

Social Protection in the Context of HIV and AIDS*

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- “AIDS-sensitive” rather than “AIDS-specific” social protection instruments, including cash transfers, protect vulnerable households from the impoverishing effects of HIV and AIDS, while potentially encouraging pro-poor growth.
- Transformative social protection supports the promise to realise the rights of women and girls. Social protection instruments that incorporate a transformative agenda may empower women to access their rights and entitlements in terms of inheritance, education and labour market access, both protecting and mitigating against HIV and AIDS.

Why are HIV and AIDS important in the context of pro-poor growth?

HIV and AIDS are a serious constraint to growth in sub-Saharan Africa¹ and are destroying hard won development gains (AFRODAD, 2007). 33.2 million people are living with HIV and AIDS globally, two-thirds of whom are in sub-Saharan Africa. Over half the adults living with HIV in sub-Saharan Africa are female and in recent years the number of women and girls testing positive for HIV has increased in all regions of the world (UNAIDS, 2007).

HIV and AIDS impacts on adults at the peak of their productivity and earning capacity, with 60% of all deaths recorded in sub-Saharan Africa between the 20 to 49 year old age brackets. Although most diseases undermine economic development and usually affect the poor disproportionately, HIV and AIDS is uniquely damaging because it is primarily concentrated among adults in their most economically productive years.

Each bout of illness presents a range of negative economic consequences for households and loss of productivity for the sectors in which the sick and their caregivers are involved. Loss of labour and consequently income when a breadwinner falls ill coupled with rising medical costs and ultimately funeral expenses may plunge a household into chronic poverty. Furthermore, the poorest households are most likely to resort to non-reversible coping strategies including the sale of land or livestock or withdrawal of children from school. During a three year survey conducted in Kenya it

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was found that neither crop production nor incomes returned to pre-death levels within households affected by AIDS (USAID, 2005). Women, children and elderly caregivers are frequently the least empowered and hardest hit by HIV and AIDS as they endeavour to balance both care giving and income earning roles with fewer physical assets (UNAIDS, 2006).

HIV and AIDS results in reduced investment in human capital and as worker productivity falls, less skilled workers replace them. The International Labour Organisation (ILO) estimates that by 2020, the labour force in high prevalence countries will be reduced by between 10% and 22% contributing to significant losses in knowledge, skills, domestic, agricultural and community customs and practices (ILO, 2000). The agricultural workforce in twelve high prevalence countries was between 3% and 10% smaller than it would have been without the AIDS epidemic, thus contributing to food shortages and exacerbating poverty levels (UNAIDS, 2006).

Health and education levels have been negatively affected in countries with high HIV prevalence rates and it has been suggested that this trend will be even more pronounced in the next generation, a significant proportion of whom will have reduced basic education, life skills, health and social mentoring (ING Barings, 1999). Children orphaned and vulnerable in communities affected by AIDS are at increased risk of missing out on education thus the next generation's capacity to climb out of poverty is significantly reduced.

HIV and AIDS erodes the primary production and consumption band of the population, while private and public sector impacts include reduced productivity due to staff illness and death, increased cost structures, reduced market size, market investment and savings patterns. Public sector commitment to economic growth is reduced as a result of diminished revenue and diversion of revenue to respond to AIDS. Furthermore, additional spending on AIDS may increase borrowing thus discouraging potential private investment (ING Barings, 1999). Savings are diverted to pay for cost of illness which lowers GDP, while the net impact on GDP in sub-Saharan Africa is estimated to be in the region of 1% (UNAIDS, 2006).

Social protection mechanisms have a significant AIDS mitigation impact. Recent research has demonstrated that, in particular, cash transfer programmes piloted in countries with high HIV prevalence have a significant impact on poverty reduction in households affected by HIV and AIDS (UNICEF, ESARO, 2007), while supporting livelihoods, enabling access to education and improving nutrition (Agüero *et al.*, 2007). Hence, it may be argued that cash transfers, when used for productive investment purposes, *e.g.* to purchase education, health care, fertiliser etc. may facilitate a multiplier effect on local economies thus contributing to pro-poor growth (Farrington *et al.*, 2005).

What major risks are tackled by which instruments?

Social health protection that incorporates prevention of mother-to-child transmission (PMTCT) and universal access to Antiretroviral Therapy (ART) is critical if the impoverishing effects of HIV and AIDS are to be reduced. Despite increased access to prevention, treatment and care services, a significant proportion of AIDS-affected communities remain excluded from these services due to infrastructural barriers to delivery, prohibitive transport, virology testing, treatment and other costs. Breaking the intergenerational cycle of HIV transmission from mother-to-child, while prioritising access to free Antiretroviral Therapy (ART) are vital for pro-poor growth and

poverty reduction in countries with high HIV prevalence. The vast majority of people respond well to treatment and consequently skilled workers may be retained, productivity and revenue maintained, livelihoods supported, while the most vulnerable households are spared the necessity of resorting to non-reversible coping strategies. Furthermore, the relationship between maternal and child health is well established; keeping Mothers alive and healthy is crucial for child survival and wellbeing (Save the Children, 2007).

Child benefit, cash transfers or school assistance packages can increase school attendance and education is the single most effective HIV prevention asset. Realisation of quality education for all is central for poverty reduction and sustainable pro-poor growth. The abolition of school fees in many countries has contributed to an increased up-take in education. However, the cost of uniforms, books or shoes is prohibitive for those children orphaned or particularly vulnerable in the context of AIDS. Girls are oftentimes the first to be removed from school when a parent or caregiver falls ill and as such are the most vulnerable in the context of HIV and AIDS. Cash transfer schemes in low income, high HIV prevalence countries are reaching approximately 80% of HIV and AIDS affected households experiencing chronic poverty and labour constraints (UNICEF, ESARO, 2007). As 60% of the members of these households are children, cash transfers at household level reduce risk by enabling access to education.

Cash transfers may prevent households affected by AIDS from adopting non-reversible coping strategies. Emerging evidence is demonstrating that cash transfers are an effective risk management mechanism, which enables the poorest households to better manage the economic consequences of AIDS-related illness or death (UNICEF, ESARO, 2007). Cash transfers may prevent diversion away from household savings to pay for medical or funeral expenses. They may further prevent the sale of livestock or the removal of children from school to care for sick adults or to engage in income earning activities (Farrington *et al.*, 2005). Cash transfers that are conditional on the retention of women and girls in education or those that are transferred to women only may contribute to the empowerment of women and the transformation of unequal relationships.

Labour market interventions mitigate against skills and experience diminished through illness and prolonged labour market absence. HIV is a slow but progressive disease and each bout of illness may present a range of negative economic consequences. Vocational training initiatives coupled with the provision of job creation and back-to-work programmes are critical in the context of HIV and AIDS and pro-poor growth.

The private sector is an important stakeholder and partner in addressing HIV and AIDS. Private sector organisations are in a unique position with a captive audience to promote HIV/AIDS prevention and sexual health promotion among employees, while supporting health insurance and the delivery of treatment programmes to employees and their families. Private sector enterprise has been hard hit by HIV and AIDS particularly in high prevalence regions. Increased costs and decreased revenues as a result of higher absenteeism and staff turnover, reduced productivity, declining morale and a shrinking consumer base have all taken their toll. Public/private partnerships have been effective in South Asia where large company's like Tata Tea Ltd and Tata Steel Ltd. employing 43,000 people have initiated voluntary counselling and testing accompanied by HIV awareness activities and treatment programmes for employees and dependants².

Gender inequality fuels the spread of HIV and AIDS but empowering and increasing resources in women’s hands enhances child survival and nutritional status, while improving school attendance (UNICEF, 2007). Gender inequality in education and employment has a negative impact on economic growth and in sub-Saharan Africa where women and girls make up 60% of adults living with HIV and AIDS they are often engaged in non-market production. Legal and institutional frameworks that protect inheritance, land access and other rights denied to women and vulnerable groups are lacking in some countries with a high HIV and AIDS prevalence rate. Women, children and elderly caregivers are frequently the hardest hit by HIV and AIDS as they endeavour to balance both care giving and income earning roles with fewer physical assets. Female headed households tend to have a higher dependency ratio and are consequently at higher risk of poverty. Help Age International estimates that half of older people, mainly women, in high prevalence areas are raising grand children orphaned by AIDS and tend to have fewer economic resources (HelpAge International). When women are healthy, educated and free to avail of life’s opportunities, children also thrive. In households where women are key decision-makers, the proportion of resources devoted to children is far greater than in those in which women have a less decisive role. (HelpAge International). Consequently, who controls cash transfers at household level is crucial in terms of AIDS and poverty mitigation, child survival and empowerment of both women and children.

Transformative social protection supports the potential to realise the rights of women in the context of HIV and AIDS. For every ten adult men living with HIV in sub-Saharan Africa, there are fourteen adult women (UNAIDS, 2006)³ infected. Physiological susceptibility and gender inequality in some societies renders women more vulnerable to HIV infection. Social protection mechanisms that incorporate a transformative agenda have the capacity to empower women to access their rights and entitlements in terms of inheritance, education and labour market access (Sabates-Wheeler and Devereaux, 2007). In this regard “transformative” social protection refers to policies that tackle power imbalances in society that may directly or indirectly encourage, create and sustain vulnerabilities (Devereaux and Sabates-Wheeler, 2004) for example changes to the regulatory framework that afford succession rights including land retention to women and are supported by awareness campaigns to help change societal attitudes. Women’s empowerment in the context of safer sexual negotiation, sexual and reproductive health naturally extends from the realisation of broader socio-economic, legislative and cultural equality of access and both “men and women need to be allies and partners in reform.”⁴

What controversies exist?

Budget substitution may emerge as health and education expenditures decline in favour of increased welfare transfer expenditures (Pauw and Mncube, 2007). This is problematic in the context of already weak health and education systems that are essential for HIV prevention, treatment, care and support. There is a risk, particularly in HIV and AIDS discourse, that the cash transfer element of social protection may dominate to the detriment of an equal focus on essential social services development.

Systems that target narrowly perform badly in terms of redistribution or poverty reduction (Sabartes-Wheeler and Devereux, 2007). “AIDS orphan” targeting or social protection mechanisms that seek to isolate and target households affected by AIDS, risk stigmatising individuals, while proving administratively costly. It has been

demonstrated, however, that general poverty targeting, using a number of variables, which take the impact of AIDS into account (*e.g.* high dependency ratios, prime-age disability) can reach the most vulnerable including those affected by AIDS.

Positive rates of economic growth do not necessarily reduce vulnerability. Poverty is correlated with higher rates of infection and the poorest are most vulnerable to the impacts of the disease. Cross country analysis shows that those with the highest rates of income inequality also have the highest rates of infection. (Gillespie and Greener, 2006). If economic growth is to help reduce HIV and AIDS prevalence, it must reduce inequality. In some countries with the highest HIV prevalence, the wealthiest 10% of the population have revenues that are in the region of 70 times higher than the poorest 10% (UNAIDS, 2006).

Private sector responses to HIV and AIDS tend not to be pro-poor and consequently public/private partnerships, while relevant to the response, have limited overall impact on pro-poor growth. Private sector responses to HIV and AIDS are often confined to large scale organisations that are situated in urban centres. The workforce is comprised of people with the skills, education and ability to access formal employment; hence the most vulnerable to the impoverishing effects of HIV and AIDS, often situated in hard to reach rural communities, are precluded from access.

In sub-Saharan Africa two-thirds of all births go unregistered and birth registration may be required in order to access health, welfare services or for school enrolment. Countries affected by HIV and AIDS tend to have especially low levels of birth and other forms of registration, which has particular implications for women and children leaving them at risk of abuse, exploitation and inheritance violations (UNICEF, UNAIDS, 2004).

Responding to poverty and vulnerability through a HIV lens has been controversial, however, it may also be argued that HIV and AIDS has proved a successful vehicle through which political leadership at a range of levels has been garnered to respond to broader poverty and vulnerability issues.

Mainstreaming the response to HIV and AIDS is widely advocated. Mainstreaming can facilitate the achievement of a multi-sectoral response and national policies and frameworks provide entry points for mainstreaming. However, experience has yet to demonstrate that mainstreaming efforts promoted by donors have been successful in delivering effective multi-sectoral responses. While an emphasis on mainstreaming should be maintained, it should not be at the expense of more specific interventions. Consequently, social protection planning will need to ensure that HIV and AIDS-specific responses do not unwittingly lose priority status.

What are the good practices, based on lessons of experience?

Strengthened health and education systems are crucial to the realisation of universal access to HIV prevention, treatment, care and support. HIV and AIDS have devastating effects on education and health systems. In Zambia for instance, 40 % of all teachers are HIV-positive and are dying at a faster rate than they can be replaced by new graduate (UNICEF, 2006). Strong health and education systems in high prevalence countries are the key to the achievement of Millennium Development Goal 6 in terms of halting and reversing the spread of HIV and AIDS by 2015.

Cash transfers have a significant AIDS mitigation impact and are proving successful in removing the barriers that preclude access to education for the most vulnerable children affected by HIV and AIDS and this is central to the achievement of empowerment and ultimately pro-poor growth (UNICEF, ESARO, 2007). AIDS-sensitive rather than AIDS-specific targeting criteria should be applied.

Economic support in the form of social assistance to children (Guthrie, 2006) and older citizens is a direct and intergenerational poverty reduction mechanism (Townsend, 2002). Research has consistently demonstrated the poverty reduction effectiveness of an old age pension (Townsend, 2002). Similarly, the child support grant in South Africa has increased school attendance and nutrition levels, while impacting positively on income poverty at household level (Guthrie, 2006).

A multi-sectoral response to HIV and AIDS is widely advocated, however, a review of Poverty Reduction Strategy Papers and National Strategic Plans on AIDS in Africa in 2004 revealed that the priority focus remains on tackling HIV and AIDS through health sector responses (UNAIDS, 2006). Mainstreaming HIV and AIDS is central to the achievement of a multi-sectoral response and national policies including social protection frameworks are appropriate entry points for mainstreaming (UNAIDS/GTZ, 2002).

Empowerment can lead to improved health outcomes particularly for women and those most particularly vulnerable to HIV infection. Hence, social protection mechanisms need to incorporate a transformative element in order to challenge inequalities of access and remove barriers to the empowerment of women. The most effective empowerment strategies are those that promote meaningful participation, ensuring autonomy in decision-making, reinforcing a sense of community and local bonding, thus facilitating psychological empowerment of the community members themselves (WHO Europe, 2006).

A supportive policy environment, that is HIV and AIDS sensitive, is required for investment and while in some of the worst affected countries HIV works against investment, governments need to enable a supportive policy environment that is conducive to investment by enhancing labour skills through the provision of vocational education and training. A skilled labour supply will meet the needs of both the public and private sector, thus providing an incentive for investment and retention of skilled staff through employer sponsored AIDS treatment programmes (ILO, 2004).

Planning processes that include vulnerable communities affected by HIV and AIDS are crucial for the realisation of empowerment and pro-poor growth. Governments, ministries of finance, donors, and private sector enterprise and development planners need to factor HIV and AIDS into poverty reduction strategies and National AIDS Plans from the outset. Empowerment begins with active and meaningful engagement of HIV+ people and communities affected by HIV and AIDS at the earliest stages of planning, programme design, and delivery.

Empowering women through increased access to education, strong economic independence and the transformation of inequitable relationships between men and women at all levels is urgently required to both contain and reverse the spread of HIV and AIDS⁵.

What are the policy implications and recommendations?

Leadership at all levels is required to transform the response to HIV and AIDS. The United Nations General Assembly Special Session (UNGASS) Declaration of Commitment on HIV and AIDS, 2000, posits political leadership and commitment at the core of the response. If the Livingston Call to Action on Social Protection is to be realised and if this is to affect an impact on HIV and AIDS in some of the worst affected regions of the world, leadership from community to national, regional to global levels is essential.

National budgets that are both pro-poor and HIV and AIDS-sensitive must be a priority of government. Ministries of Finance need to dialogue with national HIV and AIDS planners to ensure that adequate resources are allocated in national budgets. Furthermore, broadly targeted social protection instruments must ensure that HIV and AIDS affected households and individuals are captured.

HIV/AIDS and social protection are central to policy dialogue focused on reaching the Millennium Development Goals (MDG's) and are cross-cutting themes in poverty, inequality and vulnerability discourse. HIV prevention, treatment, care and support constitute the four pillars characterising the global response to HIV and AIDS, while at country level, equitable access to these services must be incorporated into national targets. The removal of barriers inhibiting the most vulnerable from accessing services may be realised through AIDS-sensitive social protection instruments.

Health, education and social welfare systems strengthening must remain a priority focus for governments in the context of HIV and AIDS if universal access to prevention, treatment, care and support is to be achieved. These are priority sectors both in terms of an effective HIV and AIDS response and their capacity to promote and protect empowerment and pro-poor growth.

Support the development of civil registration systems in countries with a high HIV prevalence in order to facilitate access to social protection on a citizenship, rights and entitlements basis. Increasing civil registration in countries severely affected by HIV and AIDS is an important step towards empowerment of the most vulnerable, while enabling access to social assistance, protecting against inheritance violations and securing access to other social protection instruments as a right of citizenship.

Cash transfers have a significant AIDS mitigation impact and may be advocated and supported in the context of their ability to remove barriers to health and education access, while preventing adoption of non-reversible coping mechanisms among the most vulnerable households affected by HIV and AIDS. In this regard, social protection mechanisms including cash transfers have the capacity to realise the delivery of the Millennium Development Goals and the UNGASS Declaration of Commitment on HIV and AIDS. Investment in social protection may impact on economic growth and empowerment in the context of HIV and AIDS, while influencing the current 1% per annum reduction in growth in high prevalence countries. (Wiman and Voipio; UNAIDS, 2006).

Social protection strategies must incorporate a strong transformative agenda to facilitate pro-poor growth and to ensure that the rights of women, children and other groups vulnerable in the context of HIV and AIDS are realised in legal and institutional frameworks.

Equal engagement of men in the realisation of the rights of women is central to improved sexual and reproductive health outcomes, while increasing resources in the hands of women thus potentially mitigating against the impoverishing effects of HIV and AIDS.

Create policy environments that are conducive to foreign investment through facilitation of private and public sector partnerships in HIV prevention and treatment, while facilitating staff retention, skills development and training initiatives.

Notes

- 1 Whilst this paper focuses largely on sub-Saharan Africa, social protection is highly relevant in other regions experiencing concentrated epidemics e.g. the need for labour and legal standards which protect those living with HIV and AIDS and health insurance programmes, which ensure access free-of-charge to life saving treatment.
- 2 www.worldbank.org/The Business Case for AIDS.
- 3 Defined as age 15 years and over.
- 4 DAC Network on Gender Equality, Women's Empowerment and HIV Prevention - donor experience, 5th meeting, OECD, Paris, 27-29 June 2007.
- 5 DAC Network on Gender Equality, Women's Empowerment and HIV Prevention - donor experience, 5th meeting, OECD, Paris, 27-29 June 2007.

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