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| HIV-AIDS and social protection |
| How social protection can help deliver the 'triple zero option' in the post-2015 development agenda: a World AIDS Day report |

World AIDS Day 2013

Today, 1 December, as we join the international trade union movement to mark the World AIDS Day, let us make sure that the protection and promotion of employment and human rights of people living with HIV/AIDS remain a priority for all and that stigma and discrimination associated with the disease is eliminated from workplace. In our view, workplaces can play a decisive role in facilitating the treatment, care and support for people living with HIV/AIDS while it has also demonstrated effectiveness in prevention strategies.

Despite recent progress in the prevention of HIV/AIDS and in the treatment, care and support for people living with the disease, the number of deaths of adults and children attributable to it was estimated at 1.6m by UNAIDS in 2012[[1]](#footnote-1). The number of people living with HIV-AIDS stood at 35.3m while new infections numbered 2.3m in the same year according to the same sources[[2]](#footnote-2). Sub-Saharan Africa remains the worst affected region in the world with Swaziland at the top with a prevalence rate of 26% in the 15-49 age-groups. In South Africa alone, 5.6m people are estimated to be living with the disease. In June 2010, in recognition of the role of workplace in the fight against the disease, the ILO adopted a recommendation[[3]](#footnote-3) on HIV and AIDS and the World of Work which seeks to strengthen the impact of the ILO Code of Practice[[4]](#footnote-4).

As we mark yet another World AIDS Day on 1st December, this report looks at the impact of the pandemic on the world of work and its wider implications for development, examines the relevance of social protection and the concept of Social Protection Floors (SPFs) in the fight against the disease in developing countries and argues that the introduction of SPFs will contribute to the effectiveness of the fight against the pandemic.

Global commitment

The global commitment to action on the pandemic was summed up in a number of UN declarations, notably in 2001, 2006 and 2011 and in the integration of specific milestones and indicators in the fight against it into the Millennium Development Goals (MDGs) to be achieved by 2015. There is little doubt that HIV/AIDS will drop off the post-2015 development agenda, as the main thrust of the debate seems to be gradually shifting away from past priorities to more fundamental issues from a global perspective and making way for action to deal with new challenges like climate change and environment degradation.

Nevertheless, HIV-AIDS, since its onset in the 1980s, has had a profound impact on development prospects. It has, in essence, set the clock back by decades in Africa, negating the painstakingly made advances in health, education and other key areas and erecting formidable obstacles to development. Progress against the onslaught of the disease has often been hampered by lack of political will and leadership, ignorance and a host of other factors.

Poverty in its manifold facets remains the most intractable barrier to the fight against the pandemic. The spread of HIV/AIDS in developing countries has been driven by chronic poverty and problems associated with it have been exacerbated by recent economic and financial crises which starve key sectors such as health, education and water and sanitation of vital resources and limit access to treatment, care and support for people living with HIV-AIDS. The TUC and the international trade union movement, spearheaded by the International Trade Union Confederation (ITUC), view decent work and social protection as an effective and indispensable tool in the struggle against HIV/AIDS, especially in the developing world where the disease continues to take a heavy toll on impoverished vulnerable sections of the population. In our view, the fight against the disease cannot be won without comprehensive social protection and the introduction of social protection floors at country level.

Economic consequences of the pandemic

HIV-AIDS affects workers in the prime of their economically active and productive life[[5]](#footnote-5). It reduces[[6]](#footnote-6) labour supply[[7]](#footnote-7) due to increased mortality and morbidity attributable to the disease. Moreover, the loss of expertise and skills in key sectors – health and education, transport, tourism, as well as in strategically important sectors of the economy such as mining in Botswana, South Africa and Zambia - causes significant drops in labour productivity. This, in turn, has adverse effects on competitiveness and therefore on trade prospects.

Exports tend to decline while imports rise partly due to increased demand for expensive drugs and other essentials. Poor economic performance is reflected in the gradually shrinking GNI which, in turn, results in drops in government revenue in terms of tax proceeds while increasing costs of treatment, care and support for HIV-AIDS patients further aggravate the problem and lead to the diversion of investment from physical and human capital to current consumption related to treatment and care for people living with HIV-AIDS (PLWHAs). Persistent deficits in the balance of payments force countries to borrow and plunge them into unsustainable indebtedness. Reduced aggregate demand further depresses production and employment and impacts[[8]](#footnote-8) adversely on growth.

A similar scenario develops within the household[[9]](#footnote-9) at microeconomic level. The loss of income due to absenteeism, dismissal or death reduces consumption and savings, if any. Medical expenses, costs of transport and eventual funerals further impoverish households and often compel them to borrow. In addition, the care of the chronically sick diminishes scope for any income-generating activity by other family members, placing severe constraints on ever decreasing family income. Households are often forced to cut down on expenses at all levels including those on nutrition, education and health. The withdrawal of children from school deprives the younger generation of opportunity to learn and enhance their capacity to earn in later life. It also denies them the chance to receive information[[10]](#footnote-10) on HIV/AIDS and sexually transmitted diseases (STDs) and avoid infection.

Research carried out in India by UNDP and the National AIDS Control Organisation (NACO) has shown that extra money spent on health care has a direct bearing on the amount the household is able to afford on education and food. Comprehensive social protection including access to free health care, therefore, is a crucial element in an effective response to HIV/AIDS[[11]](#footnote-11). The pandemic has a disproportionately high impact on women and girls. Not only is the incidence higher among them, but also it is known that they get infected earlier than their male counterparts. Furthermore, more than a fair share of the burden of caring for the sick falls on them. In the absence of an efficient, adequate and affordable social protection system, it is inevitable that vulnerable households get trapped in a vicious circle in the event of HIV infection.

Social protection and social protection floors

In 2011, in the UN General Assembly High Level meeting on HIV-AIDS, member countries committed themselves to work towards the triple zero option: zero deaths from HIV-AIDS, zero new infections and zero stigma and discrimination against PLWHA. The 2011 Political Declaration commits the international community to work towards universal access to HIV prevention, treatment, care and support and establishes global targets to be achieved by 2015. In our view, these cannot be achieved without a major boost to social protection in the countries adversely affected by the pandemic. Universal social protection is an essential element of a successful strategy to reverse the trend and halt the spread of HIV/AIDS, especially in the developing world. Social protection floors will go a long way in countering the adverse effects of the pandemic on development.

The pandemic has a serious impact on basic human rights of affected workers, including their right to work, non-discrimination, social security and privacy. Therefore, an effective social protection system needs to be underpinned by a rights-based approach and should take into consideration the needs and interests of people affected by HIV-AIDS as well as those of other vulnerable members of the community. There is an imperative need for a comprehensive social protection system characterised by equity, inclusiveness and non-discrimination which caters to the needs of all vulnerable sections of society without exclusive targeting.

Access to health care as part of social protection can play a critical role both in the treatment of, and care and support for, PLWHA and in effective prevention strategies. Yet the pledge to provide universal access to all PLWHA still remains unfulfilled[[12]](#footnote-12), while 9.7m[[13]](#footnote-13) had access to antiretroviral therapy (ART) by the end of 2012. Mother to child transmission has been a crucial factor in the spread of the disease from one generation to the other and continues to thwart preventive strategies in the most affected regions[[14]](#footnote-14). Access to free antenatal and perinatal care should be available to all pregnant women as part of social protection in order to prevent mother to child transmission.

Research shows that social protection in the form of cash transfers cushions the impact on households affected by HIV-AIDS and makes it possible for them, for instance, to keep children at school. Moreover, such transfers, if used for purchases from the community, could provide a boost to the local economy through the multiplier effect and spur pro-poor growth. In a comprehensive study of social protection and cash transfers to strengthen families affected by HIV and AIDS researchers from the International Food Policy Research Institute (IFPRI) conclude that:

“Social protection plays an important role as part of a comprehensive response to HIV and AIDS. It is needed to break the vicious circle of HIV/AIDS and food insecurity and to stem the loss of human capital among AIDS-affected families. Cash transfers have demonstrated a strong potential to reduce poverty and strengthen children’s education, health, and nutrition, and thus they can form a central part of a social protection strategy for families affected by HIV and AIDS. This conclusion is based on evidence from (1) studies of several large-scale, well-established transfer programs in south­ern Africa; (2) studies from newer, smaller cash transfer programs in southern and eastern Africa; (3) modelling of impacts of cash transfers in Sub-Saharan Africa; and (4) studies of CCTs in Latin America and Asia[[15]](#footnote-15).”

Economic and gender inequality tend to increase women’s vulnerability to HIV-AIDS. Social protection measures can minimise it by providing equal access to economic assets and resources to women. The spread of the disease among at-risk populations including sex workers and intravenous drug users was accelerated by a host of socioeconomic factors intimately linked with chronic poverty and the lack of access to vital public services – health, education and sanitation. Currency devaluations, removal of food subsidies, privatization of public services, trade and financial liberalisation, and introduction of user fees for health and education have been responsible for the deterioration of working and living conditions of millions in sub-Saharan Africa and their drift into destitution or precarious livelihoods including sex work in the case of women and children, increasing their vulnerability to HIV/AIDS[[16]](#footnote-16). Exclusion, harassment, stigma and discrimination also play a decisive role in increasing vulnerability to HIV-AIDS. Moreover, sexual orientation, ethnicity and migrant status often confound the situation, keeping people away from VCT and other services. Legislative reforms and changes to policies and practices need to ensure realisation of rights and entitlements of affected populations and reduce stigma and discrimination.

The ILO Recommendation (R202[[17]](#footnote-17)), in this regard, is a crucial step in the right direction, the implementation of which is supported by the international trade union movement. Scepticism has been expressed in some quarters on the feasibility of the implementation of social protection floors in general. It should be noted that the ILO recommendation does not advocate universally applicable SPFs[[18]](#footnote-18) irrespective of the level of economic development, but “social protection floors[[19]](#footnote-19) tailored to national circumstances and levels of development, as part of comprehensive social security systems…” It is pertinent to point out that the Social Protection Committee of the EU has included SPFs in its Work Programme 2012[[20]](#footnote-20). “Social protection is particularly relevant to HIV because of its potential to address issues, such as gender inequality, stigma and discrimination, which exacerbate marginalisation and vulnerability faced by key populations at higher risk of infection”, concludes a joint study by UNICEF, UNAIDS and IDS[[21]](#footnote-21).

There is a growing body of evidence on the impact of social protection floors on children and households affected by HIV/AIDS in many parts of the world. While SPFs or systems in operation in various countries differ considerably, they all seem to combine some key elements; access to services, financial protection for households, HIV-sensitive social protection policies, legislation and regulation to uphold the rights of vulnerable groups.

“Social protection has the potential to mitigate risks for individuals susceptible to infection (such as children of most-at-risk population groups), or subject to the consequences of HIV, and to supplement the response at all points along the pathway: to address susceptibility to infection (improve knowledge and empowerment to prevent HIV), to manage disease progression (enable continued access to ART) and to cushion the downstream social and economic impacts on households and communities”, says a UNICEF study, following a comprehensive survey of social protection programmes in nine countries in the Asia Pacific Region[[22]](#footnote-22).

Affordability

There is no intention or scope in this report to look into the details of affordability[[23]](#footnote-23) of social protection floors. Each country needs to examine the question in its own socio-economic context and in line with its national policies, practices and priorities. However, it is important to point out that such schemes are already in operation in a number of countries, especially, in some Least Developed Countries (LDCs). With technical expertise from the ILO, WFP and UNICEF, the Government of Mozambique has put in place a system of social protection which consists of four key components: social transfers, access to primary health care, access to education and work opportunities[[24]](#footnote-24). In Rwanda, the National Social Protection Strategy (NSPS) is composed of two key elements – regular and predictable cash transfers to people living in poverty and other vulnerable groups and access to public services[[25]](#footnote-25). *“International experience shows that effective country-specific floors, which can gradually expand, are not only affordable, but can pay for themselves in the long run by enhancing the productiveness of the labour force, the resilience of society and the tax revenues often forgone because of ineffective collection. In the short term, reducing widespread tax evasion and inefficiencies in tax collection will help to mobilize resources for the phasing-in of social protection floors”,* says the Report of the Advisory Committee on Social Protection Floor for a fair and inclusive globalisation[[26]](#footnote-26). A recent review of best practice in the integration of HIV-AIDS into national social protection plans in Cambodia recommended five key guiding principles and stressed the need for HIV-sensitive social protection, as distinct from HIV-specific social protection, in the development and implementation of policies and programmes[[27]](#footnote-27).

Conclusion

In the long-run, the battle against the pandemic can be won only if the main drivers of the disease are dealt with efficiently and effectively. Chronic poverty and attendant factors are largely responsible for the current state of the pandemic and for the failure to halt its spread. Trade unions, employers, governments and other stakeholders need to work in hand in hand to ensure that all their efforts are properly coordinated and directed at the elimination of root causes. In this regard, the implementation of the twin recommendations of the ILO - R200 and R202 – across the globe assumes supreme importance. And the need for the inclusion of comprehensive social protection in the post-2015 Development Agenda remains as imperative and important as ever.

1. UNAIDS Report on the Global AIDS epidemic 2013. Estimates vary from 1.4m to 1.19m. p4 [↑](#footnote-ref-1)
2. Op cit [↑](#footnote-ref-2)
3. ILO Recommendation 200 [↑](#footnote-ref-3)
4. ILO Code of Practice on HIV and AIDS and the World of Work, 2001 [↑](#footnote-ref-4)
5. ***“****Nine out of ten people living with HIV and AIDS are of working age – most of those at risk are also working women and men”* Juan Somavia, Director General of the ILO, Statement for World AIDS Day 2005. [↑](#footnote-ref-5)
6. ILO estimated in 2000 that labour force in high prevalence countries would fall by 10%-22% by 2020. [↑](#footnote-ref-6)
7. See Impact of HIV/AIDS on the labour force in sub-Saharan Africa: A preliminary assessment for details, ILO 2005, ILO, Geneva [↑](#footnote-ref-7)
8. One of the earliest analyses of the impact of HIV/AIDS can be found in the *Impact of AIDS* by the Population Division of the Economic and Social Affairs Department of the UN, 2004, see Chap VIII in particular. [↑](#footnote-ref-8)
9. Social Protection in the Context of HIV/AIDS, Ann Nolan, Irish Aid, OECD, 2009 [↑](#footnote-ref-9)
10. “Education is the foundation for the success of all HIV programming. It is only through comprehensive HIV education that young people can learn about HIV risk in their context and develop the skills to understand, access, and use the HIV programmes that can protect them all their lives.”, UNESCO, WAD, 2012 [↑](#footnote-ref-10)
11. “Linking social protection to HIV responses is critical in helping overcome structural inequalities and barriers that people living with HIV face in accessing essential services,” Caitlin Wiesen, UNDP’s country director in India. <http://www.undp.org/content/undp/en/home/ourwork/hiv-aids/successstories/india--social-protection-for-people-living-with-hiv/> [↑](#footnote-ref-11)
12. ***Treatment 2015***, UNAIDS initiative launched in Abuja, Nigeria, in 2013, plans to reach 15m by 2015. [↑](#footnote-ref-12)
13. <http://www.who.int/hiv/pub/guidelines/arv2013/infographic_all.pdf> [↑](#footnote-ref-13)
14. About 41% of pregnant mothers are infected with HIV in Swaziland, WHO website. <http://www.who.int/features/2012/pmtct_swaziland/en/> [↑](#footnote-ref-14)
15. Michelle Adato and Lucy Bassett, Social Protection and Cash Transfers to strengthen families affected by HIV and AIDS, IFPRI, Washington DC, USA, 2012 [↑](#footnote-ref-15)
16. Potential Impact of Adjustment Policies on Vulnerability of Women and Children to HIV/AIDS in Sub-Saharan Africa Roberto De Vogli1 and Gretchen L. Birbeck, Centre for Health and Population Research, 2005 [↑](#footnote-ref-16)
17. R202 was adopted by the General Conference on 14 June 2012 with 452 votes in favour and one abstention. [↑](#footnote-ref-17)
18. See also ITUC Brief on Social Protection Floors, *Social Protection Floors made simple* [↑](#footnote-ref-18)
19. For the purpose of this Recommendation, social protection floors are nationally defined sets of basic social security guarantees which secure protection aimed at preventing or alleviating poverty, vulnerability and social exclusion, Objectives, scope and principles, R202, see also C102 on Social Security (Minimum Standards), 1952 [↑](#footnote-ref-19)
20. SPC/2011.12/8 [↑](#footnote-ref-20)
21. Enhancing Social Protection for HIV Prevention, Treatment, Care and Support – The State of Evidence 2010 [↑](#footnote-ref-21)
22. Mapping of Social Protection Measures for Children affected by HIV/AIDS in Asia and the Pacific, a Report by the Economic Intelligence Unit, EAPRO, 2012 [↑](#footnote-ref-22)
23. Visit <http://www.unicef.org/socialpolicy/index_56917.html> for estimates of costs of different social protection schemes. [↑](#footnote-ref-23)
24. Social Protection Floor initiative, Country brief, Mozambique, 2010 [↑](#footnote-ref-24)
25. The mission of the social protection is ensuring that all poor and vulnerable people are guaranteed a minimum income and access to core public services, those who can work are provided with the means of escaping poverty, and that increasing numbers of people are able to access risk sharing mechanisms that protect them from crisis and shocks, NSPS, Ministry of Local Government, 2011. [↑](#footnote-ref-25)
26. The case for the social protection floor, Chapter 3, p47 [↑](#footnote-ref-26)
27. HIV sensitive social protection: a review of Cambodia’s social protection schemes for incorporating HIV sensitivity, UNDP, 2013, pp 10-11 [↑](#footnote-ref-27)