wazee developed complementary programme components for empowerment or protection, and with support from international NGOs and government organizations, it was able to develop and strengthen its networks.

Reach of the programme

The programme started in one ward in the Muleba District (Nshamba) and gradually extended to other wards. The primary focus was skipped generation households and those headed by the most vulnerable older people, and it included special programmes for children. The main criterion for inclusion in the pension programme was not HIV status, but the extent of poverty and vulnerability (defined by age, health condition, condition of house and land, and the number of children in care).

By the end of 2013, 1100 older people had received pensions and child support for a total of 700 children. In all, 950 older people were members of one of 78 mutual support groups, and most of the children also were part of mutual support groups.

Kwa Wazee's main complementary programmes were training health assistants in peer-to-peer care and prevention, self-defence and self-protection training, access to health facilities (such as eye clinics) and advocacy on legal issues.

Impact of the programme

A 2008 study of those supported by the programme showed significant results in poverty reduction, food intake and psychological well-being, as well as a slight improvement in health (5). Older people supported by cash transfers demonstrated strengthened reciprocity with their family, neighbours and community, while children who grew up in supported households had less work to perform and experienced improved conditions for their education.

In 2012, a Marburg University study found evidence that livelihoods stabilized by means of pensions and the formation of mutual support groups were decisive elements in strengthening the human capital of older people (6). A 2014 study by HelpAge International that focused on the feasibility of a pension programme in particularly remote areas strongly confirmed the vulnerability of older people and the crucial impact that pensions could have on older people and their dependents (7).

Financing and management

Kwa Wazee Tanzania is a locally registered NGO that is run by a local management advised by a retired international development expert.

The core activity—the pension programme—is funded by Kwa Wazee Switzerland and HelpAge Germany. Both organizations are committed to providing sustainable financing until the Government of the United Republic of Tanzania delivers on a pledge to introduce a national programme of social pensions.

Complementary activities focused on children in the care of older people of Kwa Wazee Tanzania are funded by various donors, such as the Firelight, Novartis and Symphysis foundations.

Lessons learned and recommendations

Pensions and child support have an immediate and significant impact on supported households. Depending on the baseline, cash transfers reduce extreme poverty, prevent households from falling into extreme poverty or are a decisive element in moving out of poverty.

Evaluations of Kwa Wazee have shown that an effective and socially accepted focus on beneficiaries—such as people living with HIV—is likely to fail in an environment of widespread poverty if it does not take into consideration the broader family and community support system on which the most vulnerable people depend.

To increase the impact of the approach, it is crucial that Kwa Wazee cooperate with larger networks, particularly with organizations like HelpAge Tanzania, which have connections to relevant ministries and working groups in a national context.

Further information

Kwa Wazee [website]. Bern: Kwa Wazee Switzerland (<http://www.kwawazee.ch/index.php/en-uk/start>, accessed 7 October 2015).

HIV-RELEVANT SOCIAL PROTECTION FOR MIGRANTS

Thailand: health insurance policy and practice for non-Thai residents

Background

There are an estimated 3 million labour migrants and their dependents in Thailand; of these, approximately 1.8 million are undocumented. In September 2013, the Government of Thailand launched the Compulsory Migrant Health Insurance scheme, which expanded its Universal Health Coverage scheme to cover non-Thais residing and working in Thailand. The new policy was designed to ensure access to health care for migrants, whether they are documented or not. It did this by introducing an insurance card that any migrant could buy at a public health facility; having purchased the card, which is valid for a year, a migrant gains access to a range of health-care services, including maternal health and HIV treatment.

Approach

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

The policy is being promoted and implemented nationally through the collaborative efforts of government bodies (such as the Department of Health Service Support and the Bureau of Health Administration at the Office of the Permanent Secretary under the Ministry of Public Health), NGOs (such as the Raks Thai Foundation and the Foundation for AIDS Rights, as well as those implementing grants from the Global Fund to Fight AIDS, Tuberculosis and Malaria), and United Nations agencies (such as the International Organization for Migration).

Reach of the programme

The primary focus of the initiative is to ensure that documented and non-documented migrants—including pregnant women living with HIV—have access to primary health-care services. This includes HIV counselling and testing and antiretroviral therapy.

Impact of the programme

The introduction of Compulsory Migrant Health Insurance scheme has been an important step in reducing disparities in access to health care and ensuring equitable access to health services—including HIV-related services—for non-Thai populations residing and working in Thailand.

In the first three months, approximately 63 500 migrants purchased the insurance cards and obtained access to quality health-care services. By May 2014, an estimated 140 000 migrants had enrolled in the insurance scheme under the new policy.

Financing and management

The Ministry of Public Health manages and coordinates the implementation of the Compulsory Migrant Health Insurance policy. The initiative was designed to be eventually self-sustaining, financed by payments for the insurance cards.

The current price of an insurance card, which is valid for 365 days, is 365 Thai baht (US\$ 10.90) for children under the age of 7. For adults and children over the age of 7, it is 2800 baht (US\$ 83.60).

The scheme is expected to become self-sustaining when the number of adult clients enrolled exceeds 200 000 per year.

Lessons learned and recommendations

Strong commitment at the highest political levels was a major factor in the success of the initiative. The Prime Minister demonstrated personal commitment and leadership, and all of the concerned ministries were appropriately engaged in the development of the new policy.

Partnerships have been instrumental in translating the commitment into practice. Civil society and communities advocated for the extension of universal health coverage to cover migrant populations, and they worked with the government to develop and implement the policy. International organizations supported the effort. Collaborative multisectoral efforts continue in the national roll-out of the policy, utilization of local opportunities and analysis and removal of bottlenecks.

As mobile populations, migrants present a challenge to ensuring the continuous uptake of services, especially treatment. Collaboration between public health and community-based organizations will be instrumental in stimulating demand and support for adherence.

Enhanced bilateral and multilateral collaboration among the concerned countries of the region will be required to ensure a continuum of prevention and treatment for migrant populations across borders. Significant steps have been made in enhancing cooperation in the area between Thailand and Myanmar, while action is being taken to strengthen collaboration between Thailand and both the Lao People's Democratic Republic and Cambodia.

HIV-RELEVANT SOCIAL PROTECTION FOR TRANSGENDER PEOPLE

Uruguay: affirmative action for transgender people through the Uruguay Social Card

Background

The Tarjeta Uruguay Social—the TUS—is the first social protection action that focuses on transgender people in Uruguay, a population group known to be at higher risk of acquiring HIV. An affirmative action scheme within the government’s social protection programme, the TUS addresses extreme poverty, inequality and exclusion. Prior to this, the social protection scheme was restricted to pregnant women and families with children under the age of 18 who were living in extreme poverty; because most transgender people (99% of whom are transgender women) were treated as men without children, they were not covered by the earlier programme.

Approach

The programme is not a specific social protection programme for people living with HIV; rather, it is an affirmative and transformational social protection programme that addresses the inequality and exclusion of some of the most vulnerable people in Uruguay, including women and transgender people. The programme consists of a monthly cash transfer of US\$ 30 to buy essential commodities such as food, soap and washing powder at shops that are participating in the programme.

Reach of the programme

All transgender people across the country are eligible for the TUS, and the programme has reached 1088 transgender people (of an estimated population of 1200–1500).

Impact of the programme

Since its inception in September 2012, the TUS has not yet been formally assessed, but there are some results that can be highlighted.

The scheme gives symbolic recognition to a group of people who thus far have been subject to social exclusion, stigma and discrimination. For transgender people, interaction with the state had previously been limited to the health system or the police, but this scheme now provides them with access to state support within the context of a wider social protection programme.

Data collected through the scheme can be useful for other programmes, such as change of name and sex in government registries, and for increasing access to training and employment programmes for transgender people. The scheme also generates much-needed information about HIV prevalence among the transgender population that can help guide the effective allocation of resources and planning for HIV programmes that will reach this group.

Finally, the scheme has provided more than 1200 people transgender people with training on sexual diversity and non-discrimination. This training provide transgender people with knowledge of their rights.

Financing and management

The Ministry of Social Development administers the programme through 35 offices that cover the whole country. Financing is assured under the US\$ 50 million national public budget for the Social Uruguay Card, of which US\$ 397 000 is earmarked for the TUS Trans Card annually.

Lessons learned and recommendations

Within lesbian, gay, bisexual and transgender organizations in Uruguay, the consensus is that transgender people are the most socially excluded group in family, education, workplace and health-care settings. This is due in part to their participation in sex work as a means of economic survival.

The *2010 Direction of Social Policies* took a human rights paradigm as a guideline, and from that perspective, transgender people are one of the most vulnerable social groups. The TUS Card, which was prepared with the help of transgender organizations, is one of the actions resulting from the Ministry of Social Development's Social Policies and Sexual Diversity Agenda.

Organizations advocating for the rights and interests of sexual minorities have emerged from the transgender community, and the country has embarked on a national campaign to combat stigma. The Parade for Diversity, which includes several organizations of transgender people, has become one of the most popular parades in the country and an important platform for celebrating sexual minority rights (including laws permitting the change of name and sex and equal marriage rights).

SOCIAL TRANSFORMATION FOR SEX WORKERS

Kenya: window of hope for sex workers

Background

Sexual transmission of HIV is the primary driver of Kenya's HIV epidemic. Kenya's estimated 138 000 female sex workers shoulder an extremely high burden of HIV, with 45.1% living with the virus (8) (the number of male sex workers and their HIV burden is unknown, but it also is assumed to be significant). Furthermore, sex workers in Kenya face human rights violations, including physical and sexual violence, emotional abuse, rape and extortion. Despite this, most projects engaging sex workers focus exclusively on HIV prevention and treatment, even though the well-documented link between violence and HIV demands a human rights-based approach to protect sex workers from both HIV and violence.

Sex workers have developed particular stereotyped ideas about the different parties involved in commercial sex, including their clients, the police and bar owners. As a result, they often internalize the stigma associated with sex work; the result is negative feelings about their work and anxiety, which can lead to depression, poor self-esteem and a lack of confidence. The relationship between sex workers and law enforcement authorities also is problematic, and it is generally characterized by harassment, violence, abuse, repression and fear.

Formed in 1998 by and for sex workers and women working in bars, the Bar Hostess Empowerment and Support Programme is an organization advocating for appropriate policies, human rights and recognition for bar hostesses and sex workers in Kenya. The organization's leadership comprises both sex workers and people from outside the sex industry.

Approach

The Bar Hostess Empowerment and Support Programme built constituencies of sex workers to understand their rights as citizens and support one another in raising awareness about HIV, safe sex, human rights, abuses facing sex workers, and responses to violence. The Programme has been facilitating access to legal aid and psychosocial support by training sex workers as paralegals who reach out to their peers, promote rights awareness and report instances of rights violations. It also has been building a revolving fund that is used to post bail for sex workers who have been arbitrarily arrested by police or county officers.

The Programme partners with human rights organizations in Kenya to offer sex workers legal aid support, and it has been building strategic partnerships with the police force, prosecutors service and county government leadership, with the aim of developing a meaningful relationship between sex workers and the authorities. The Programme has sensitized the police, prosecutors and county leadership about the trial process for sex workers by advocating for non-custodial sentencing or simple fines for sex workers prosecuted for engaging in sex work.

The Programme also runs drop-in and wellness centres. These are safe spaces where sex workers and men who have sex with men can easily access medical services, including HIV

testing and counselling, pap smears and other cancer screening, lubricant and condom demonstration and distribution, and sexual and reproductive health services.

Reach of the programme

To date, the Bar Hostess Empowerment and Support Programme has helped form and strengthen 30 sex workers' networks, train more than 500 paralegals and 600 peer educators, provide more than 1000 sex workers with medical support, run 15 free legal aid clinics, post bail for 400 sex workers and take 70 cases to court (of which it has won 10).

Impact of the programme

Thanks to increased knowledge of their rights and improved legal support (when necessary), most sex workers have become assertive and able to demand their rights. The drop-in and wellness centres are well-established, and they have boosted access to health and HIV services for sex workers and men who have sex with men. The Programme provides a good model for replication in other settings.

Lessons learned and recommendations

Integration of services engaging sex workers and bar hostesses is critically important. It also is feasible and acceptable to the intended population, who are able to receive different services in one location, thereby reducing the transactional costs of accessing services in different locations and the risk of not accessing services.

Empowering and creating safe spaces for sex workers and other vulnerable and stigmatized populations is critical to increasing access to services.

Successful programmes by one group of bar hostesses and sex workers can be shared with others and effectively adapted to meet different local contexts. This will provide impetus for mobilization and action of sex workers on particular issues.

Working with peer educators drawn from the sex worker community has helped the project gain access to the intended population.

Developing the capacity of beneficiaries to participate in programme implementation encourages ownership and helps scale-up.

Discussing leadership and personal security issues strengthens facilitation teams and helps them bond with local stakeholders.

Further information

Bar Hostess Empowerment and Support Programme [website]. BHESP; 2015 (<http://www.bhosp.org/>, accessed 7 October 2015).

HIV-SPECIFIC SOCIAL PROTECTION FOR ORPHANS AND OTHER VULNERABLE CHILDREN

Honduras: a strengthened AIDS response with an emphasis on orphans and other vulnerable children

Background

In 2004, the Honduran government decided to include activities focusing on orphans and other vulnerable children as part of the fifth pillar of its Poverty Reduction Strategy. A committee—led by the Ministry of the Presidency, with intersectoral participation by the government, civil society and international organizations (namely the Pan American Health Organization and UNICEF)—was formed for the protection and care of orphans and other vulnerable children. This organization and its efforts led to the country receiving specific funding for activities for orphans and other vulnerable children in Round 9 of the Global Fund to Fight AIDS, TB and Malaria (the Global Fund) grants. It ran from 1 May 2011 to 31 December 2013, and its purpose was to improve the quality of life and reduce the impact of HIV on orphans and children made vulnerable due to HIV.

Approach

The main objective of the project was to improve the quality of life of orphans and other vulnerable children throughout seven pillars: health, education, nutrition, housing improvement, legal support, psychosocial support and income generation. The programme was based on a human approach, which focused on the best interests of children and recognized their rights to survival, well-being, support and respect. It also addressed the social and economic needs of their families and communities. Implementation of the program involved a cross-sectoral approach that sought comprehensive care for this vulnerable population.

Reach of the programme

The scope of the project was based on several factors: the geographic areas that accounted for 85% of the HIV burden in the country, the size of the population of reproductive age living with HIV and the fertility rate. This enabled a rough estimation of the total number of children of orphans and other vulnerable children.

During implementation of the project, children and their families received benefits under each pillar, and eventually some pillars proved to be more sustainable than others. For example, the health pillar increased the number of children living with HIV who were receiving comprehensive care. The project also succeeded in increasing the school and health programme enrolment of children living with or affected by HIV.

Impact of the programme

The project reached 12 600 children nationwide; it also supported families within black communities, which are considered to be a population at higher risk of HIV. The project

improved the quality of life of children, ensuring they had access to health care and comprehensive services. These services included keeping children in the education system and improving nutritional status through the delivery of a monthly food basket for families. A total of 4136 orphans and other vulnerable children under the age of six—or youth up to the age of 18 who were living with HIV—received a monthly ration rich in protein and carbohydrates. The children remained in the program for a year.

In addition, 428 families with orphans and other vulnerable children received technical and financial assistance, including seed capital to strengthen household income generation. This surpassed the planned goal of 400 families.

Financing and management

The project was financed by the Global Fund, and it was executed and managed by one of the Global Fund's principal recipients: CHF International (an NGO). Implementation occurred through numerous sub-recipients, such as the National HIV Program of the Ministry of Health, the Commissioner of Human Rights, and eight national and international NGOs that had experience working with orphans and other vulnerable children.

The private sector collaborated by establishing an agreement with Walmart to deliver food baskets through their stores in implementation areas. This facilitated access for beneficiary families and fostered greater acceptance of people living with HIV.

Lessons learned and recommendations

The government has created the Ministry of Social Development and the Ministry of Justice and Human Rights, and related institutions manage and co-ordinate social protection services in collaboration with the health, education and labour ministries.

Despite the fact that stigma and discrimination have decreased over time, they are still very negative factors affecting the national AIDS response in Honduras. Families were ambivalent about participating in the programme because they feared discrimination against their children.

HIV-SPECIFIC SOCIAL PROTECTION FOR PEOPLE LIVING WITH HIV

Canada: The Committee for Accessible AIDS Treatment

Background

The Committee for Accessible AIDS Treatment is a coalition of more than 30 Ontario-based organizations from the legal, health, settlement and HIV sectors. It was formed in 1999 to improve HIV treatment and service access for marginalized people living with HIV. Since its inception, the Committee has been at the forefront of education, research, service coordination and advocacy on issues related to HIV, immigration and access.

Approach

The Committee's programmes provide the poor with an income (through capacity building, honoraria and employment opportunities) and consumption transfers (such as ensuring access to medical, legal and housing services). This helps to enhance the social status and rights of marginalized and vulnerable groups, and to protect them against livelihood risks.

Reach of the programme

The geographic reach is the province of Ontario, with most of the programmes based in Toronto.

Impact of the programme

As part of the Newcomer Sexual Health Promotion project, four training sessions per year on HIV and immigration service access are held for both people living with HIV who have immigrated to Canada and service providers. This training helps to bolster their understanding of how to navigate the Canadian immigration system. Of the people living with HIV who have attended these sessions, 95% were able to successfully complete their immigration process.

Almost 200 peer counsellors have been trained as part of an ethno-racial treatment support network. Most of them have moved to paid positions within both HIV and non-HIV organizations and businesses.

As part of its Legacy Project, the Committee has paired more than 100 mentors, who often themselves are living with HIV, with people living with HIV to help mentees achieve their life goals and to promote reciprocal learning.

Lastly, the Committee has trained more than 40 peer research associates in different roles through its various research projects under the Community Champions HIV/AIDS Advocates Mobilization Project (CHAMP). Many of the peer research associates have returned to education to pursue further academic studies or have taken other research positions.

Financing and management

The Committee for Accessible AIDS Treatment receives funding from the federal, provincial and municipal arms of government. Its core program is funded by the AIDS Bureau of the Ontario Ministry of Health and Long-Term Care, while the mentorship programme is funded by the Public Health Agency of Canada. The Newcomer Sexual Health Promotion project is funded by the City of Toronto, and the CHAMP research study is funded by the Canadian Institutes of Health Research.

Lessons learned and recommendations

The Committee demonstrates the crucial role of accountability and ethno-racial community ownership. By being inclusive and responsive to the needs of its diverse communities—and by honouring the lived experience of immigrant, refugee and non-status people living with HIV—the Committee has built trust and credibility in the communities.

The Committee is innovative and resourceful, and it uses action research to generate knowledge and develop evidence-informed programmes by translating that knowledge into action. Its approach of community-based research is a good example of the greater and more meaningful involvement of people living with HIV in the design and implementation of activities.

Challenges faced include a hostile political climate with punitive federal and provincial immigration policies, the criminalization of non-disclosure and the impact of HIV-related stigma among newcomers. Furthermore, a negative funding environment for ethno-racial organizations may lead to volunteer and staff burnout and attrition.

Further information

The Committee for Accessible AIDS Treatment [website]. Toronto: The Committee for Accessible AIDS Treatment; 2010 (www.hivimmigration.ca, accessed 7 October 2015).

HIV-SPECIFIC SOCIAL PROTECTION FOR HOMELESS PEOPLE LIVING WITH HIV

The United States: low-threshold harm reduction housing for people who use drugs and are living with HIV

Background

Rates of homelessness and housing instability are high among people living with HIV in the United States: according to government statistics, 16% of all people living with HIV—a total of 145 000 households—have an unmet housing need. They often are effectively or literally excluded from HIV services. People living with HIV who are members of marginalized groups and who have concurrent issues (such as past or current substance use) are most severely affected by both housing loss and HIV disparities. A systematic review found that the estimated 100 million people worldwide who are homeless experience dramatically higher rates of TB, hepatitis C and HIV than the general population (9-12).

Housing support has been part of the AIDS response in the United States since the mid-1980s. Housing programmes for people living with HIV in New York City are operated by NGOs and funded through a combination of local, state and federal government grants and government-funded, tenant-based rental assistance programmes.

Housing Works was established in 1990 with a mission to end homelessness and HIV. Since then, its housing programmes have focused on underserved persons and have employed a low-threshold, harm reduction services approach in which neither programme admission nor retention is based on abstinence or a commitment to end drug use.

Approach

Housing subsidies and related support services focus on extremely poor individuals, the majority of whom are single adults, homeless or unstably housed. Referrals come from medical providers, government agencies responsible for administering subsistence benefits, or NGO social service providers. Supportive housing programmes provide medical and social support on-site at a housing programme, and through referrals to medical and behavioural health-care services.

Low-threshold housing programmes like Housing Works involve the residents in their harm reduction programmes, with a focus on behaviour rather than their status as a person who uses drugs. Housing is viewed as a health programme, with government and private funders of housing services increasingly requiring NGOs to track HIV medical outcomes among residents and be accountable for health disparities.

Reach of the programme

Housing Works provides direct housing assistance for homeless and unstably housed people living with HIV in New York City. Housing acts as a critical enabler of HIV treatment, an HIV

prevention programme to reduce the risk of ongoing HIV transmission and a harm reduction programme for people using drugs. Housing also provides the required stability for program participants to work towards employment and other life goals.

Community residences provide permanent housing for adults living with HIV at 72 studio apartments at two sites that are co-located with medical and supportive services. A Transgender Transitional Housing Program also provides 36 units of scatter-site apartments for transgender and gender non-conforming people living with HIV.

Impact of the programme

Programme evaluations show increased stability of people participating in the program, improved HIV health outcomes, strengthened harm reduction programmes and longer periods of abstinence among people using drugs. Low-threshold housing alters the HIV risk environment and improves the ability of people living with HIV to adhere to medication.

A review of programme data for 66 current and 152 former residents of the two community residence programmes over a six-year period shows that residents achieved high levels of stability, despite the fact that 95% continued to be substance users, 82% had a history of incarceration, 80% had mental health issues and 90% were long-term homeless.

Residents were almost three times more likely to have an undetectable viral load at their most recent check-up (when compared to their viral load at the time of intake), and they were 50% more likely to have a CD4 cell count above 200 cells/mm³ than they were at intake.

Financing and management

The community residences facilities are owned by Housing Works, with capital costs financed through government grant funding, government-backed bond financing and private donations. Operating costs for the community residences and Transgender Transitional Housing Program are funded through a combination of tenant-based rental assistance (provided by local government for extremely poor people living with HIV) and grant funding for linked supportive services. Housing Works coordinates and manages funding sources and the delivery of services, and it also reports outcomes to funders, with regular oversight from government and private funders.

Government funding comes from local, state and federal agencies charged with broader social protection responsibilities to meet housing and other subsistence needs for extremely poor people. These agencies direct housing support to people living with HIV, recognizing that mainstream social protection programmes do not adequately meet their needs, and that housing is a critical enabler of HIV prevention and treatment.

Lessons learned and recommendations

Substantial empirical evidence of the impact of housing status on HIV health outcomes has been critical to successful advocacy for the creation and maintenance of HIV-specific housing support.

The public cost of providing housing support for people living with HIV is more than offset by the savings realized through reductions in public spending for health costs associated with advanced HIV disease and through costs saved by averting downstream HIV infections.

Cost analyses are being used to advocate for scaling up housing support interventions that support and engage (rather than exclude) people who are using drugs and who are at high risk of poor health outcomes.

Enabling people living with HIV to maintain health and reduce the harm associated with drug use also helps them maintain employment or return to work, reunite with children and other family members, and achieve greater independence and well-being.

While most research on the relationship of housing status and HIV health outcomes has been conducted in North America, the available literature indicates consistent findings on the impact of housing insecurity in middle- and low-income countries.

Further information

Housing Works [website]. Brooklyn: Housing Works; 2011 (<http://www.housingworks.org/>, accessed 7 October 2015).

HIV-SPECIFIC SOCIAL PROTECTION FOR PEOPLE LIVING WITH HIV

Eastern European and central Asian countries: client management programme and transitional client management

Background

In countries of the former Soviet Union, people living with HIV and key populations at higher risk of HIV—including people who use drugs, prisoners, sex workers and their clients, men who have sex with men, transgender people and, in some cases, street children and migrants—often have multiple and simultaneous health care needs that require services from several providers. Access to health services for these populations is very limited, primarily due to high levels of stigma and discrimination: they face discrimination both from general society and from the professionals with whom they most often come into contact (e.g. doctors, law enforcement officers and prison staff).

In 2005, the AIDS Foundation East–West (AFEW) introduced a unique client management programme to improve access to health-care services for key populations. Since 2009, the foundation has undertaken transitional client management for prison inmates to develop a systematic mechanism for the social support of prisoners before and after their release, and for their subsequent rehabilitation.

Approach

HIV client management is a collaborative process between individuals, client managers and local service providers that is aimed at improving access to appropriate and timely health and psychosocial care. Client managers help individuals assess their specific needs and develop strategies to best address them (e.g. identifying where and how different psychosocial and economic needs can be met). A social worker or client manager often accompanies the client to hospitals for examination and medical care, and to government institutions to obtain identification documents, disability allowances and vouchers for various social needs. This is important because most medical and social services are provided to clients free of charge, but only with recognized national identity cards (which some clients may lack). Social workers and client managers usually come from the community of key populations; they are regularly trained on human rights issues, ethics and new approaches to working with the key populations.

Reach of the programme

Since 2005, AFEW's client management programme has been running in various countries in eastern Europe and central Asia, including Belarus, Georgia, Kazakhstan, Kyrgyzstan, the Russian Federation, Tajikistan, Ukraine and Uzbekistan. In some countries, the programme has stopped (or has been significantly reduced in scope and reach) due to a number of reasons, most notably a lack of funds. Despite this, at least 100 000 people have been reached with different social services through the foundation's client management programme.

Impact of the programme

Due to the programme, a greater number of people have access to free prevention, treatment, care and support services. Key populations also have correct information on HIV prevention and harm reduction programmes, as well as access to training and personal development opportunities.

Financing and management

The client management programme is financed by AFEW, but the plan is that—after a certain period of time—NGOs involved in the programme will become self-sustaining through the provision of fee-based services or the production of goods. For example, some NGOs in Tajikistan produce dumplings, operate stone processing shops and provide carpet cleaning. In Kyrgyzstan, NGOs produce and sell paving stones.

Lessons learned and recommendations

The client management programme has proved its effectiveness in increasing access to prevention, treatment, care and support for key populations.

The programme needs to be expanded to enrol more people, among both key populations and service providers, and it must become part of national health-care strategies.

Further information

Client management in Kazakhstan [video with English subtitles]. Posted 27 November 2009. AFEW; 2009 (<https://www.youtube.com/watch?v=dNutnv7Cidg>, accessed 7 October 2015).

References

1. Fast-Track: ending the AIDS epidemic by 2030. Geneva: UNAIDS; 2014.
2. Pettifor A. Cash incentive HIV prevention programmes. Presented at International AIDS Society in Vancouver, 2015 (available from http://pag.ias2015.org/PAGMaterial/Webcast/39_11093/webcast.mp4, accessed 7 October 2015).
3. The transfer project [website]. University of North Carolina Population Centre; 2015 (<http://www.cpc.unc.edu/projects/transfer>, accessed 7 October 2015).
4. HIV and AIDS estimates, 2013 [website]. Geneva: UNAIDS (<http://www.unaids.org/en/regionscountries/countries/india>, accessed 7 October 2015).
5. The impact of pensions on the lives of older people and grandchildren in the Kwa Wazee project in Tanzania's Kagera region. HelpAge International, Regional Psychosocial Support Initiative (REPSSI), Swiss Agency for Development and Cooperation (SDC), World Vision International; 2008.
6. Borchard J et al. Evaluation of social cash transfer plus programme implemented by Kwa Wazee. University of Marberg; 2012.
7. Towards universal pensions in Tanzania: evidence on opportunities and challenges from a remote area, Ngenge ward, Kagera. HelpAge International, HelpAge Deutschland and Kwa Wazee Switzerland; 2014 (<http://www.helpage.org/silo/files/towards-universal-pensions-in-tanzania-evidence-on-opportunities-and-challenges-from-a-remote-area-ngenge-ward-kagera.pdf>, accessed 7 October 2015).
8. Odek W, Githuka G, Avery L, Njoroge P, Kasonde L et al. Estimating the size of the female sex worker population in Kenya to inform HIV prevention programming. PLoS ONE. 2014;9(3):e89180. doi:10.1371/journal.pone.0089180
9. V.Shubert, et al. Employing use-tolerant, harm reduction housing to establish stability and connection to care among chronically homeless active drug users living with HIV/AIDS. : AIDS 2006 - XVI International AIDS Conference: Abstract no. CDD0612.
10. Shubert Virginia et al. Housing as a structural intervention for transgender people living with HIV. 20th International AIDS Conference, Melbourne Australia June 20-25, 2014. WEAD0301 - Oral Abstract Session.
11. Housing is HIV prevention and care: key facts and recommendations. Washington, D.C.: National AIDS Housing Coalition; 2012.
12. King Charles, et al. Housing status as a key social driver of HIV health outcomes: findings from a global survey of non-governmental organizations. 3rd Structural Driver's Conference, Cape Town, South Africa, 5-6 December 2013.



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