



Experiences from HIV-sensitive social protection

Brian Lutz

Policy Specialist, HIV Practice, UNDP

Symposium on social determinants of TB

15 February 2012

London School of Hygiene & Tropical Medicine





Context and objectives

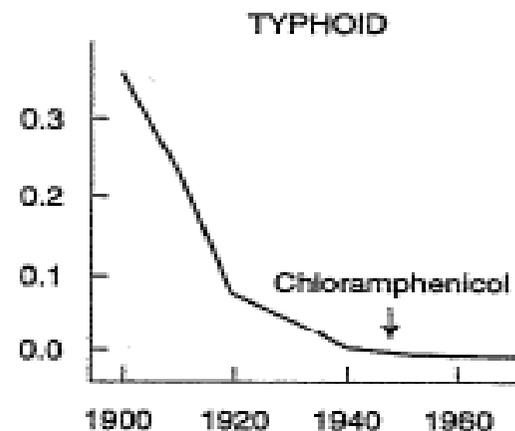
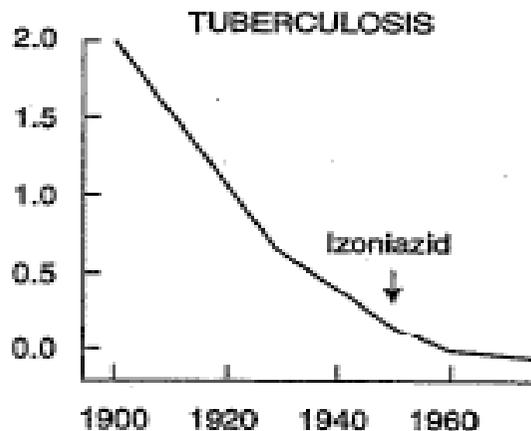
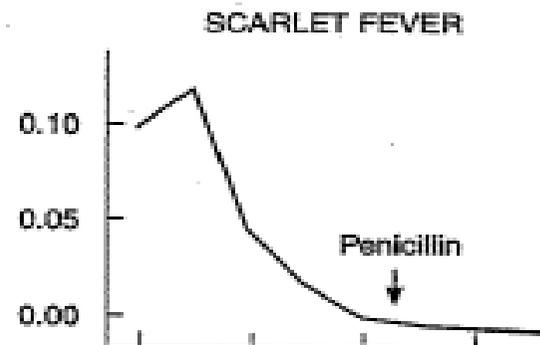
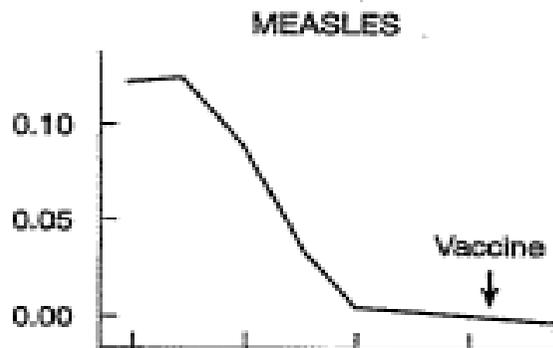
- **TB has well-known social determinants** – these may have a more profound impact than does direct medical care (e.g., DOTS)
- **Social protection**, which is receiving increasing attention globally, **is potentially one option** to address social determinants
- **But little is known** about the effectiveness and feasibility of social protection approaches to TB
- **HIV has (relatively) more experience** in using social protection approaches. Though still evolving, these experiences could inform if and how social protection can influence TB outcomes – and / or what direction future research might take.
- **This presentation summarizes concepts and examples in social protection approaches to HIV**



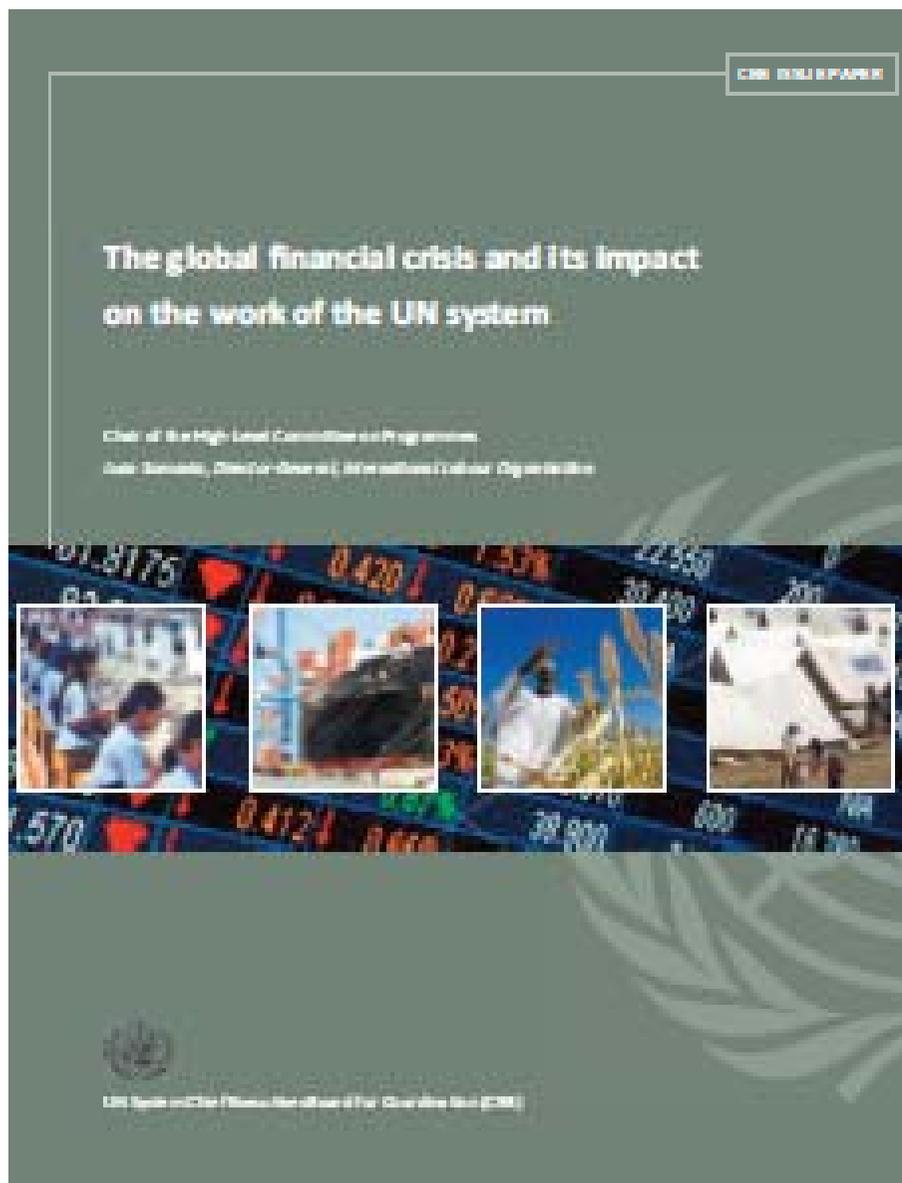
Social determinants matter for TB and other diseases



Historical declines in major infectious disease mortality in the United States



Social protection is a global opportunity



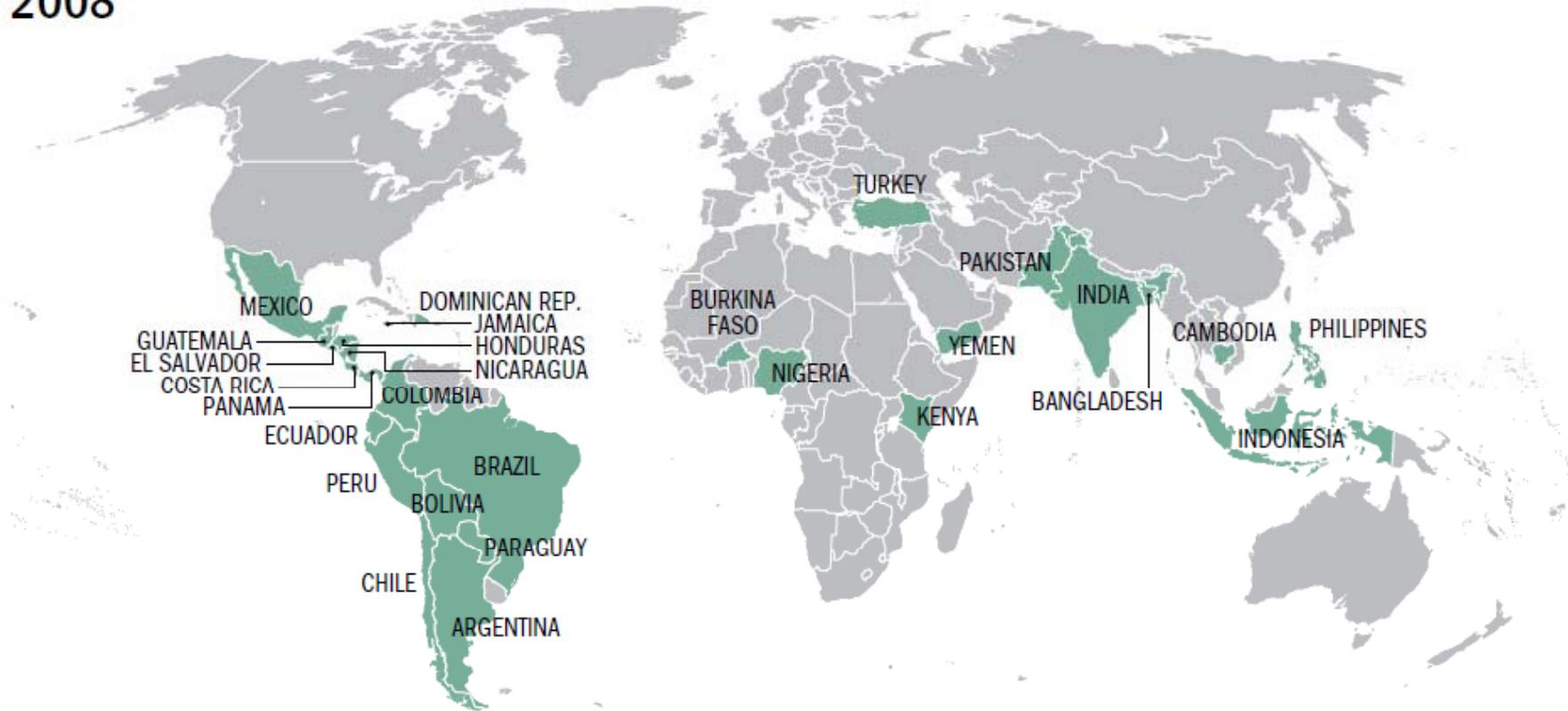
The Social Protection Floor Initiative:

1 of the 9 initiatives to confront the global economic crisis and accelerate recovery

Conditional cash transfers, for example, have spread



2008



- 29 developing countries had CCTs by 2008 – most conditional on MCH or education
- Brazil's Federal program, Bolsa Familia, now reaches 11 million families, or 46 million people
- Mexico's Oportunidades now serves 5 million households

Source: World Bank
2009 "Conditional Cash
Transfers"



But questions linger on social protection for TB

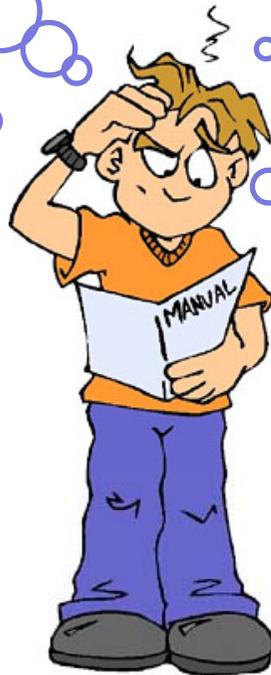


What social protection approaches might **work**?

Where and how should they be **targeted**?

Can social protection influence TB **outcomes**?

Are they **feasible**? What is required to **implement** and **scale-up**?



HIV offers three key messages



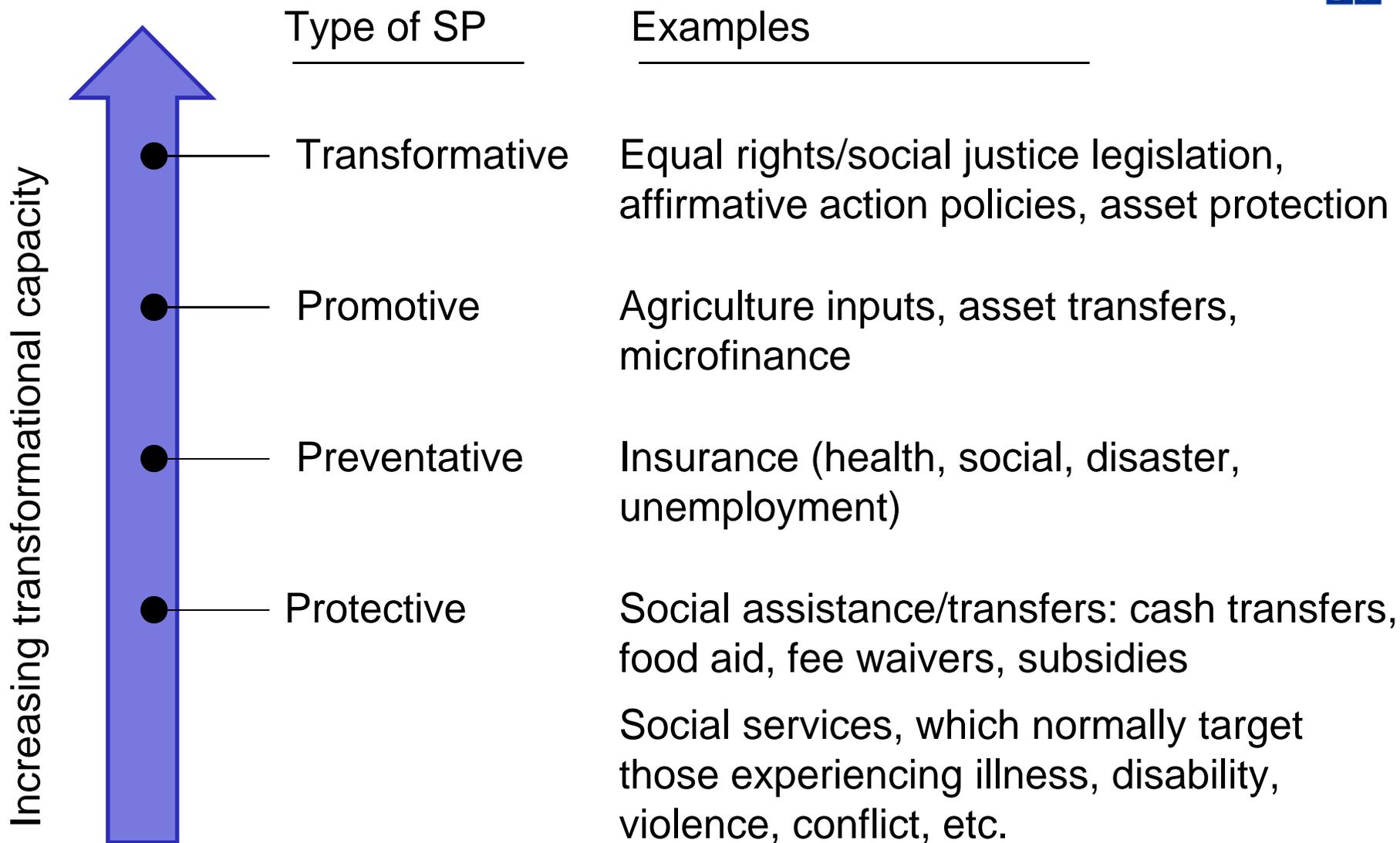
1. Social protection has many potential entry points to influence health outcomes

2. But social protection is not a magic bullet; challenges, risks and unknowns remain

3. For social protection to work, especially for prevention, multisectoral frameworks are required



Social protection exists across a spectrum



Entry points exist across the HIV continuum



Impact mitigation

	HIV Prevention for those most vulnerable to HIV infection	Treatment for people living with HIV	Care and Support people living with and affected by HIV
Financial protection <ul style="list-style-type: none"> <i>Social assistance</i> protective for v. poor <i>Livelihoods support</i> for poor and vulnerable 	Transfer payments for the very poor to support HIV prevention Income generation or micro-credit to reduce HIV risk for poor key population groups	Transfers to poor PLHIV for better HIV treatment access and adherence Economic empowerment for PLHA to prolong and improve life	Transfers to mitigate the impact of AIDS on individuals and households Income generating activities, livelihoods strengthening, micro-finance for affected
Social Health Protection <ul style="list-style-type: none"> <i>Social insurance</i> ensuring service access for the vulnerable 	Social insurance to prevent HIV risk (social security, public finance of RH, MH and HIV prevention services etc.)	Social health protection to <i>ensure access</i> to health care and to prevent erosion of savings	Preventive insurance measures appropriate for those affected (pension schemes, funeral clubs etc.)
Laws, policy, regulation <ul style="list-style-type: none"> <i>Social justice</i> for the marginalised 	Legal reform, policy process, and protection regulation to reduce HIV risk (decriminalisation)	Protection of rights to health, treatment and work to improve life for PLHA (anti-discrim)	Legal protection for affected (e.g. widow's and orphans' property rights, birth registration etc.)

(Source: based on HIV-sensitive social protection - What Does the Evidence Say? Miriam Temin, UNICEF)

TB could differentiate between prevention of infection and prevention of active disease

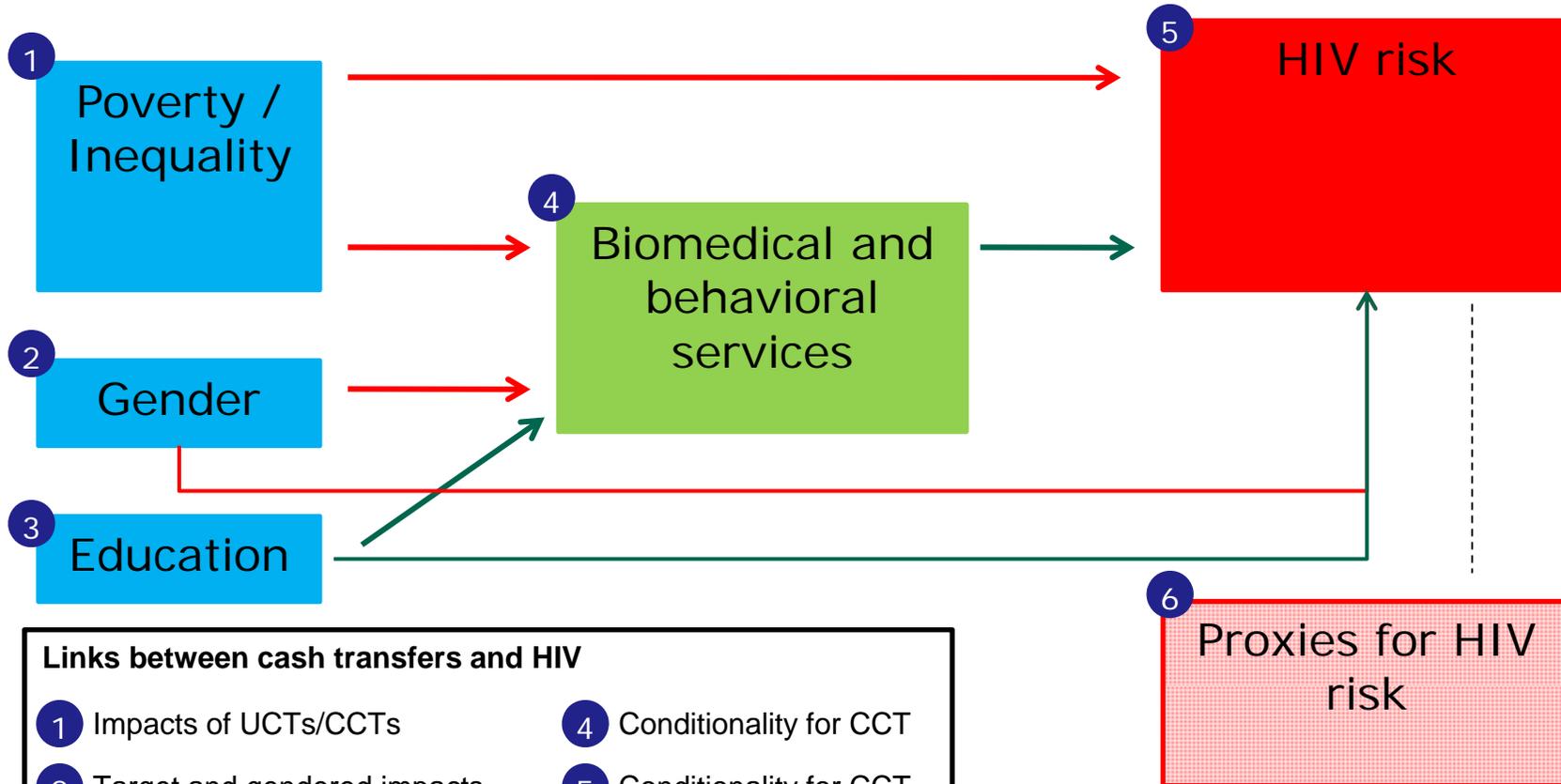


Cash transfers have multiple entry points for HIV prevention

Distal / structural risk factors*

Proximal services

Outcomes



- Links between cash transfers and HIV**
- 1 Impacts of UCTs/CCTs
 - 2 Target and gendered impacts
 - 3 Conditionality for CCT
 - 4 Conditionality for CCT
 - 5 Conditionality for CCT
 - 6 Conditionality for CCT





1 Cash transfers have reduced poverty and inequality, but downstream HIV impacts are not typically tracked

Impact of cash transfers

- Very strong evidence for **sizeable reductions in national poverty**



Specific measures

- Modest decreases in poverty headcount
- Strong decreases in severity of poverty (poverty gap and squared poverty gap)



Oportunidades

- Red de Protección Social - Nicaragua

- Some evidence for **reductions in national inequality**

- Declines in Gini coefficient

Oportunidades



Sources: Fiszbein 2009; Soares et al. 2009; Paes de Barros 2006

HIV impacts would have to be inferred:
little to no linking of pathway from CCT
→ income → HIV risk or proxies





2 The targeting and impacts of cash transfers tend to be gendered

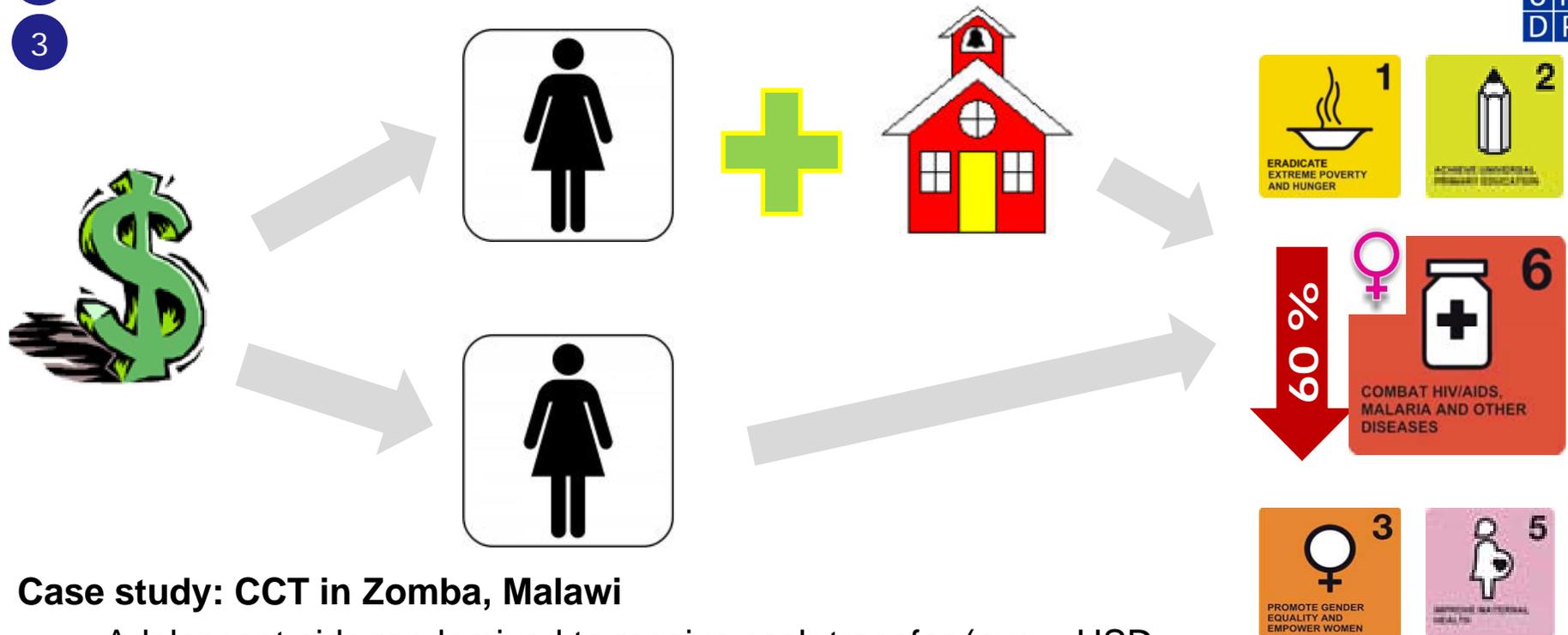
- Mothers are often the target recipients of CCTs, especially those dealing with MCH services and education
- Women and girls are disproportionately at risk for HIV, especially at younger ages and due partly to economic inequalities along gender lines
- **Women and their social networks have positive spill-over effects** in CCTs for VCT:
 - Women (but not men) had small uptick in VCT access when neighbors received CCT
 - When women received CCT, their husbands were more likely to attend (but not vice versa)
- Some studies have shown that the **income effects** (separate from the conditionality) of a CCT for HIV status **tend to have opposite effects on men and women**. Men increase risky sex while women decrease risky sex.

Sources: Thornton 2005 and 2008; Kohler and Thornton 2010 – working paper



1 Cash transfers have been shown to address structural drivers effectively and reduce HIV risk (Zomba study)

- 2
- 3



Case study: CCT in Zomba, Malawi

- Adolescent girls randomized to receive cash transfer (avg = USD 10/month to girl and family), some conditional on school attendance
- Results:
 - **60% decrease in HIV risk** (1.2% vs. 3.0%) and 75% decrease in HSV 2
 - 3-4 times more likely to be in school
 - More likely to delay marriage and pregnancy
 - Less sex, including transactional sex, and younger partner selection

Source: Baird et al. 2010. in *Health Economics*; World Bank Brief 2010



- 1 Zomba study cont: The income effect is a clear part of the pathway; schooling effect is less clear
- 2
- 3



Income or Schooling? (using the unconditional treatment group only)
Prevalence of "any STI" by treatment status and school attendance in 2008.

	Did not attend school regularly in 2008	Attended school regularly in 2008	Total
Control	14.7%	2.8%	5.2%
Unconditional treatment	0.0%	2.0%	1.7%
Total	11.6%	2.6%	4.3%

Source: unpublished World Bank brief 2010; presentation at Vienna AIDS conference 2010. Peer-reviewed publications forthcoming

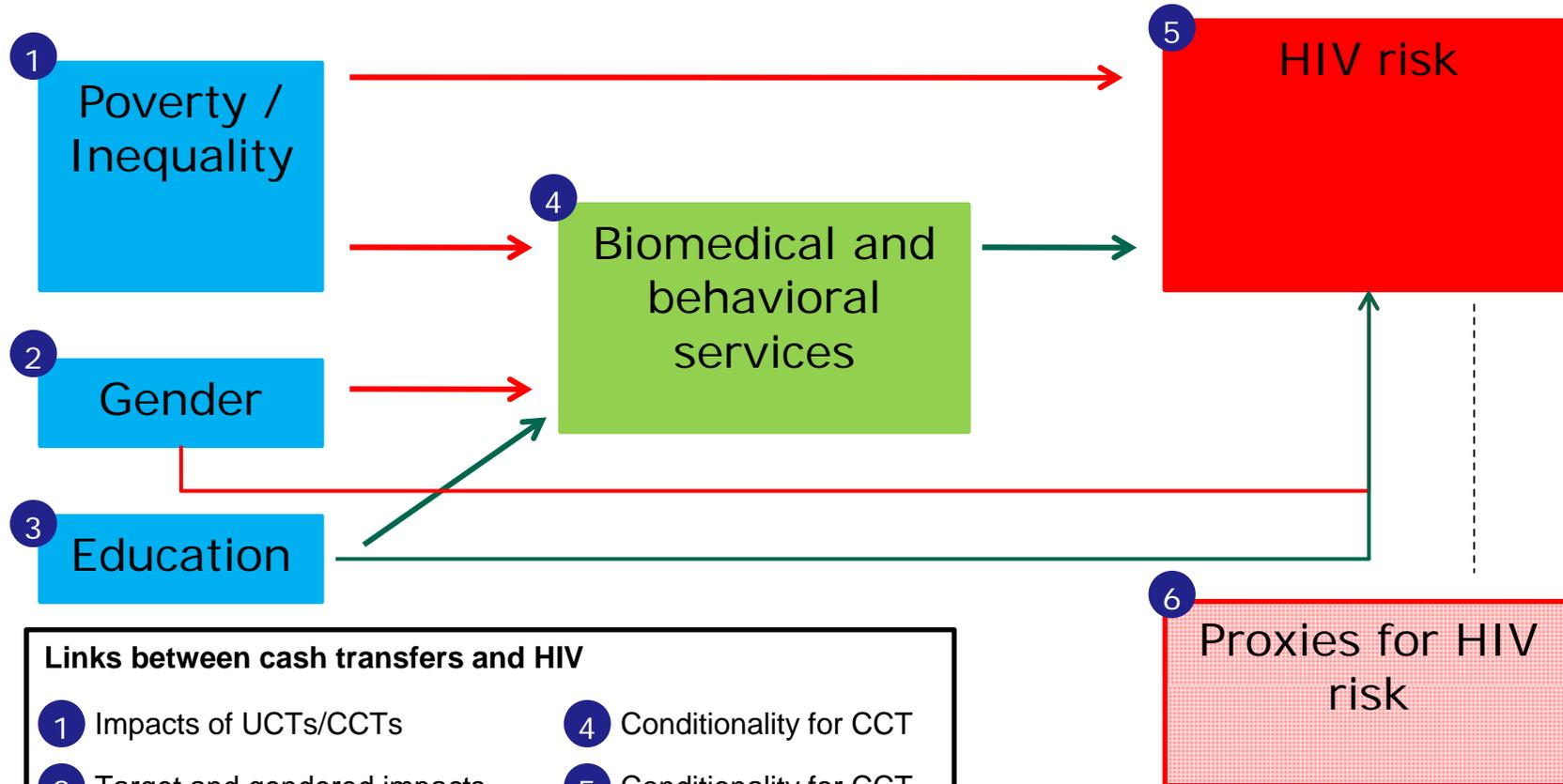


Cash transfers have multiple entry points for HIV prevention

Distal / structural risk factors*

Proximal services

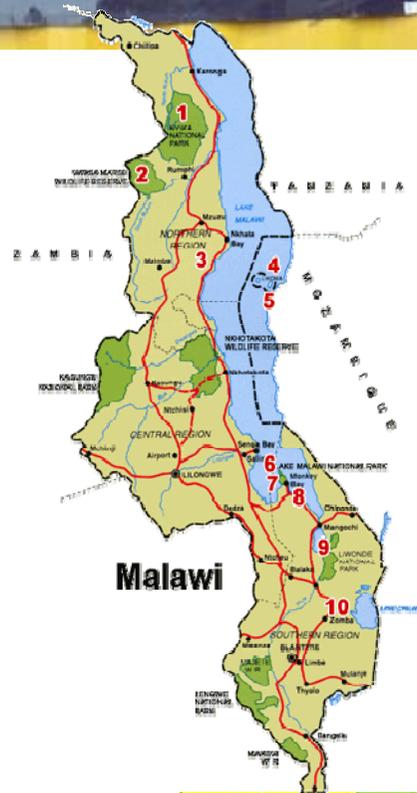
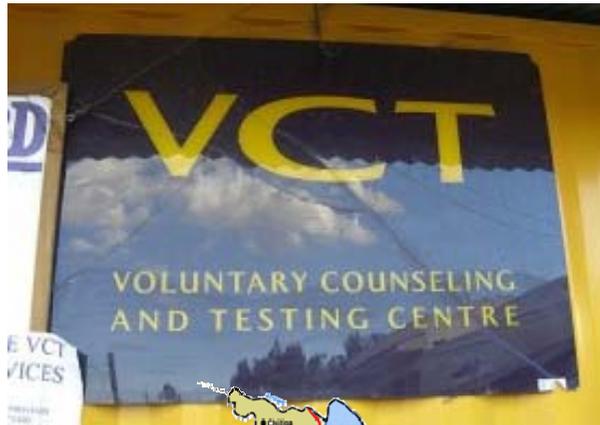
Outcomes



- Links between cash transfers and HIV**
- 1 Impacts of UCTs/CCTs
 - 2 Target and gendered impacts
 - 3 Conditionality for CCT
 - 4 Conditionality for CCT
 - 5 Conditionality for CCT
 - 6 Conditionality for CCT



4 CCTs have been shown to increase uptake of VCT



Case study – CCT for VCT in Malawi

Methodology: Community-randomized control trial

Design:

- cash transfer = USD 0-3 (mean 1.04)
- conditionality = retrieving VCT results

Results:

- CCT-recipients 2x likely to get VCT results vs controls (increase of 27-39%)
- Each USD 1 of transfer = increase 9%
- Final attendance = 72%

Source: Thornton 2005 and 2008;





5 So far, CCTs tied directly to HIV status have not shown effect



Case study – CCT for HIV status in Malawi

Methodology: RCT

Design:

- cash transfer = USD 0, 4 or 16
- conditionality = remaining HIV negative
- 1 year time lapse before incentive
- Include PLHIV

Results:

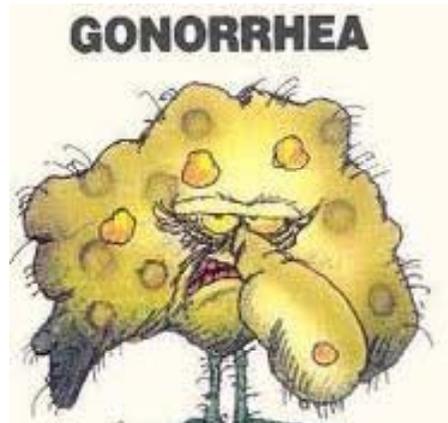
- **No effect on HIV status or reported sexual behaviors**
- After final incentive paid, men increased risky sex while women decreased risky sex

Issues: stigma, frequency of incentive, perverse incentives, income effect vs conditionality

Source: Kohler and Thornton 2010 – working paper



6 CCTs tied to curable STIs, however, have been shown to reduce biomarker proxies for HIV risk



Case study – CCT to remain STI-free - Tanzania

Methodology: RCT

Design:

- cash transfer = USD 0, 10 or 20 (every 4 months)
- conditionality = remaining free of ~ 6 curable STIs
- HIV status not considered, not measured; PLHIV included

Results:

- USD 10 / 4 months = no effect
- USD 20 / 4 months = 25% reduction in STIs

Conclusions:

- CCTs tied to HIV proxies can work
- Value of cash transfer matters
- Curable STIs can be non-stigmatizing proxy

Source: RESPECT study World Bank 2010



Social protection can facilitate HIV treatment access directly and indirectly

Prevention

Treatment

Impact mitigation



Some examples

Direct

- Cash transfers or vouchers for transportation
- Food/nutrition assistance
- Reduction in stigma and discrimination in medical service delivery
- Abolition of user fees
- Health insurance reforms

Uganda – RCT showed \$5-8 per month improved adherence and retention

India – New insurance guidelines to cover PLHIV

Indirect

- **Social protection that creates or frees up resources**, such as time and money, for treatment adherence (e.g., life and disability insurance, nutritional support, abolition/payment of school fees).
- **Includes mitigating impacts related or unrelated to AIDS**

Source: Economic Times 4 February 2012; Emanyau et al. 2010



UNDP-sponsored studies demonstrate impact of AIDS at household level



Prevention

Treatment

Impact
Mitigation

Methodological overview

- 5 countries co-led: Cambodia, China, India, Indonesia and Viet Nam
- Surveys conducted 2004-2010
- Matched case-control methodology: 7,000 affected HHs, 10,000 non-affected control HHs

Summary of key results

- **Negative economic impacts** (income, poverty, employment and asset ownership)
- **Negative impacts on coping mechanisms** (savings, debt, asset liquidation)
- **Negative impacts on food security**
- Increase in health spending, at expense of education
- Negative impacts on education (attendance, drop-out rates)
- Negative impacts in some countries on health-seeking behavior
- High-levels of stigma and discrimination



Social protection can play a role in mitigating the multiple impacts of AIDS



Prevention

Treatment

Impact mitigation

Impacts of AIDS*

Social protection interventions*



- Poverty
- Unemployment
- Hunger and food security

- cash and asset transfers, insurance (social, health), microfinance
- law and policy reforms, public works
- cash, food and asset transfers, input subsidies, microfinance



- School absenteeism

- fee waivers, cash transfers, social services



- Gender inequalities
- Stigma and discrimination

- social transfers and services, transformative social protection (e.g., law and policy reform)

* not exhaustive



Pension reforms in Orissa have helped women widowed by HIV

Prevention

Treatment

Impact
Mitigation



Scheme: *Madhu Babu Pension Yojana*

- **Initiation:** Feb 2008
- **Entitlement:** Lifelong monthly pension
- **Beneficiaries:** Elderly, disabled, widows. Includes widows of PLHIV or any PLHIV, irrespective of age.
- **Implementation agency:** OSACS with the district machinery
- **PLHIV benefited:** 23,052

Special features:

- All PLHIVs irrespective of age, marital status, sex, economic status were eligible to apply for the scheme.
- The pension card served as an identity, ensured linkages with a bank, self help group and the community.
- One of the NGOs in Orissa facilitated the process of availing the scheme to PLHIVs through their link to workers thereby maximising the scope of this project.



- Other states in India have implemented or are considered implementing similar pension reforms for people affected by HIV.
- Multiple SP exists in India, with opportunities to expand to include people affected by HIV

Life and disability insurance is now available to PLHIV with South Africa



Prevention

Treatment

Impact Mitigation



1st Insurer of HIV+ People

50,000 Policyholders targeted

15% average improvement in health

Key innovation: continuous underwriting

Other impact: access to credit



HIV offers three key messages



1. Social protection has many potential entry points to influence health outcomes

2. But social protection is not a magic bullet; challenges, risks and unknowns remain

3. For social protection to work, especially for prevention, multisectoral frameworks are required



Snapshot: issues, concerns for social protection for HIV (especially cash transfers)



GENERAL

- Program design
 - Targeting: recipients, eligibility
 - Payments: size, timing, frequency
 - Conditionality selection
- Perverse incentives
- Complement vs substitutes
- Costs – going to scale, M&E
- Cost-effectiveness
- Long-term dependency
- Human rights concerns
 - Stigma
 - Coercion (irreversibility, external barriers)
- HIV-sensitive vs. HIV-exclusive

HIV

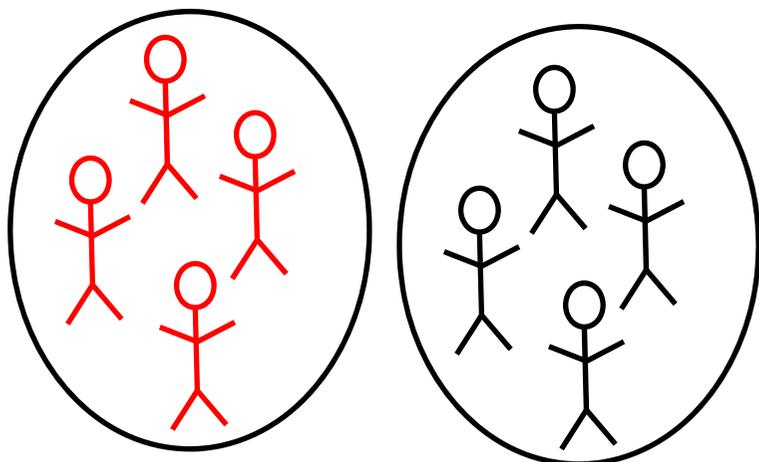


Countries balance two basic models of social protection for HIV: HIV-specific and HIV-sensitive



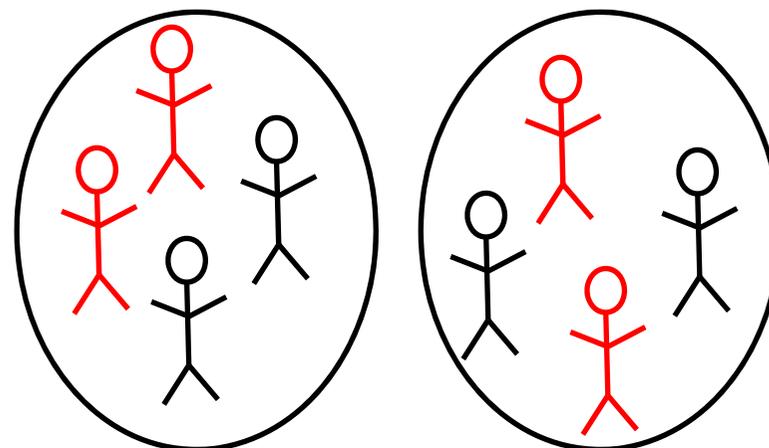
HIV-specific

(stand-alone/vertical)



HIV-sensitive

(integrated)



Countries typically have both kinds, with the following issues at the fore:

- Stigma
- Cost and feasibility
- Reach
- Social protection policy and programmatic breadth and coherence
- (Unique) needs of different groups, including those affected by HIV

Red = affected by AIDS

Black = not affected
by AIDS



HIV offers three key messages



1. Social protection has many potential entry points to influence health outcomes

2. But social protection is not a magic bullet; challenges, risks and unknowns remain

3. For social protection to work, especially for prevention, multisectoral frameworks are required





Multisectoral frameworks are required

Specific recommendations:

1. Integrate STI/HIV and other health outcomes into ongoing and new research of general social protection interventions
2. Consider the multiplicity of impacts in design of HIV-specific social protection interventions, especially in terms of cost-effectiveness and financing
3. Develop cross-sector/ministerial structures for programme design, implementation and monitoring

Variants of these recommendations likely apply to TB as well – for discussion





'Lessons' from HIV

1. Design studies rigorously – multiple arms, incentive tiers, tracking biomarkers where possible
2. Look for 'structural' or 'combination prevention' approaches (structural bigger than social protection per se)
3. Incorporate feasibility and operational assessments – e.g., costs, cost-effectiveness, implementation models
4. Piggy back on existing research
5. Work with other health and development partners –
SOCIAL determinants of **HEALTH**





Thank You

