Lessons learnt from HIV: HIV-sensitive social protection
Topics of this presentation

• How does social protection relate to HIV?
• Why are access and adherence becoming more important in the response to HIV? Why do people fail to be retained in care?
• What are the experiences from cash transfers?
• How does the World Food Programme (WFP) implement food and nutrition interventions to increase access and adherence?
Investment Framework recognizes social protection under development synergies

- Reduce Risk
- Reduce the likelihood of transmission
- Reduce mortality and morbidity

Basic Programme Activities
- PMTCT
- Condom promotion and distribution
- Key populations
- Treatment care and support to PLWH
- Male Circumcision
- Behavior Change programmes

Critical Enablers – incl. nutrition support

Synergies With Development Sectors including social protection

Source(s): Schwartlander et al., 2011 Lancet
Why is social protection an important investment for HIV outcomes?

• **Prevention:** address the multiple social determinants of the epidemic – income inequalities, gender inequalities, social exclusion – and thus contribute to a reduction in new infections,

• **Treatment:** address demand side barriers to access HIV services with potential to improve prevention, treatment and care and support outcomes.

• **Mitigation:** mitigate the significant social and economic impacts of HIV and AIDS on households and individuals,
What are some of the key components of social protection in relation to HIV and AIDS?

- **Initiatives to promote access** to affordable quality services, e.g. *fee waivers, social insurance* and social care (home based care, child welfare workers who link under-served and marginalised to services)

- **Financial protection** including through targeted social *transfers* (such as food or cash) to *protect some minimum level of consumption for the very poor and/or to influence behaviours*

- **Laws, policies and regulation** to empower marginalised people to participate fully in development, such as addressing systemic discrimination - often referred to as ‘transformative measures’

Source(s): UNAIDS Business case on social protection, 2010
Social protection critical when we need to get more people to adhere than to start ART!

Number of individuals accessing treatment

Retention exhibited over time on ART

- 2002: 0.3 M
- 2004: 0.4 M
- 2006: 0.7 M
- 2008: 3.0 M
- 2010: 6.7 M

- 0%  20%  40%  60%  80%  100%
- 0  12  24  60 months

- 81% 75% 67%
Rosen and Fox (2011) suggest significant loss to follow-up before treatment initiation.

Source(s): Rosen and Fox (2011): Retention in HIV care between testing and treatment in sub-Saharan Africa: a systematic review.

~18% of PLHIV diagnosed but not immediately eligible remained continuously in care until ART.
Access and adherence are dependent on both the supply- and the demand-side of health care

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Definition</th>
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<tbody>
<tr>
<td><strong>Supply</strong></td>
<td></td>
</tr>
<tr>
<td>1 Infrastructure</td>
<td>Material assets used to deliver health services (e.g., health clinics)</td>
</tr>
<tr>
<td>2 Human resources</td>
<td>Individuals involved in delivering health services, with focus on number and associated skills</td>
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<tr>
<td>3 Intervention</td>
<td>Details pertaining to an intervention (e.g., type, duration)</td>
</tr>
<tr>
<td>4 Service delivery</td>
<td>Specific act of providing health services to beneficiaries, with focus on quality, quantity and costs</td>
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<tr>
<td><strong>Demand</strong></td>
<td></td>
</tr>
<tr>
<td>5 Economic</td>
<td>Resource situation (including financial) of the beneficiary</td>
</tr>
<tr>
<td>6 Social</td>
<td>Interactions of the beneficiary with other members of the household and members of society at-large</td>
</tr>
<tr>
<td>7 Physiological</td>
<td>Pathophysiologica (i.e. the effects of the disease) and non-pathophysiologica situation of the beneficiary</td>
</tr>
<tr>
<td>8 Psychological</td>
<td>Psychological situation and knowledge of the beneficiary</td>
</tr>
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Source(s): WFP analysis
Cash transfers rapidly expanding in Africa: the $10 billion dollar opportunity…

9 countries in 2000

25 programmes

41 countries in 2012

245 programmes

Source(s): Garcia and Moore (2012)
Zomba trial (2012): Cash transfers result in younger sexual partners and fewer sexual encounters, fewer HIV infections

Cluster randomised controlled trial, 1289 adolescent girls in Zomba/Malawi, an area with high levels of school drop-outs, high food insecurity and a lot of evidence of transactional sex

Goal: improve retention in school for girls & build human capital

Primary outcomes: HIV status, HSC status at 18 months (not measured at baseline), intervention: cash payments (conditional/unconditional) of differing amounts

- 12mth outcome - declines in early marriage, teenage pregnancy, and self-reported sexual activity
- 18mth outcome – HIV prevalence in intervention group less than half that in controls (OR: 0.36), no change in protected sex or in sexual debut, but younger male sexual partners and reduced sexual activity with them
- Cost of preventing an HIV infection: $5k ($5 payment) to $12.5k ($10 payment)

Source(s): 2012 Baird et al., Effect of a cash transfer programme for schooling on prevalence of HIV and herpes simplex type 2 in Malawi: a cluster randomised trial
In 2012, WFP had HIV and TB programmes in 33 countries providing support to close to 3 million beneficiaries.

Geographical presence: HIV specific work

- Asia: 4
- Middle East: 1
- Africa: 25
- Americas: 3
- Total countries: 33

Key facts

- **HIV-specific interventions:** 1,564,000
  - Care and treatment: 923,000
  - Mitigation and safety nets incl. OVC: 641,000
  - 72% HIV, 28% TB

- **HIV-sensitive interventions:** 1,237,000
  - Estimated HIV+ PLW and exposed infants receiving food to treat malnutrition: 78,000
  - Estimated OVC in School Feeding: 1,159,000

Source(s): WFP annual performance review 2012
ART clients in Zambia that receive food and nutrition support are 48% more adherent than control group

<table>
<thead>
<tr>
<th>Programme/study design</th>
<th>Results</th>
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<tr>
<td>• 636 food insecure clients between 2004 and 2005</td>
<td>&gt;95% treatment adherence after 1 year ART</td>
</tr>
<tr>
<td>• 8 government clinics in cooperation with World Food Programme</td>
<td>70%</td>
</tr>
<tr>
<td>— 4 intervention</td>
<td>+48%</td>
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<tr>
<td>• Food assistance provided on average for 9 months</td>
<td>48%</td>
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<tr>
<td>— Individual ration (monthly): 6.2kg high-energy protein supplement and 0.62l oil</td>
<td>Findings unchanged after adjustment for sex, age, and baseline CD4 cell count</td>
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<tr>
<td>— Household ration (monthly): 37.2kg high-energy protein supplement, 1.9l oil, 37.2kg maize and 3.7kg beans</td>
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Source(s): Cantrell (2008): A pilot study of food supplementation to improve adherence to antiretroviral therapy among food-insecure adults in Lusaka, Zambia
Summary

Social protection interventions can influence the course of the HIV epidemic - UNAIDS investment case shows us how HIV-specific and sensitive work complements each other.

Cash and food transfers can help mitigate the impacts of HIV on individuals and households, while also supporting access to treatment.

Significant scale-up of cash transfer programmes in Africa, some with documented benefits in terms to HIV prevention, treatment, care and support.

World Food Programme with close to three million HIV (and TB) beneficiaries reached through HIV specific or –sensitive safety nets.

While some evidence on effectiveness exists, we need to become better at documenting results and cost effectiveness.

Cost effectiveness also critical when deciding on modality - food or cash?