HIV-SENSITIVE SOCIAL PROTECTION FOR IMPACT MITIGATION

in Asia and the Pacific

Report on the High-level Technical Consultation
Siem Reap, Cambodia
27–29 April 2011

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This report summarises the outcomes and critical elements of the presentations, technical papers and discussions from a **High Level Consultation on HIV-sensitive Social Protection for Impact Mitigation in Asia and the Pacific** held in Siem Reap, Cambodia from 27 to 29, April 2011.

The consultation was organised by UNDP in partnership with UNAIDS, UNICEF, ILO and APN+ with participation from more than 60 HIV and social protection specialists from eight countries (Cambodia, China, India, Indonesia, Nepal, PNG, Viet Nam and Thailand) in the Asia-Pacific region.

While preparing this report, special attention has been paid to the technical and policy aspects of the presentations and discussions with a view to deepening the understanding of HIV-sensitive social protection in the region, as well as to facilitate South-South learning.

Key materials produced for or during the consultation are included in the annex. All the background documents, presentations and other materials can be accessed online by clicking here.

This report has been prepared by Silja Rajander, an independent consultant with inputs from Clifton Cortez, G. Pramod Kumar and Kazuyuki Uji. Review comments were received from Robin Jackson, Brian Lutz, Paul Causey and Lee Nah Hsu.

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FOREWORD

Since the Asian financial crisis of the late 1990s, there has been heightened attention to social protection in Asia and the Pacific to safeguard vulnerable populations from economic and livelihood shocks. The recent global financial crisis and the continuous food and fuel price inflation further underscore the significance of social protection.

Social protection reduces people's vulnerability to socio-economic risks and impoverishment. It protects them from shocks and helps them conserve and accumulate assets so that they can improve their livelihoods and productivity. It also contributes to transforming economic and social relations in ways that strengthen the longer term livelihood prospects of the poor and vulnerable people.

People living with HIV are one such vulnerable group that needs social protection support. Studies by UNDP in Asia clearly show that people living with HIV and their households are chronically burdened by illnesses, loss of jobs and income, rising medical expenses, food insecurity and depletion of savings and other resources. The impact is more severe on women.

This calls for strategic HIV-sensitive social protection initiatives that can protect affected people from irreversible coping mechanisms and poverty. The key to sustainable HIV-sensitive social protection, as examples in the region and elsewhere show, is not to create parallel systems, but to appropriately integrate HIV into existing social protection initiatives.

This report summarises the outcomes and critical elements of the presentations, technical papers and discussions from the "High Level Consultation on HIV-sensitive Social Protection for Impact Mitigation in Asia and the Pacific" that UNDP organized in partnership with UNAIDS, UNICEF, ILO and APN+ in Siem Reap, Cambodia from 27 to 29, April 2011. I am glad to note that more than 60 senior representatives from eight national governments, UN agencies and civil society participated in the consultation. While preparing this report, special attention has been paid to the technical and policy aspects with a view to deepening the understanding of HIV-sensitive social protection and facilitating South-South learning.

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INTRODUCTION

The importance of HIV-sensitive social protection to achieve Universal Access outcomes for HIV prevention, treatment, care and support, and its inclusion in national AIDS-responses have gained considerable currency recently. Social protection for people impacted by HIV is a priority and among the cross-cutting strategies in the UNAIDS Outcome Framework. There is widespread acknowledgement that HIV-sensitive social protection is a pre-requisite to strengthen impact mitigation, service delivery, and human rights.

In Asia and the Pacific, since 2006, UNDP has been engaged in the assessment of socio-economic impact of HIV at the household level, with a view to help countries and communities develop impact mitigation strategies. UNDP's focus on HIV-sensitive social protection is in its usefulness in mitigating the socio-economic impact of HIV on people living with HIV and their households, and to integrate it into UNDP's overall social protection agenda. It's in this context that UNDP, in partnership with UNICEF, ILO and APN+, organized the High Level Consultation in Siem Reap in April.

An encouraging result of the Consultation, among others that are described in this report, has been the increasing acknowledgement of the importance of HIV-sensitive social protection among governments, communities and other stakeholders, and their commitment towards integrating it both within AIDS responses and national social protection strategies. Some countries are ahead of the curve, while some are just beginning to start up, indicating considerable scope for South-South cooperation.

I would like to thank my colleagues G. Pramod Kumar, Kazuyuki Uji (UNDP APRC) and Brian Lutz (UNDP New York); Steve Kraus (UNAIDS RST); Robin Jackson (UNAIDS, Geneva); Ketan Chitnis (UNICEF Regional Team); Richard Howard (ILO Regional Team); Lee Nah Hsu (ILO, Geneva); Douglas Broderick (UN RC Cambodia), Elena Tischenko, Sophie Barnes, Rany Pen and Flavia Di Marco (UNDP, Cambodia); Kirenjith Kaur (APN+, Bangkok) and the Government of Cambodia for their support in organising the consultation. I would also like to thank the Governments of Cambodia, China, India, Indonesia, Nepal, Vietnam, Thailand and Papua New Guinea for their high level participation.

I hope this report will be a useful resource for HIV-sensitive social protection for impact mitigation not only in Asia and the Pacific, but also in other parts of the world.

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CONTENTS

Acronyms	**1**
Executive summary	**2**
Day 1: The landscape of social protection and HIV in Asia and the Pacific	**4**
Opening remarks	4
Session 1: Defining social protection	6
Introducing a general social protection framework and the Social Protection Floor Initiative	6
Plenary discussion	8
Session 2: Social protection and HIV	8
UNAIDS business case for social protection and HIV-sensitive social protection	8
Plenary discussion	10
Social protection for children affected by HIV/AIDS in Asia-Pacific	10
Plenary discussion	11
Socio-economic impacts of HIV on households in Asia and the Pacific	11
Plenary discussion	14
Social protection from the perspectives of the PLHIV community	14
Plenary discussion	14
Session 3: Lessons from Asia and the Pacific	15
Country case study: Cambodia	15
Country case study: China	16
Country case study: India	17
Country case study: Indonesia	18
Country case study: Nepal	19
Country case study: Papua New Guinea	20
Country case study: Thailand	20
Country case study: Viet Nam	21
Highlights from plenary discussions	22
Day 2: HIV-sensitive social protection needs: Ideas and action	**24**
Session 4: What is needed?	24
Selected priority impact categories	25
Plenary discussion	25
Session 5: Ideas to action	26
Day 3: Principles for action	**27**
Preparing for action: Core competencies and focus areas of UNAIDS cosponsors	27
Session 6: Defining priorities and identifying in-country follow-up action	28
Principles for actions	30
Plenary discussion	31
UN support to move the agenda forwards	31
Plenary discussion	31
Closing remarks	32
Appendix	**34**
1: Concept note	34
2: Agenda	38
3: Participants' list	40
4: Group photo	45

ACRONYMS

ADB	Asian Development Bank
ART	Antiretroviral Therapy
AWPB	Annual Workplan and Budget
CABA	Children Affected by HIV/AIDS
CBO	Community Based Organisation
CCM	Country Coordinating Mechanism (Global Fund)
CSO	Civil Society Organisation
CSR	Corporate Social Responsibility
EDP	External Development Partner
FBO	Faith Based Organisation
GF	Global Fund
HH	Household
HIV-HH	HIV-affected Households
ILO	International Labour Organisation
JUTH	Joint UN Team on HIV/AIDS
KP	Key Populations
MDG	Millenium Development Goal
MOE	Ministry of Education
MOP	Ministry of Planning
MOH	Ministry of Health
MOF	Ministry of Finance
MOL	Ministry of Labour
MMT	Methadone Maintenance Therapy
MSM	Men who have Sex with Men
MVC	Most Vulnerable Children
NA-HH	Non-Affected Household
NGO	Non-Governmental Organisation
ODA	Official Development Assistance
OI	Opportunistic Infections
PMTCT	Prevention of Mother-to-Child Transmission (of HIV)
PPTCT	Prevention of Parent-to-Child Transmission
RH	Reproductive Health
SHG	Self Help Group
SPF	Social Protection Floor
SWAP	Sector Wide Approach
TOT	Training of Trainers
TWG	Technical Working Group
UA	Universal Access
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Program
UNICEF	United Nations Children's Fund
WAPN+	Women Working Group of the Asia Pacific Network of People Living with HIV and AIDS
WB	World Bank
WWA	Women Widowed by AIDS

Cambodia

CARD	Council for Agricultural and Rural Development
CMDG	Cambodian Millenium Development Goal
CPN+	Cambodian People Living With HIV/AIDS Network
HEF	Health Equity Funds
MEF	Ministry of Economy and Finance
MOI	Ministry of Interior
MOLVT	Ministry of Labor and Vocational Training
NAA	National AIDS Authority
NCDD	National Committee for the Management of Decentralisation and De-concentration
NNS	National Nutrition Strategy
NSP III	National Strategic Plan for Comprehensive & Multisectoral Response to HIV/AIDS III (2011–2015)
NSPD	National Strategic Plan for Development
NSPS	National Social Protection Strategy
RGC	Royal Government of Cambodia
VSL	Village Saving and Loan

China

MOCA	Ministry of Civil Affairs of China
MOHRSS	Ministry of Human Resources and Social Security
SCAWCO	State Council AIDS Working Committee Office

India

AWW	Anganwadi Workers
ICDS	Integrated Child Development Services
ICPS	Integrate Child Protection Scheme
IRDA	Insurance Regulatory and Development Authority
JNURM	Jawaharlal Nehru Urban Renewal Mission
MOHUPA	Ministry of Housing and Urban Poverty Alleviation
LAC	Legal Aid Clinic
NACO	National AIDS Control Organisation
NREGA	National Rural Employment Guarantee Act
NRHM	National Rural Health Mission
RSBY	Rashtriya Swasthya Bima Yojna
PRI	Panchayati Raj Institution
SACS	State AIDS Control Society

Indonesia

APBD	(Provincial and District Budget)
APBN	(National Budget)
ODHA	Orang Dengan HIV/AIDS (PLHIV)
PNPM	Program National Pemberdayaa Masyarakat ("A Healthy and Bright Generation"-program related to the MDGs)
RPJMN	Rencana Pembangunan Jangka Menengah Nasional (National Medium Term Development Plan)

Nepal

DPHO	District Public Health Office
GON	Government of Nepal
LGAF	Local Government Accountability Facility
LGCDP	Local Government and Community Development Program
MOAC	Ministry of Agriculture and Cooperatives
MOHP	Ministry of Health and Population
MOHUPA	Ministry of Housing and Urban Poverty Alleviation
MOLD	Ministry of Local Development
MOLT	Ministry of Labour and Transport
MOWCSW	Ministry of Women, Children and Social Welfare
NCASC	National Centre for AIDS and STD Control
NPC	National Planning Commission

Papua New Guinea

HAMP Act	HIV/AIDS Management & Prevention Act
NAC	National AIDS Council
NDOE	National Department of Education

Thailand

MOE	Ministry of Education
MOJ	Ministry of Justice
MOPH	Ministry of Public Healthndoe
MSDHS	Ministry of Social Development and Human Security
TDRI	Thailand Development Research Institute

Viet Nam

MIC	Ministry of Information and Communication
MOLISA	Ministry of Labour, Invalids and Social Affairs
MOPI	Ministry of Planning and Investment
MOPS	Ministry of Public Security
PPC	Provincial People's Committees

EXECUTIVE SUMMARY

In the context of the wide-ranging socio-economic impact of HIV on people living with HIV and their households and other key populations[1], social protection is emerging as a key impact mitigation strategy in Asia and the Pacific. In the UNAIDS Outcome Framework, social protection for people impacted by HIV is a key priority and a cross-cutting strategy.

Recent studies by UNDP in various countries of the region show that the impact of the epidemic on affected households is very severe and often pushes them to irreversible coping mechanisms and poverty although the macro-economic impact is not significant. The burden of HIV at the affected household and per capita levels is significant compared to the non-HIV households across a wide spectrum of indicators ranging from loss of income to education of children. For example, the medical expenditure of HIV-households is considerably higher than that of non-HIV households and the quality of food consumed, despite comparable levels of expenditure, is poorer. HIV reduces households' ability to borrow and they liquidate assets more frequently than the non-HIV households. HIV also has a serious impact on food security as indicated by the reduced farm activity, reduced area under cultivation as well as non-diversity of crops. It leads to school drop-outs, which is higher among girls, and considerable household burden on women. Discrimination is rampant and has a wide-ranging impact including on loss of income.

Despite the acute socio-economic vulnerabilities, the attention to strategically integrate HIV into appropriate social protection schemes (HIV-sensitive social protection) is very limited in the region. The recent financial crisis and the food and fuel price inflation add a more complex dimension to the situation. Already burdened by the severe socio-economic impact of HIV/AIDS, people living with HIV are among the most vulnerable to external shocks. In addition, the possibility of rollback of resources by donors in the wake of the crisis worsens the situation as the AIDS programmes in many countries in the region are largely dependent on donor funds. A World Bank/UNAIDS study[2] concludes that a majority of countries will be forced to cut their HIV programmes as they are dependent on external sources of support that will be reduced because of the crisis.

Available examples show that social protection has significant AIDS mitigation impact. For example, cash transfer programmes piloted in countries with high HIV prevalence have a significant impact on poverty reduction in households affected by HIV and AIDS[3], while supporting livelihoods, enabling access to education and improving nutrition[4]. As the State of Evidence paper of UNICEF[5] notes, social protection, mainly through instruments such as social transfers, livelihoods, social health protection, legislation, policies & regulation, can promote Universal Access outcomes on HIV prevention, treatment, care & support.

In this context, UNDP in partnership with UNICEF, ILO, UNAIDS, and APN+ organised a high level technical consultation on HIV-sensitive social protection for impact mitigation in Asia and the Pacific in Siem Reap, Cambodia from 27 to 29 April 2011. It brought together more than 60 HIV and social protection specialists from Cambodia, China, India, Indonesia, Nepal, Papua New Guinea, Thailand and Viet Nam, including representatives from UNDP, UNICEF, UNAIDS, ILO, WB and WFP. Each national government was represented by senior officials from the HIV/AIDS establishment (e.g. NAC, NACO) as well as the appropriate line ministry/department that is responsible for social protection.

Through technical papers/presentations and group and plenary discussions, the consultation reviewed the social protection situation in the region and elsewhere, with a specific focus on HIV and impact mitigation. It examined in detail the existing good practices of HIV-sensitive social protection; the most strategic sectors that may be involved; and analysed the strengths/weaknesses of the most successful social protection schemes and their adaptability in the context of HIV-related impact in relevant settings.

The opening remarks of H.E. Ngy Chanpal, Secretary of State, Ministry of Interior and Vice Chairman, Council for Agriculture and Rural Development (CARD), Government of Cambodia, set the tone for the consultation, when he said "social protection is an investment to a country's development". It turned out to be the most repeated quote at the meeting. Mr. Douglas Broderick, UN Resident Coordinator & UNDP Resident Representative, Cambodia, highlighted the wide-ranging impact of HIV on people and their households and the importance of social protection in addressing it.

While some countries were ahead of the others (e.g. India) in HIV-sensitive social protection, all the governmen-participants agreed to the need for such efforts so that HIV-affected households are not pushed into irreversible coping mechanisms. Concerns, however, were raised about sustainability, particularly in view of the financial constraints and competing priorities, and making it accessible to vulnerable and marginalised populations. National plans accord increasing priority for social protection and there is considerable scope for integrating HIV into them. The Social Protection Floor (SPF) – a global social

1 The term 'key populations' or 'key populations at higher risk of HIV exposure' refers to those most likely to be exposed to HIV or to transmit it – their engagement is critical to a successful HIV response, i.e. they are key to the epidemic and key to the response. In all countries, key populations include people living with HIV. In most settings, men who have sex with men, transgender persons, people who inject drugs, sex workers and their clients, and seronegative partners in serodiscordant couples who are at higher risk of exposure to HIV than other people. Each country should define the specific populations that are key to their epidemic and response based on the epidemiological and social context: UNAIDS Terminology Guidelines (January 2011)

2 The global economic crisis and HIV prevention and treatment programmes: vulnerabilities and impact, World Bank and UNAIDS, 2009

3 UNICEF, ESARO, 2007 as quoted in "Social protection in the context of HIV and AIDS"; Ann Nolan, Irish Aid, Promoting Pro-Poor Growth; Social Protection, OECD, 2009

4 Agűero *et al.*, 2007 as quoted in quoted in "Social protection in the context of HIV and AIDS"; Ann Nolan, Irish Aid, Promoting Pro-Poor Growth; Social Protection, OECD, 2009

5 Social protection in the context of the HIV epidemic, State of the Evidence and implications for further action, Dr. Rachel Yetes, UNICEF, 2010

policy initiative on social protection – adopted by the UN in 2009 as one of nine key priorities to confront the global financial crisis, accelerate recovery, and help achieve the Millennium Development Goals (MDGs) is significant in this regard. Led by the International Labour Organisation (ILO) and the World Health Organisation (WHO), the SPF provides considerable scope for HIV-sensitive social protection.

A cornerstone of the discussions was the socio-economic impact of HIV at the household levels in the region that calls for impact mitigation steps, including social protection. Based on UNDP studies on the household socio-economic impact of HIV in the region (Cambodia, China, India, Indonesia and Viet Nam) and inputs from participants, the consultation zeroed in on three key types of impact that indicated an urgent need for social protection measures: **economic** (income and employment); **health-seeking behaviours** (which will require actions to increase demand and to ensure services are friendly and non-stigmatising); and **stigma and discrimination**. Most of the priority actions identified were built on modifying or scaling up existing programs or interventions.

An important result of the consultation was unanimous agreement to five key principles that were distilled from the presentations and country group work, and that the consultation participants believed should be the basis for planning and implementing HIV-sensitive social protection in the Asia-Pacific region. The participants decided that instead of recommendations, the key principles will have more practical value in terms of policies and programmes. The key principles finalised were:

1. **Aim for HIV-sensitive social protection rather than HIV-specific social protection[6]:** For reasons of sustainability, coverage, involvement of multiple sectors and the opportunities for mainstreaming HIV into national and decentralised development plans.
2. **Involve multiple sectors and partners:** HIV-sensitive social protection requires the involvement of different ministries, the private sector, civil society and communities. Their involvement and partnership is required at every stage - from planning to implementation. This is also important for sustainability.
3. **Engage affected individuals, networks and communities, especially key populations:** Design of HIV-sensitive social protection programs should be inclusive and participatory so as to ensure that the interventions address the specific needs and concerns of the affected people.
4. **Protect and enhance human rights:** While implementing HIV-sensitive social protection schemes, special attention must be paid to ensure that the human rights of the participants are not violated but rather are enhanced. Issues of concern are mandatory testing, disclosure of beneficiary details, breach of confidentiality and involuntary confinement.
5. **Take into account sustainability:** As in the case of ART, HIV-sensitive social protection requires long-term political and financial commitment, and hence sustainability should be an integral part of the planning process.

Based on the key areas of socio-economic impact that require urgent attention the participants, divided into country groups and formulated strategic steps for HIV-sensitive social protection in their respective countries which should guide all country stakeholders' work, including the respective UNAIDS cosponsors. The organisers agreed to produce a guidance note on HIV-sensitive social protection (UNAIDS); assessment tools (ILO), and a compendium of good practices (UNDP, UNAIDS).

6 HIV-sensitive social protection denotes integration of HIV into existing social protection policies and programs, while HIV-specific social protection refers to exclusive social protection initiatives targeted solely at people living with and affected by HIV and AIDS.

DAY 1: THE LANDSCAPE OF SOCIAL PROTECTION AND HIV IN ASIA AND THE PACIFIC

"It is extremely significant to note that more than a decade of unprecedented economic growth could not protect a large amount of people in the Asia-Pacific region and in Cambodia from social economic risks, and hence the institutional mechanisms for social protection for vulnerable people is absolutely necessary."

- Douglas Broderick, UN Resident Coordinator & UNDP Resident Representative in Cambodia

"Social protection is an investment to a country's development, offering returns in poverty reduction, increased demand, and translating to expanded markets and a healthier, better educated, and more productive workforce."

- Ngy Chanphal, Secretary of State, Ministry of Interior & Vice Chairman, Council for Agricultural and Rural Development, Cambodia

Day 1 was dedicated to deepening the understanding on HIV-sensitive social protection for impact mitigation, sharing of experiences and good practices, and was composed of presentations by UN agencies, governments and the Asia Pacific Network of People Living with HIV. Key messages put forward during the first day include:

- Social protection is a form of investment: it is not an expense, or charity.
- Social protection strategies require multisectoral mechanisms to facilitate multistakeholder involvement and scale up of programs.
- The successful implementation of social protection instruments requires effective coordination among different levels (national, provincial, and local).
- The development of social protection priorities and approaches needs to be country-led.
- There is a need to generate data to inform sustainable and cost-effective social protection strategies.
- Stigma and discrimination are significant barriers to seeking healthcare- and other services.
- While developing HIV-sensitive social protection, it is important to focus on key populations.

OPENING REMARKS

Clifton Cortez, Practice Team Leader; HIV, Health and Development, UNDP Asia-Pacific Regional Centre (APRC)

Welcoming the participants and the dignitaries, he stressed the need for joint efforts, involving multiple sectors, governments and civil society, for the succesful planning and implementation of HIV-sensitive social protection in the region. He expressed the hope that the consultation would catalyse strategic action in this direction.

Ngy Chanphal, Secretary of State, Ministry of Interior; & Vice Chairman, Council for Agricultural and Rural Development (CARD)

His Excellency Ngy Chanpal set the tone for the discussion on HIV-sensitive social protection by sharing insights on Cambodia's HIV response and on the recently endorsed Social Protection Strategy in Cambodia. Cambodia has made remarkable progress in reducing HIV prevalence through effective prevention strategies and universal ART coverage. The HIV response in Cambodia formally began in 1991, and since 1998 it has been under the leadership of the National AIDS Authority (NAA). To reach its mission, the NAA has developed the National Strategic Plan for Comprehensive & Multisectoral Response to HIV/AIDS III (2011–2015; NSP III) in 2010, which is based on the current HIV situation and the need to address high-risk behaviours.

The global financial and economic crisis has led to broad agreement and understanding that economic growth and social infrastructure are not going to eradicate poverty and protect vulnerable groups on their own: there is an urgent need to develop various measures of social protection. Alongside protecting the poor from shocks, social protection promotes human capital and sustainable growth and improves productivity. Reflecting this view, the Cambodian National Strategic Plan for Development (NSPD) was updated in 2009 and emphasized growth strategies and the relationship between growth and poverty reduction. A National Social Protection Strategy (NSPS) was adopted by the Royal Government of Cambodia (RGC) in March 2011 with the following objectives:

- Address the basic needs of the poor and the vulnerable in situations of emergency and crisis.
- Reduce the poverty and vulnerability of children and mothers and enhance their human development.

- Address seasonal unemployment and underemployment and provide livelihood opportunities for the poor and the vulnerable.
- Promote affordable health care for the poor and the vulnerable.
- Improve social protection for special vulnerable groups.

The implementation of the NSPS will require scaling-up current interventions, designing institutional arrangements, including health equity funds and subsidy schemes administered by the Ministry of Health and community-based health insurance schemes; and introducing new programs to cover existing social protection gaps. The short- and medium-term priority articulated in the NSPS is to develop social safety nets targeted to the poor and vulnerable, with complementary services for special vulnerable groups, which include PLHIV and their families. The long-term priority is to achieve universal coverage, providing all Cambodians with a basic package of transfers and services – including social security mechanisms for the formal sector and social safety nets for the informal sector – commensurate with the economic development of the country. The achievement of this long-term vision requires:

- A consolidated and comprehensive action plan and interministerial dialogue;
- A focus on inclusive growth;
- A mix of programs that cover poverty and hunger, and promote human capital;
- Prioritising interventions that address major sources of vulnerability;
- Scaling up and harmonising current interventions;
- Harmonising processes, ensuring regular financing and reassessing program coverage to better address the concentration of poverty and vulnerability in particular areas;
- Developing new programs to address social protection gaps for the poor and vulnerable.

Cambodia faces many challenges in the area of social protection. Ngy Chanphal identified the following issues as key to increasing the effectiveness of social protection interventions, and reiterated the RGC's commitment to addressing these:

- Improving coordination of social protection activities of implementing ministry departments and civil society organisations at all levels, developing appropriate structures and mechanisms;
- Strengthening monitoring and evaluation, as well as information and knowledge management;
- Building capacity for program design and implementation;
- Ensuring effective targeting of interventions;
- Ensuring re-alignment and harmonisation of social protection programs, also at decentralised levels, and coordinating with development partners to achieve policy cohesion.

The Council for Agricultural and Rural Development is responsible for the overall coordination of the NSPS, and the implementation of sectoral social protection programs is the responsibility of respective ministries – thus the NAA is responsible for social protection programs specific to HIV. While HIV programs face many daunting challenges, there are also opportunities to work together, share experiences, learn from each other, and act responsively, including at this consultation. Hopefully, the future will see more such dialogues, and increased support to social protection, vested as it is in sustainable development and poverty reduction in the Asia-Pacific region, including Cambodia.

Douglas Broderick, UN Resident Coordinator & Resident Representative; UNDP, Cambodia

Social protection is key to the inclusive socioeconomic development of Asia and the Pacific, and given the demonstrated impact of HIV on people and on households, there is a need to ensure that social protection is HIV-sensitive. Social protection is one of the pillars of the 5-year UN Development Assistance Framework in Cambodia, and social safety networks are a core component of the joint UN efforts. Social protection is needed to reduce people's vulnerability to socioeconomic risks and impoverishment, and to enable the poor and vulnerable populations improve their livelihoods and productivity in the long-term. People Living with HIV (PLHIV) are a vulnerable population group, and findings of studies by UNDP in the region show that PLHIV and their households are acutely burdened by illnesses, loss of jobs and income, medical expenses and depletion of savings and other resources. They are also affected by food insecurity, discrimination, social exclusion, psychological stress and related morbidity, and often irreversable impoverishment. The impact of HIV is even more severe on women, and often HIV has inter-generational consequences, such as on the education of girls and on liquidation of assets. There is consensus that concrete steps for impact mitigation are needed, in which HIV-sensitive social protection has a significant role.

While countries in the Asia-Pacific region are undertaking social protection activities to support HIV affected households, the idea and the operative aspects of HIV-sensitive social protection are still in the initial stages. This calls for broadening the understanding of the concept and of the ways for its operationalisation and implementation, political commitment, appropriate policies and programs, and technical capacity. This consultation presents an opportunity for discussion and learning from the

considerable knowledge and experience that exists in the countries of the region. The Joint UN team is committed to playing a facilitative role to ensure that optimal social protection is possible and is available for people and households affected by HIV.

Ketan Chitnis, Regional HIV Specialist; UNICEF Asia-Pacific Shared Services Centre

There is growing recognition and importance attached to social protection as a strategy to address food insecurity, chronic poverty, and the impacts of HIV and AIDS. As part of its global mandate, UNICEF is working towards ensuring that social protection measures are HIV-sensitive, especially in countries where the epidemic is in low and concentrated levels, and that they address the needs of the most vulnerable and disadvantaged children. There is a need for social protection that addresses the unique needs of the children of key affected populations (KAPs), and that targets affected households to ensure that they do not fall further into poverty, compromising the future of the children living in these households. Due to their parents' drug use and sex work, which is often illegal and hidden, identifying children of KAPs is difficult. This increases the vulnerability of these children and potentially contributes to their further marginalisation. Linking social protection with the achievement of Universal Access (UA) outcomes related to prevention, care, support and treatment is critical.

There are several ongoing large-scale national social protection programs in the region providing social protection instruments including social assistance, insurance, and social services. The task ahead is to make national programs and policies HIV-sensitive. Evidence supports the view that this will have a lasting effect on achieving the UA outcomes. Further evidence that will make HIV-sensitive social protection attractive is the demonstration of the cost-effectiveness of strengthening ongoing programs, and determining how to develop opportunistic linkages between health, social welfare and social protection sectors. This joint consultation is an important milestone in setting the agenda forward.

Considerable strides have been made following the 2006 "Hanoi Call to Action" for children and HIV/AIDS, where governments agreed to develop protection, care and support programs and policies as part of the national strategic plans for HIV and AIDS. Several of these plans take into account the most marginalised or vulnerable children so they are not necessarily HIV-exclusive. Needs assessments of affected children conducted over the past 5 years have identified some unique needs and demands that children living with HIV and impacted households face. A regional evidence-informed HIV-sensitive social protection framework that looks to newer, wider definitions of social protection and incorporates a transformative element, would help alleviate the impact of HIV and AIDS in the region and help guide national policies and programs responsive to the needs of families and children impacted by the epidemic.

SESSION 1: DEFINING SOCIAL PROTECTION

Objective: To provide a conceptual framework for social protection

Introducing a general social protection framework and the Social Protection Floor Initiative
Celine Felix, consultant for social protection; ILO Decent Work Team, Bangkok

Social protection is a key priority in international development, and takes various forms in different national settings. There are many overlapping and differing definitions of social protection. For instance the ADB defines social protection as a "set of policies and programs designed to reduce poverty and vulnerability"; UNICEF defines social protection as "a set of transfers and services meant to ensure a minimum standard of dignity and wellbeing throughout the course of life"; and ILO defines it as "the set of public measures that a society provides for its members to protect them against economic and social distress". There are also differences among societies in how they approach and define social protection. Societies have different needs, objectives and capacity; thus it is important to conceptualise social protection at the national level to ensure a coherent, effective approach. There are different functions of social protection:

- **Protective:** To protect basic needs and provide relief from deprivation.
    - Instruments include cash transfers such as children's grants, old age pension.
- **Preventive:** To stop those at risk from falling into poverty.
    - Instruments include social insurance mechanisms such as health insurance and employment guarantees.
- **Promotive:** To enhance income and promote livelihoods.
    - Instruments include youth training and microcredit.
- **Transformative:** To address social inequity and exclusion.
    - Instruments include anti-discrimination legislation.

Arguments for investment in social protection include the following: social protection and social security are a human right[7];

7 See articles 22 and 25 of the Universal Declaration of Human Rights.

evidence demonstrates that social protection is an important social and economic stabiliser; it is an anti-crisis tool that facilitates recovery; and establishing a basic set of social protection for all is both affordable and feasible.

The Social Protection Floor (SPF) – a global social policy initiative on social protection – was adopted by the UN in 2009 as one of 9 key priorities to confront the global financial crisis, accelerate recovery, and help achieve the Millennium Development Goals (MDGs). It is led by the International Labour Organisation (ILO) and the World Health Organisation (WHO), and is organised through national, regional and global task forces, with national SPF taskforces (consisting of national stakeholders from relevant ministries, social partners, NGOs, and UN agencies) supporting the development of in-country SPF work.

The SPF works on both the supply and demand sides of social protection. Its aim is to ensure both the **availability** of essential services such as housing, education, and health care; and **creation of demand** for them through basic social transfers in cash or in kind. It emphasizes the need to guarantee:

1. All residents have access to essential health care.
2. All children enjoy income security through transfers in cash or in kind, such as school feeding, cash transfers, and access education and care.
3. All those in active age groups who cannot earn sufficient income enjoy a minimum income security through transfers in cash or in kind, and/or employment guarantee schemes.
4. All residents in old age and with disabilities have income security through pensions or transfers in kind.

Key characteristics of the SPF include: a **rights-based approach**; the promotion of **nationally defined strategies** that protect **a minimum level of access to essential services and income security** for all across the life cycle, with attention to vulnerable groups; the promotion of **policy coherence**, involving multi-stakeholder involvement to tackle the multi-dimensional aspects of poverty and vulnerability; **universal entitlement** to protection through a **basic package** for all in need; and conceptual flexibility and adaptability reflecting its **focus on outcomes**. SPF is a first step in the process of improving social security: "it is a floor, not a ceiling."

The social protection landscape in Asia-Pacific: What has been done, what have we learned, and where are we headed?

A major challenge facing social protection is the coverage gap of current schemes: only about 20 percent of the world's working-age population and their families have effective access to comprehensive social protection schemes. Public spending on social protection, particularly in developing countries, is low. In Asia and the Pacific, public expenditure on heath care and social security is 5.3 percent of GDP. However, many Asian countries have developed elements of the SPF. Examples include CARD's Social Protection Strategy, and Health Equity Funds (Cambodia); the Minimum Living Standard Guarantee Program, the New Rural Corporative Medical Care, Health Insurance for Urban Uninsured Residents, and rural old-age pension (China); the Rashtriya Swasthya Bima Yojna health insurance scheme and the National Rural Employment Guarantee Scheme (India); the Social Security Law (Indonesia); the Universal Healthcare Coverage Scheme (Thailand); and the 10 year Social Protection Strategy (Viet Nam). In this context, the SPF can be used to:

- Trigger a participatory approach.
- Assess social protection coverage.
- Bring more coherence at policy level and develop a coherent national social protection strategy.
- Make sure the right to social protection is protected.
- Operationalise social protection strategies.
- Channel Technical Support, for example from UN organisations.

The SPF has many opportunities for HIV-sensitivity. These are summarised in the table below:

Table 1. Opportunities for HIV-Sensitivity within the SPF

SPF's Key characteristics	Opportunities for HIV-Sensitivity
Rights approach	Legally binding obligations: Legislative framework Principles to guarantee final outcome design and implementation of social protection schemes, such as equality and non-discrimination; participation, transparency, accountability, and access to information
Minimum Income Support	Reduce the socio-economic impact of HIV on households through financial protection
1st stair of the Social Security Staircase	Facilitate graduation for people with work capacity
Universal comprehensive approach	Guarantee affordable quality services (health, education)
Assessment and priority setting through national dialogue	Opportunity to assess HIV-sensitivity of schemes and improve them based on results

Plenary discussion

Social protection is needed to sustain economic growth: In Asia, the argument for a long time has been that social protection is too expensive. The financial and economic crisis provoked recognition and increasing political commitment to implementing social protection measures. There is also growing acknowledgement of the need to extend the coverage of social protection schemes to the informal economy.

The costs of financing social protection, and the need for related evidence: Significant financial challenges exist in providing (unconditional) health services and education for all. There is emerging evidence that the universal healthcare coverage scheme introduced in 2001 in Thailand may not be completely sustainable. The scheme, which has relied on patients paying a set fee for healthcare services, has led to healthcare sites having to lay off personnel and reduce the number of services to patients, compromising healthcare standards.

It is important to plan how to finance social protection and to generate data on the costs of social protection schemes to ensure they are sustainable, and to advocate on their behalf. There may be an initial need to seek funding from donors, but national budget is central to long-term, sustainable programming.

Coordination is the key: National dialogue to identify priorities is the key to developing effective, coordinated and coherent social protection strategies. This requires multi-stakeholder engagement and working across sectors. It is important for also donors to align their programs with national priorities and strategies.

The role of leadership: Members of Parliaments need to be involved to push social protection forward, and provincial heads play an important role in community-led social protection. A good example is the High-Level SPF Advisory Group chaired by the former president of Chile, Her Excellency Michelle Bachelet.

The role of donors: Donors play a key role in empowering the community, advancing the social protection agenda, and channeling support.

SPF and vulnerable populations: The SPF is ingrained in rights-based language, which suggests the need in Asia and the Pacific to develop HIV-sensitive social protection measures that focus on marginalised groups such as MSM, people who use drugs, or sell sex.

Addressing the needs of mobile populations: Migrant workers are one of the most affected populations and often face particular barriers to accessing essential healthcare and other services. They may have to pay more for health services, or are not entitled to accessing health services due to lack of health insurance, for instance. There is a need to ensure finances for migrants to access health care and other services.

Transformational aspect of social protection: Newer interpretations of social protection present it as a means to transform existing inequalities and power relations. This fits in well with the objective of reducing stigma and discrimination related to HIV.

SESSION 2: SOCIAL PROTECTION AND HIV

Objective: To understand why social protection matters for HIV, especially impact mitigation in the region, and how to plan HIV-sensitive social protection

UNAIDS business case for social protection and HIV-sensitive social protection
Robin Jackman; UNAIDS, Geneva

The UNAIDS business case on enhancing social protection[8] was developed in 2010, and it aims to respond to the following questions:

- Why is social protection important for the AIDS response?
- What should we build on and what needs to be done differently to ensure social prtection is HIV-sensitive?
- How to ensure accountability and measure progress?

Social protection can help accelerate universal access to treatment, care, support, and prevention. It has the potential to address structural drivers of the epidemic, and barriers in access to treatment. There is increasing interest in social protection around the world, but linkages to HIV are often very weak. There is a need to develop more comprehensive approaches to social protection, moving beyond preventive safety- net areas of social protection towards other kinds of promotional and transformational social protection mechanisms. The recommended approach is that of "HIV sensitive"and not "HIV exclusive" social protection measures - developing mechanisms within broader social protection programs so that they are inclusive of those living with and affected by HIV. The three pillars of HIV-sensitive social protection are:

8 This business case cites Devereaux and Sabates-Wheeler's (2004) definition of social protection, which is: "all public and private initiatives that provide income or consumption transfers to the poor, protect the vulnerable against livelihood risk, and enhance the social status and rights of the marginalized; with the overlall objective of reducing the economic and social vulnerability of poor, vulnerable and maginalise groups."

- Policies, legislation and regulation (addressing social exclusion, stigma and discrimination, particularly among key populations; access to services related to care, support, prevention, and treatment);
- Financial protection, including social transfers (protecting affected households from chronic poverty; reducing negative coping strategies; and addressing inequalities that drive the epidemic, particularly those related to gender);
- Access to affordable quality services (health services, education, OVC programs, family-based support).

Systems and community strengthening underpins all three pillars. While social protection is for everyone, the aim of applying an HIV lense is to have the biggest impact on the epidemic. The goal, articulated in UNAIDS' new strategy (2011–2015), is that "PLHIV and households affected by HIV are addressed in all national social protection strategies and have access to essential care and support." Priority actions for Asia and the Pacific identified by the Joint UN Teams on HIV/AIDS (JUTH) include:

- Ensure legal rights, right to health, education and livelihoods.
- Ensure social protection measures in high burden countries are informed by data on national impact.
- Barriers to social protection assessed and addressed; care and support is integrated into GFATM proposals.
- AIDS coverage in social insurance schemes for formal sector workers is advocated.

Key challenges include:

- Building broader, country-wide linkages, moving away from isolated projects and transfers towards livelihood protection and strengthening.
- Improving the evidence base, which is patchy and has limited coverage (most evidence is from high burden countries and Sub-Saharan Africa).
- Ensuring inclusion of PLHIV (particularly PLHIV representing marginalised groups) in planning, designing and implementing social protection.

Evidence of the positive impact of social protection for people living with and affected by HIV and AIDS includes:

- Good evidence on positive impact of social transfers on care and support, including for OVC (mitigating the socio-economic impact of HIV/AIDS).
- Strong evidence on cash transfers (conditional and non-conditional), particularly for OVC (improving nutrition, health, and possibly health-seeking behavior).
- Emerging evidence on the contribution of social protection to HIV prevention, treatment uptake and adherence (e.g. vouchers for transport to clinics; food and nutritional support; livelihood support; transfers for girls' schooling; HIV-sensitive microcredit, e.g. the IMAGE study).
- Good evidence on importance of free services at point of access for the poorest.
- Importance of looking at interventions as a 'graduated continuum' from social transfers to livelihoods packages (public works programs, income generation, micro-credit etc); moving from consumption- enhancing to productivity-enhancing interventions.

Social protection has a transformational aspect that is particularly relevant to HIV. It contributes to empowering people and guaranteeing human rights, which is relevant to key populations at higher risk of HIV exposure; and it addresses the social and economic vulnerabilities of marginalised populations. An example is the Sonagachi project from India in which sex workers are involved in the design and implementation of activities. The following gaps have been noted in existing evidence on social protection and HIV/AIDS:

- How far social protection is covering vulnerable AIDS affected households;
- Qualitative and quantitative studies to better understand barriers to access to all kinds of services;
- What is the optimal combination of transfers in different epidemic contexts (food, cash, vouchers, agricultural inputs) for HIV impacts;
- The identification of lessons learned from TB and other chronic diseases on access and adherence;
- Participatory studies involving PLHIV.

Achieving optimal outcomes for HIV-sensitive social protection requires good **partnerships** to exchange evidence (government, academics, civil society, UN agencies); inter-governmental work to ensure effective planning (particularly health, social welfare, finance/economic); identifying the most **appropriate interventions** (working closely with PLHIV); and improving **linkages** between those working on social protection and those working in HIV treatment, prevention, care and support.

Plenary discussion

Planning HIV-sensitive social protection: First steps in developing HIV-sensitive social protection should include analysis of the HIV epidemic and the HIV response, including identifying what the KAPs are, what legal rights they have, and what challenges they face in accessing services; and identifying what social protection measures are in place, what needs to be expanded, and what needs to be built to ensure that they are HIV-sensitive.

Integrating HIV within social protection: Reconciling the urgent needs of key populations with the need to strengthen broader social protection for all, avoiding building parallel systems, can be challenging. It is important to identify existing social protection systems and mechanisms, and incorporate HIV within these, moving away from stand-alone pilot projects.

Social protection for children affected by HIV/AIDS in Asia-Pacific
Ketan Chitnis, Regional HIV Specialist; UNICEF Asia-Pacific Shared Services Centre

In the Asia-Pacific region, there are an estimated 158,000 children between 0–14 years living with HIV, and 1.75 million children who have lost one or both parents to AIDS. While there is lack of data detailing the burden HIV/AIDS places on children, consequences of HIV/AIDS on children in the region include lower household income; the economic decline of households; loss of either one or both parents (56% of AIDS affected children); reduced access to education; and poor school performance, especially among orphans. Children with parents who inject drugs, and sell or buy sex are most affected by the HIV epidemic.

Positive trends regarding social protection for children affected by HIV/AIDS in the region include the development of national strategic plans for HIV/AIDS that include specific components connected to affected children; the move towards addressing the needs of all vulnerable and marginalised children as part of the national response; and the ways in which responding to the needs of affected children has prompted strengthening social protection and social welfare systems. Capacity, insufficient resources, and the lack of size estimations of affected children present challenges to social protection for OVC.

The socio-economic outlook and vulnerability in the region can be summarised as follows:

- The economic outlook is improving, yet there are a lot of equity issues
- Employment in the formal labour market remains predominantly agricultural, exposing households to climate shocks and the risk of seasonal unemployment
- The informal labour market plays a substantial role in sustaining the economies, exposing millions to income instability
- Structural causes of poverty and exclusion shape susceptibility to risk because of limited access to assets, and social exclusion
- In the context of HIV, strong economic growth has not reduced vulnerability

Poverty, while interconnected to the epidemic, is not the sole driver of the HIV epidemic in the region. Drug use and selling sex drive the epidemic in Asia, and underscore the need to address harmful legal environments and weak human rights contexts to prevent new infections. Income inequality is associated with HIV prevalence in the region, with the exception of countries such as China and Nepal, which have relatively high income inequality, but low HIV prevalence rates.

Findings from the regional mapping of child and HIV-sensitive social protection:
The regional mapping of child and HIV-sensitive social protection – analysing secondary data and documented evidence on policies and national programs designed to meet the needs of children – was conducted in 9 countries[9] in the Asia and Pacific in 2010/2011 to provide a snapshot of available social protection[10] for children, particularly those affected by HIV/AIDS. The methodology included developing a scoring key to establish the level (limited to extensive) of how child-sensitive and HIV-sensitive existing social protection/welfare programs were. Key findings from the regional mapping include:

- **Social assistance**: Substantial to extensive progress has been made in most countries in this area. Social assistance is most extensive in areas with robust civil society networks.
- **Social insurance**: Social insurance exists particularly in the formal work force sector, and some programs focused on maternal support and access to healthcare exist in the informal sector. Few social insurance schemes are HIV-sensitive, and social insurance is not reaching affected children.
- **Social services**: Progress has been made in making ARV widely available, and in ensuring poor households and vulnerable children have access to e.g. healthcare and education. Employment support is weak across the region, and employment schemes are often unsuitable for the chronically ill, and do not take account of the limitations faced by people living with HIV. The psycho-social needs of children affected by HIV are not being consistently addressed.

9 Bangladesh, Cambodia, China, Indonesia, Nepal, Pakistan, Papua New Guinea, Thailand, and Viet Nam

10 Social protection was defined in the mapping exercise "as a set of transfers and services to reduce economic and social vulnerability, protect against livelihood risks, and ensure a minimum standard of dignity for excluded and marginalized people."

- **Policies and legislation**: The legal environment is relatively advanced in the region. There is a need to strengthen the legal environment related to high risk behaviours, however.
- **National expenditure**. Asia-Pacific spends about 5% of GDP on social protection, and about 57% of its poor receive some form of social protection.
- **Key drivers of social protection including for children**. The most common drivers include pro-poor assistance (6 countries), children's needs (7 countries), women's development (3 countries), and HIV (3 countries).

In moving forward and developing HIV-sensitive social protection in the region, there is a need to integrate HIV-sensitivity within social assistance, social welfare, and social insurance programs. This needs to be informed by evidence on how social protection instruments can mitigate the impact of HIV, and benefit the most vulnerable and at risk children and families. The role of civil society organisations (CSOs) is critical to reaching most affected children, as is the role of governments at national and sub-national levels.

Plenary discussion

Social insurance, formal and informal work: Some form of social insurance, such as health insurance, is largely available for people in the formal workforce in the region. A particular challenge is that of how to make sure policies and programs address the needs of people in the informal workforce, and marginalised populations such as the poor.

Social assistance is a targeted intervention: Social assistance is a targeted form of intervention. Existing packages include cash transfers, food vouchers, and nutritional support, for example. These packages are decided on the basis of certain criteria. Most existing packages target vulnerable and poor households, and are not HIV-specific.

HIV-sensitive versus HIV-exclusive programs : While HIV-exclusive pilot programs for children exist, the future direction is to integrate these programs within broader social protection programs that address all vulnerable and marginalised children, (e.g. the Child Friendly Local Governance-program in Nepal).

Socio-economic impact of HIV on households in Asia and the Pacific
Pramod Kumar, Senior Program Advisor; HIV, Health & Development, UNDP APRC

It is widely acknowledged that HIV severely impacts the economic and social spheres of all societies. Over the past several years, governments in the Asia-Pacific region have made important advances in the introduction of new policies and programmes aimed at mitigating the socio-economic impact of HIV on individuals living with HIV and their households. Despite these advances, there have only been limited attempts to measure the specific impact of HIV at the household level and use this information for evidence-based policy interventions. To address this vital gap, UNDP undertook nationwide socio-economic impact studies in Cambodia, China, India, Indonesia and Viet Nam between 2005 and 2010. This regional analysis is based on the data and findings from the country level studies and is meant to support the development of targeted, evidence-informed impact mitigation policies and programs, including HIV-sensitive social protection.

Methodology and data

The studies involved surveys of HIV-affected households (HIV-HHs) and non-affected households (NA-HHs) and examined critical socio-economic issues: income, employment, revenues, expenditures, coping mechanisms, health, education, food security, family composition, impact on women and girls, and stigma and discrimination. While the survey instruments used in the various studies were adapted to meet the specific needs and circumstances of each country, they followed a broad common methodology developed by UNDP that allowed for inter-country comparisons.

The surveys were conducted over a period of six years, starting with India in 2004 and ending with Cambodia in 2010. In total, over 17,000 households were included in the surveys, compiling data on over 72,000 household members.

Limitations

(i) The national studies occurred in different time periods

(ii) Non-probability sampling in Viet Nam, India, Indonesia, and China does not allow for statistical inferences on population parameters or other estimates.

(iii) Primary databases from China and India were not accessible for confidentiality reasons, limiting the possibility to include dimensions of analysis that were possible in the other three countries.

(iv) Because of the local adaptation of the methodology and questionnaire, there are some limitations on the availability of comparable indicators across all countries.

Key findings

Living conditions, income and employment

Overall, members of HIV-HHs lived in lower living conditions, were more likely to be unemployed, and had lower household incomes than members of NA-HHs. At the most basic level, respondents from NA-HHs in Cambodia, China, India and Viet Nam

were more likely to live in stable structures than those in HIV-HHs. With regards to employment, male members of HIV-HHs in Cambodia, China and Indonesia had lower employment levels than those in NA-HHs, and PLHIV in Cambodia and Indonesia had were almost twice as likely to be unemployed as NA-HH members. Specifically for PLHIV, their employment levels in Cambodia, China, India and Viet Nam dropped substantially after their diagnosis.

A common thread throughout the countries was the additional impact of care-giving on income and employment. A quarter of PLHIV in Cambodia, India and Indonesia had a caregiver, many of whom had either left their job or experienced reduced income as a result of their care-giving duties.

In terms of productivity, in all countries, HIV-positive status or care-giving resulted in greater numbers of lost work days than was experienced by members of NA-HHs. Additionally, in all countries, child labour levels were higher in HIV-HHs than NA-HHs, especially for girls, providing insight to some of the coping mechanisms taken on by HIV-HHs to deal with lower total annual household incomes than NA-HHs. Additionally, in China, India and Indonesia, a greater percentage of HIV-HHs were below the poverty line than NA-HHs.

Coping mechanisms: asset liquidation, migration, debt, consumption, and loss of savings

In addition to the effects of reduced employment and income, HIV affects individuals through the continual need to outlay high medical expenses, often resulting in the need for coping mechanisms such as asset liquidation or assumption of debt.

In all countries, HIV-HHs were less likely to own their house than NA-HHs and were less likely to own most assets included in the surveys. This finding points to a reduction in asset accumulation that has deleterious effects on the economic stability of the HIV-affected households. Additionally, HIV-HHs and PLHIV in Cambodia and Viet Nam more likely to have migrated than NA-HHs, and there were high levels of HIV-HH migration in Indonesia. The reasons for migration varied, but discrimination and seeking medical care were important issues in many countries.

Many HIV-HHS reported a loss of savings due to HIV, with Indonesia losing as high as three-fourth of their savings. In addition, HIV-HHs in Cambodia, India, and Viet Nam were more likely to be in debt than NA-HHs, likely due to the need to supplement their lost incomes or the high costs of medical care. In China, HIV-HHs found it difficult to borrow compared to the NA-HHs and liquidated assets twice as much as NA-HHs to cope with the rising economic burden on the households. Liquidation of assets was also widely prevalent among the HIV-HHs in Indonesia. Indeed, HIV-HHs in India, Indonesia and Viet Nam spent three to four times as much on health care as NA-HHs, although it should be noted that in Cambodia, with its universal ART coverage policy, HIV-HHs spent less on health care than NA-HHs.

Impact on education

The studies showed that HIV has a destructive toll on the human capital accumulation of HIV-HHs through reduced educational opportunities and outcomes. Children in HIV-HHs in China, India, Indonesia and Viet Nam were less likely to attend school than those in NA-HHs, and the most vulnerable, poor children living in HIV-HHs in China and India were much less likely to attend school than those in NA-HHs (71% in the poorest Chinese HIV-HHs compared to 100% in the wealthiest NA-HHs).

Additionally, the negative impact of HIV on female household members, as discussed earlier, is much higher than that of males. Girls in HIV-HHs in China, India and Indonesia were substantially less likely to attend school than those in NA-HHs or boys in any household. In China, the difference ranged from 86% attendance for girls in HIV-HHs to 99% for boys in NA-HHs. In addition, children in HIV-HHs in China, India and Indonesia more likely to have dropped out of school, and again, girls were more likely than boys to have dropped out.

However, HIV-HHs in Cambodia, Indonesia and Viet Nam more likely to have received education assistance than NA-HHs, pointing to the positive steps that government policies have taken to mitigate the effects of HIV on households. In contrast, children in HIV-HHs faced significant stigma and discrimination, a possible contributor to the negative education results observed, and one that cannot be overcome by financial assistance alone.

Impact on health

The increased demand for healthcare that results from a diagnosis of HIV has a dual effect. First, the absence from the workplace has an important effect on the household's productivity. Secondly, the increased cost of medical care which the households are faced with forces them to adjust consumption and savings levels, further exacerbating the impact on income and living conditions. Access to ART clearly mitigates the high health care utilization traditionally associated with HIV, and, can even lead to decreasing levels of expenditure thus constituting a basic pillar of any financial protection strategy targeted to PLHIV.

In all countries, members of households were likely to have not sought care when they reported being sick, but PLHIV in China and Indonesia were more likely to have not sought care than NA-HH members when sick due to financial reasons.

With regards to spending patterns, HIV-HHs in China, India, Indonesia and Viet Nam allocated substantially more of household consumption to health care than NA-HHs. Additionally, the poorest HIV-HHs in China, India and Viet Nam allocated the greatest share of household expenditures to health. However, in Cambodia, the reverse was true, and NA-HHs actually reported spending more on health than HIV-HHs, possibly due to the universal ART coverage policies implemented in Cambodia, a striking pointer to the benefits of universal access to treatment.

The percentage of health expenditures allocated to HIV-related costs varied by country (data was available for China, Indonesia, and Viet Nam) and ranged from 26% in Viet Nam to 59% in Indonesia.

Food security
In light of increasing world-wide food prices, the relationship between HIV and food expenditures has gained increasing importance. The results from these studies show that HIV has substantially affected food expenditures in Viet Nam and the poorest households in India. Members of HIV-HHs in Cambodia and Viet Nam were more likely to have experienced hunger than members of NA-HHs. Additionally, in all countries, there were differences in how food budgets were spent, as HIV-HHs spent less on protein-rich foods than NA-HHs, indicating that even when quantities were considered sufficient, adequate malnutrition was potentially still an issue. Finally, food support for HIV-HHs varied across the region, but HIV-HHs in Cambodia and Viet Nam were more likely to have received food support than NA-HHs, again indicating well-targeted government policies.

Stigma and discrimination
The studies reported high levels of internal stigma (shame, low self-esteem, and suicidal thoughts) by PLHIV. In addition, regional differences were seen in PLHIV who immediately reported their status to their spouse; however, in all countries males were less likely to have done so than female PLHIV. There were also differences in spousal reactions to the disclosure, but all countries showed improved support over time.

NA-HHs in India and China reported very high levels of bias against PLHIV and their families. In conjunction, PLHIV reported very high levels of stigma and discrimination. Over 50% of PLHIV in China and India reported social isolation and neglect - an average of 20% of PLHIV in all the countries reported being verbally abused because of their status. Perhaps most concerning was the high level of discrimination in health facilities in Indonesia (30%), Viet Nam (17%) and China (13%). This reduces the likelihood of PLHIV disclosing their status and receiving the care they need, as evidenced by the high percentage (over 40%) of pregnant HIV-positive women in Indonesia who had not disclosed their status to their health care provider.

Family structures, impact on women and girls and Intimate Partner Transmission
In the three analysed countries, Cambodia, China and Indonesia, HIV-HHs were less likely to have a nuclear family structure than NA-HHs, which may reflect the high percentage of widowers in the survey population and indicates the impact on the economic earning potential of the households.

Pregnant HIV-positive women are a particularly vulnerable group. While the surveys in Cambodia and Indonesia were being conducted the World Health Organisation changed its recommendations for HIV positive women and their newborns, so the low levels of ART utilisation and breastfeeding reported can serve as baseline data against which to measure future improvements.

Another particularly vulnerable group, widows, were analysed with regards to their property inheritance rights. In Cambodia, it was found that widows in HIV-HHs were less likely to have inherited their deceased husband's property or assets than widows in NA-HHs. In Indonesia and Viet Nam high levels of loss of inheritance rights were reported (71% in Indonesia and 62% in Viet Nam).

Social safety nets
Insurance and pensions offer HIV-affected households potentially important mechanisms to mitigate the effects of loss of income through elevated morbidity and mortality. However, in most countries, HIV-HHs were less likely to have access to such protective measures, and other than in China, coverage levels were all below 15%.

However, in Cambodia, China and Viet Nam, HIV-HHs were more likely to have received financial support from government programs or NGOs than NA-HHs. In addition, the poorest HIV-HHs were the most likely to have received such support, again indicating good targeting by support providers. The data in Cambodia, China and Viet Nam also allowed for analysis of the financial support as a percentage of total household income. In Cambodia and Viet Nam the support had a moderate impact (8% of total income), but support was critical in China, accounting for 18% of household income.

Conclusion and policy recommendations
As the HIV epidemic matures, it has significant and lasting impact on the ability of households to cope with the loss of family members; the loss of income and assets; HIV-related morbidity and mortality; and the loss of educational opportunities, particularly for girls who are pulled out of school to care for sick and dying family members and social exclusion that prevents them from taking part in the socio-economic growth of the country.

Equally, this study points to the positive impact that targeted interventions, such as food support, government medical insurance and welfare programs can have on the health, nutrition, well-being and quality of life of HIV-affected households. Most importantly, they provide further empirical evidence of the effects of HIV on the household that can be used to better prioritize interventions in the region.

While there is some attention to social protection programmes for PLHIV since these studies were completed, continued evolution of those programmes is required to support the people, households and communities that are hardest hit.

Plenary discussion

The economic impact of HIV: As expected, the economic impact of HIV is severe, and has intergenerational consequences. While there has been recognition that PLHIV are getting into poverty for some time, the findings of the socioeconomic studies provide data on the severity of the impact and irreversible coping mechanisms, such as shockingly high asset liquidation rates.

Partner notification: A significant finding is the low level of partner notification.

Stigmatisation by health service providers: It is important to identify how to address the stigmatisation of PLHIV by healthcare professionals to increase demand for health services.

Need for HIV-sensitive social protection schemes in health care: HIV places a severe or even "catastrophic" burden on HHs, and due to the impact of HIV, PLHIV should be included within social protection schemes, such as cash transfers, food support, and other social transfers, including for the most vulnerable people. This is not the case in all the countries in the region.

Inclusion of MARPs: Since the study was on the impact of HIV on households, the samples were people living with HIV and their households. MARPs was not a criterion for sampling; however, in Indonesia a large majority of the samples were people who inject drugs, and in Cambodia, the number of women respondents was considerably higher in number.

Social protection from the perspectives of the PLHIV community
Kirenjit Kaur, WAPN+ Coordinator; Asia Pacific Network of People Living with HIV/AIDS

Speaking on behalf of the community of people living with and affected by HIV/AIDS in the Asia-Pacific region, Kirenjit Kaur emphasized that being HIV+ has far-reaching implications for the social well-being of HIV+ people. The dream of having social protection[11] in any context or any surrounding is not realized for the majority of PLHIV in the Asia-Pacific region. For almost two-thirds of the HIV+ community, the reality appears as one where they do not have any rights to seek any kind of social protection "whether it's the right to proper and affordable access to treatment, employment, insurance, or other medical care and support." PLHIV are often not able to access similar benefits as other people in need of treatment, and many children are denied proper education if their status is known.

Social, economic, and geographic contexts have been identified as impacting social protection available to PLHIV. One of the biggest issues that PLHIV face in social protection, she noted, is their lack of access to private insurance schemes. Having lived with HIV for 17 years, Kirenjit highlighted that she has not to date been able to purchase accident insurance, for example, not to speak of health insurance to cover hospital fees for when she has been sick. "It's like, if you are living with HIV, you are living a death sentence already," she said.

PLHIV and their families – in remote, poor, rural areas who live from subsistence farming, but also some living in urban areas – Kirenjit Kaur claimed, are the most affected as there is no social protection for them when they lose their stable sources of income. There have been incidents of young people being denied education because of their status, she noted, sharing the story of a widow with HIV that she recently met whose son was denied access to school by the principal on the basis that "if your son is in pain, or if he gets hurt, or other children get hurt while being with him, I cannot be answerable to their parents."

Women and children are invariably impacted by HIV/AIDS and are the most vulnerable in family settings. Stigma towards PLHIV continues to be strong, and results in PLHIV not being able to live normal lives. Kirenjit Kaur shared the story of a woman living with HIV (WLHIV) who participated in a WAPN+ survey on the accessibility to WLHIV of maternal and child health care services in 6 countries. The WLHIV, who lived with her in-laws, was locked into her room by her mother-in-law when she went into labour, and told to "please move away from the bed, come down to the floor, I do not want your contaminated blood to stain the mattress." In coming down to the floor, she gave birth, and her baby hit the floor and died. It was not until her husband came home, that the door was unlocked and he helped her. "This is the reality on the ground that we are looking at," Kirenjit Kaur said, asking "where is social protection for WLHIV?" PLHIV can live longer and healthier lives through ARV treatment, but while "on one hand I'm given life, on the other hand, my right to live is taken away from me," she said. Social protection is also absent for key populations, she observed, asking "where is the social protection for these populations?

It is well known that PLHIV are living more healthy and productive lives and can contribute towards the economy of their countries. However, they do not have same benefits as other people, e.g. in the workplace. PLHIV are worried to access treatment as they are afraid their HIV status will become known: "who is going to take care of social protection and social security for them?" Governments should be urged to ensure social protection, including social services and social benefits, are in place and that all people, with or without HIV, have the same benefits.

Plenary discussion

ILO and social protection: Social protection should be made universal to cover the entire population. All people have the right to work, and PLHIV should not be removed from jobs because of their HIV+ status, or discriminated against in seeking employment. ILO's a new international labour standard on HIV and AIDS was adopted in 2010, and can be used as a tool to hold

11 Kirenjit Kaur shared Shepherd's (2004) definition of social protection, as the "range of processes, policies and interventions to enable people to reduce, mitigate, cope with and recover from risk in order that they become less insecure and can participate in economic growth."

governments, employers, and other workers accountable to protecting the rights, and give accommodations to, HIV+ workers.

Private insurance: Private insurance schemes often exclude PLHIV because they want to avoid "adverse selection", and PLHIV often are denied access to all insurance schemes. When PLHIV have private insurance, their HIV status has sometimes been used as pretence to not reimburse fees unrelated to HIV.

Public insurance: Public insurance schemes are more inclusive, but need to be expanded to cover all people. Public insurance does not always cover PLHIV, and there are variations between the formal and informal sectors.

Social health insurance for the poor in Indonesia: There is a new regulation (2010) in place that stipulates all marginalised people (including PLHIV) need to be protected. PLHIV should now be able to access healthcare, including treatment for OIs.

Insurance schemes (India): There are many insurance schemes in India, e.g. a national health insurance scheme where the government pays premium for the poor, including PLHIV. There is discrimination in access to health care and health insurance, however. The argument was made that private insurance schemes should be made available to PLHIV to cover non-HIV related conditions. India has made some progress in this area, negotiating with major insurance companies to remove HIV exclusions.

Involvement of PLHIV in decision-making: PLHIV networks may not always be aware of new regulations and policies, and collaboration between the government and PLHIV networks should be enhanced. The participation of PLHIV in decision-making still faces many challenges. "Sometimes they just want to see what we look like," Kirenjit Kaur observed.

Need for change at the grassroots level: While policies and guidelines are largely in place, the reality on the ground is that PLHIV often face acute stigma and discrimination. There is a need for sensitization and awareness-raising at many levels in order to address e.g. the rights of WLHIV to have children.

HIV-sensitive social protection to address stigma and discrimination of KAPs: General social protection may not address stigma and discrimination, and there is a need to look at these issues, keeping in mind KAPs, which in the Asia-Pacific region include PLHIV, people who use drugs, sex workers, men who have sex with men, and transgender people.

SESSION 3: LESSONS FROM ASIA AND THE PACIFIC

Objective: To better understand the "why" and "how" of social protection for impact mitigation, with country examples

Country case study: Cambodia

HIV-sensitive social protection for impact mitigation
Dr. Ros Seilavath, Deputy Secretary General; NAA

Status of the HIV epidemic and response to HIV: HIV prevalence in Cambodia is estimated as decreasing to 0.6 percent in 2011, and was 1.1 percent in 2006 among pregnant women attending antenatal clinics. There are an estimated 53,100 PLHIV in Cambodia today, and prevalence is concentrated among entertainment workers (15.2 percent), MSM (8.7 percent in Phnom Penh), and people who inject drugs (24.4 percent). ARV coverage is high at almost 96 percent. If all interventions are maintained successfully, HIV incidence in 2012 will decrease to an estimated 460 women and men.

HIV impact mitigation: In the initial stages of the epidemic, HIV had a dramatic impact on livelihoods and income, and increased numbers of school drop-outs among CLHIV. The impact of HIV has become less severe through the increase in financial support to the response, which rapidly expanded ARV treatment, for example. Social protection for PLHIV includes Home Based Care (HBC), a minimum package for OVC, interventions in the areas of housing and income generation, and workplace interventions. Most efforts to address the impact of HIV adress short term impacts of HIV; there has not been significant support to e.g. capacity building, vocational training, or the provision of micro-credit.

Social protection and PLHIV: Cambodia has introduced various social protection measures such as a National Social Protection Strategy, a social safety net program, food security programs, and various related laws including the Labour Law. Cambodia's National Strategic Plan for a Comprehensive and Multisectoral Response to HIV and AIDS (2011–2015) addresses the need for social protection for PLHIV under its third goal, which is "To alleviate the socioeconomic and human impact of AIDS on the individual, family, community and society." The strategy for achieving this is to "Increase coverage, quality and effectiveness of interventions to mitigate the impact of HIV and AIDS."

HIV Funding to social protection: In 2009, about USD 6 million of HIV/AIDS spending was chanelled to social protection and social services; in 2010 this amount was USD 8 million, which represents about 12 percent of HIV/AIDS expenditure.

KHANA economic livelihoods program

Dr. Oum Sopheap, Executive Director; KHANA, Cambodia

Background: KHANA's Economic Livelihoods Program, which is supported by USAID and EC, provides social protection in the form of support to sustainable livelihoods. Its key objectives are to improve livelihoods among vulnerable communities, people affected by HIV and most at risk populations (MARPs); and to alleviate the socio-economic and human impacts of AIDS on the individual, family and community. Target populations of the program include PLHIV, OVC, and MARPs, and most recently, other vulnerable populations as well. The focus has thus moved into the direction of being HIV-sensitive from an original HIV-specific focus. The program covers 19 out of Cambodia's 24 provinces.

Model: The initial model adopted for the Economic Livelihoods Program from 2003 through to 2010 was that of providing small grants to individuals and HIV-HHs, supported by training, and follow-up. In 2010, this model was revised based on data generated through a household survey and an evaluation of KHANA's income generation activities. The new model (currently being pilot tested in 6 provinces) is that of Village Savings and Loan Schemes, which has moved from consumption enhancing-to livelihood enhancing support.

Results: Between 2003 and 2010 about 3100 PLHIV and OVC were supported through 25 Implementing Partners. From 2010, 14 village savings and loan groups (311 PLHIV, OVC and MARPs) have been established. 121 beneficiaries have received skills training in micro-business, food processing, home gardening, and crop production. A new, evidence informed livelihoods model was developed in 2010.

Challenges: PLHIV have sometimes used the livelihoods grants or savings to cover health or immediate needs. Building a strong understanding of the benefits of long term saving and investment takes time. Productivity, behaviour change, and building stronger linkages to local businesses need strengthening. Sustainability of livelihoods programs, and ensuring long-term, sustainable income for PLHIV present key challenges.

Lessons learned: The beneficiaries often lack basic skills required for income generation and livelihoods, as well as self confidence in economic activities and hope for change. The motivation and interest of beneficiaries if key to successful interventions. In this project, there were 3 groups with different intervention combinations, which received (1) training and grant, (2) grant only, and (3) nothing. The group that had received nothing seemed the most successful, probably due to the strong commitment of the group members. Based on this finding, we need to first work on mindsets before providing training on production. Generating data through the HHs survey is key to developing a more systematic, effective approach.

Future plans: KHANA plans to scale up the model to 20 provinces; establish a livelihoods centre; increase the number of groups and increase the involvement of the broader community; and document its experiences, successes and lessons learned.

Country case study: China

HIV-sensitive social protection in China

Wu Zunyou, Director, Bureau of Disease Control and Prevention, MOH

Status of the HIV epidemic: HIV prevalence in China is low at 0.057%, but prevalence is high in certain areas and among particular high risk groups. The epidemic is unevenly spread, with 6 provinces accounting for an estimated 80 percent of HIV/AIDS cases. While the Chinese Government has achieved the goal it set 5 years ago, that by end of 2010 the total number of PLHIV would be less than 1,500,000, the number of annual reported HIV cases remains high, and China has an estimated 740,000 people living with HIV, of whom 105,000 were estimated to be AIDS cases.

The response: The Chinese government has demonstrated high political commitment to the HIV response. This is demonstrated by the participation of the President Hu Jintao and Premier Wen Jiabao in HIV/AIDS events, and the allocation of significant domestic funding to the response.

Basic infrastructure has been significantly improved in recent years. Between 2006 and 2010, the number of surveillance sites increased from 729 to 1,880; the number of VCT sites increased from 3,000 to 9,475; the number of screening labs increased from 3,756 to 8,870; and the number of confirmatory labs increased from 57 to 318. Recent years have witnessed significant increases in the number of spouses testing for HIV and in PLHIV participating in CD4 tests and in follow-up healthcare services. Programs, including Methadone Maintenance Therapy (MMT), ART and PMTCT, have also been scaled up and have had a demonstrable impact. The introduction of MMT has had a significant positive impact on HIV incidence, heroin use, and on decreasing drug trade. ART, in turn, has significantly decreased mortality among patients, and the number of pregnant women accessing ART has increased from 12 women in 2002 to 1,305 women in 2010.

Policy environment: The Chinese government launched a "Four Frees, One Care" policy targeting families affected by HIV/AIDS in 2003. In 2009, the Chinese Ministry of Civil Affairs issued a policy concerning children affected by AIDS, including the provision of 95 USD per month for each AIDS orphan.

The government's new AIDS policy is "5 expansions, 6 Strengthening" (the expansion component covers education, testing,

PMTCT, intervention, ART; the strengthening component covers blood safety, medical services, care and support, rights, leadership, and personnel).

Social protection and HIV: The income level of HIV-HHs is lower than that of NA-HHs in China. Schooling rates of children from HIV-HHs are similar to the rates of children from NA-HHs. Relatedly, the "Four Frees, One Care" policy targets particularly low-income PLHIV and their families, as well as children affected by AIDS. Social protection for children affected by HIV/AIDS is provided both by the government, and by NGOs including the Chinese AIDS Foundation.

Need to further strengthen the response: Significant progress has been made towards achieving Universal Access indicators since 2006 under China's "4 frees and 1 care" policy. Within the framework of the new AIDS policy "5 expansions 6 strengthenings" the Chinese Government is committed to increasing efforts to achieve the MDG goal 6 by 2015.

Country case study: India

Aradhana Johri, Additional Secretary, National AIDS Control Orgisation
Alka Narang, Assistant Country Director, UNDP in India

Status of the HIV epidemic and HIV response: Overall, the epidemic in India shows a declining trend. HIV prevalence is estimated as being 0.31% among the adult population, and there are about 2.25 million PLHIVs in India. The primary drivers of the epidemic are unprotected paid sex, unprotected anal sex between men, and people who inject drugs. HIV prevalence is high among High Risk Groups (HRGs), which include an estimated 1.26 million Female Sex Workers (FSWs) and their clients, 351,000 MSM, and 186,000 people who inject drugs. Key strategies of the Indian government in responding to HIV/AIDS have included program monitoring and the generation of an evidence base, coordination and multisectoral collaboration, and capacity development. The judiciary has played a notably proactive role in creating an enabling legal environment, and changing discriminatory practices.

Impact of HIV: Key areas of of impact among HIV-HHs include increases in household- and health spending, household income decreases, increased unemployment and borrowing.

Social protection and HIV: The government's social protection strategy has included advocacy for addressing the underlying driving factors of the epidemic; multi-stakeholder, multi-sectoral collaboration; mainstreaming HIV; strong leadership at national and sub-national levels; ensuring a responsive policy and supportive legal environment; and the expansion of services for coverage of underserved areas and underserved populations.

Social protection schemes for HIV: Existing social protection schemes include both HIV-specific and HIV-sensitive schemes, and these schemes channel support to roughly 150,000 PLHIV beneficiaries in the areas of health, access to treatment, nutrition, social security, livelihoods, housing, legal aid, and grievance redressal. Officers from State AIDS Control Societies (SACS) are posted in different ministries to facilitate HIV mainstreaming in different areas, including social protection.

Case Study 1: HIV inclusive scheme "Madhu Babu Pension Yojana": This scheme was initiated in 2008, and involves the provision of a life-dlong monthly pension of Rs. 200[12] per month to elderly, disabled, widows, including widows of PLHIV or any PLHIV, irrespective of age, marital status, sex, and economic status. To date, it has benefited 23,052 PLHIV. Inclusion of HIV-affected people was made possible by NGOs that facilitated the process of availing the scheme to PLHIV.

Case Study 2: HIV specific scheme "Jatan project": This scheme targets PLHIV, reimbursing their travel expenses from their residence to ART centers through a Jalatan staff, who is a member of the state-level PLHIV network. Since its initiatiion in 2008, it has benefited 30,000 PLHIV.

Case Study 3: Widow pension scheme, Rajasthan: Altogether 1,000 WLHIV have benefited from this scheme offering Rs. 500 per month to widows. This scheme was initiated in 2009 and was amended to better address the needs of HIV+ widows by lowering the minimum age criterion from 40 years to 18 for HIV widows. This scheme is a good example of integrating HIV into a general social protection (cash transfer) intervention. There is an incentive of Rs. 15,000 to encourage widows to remarry.

Case Study 4: Tamil Nadu Legal Aid Clinic interventions: This initiative has enabled PLHIVs to access free legal services through Legal Aid Clinics (LACs), which are housed in district ART centres. LACs inform PLHIV of available social protection schemes and facilitate the submission of applications, which have made it possible to reach PLHIV within a short period.

Facilitating factors: At (1) Macro level: political commitment and federal structures that allow innovations, cross-learning and progressiveness; (2) Meso level: sensitisation of key stakeholders and decision makers, strengthened linkages within the HIV service provision structures, and increased outreach and scope of legal assistance programs; and (3) Microl level: empowered positive networks and creating awareness and knowledge about social protection schemes.

Challenges: Challenges to strengthening HIV-sensitive social protection include inter-state variations in benefits and outreach; low priority and funding by other sectors; cumbersome procedures; gender differentials (with a positive bias towards women); stigma and ensuring confidentiality; lack of awareness of HIV-exclusive and HIV-sensitive schemes; inadequate measuring of utilisation patterns; and monitoring and data sharing.

12 One Indian Rupee is about USD 0.02 (as of 16 May 2011).

Lessons learned: Prerequisites for effective social protection for PLHIV and HIV-HHs include political commitment, a social protection strategy, complementary public and private sector interventions, and forging referrals and linkages between community systems and the public sector.

Future plans: Future plans include ensuring a basic minimum package of social protection (health & nutrition); advocacy and partnerships for a basic minimum plus package (eduation, livelihoods, housing etc.); and developing effective channels for social protection provision.

Country case study: Indonesia

HIV-sensitive social protection for impact mitigation – the lessons learned in Indonesia

Emil Agustiono, Deputy Minister to Coordinating Minister for Population Health and Environment; Ministry of People's Welfare & Makmur Sunusi, Directo General of Social Rehabilitation, Ministry of Social Affairs

Status of the HIV epidemic: Indonesia has a growing HIV epidemic: while in 2009, there were about 298,000 PLHIV in the country, in 2014 this figure is projected to reach about 514,000. HIV prevalence is high among FSWs, MSM, and people who inject drugs; and is geographically concentrated.

The response and impact mitigation: The aims of the national response to HIV and AIDS are to prevent new infections; improve the quality of life of PLHIV including their livelihood; and mitigate the impact of HIV and AIDS by developing an HIV-sensitive social protection program. Impact mitigation is guided by the MDGs and the multisectoral efforts of the National AIDS Commission.

Poverty and vulnerability: Almost half (43.8% or 110 million people) of all Indonesians are classified as "near poor" and thus vulnerable to poverty. The percentage of poor people is particularly high in Jawa-Bali (57.8%), and Sumatera (21%). Indonesia's poverty alleviation strategies are summarised in the table below:

Table 2. Poverty alleviation strategies in Indonesia

Strategic approach	Target population	Objective
1. Social assistance and protection "Give a fish"	Chronically poor (less than 1 USD per day)	To reduce the burden of expenditure for poor families
2. Social empowerment "Teach how to fish"	Near Poor (1–2 USD per day)	To increase income and standard of living through initiatives and cooperation to promote empowerment and independence
3. Small & Micro Enterprise "Give assistance to go get their own fishing rod"	SMEs and micro entrepreneurs	To provide access to capital for SMEs.
4. Housing, public transport, clean water	All poor	

Social protection and HIV sensitivity: HIV-sensitive social protection mechanisms include the Presidential Regulation on Poverty Reduction; the Presidential Instruction No. 2/2010 on Pro-Justice Development; and inter-ministerial decrees issued by Social- and Health ministers. Components identified for HIV-sensitive social protection and social welfare include: social outreach, development of family investment, family empowerment, research, social rehabilitation, social services for children, social assistance, and empowerment of social welfare institutions.

Challenges: Current challenges include difficulties in identifying beneficiaries, lack of data (evidence), stigma and discrimination, and dependency on donor funding.

Results to date: Interventions have taken place to address stigma and discrimination; improve the social welfare response to HIV; develop a model of social protection services and family development for PLHIV and their families; provide living support assistance and direct cash transfers to PLHIV for developing SMEs; to provide consultation to PLHIV and their families on life skills and training; and to refer PLHIV to social service programs,

Lessons learned: Particularly given the growing number of PLHIV in Indonesia, there is a need to increase HIV-sensitive social protection programs. Strengthening prevention, care, treatment, and psychological as well as socioeconomic support to PLHIV is key to mitigating the impacts of HIV. There is a need for an integrated action plan; synergizing resources; and accelaration of programs, especially by national authorities.

Country case study: Nepal

Surya Prasad Acharya, Joint Secretary; MOH & Population, Government of Nepal

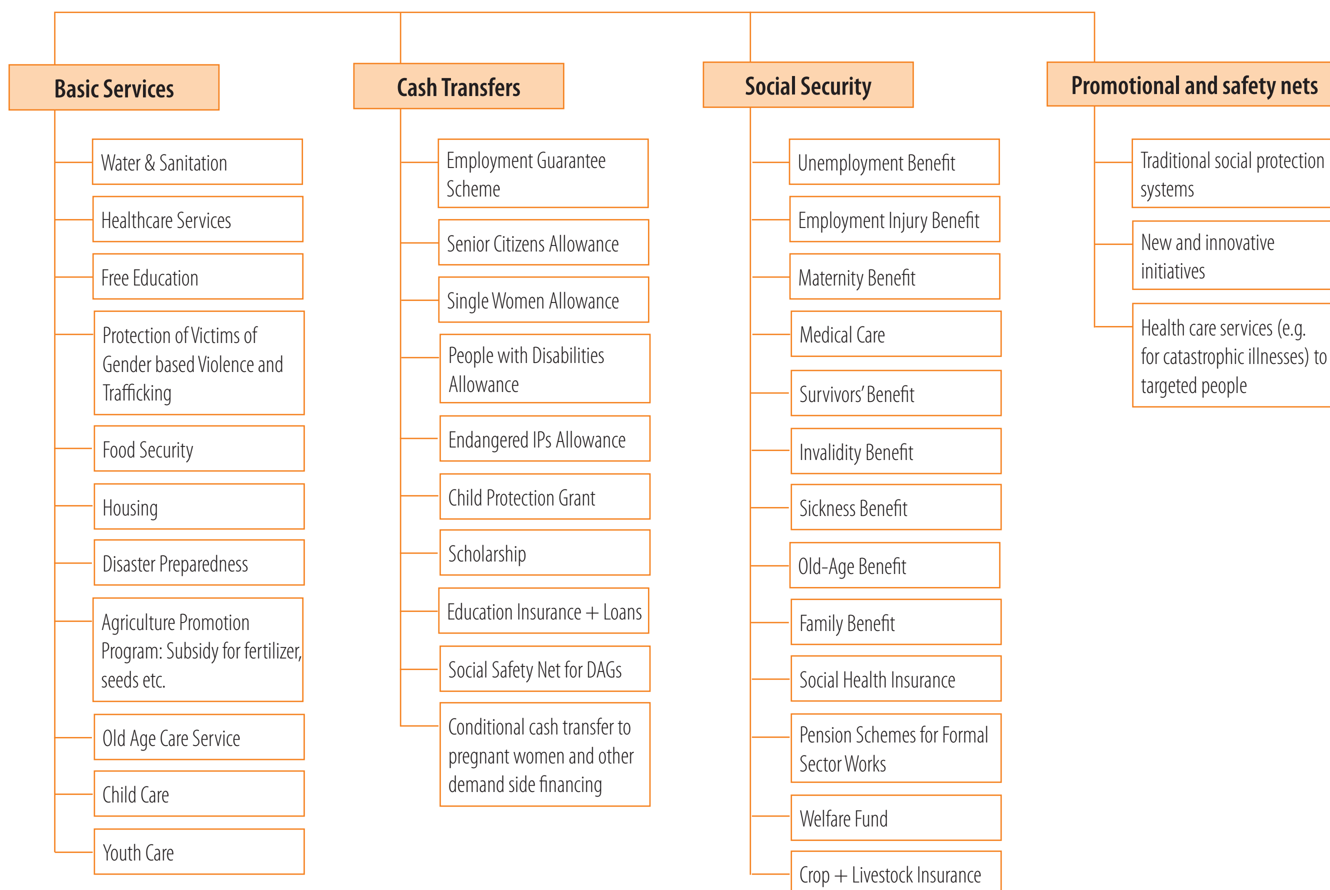
Status of the HIV epidemic: Nepal has a concentrated HIV epidemic, with an estimated 63,528 people living with HIV (2009). Of these, about 6% are children (0–14 years), and 29% are women (15–49 years). Notably, more than 75% do not know they have HIV. HIV prevalence is highest among people who inject drugs, FSWs, MSM, labour migrants and their spouses. Unprotected heterosexual sex is the main mode of transmission.

Defining social protection: The terms "social safety net", "social security", and "social protection are often used interchangeably in Nepal. In the Social Protection Framework of Nepal, social protection is defined as "the set of policies and actions designed to reduce ***poverty, vulnerability, and risks*** as well as to enhance people's capacity to protect themselves against shocks or loss of income and employment."

The response: Since 2004, ART and treatment for OI have been provided for free, although only a quarter of the people needing ART are currently receiving it. Nutrition support is provided for PLHIV (after ARV/Prophylaxis initiation). NGO-run community care centers provide shelter and food for poor and chronically ill PLHIV. Community HBC initiatives operate in highly affected locales. Also, USD 1.3 per month is provided to PLHIV by the village development committee.

Policy provisions and action plans: Nepal is in its third National HIV/AIDS Strategy Plan (2006–2011). This plan has 6 pillars (prevention; treatment, care and support; advocacy, policy and legal reform; leadership and management; strategic information; finance and resource mobilisation). Nepal has a National Action Plan (2008–2011); and a National Advocacy Plan on HIV and AIDS(2008–2011). General social protection initiatives relevant to HIV include the new Labour Bill, and the Nepal Health Sector Program II. A National Social Protection Framework (2011–2020) has been recently developed, and needs to be operationalised.

Figure 1. National Social Protection Framework in Nepal (2011 - 2020)



Lessons learned: There is a need to consolidate and integrate different programs into a national framework to avoid fragmentation. The involvement of local government has been a key success factor in program implementation. There is a need to strengthen awareness of services on the demand side, involving civil society and communities in this work.

Country case study: Papua New Guinea

HIV sensitive social protection

Philip Tapo, Deputy Director; National AIDS Council

Status of the HIV Epidemic: HIV prevalence has declined from a generalised epidemic, and is geographically concentrated. The highest number of reported infections have been diagnosed in Port Moresby and other urban and peri-urban areas. In 2009, the number of adults (aged 15–49) estimated as living HIV was 35,800, and about 5,610 children have been orphaned as a result of the epidemic.

HIV and vulnerability: People at highest risk to HIV exposure in PNG include SWs, MSM, and people who use drugs[13]. The epidemic impacts vulnerability through increasing poverty, loss of jobs/income, health expenditure, and the number of orphans; and limiting access to education, health services, and income generation schemes.

The response: PLHIV have access to free ART, and free VCCT for Prevention of Parent-to-Child Transmission (PPTCT). Faith Based Organisations (FBOs) also play a significant role in the response.

Social protection and HIV: There is a social protection strategy in place for OVC; and the government has developed an HIV/AIDS Management & Prevention (HAMP) Act; a Lukautim Pikinini ("child protection") Act; and various policy documents. The Government has initiated a process to develop a social protection policy, which is currently focused on 3 categories of beneficiaries: children, disabled, and the elderly. A Social Protection Task Force is leading this process. Progress has been made towards achieving Universal Primary Education; civil servants have access to a pension scheme; and provincial social protection initiatives have been developed and include school subsidies, free health services for the elderly, and a "One kina[14]"policy for the elderly and disabled. Faith based organisations provide community/home care support services. There are limited micro credit schemes for PLHIV.

Challenges: There is a need to advocate to the government for a formal social protection system (including for financing), as the government has largely relied on traditional safety nets. Due to stigma and discrimination, MARPs often fall outside these safety nets. There is a need to develop the legal framework, which criminalises groups such as SWs and MSM. PNG has weak governance and transparency systems in the delivery of goods and services, and there is limited capacity to implement government policies and legal frameworks. The geographic terrain and limited transportation infrastructure in PNG makes it difficult for people to access services, and infrastructure is insufficient to manage complicated cash transfer systems. There is limite data available to support program and policy development.

Way forward: More work is needed to strengthen existing social protection policies, and to revise programs (e.g. the traditional adoption and fostering system), and bring them to scale. HIV nees to be incorporated within policies, programs, and the legal framework. This will require analysis of the evidence base. Children and young people should be involved in policy and program planning and implementation.

Country case study: Thailand

Social protection programs for people impacted by HIV/AIDS: Vienping children home

Sirirat Ayuwatana, Deputy permanent secretary, Ministry of Social development and Human Security, Thailand

National social protection program: The Ministry of Social development and Human Security (MOSDHS) takes the lead in developing and managing the national social protection program in Thailand. The Department of Social Development and Welfare is responsible for service delivery, and the Bureau of Promotion and Protection of Children, Youth, the Disadvantaged and the Elderly is responsible for policy development. Objectives of the national social protection program include:

- Building capacity of organisations and networks on services and welfare protection for people living with HIV/AIDS, occupational and life skills training for children affected by HIV/AIDS;
- Providing welfare to people living with HIV/AIDS, children and poor elderly.

Key services provided by the national social protection program are:

- Providing care for children residing in children's homes;
- Providing assistance to children living with their family;
- Providing financial support to familes;
- Providing occupational training for HIV-infected women/persons affected by HIV/AIDS;
- Providing funding assistance and training program for organisations and networks for social development.

13 Note: Very little data exists on drug users in PNG, including those who inject drugs (UNGASS, 2010).

14 Kina is the currency of PNG. One Kina is about USD 0.40 (as of 16 May 2011).

Vienping Children Home

Background: The Vienping Children's Home is a children's centre located in Chiang Mai. It was established in 1986, and is an example of HIV-sensitive social protection for children operated by the MOSDHS in Thailand. It provides care and support to abandoned and orphaned children, and to children living with and affected by HIV/AIDS (as of 1990; Vienping was the first orphanage in Thailand to accept children with/affected by HIV/AIDS). Children are referred to Vienping by hospitals, and the community (social workers, community leaders, families).

Coverage and HIV-sensitive programs: Vienping covers 17 provinces, and leads a network of orphanages, group homes, and foster care families dedicated to caring for orphaned or abandoned children. It is linked with different government and non-government organisations and facilities that provide services to children living with or affected by HIV/AIDS. Programs and services for these children include:

- Foster home care for children living with or affected by HIV/AIDS;
- Services to group homes/private orphanages (funding assistance and management of legal guardianship of children);
- Financial support to families with children living with or affected by HIV;
- Caretaker program;
- Adoption program.

Financing: Funding to Vienping is mainly provided by the government, with additional resources from private individuals (local and international), and through partnerships with NGOs. About a third of Vienping's annual budget goes to its programs and services focused on children living with or affected by HIV/AIDS.

Results: One of the areas of Vienping's work is that of promoting and protecting children's rights, and its work has made concrete contributions to ensuring children's rights to health, education, care, and social inclusion. Vienping's work has brought about an improved quality of life for the people and children living with HIV/AIDS, and their families, that it serves; and greater public social awareness of people living with HIV/AIDS, children and poor elderly people affected by HIV/AIDS. As an outcome of Vienping's work, the capacity of the network organisations has been strengthened.

Lessons learned: Partnerships are essential to promoting and coordinating the operation of the social welfare service network for HIV/AIDS. Developing and standardising models and methods of providing social welfare services for HIV/AIDS ensure quality of services.

Future plans: Areas of work that Vienping plans to develop include:

Knowledge, information and training on HIV prevention for families and caretakers;

Strengthening the capacity of organisations and children's homes in the areas of welfare services and occupational training;

Engage government officers in participating in NGO activities;

Share best practices;

Establish a focal point to improve coordination between different organisations.

Country case study: Viet Nam

HIV-Sensitive social protection schemes in Viet Nam

Dr. Do Huu Thuy, Director, Department of BCC and Social Mobilisation, Viet Nam Administration on AIDS Control

Background and Status of the HIV epidemic: Viet Nam has a population of about 86 million, of which the percentage of poor HHs is estimated at 14 percent. Viet Nam has a concentrated epidemic, and the highest prevalence is found among people who inject drugs which comprise about 70 percent of those tested positive for HIV. At the end of 2010, Viet Nam had 183,938 reported cases of HIV; 44,022 reported cases of AIDS; and 49,477 reported cases of AIDS related deaths. Viet Nam has achieved its goal of decresing HIV prevalence to less than 0.30 percent. However, HIV incidence is projected to increase in Viet Nam.

Rights of PLHIV under Vietnamese Law: PLHIV have the same rights (healthcare including health insurance, education, work, privacy) as other Viet Namese citizens under Vietnamese Law. However, there are more social protection schemes available to PLHIV.

HIV-sensitive social protection schemes: Social assistance, social insurance, and health insurance are provided to vulnerable groups, including PLHIV. Many legal and policy frameworks relevant to HIV-sensitive social protection have been developed, and include:

- Law on HIV/AIDS Prevention and Control;
- Law on Health Insurance;

- Government Decree on support policies for social protection beneficiaries;
- Government Decree on the establishment and operation of social protection institutions which provide social support to PLHIV;
- Decision on Social Work Scheme, which targets vulnerable groups in particular, including PLHIV;
- Decision on Management, Care and Support for PLHIV in closed settings.

Social protection schemes target PLHIV in poor households without working capacity, children living with HIV (CLHIV), and CLHIV in poor HHs. HIV-sensitive social protection mechanisms include:

- Monthly cash allowance;
- Health insurance cards;
- Exemption or reduction of school fees and free textbooks, notebooks and learning equipment (general education/ vocational training);
- Allowance of 3,000,000 VND per person for burial costs;
- Allowance for daily necessities and common drug provision.

PLHIV, including CLHIVas well as OVC, can be considered for admission to social protection establishments or social houses in their communities. PLHIV living in state-run social protection establishments are entitled to allowances for medicine, personal hygiene (women), and everyday life. Before 2007, PLHIV were not included in health insurance - now most PLHIV are included.

Social Protection Strategy (2011–2020): Viet Nam is in the process of finalising a Social Protection Strategy for 2011–2020, one objective of which is to expand the social protection system "to ensure that all beneficiaries have a stable life, and integrate well into the community." This Strategy is expected to improve the availability of and access to social assistance for PLHIV.

Financing: The HIV response is mainly externally funded, and the government manages budget allocation to localities to support vulnerable groups, including PLHIV. In addition, the medical examination and treatment expenses of those who have purchased medical insurance and who become HIV positive, are covered by this insurance fund.

Challenges: Stigma and discrimination are a barrier to accessing the social protection system, in part because PLHIV have to share their personal information to access these services. Most people with HIV are SWs or people who inject drugs and are stigmatised because they use drugs or sell sex. The selection proceure for various social protection schemes takes place only once a year, which presents a challenge to effective program implementation. Due to budget limitations, allowances made to vulnerable people are low and there is a need to increase funds.

Lessons learned: The role of the state is key to developing the social protection system. The legal framework needs to be in place to safeguard PLHIV and to ensure the operationalisation of HIV-sensitive social protection. Social protection schemes and social security schemes need to be HIV-sensitive. It is important not to equate HIV with injecting drug use and selling sex, which are viewed as social evils. Community mobilisation can contribute significantly.

Highlights from plenary discussions

Coordination of HIV-sensitive social protection at national level (India): India demonstrates a high level of political commitment to HIV-sensitive social protection. A question posed to India was whether, however, coordination (organising meetings) at the national level faced problems.

Response: The involvement of high level leadership ensures political commitment (e.g. national and state level councils on AIDS are headed by Prime Minister and the State Chief Minister respectively) and the development of a roadmap. Coordinating meetings do pose some challenges, but they are surmounted.

Adjusting the parameters to include PLHIV (India): Another question posed to the Indian delegation was how the use of BPL (Below Poverty Line) and other cards is related to PLHA, and how these cards are linked to different services.

Response: Since a large number of PLHIV are economically marginalised, they benefit from general social protection schemes, such as the schemes for people in the BPL category. The advantage of this approach is that PLHIV are not stigmatized because of their HIV status, as it covers all living below the poverty line. Another card scheme being developed in India is the "smart card system", which will enable PLHIV to access services wherever they are in India. The plan is to make this card a "health card" which can be used for the poor to access other health services as well, thus reducing HIV related stigma. Some states have also introduced cards for transfers to health services, and the plan is to expand this scheme to include non-HIV+ people. It is critical to make social protection schemes non-HIV specific to avoid the risk of stigma.

Targeted interventions for key populations (China): A question was posed whether there is an existing social protection scheme that target KAPs in China.

Response: China has some programs specifically targeting KAPs such as methadone treatment, job training, and assistance to drug users to find employment. NGOs work with SWs, and families as well as the MSM community have provided support to MSM.

Making social protection more inclusive (India): India has many examples of making social protection more inclusive for PLHIV and other marginalised populations. This work has required a lot of lobbying and coordination with different ministries and different states. One example of the outcomes triggered by these efforts is the decision to include transgender people in the census as the third sex category. In Tamil Nadu, there is a TG welfare board. In Delhi, the government provides employment opportunities to TG persons so that they do not have to turn to sex work.

HIV prevalence and disclosure (China): Many PLHIV choose not to disclose their status, which complicates establishing HIV prevalence for China. The reliability of HIV estimates has improved in recent years through the increase in numbers of people accessing VCCT, and data is generated at healthcare sites on HIV prevalence. HIV test results recorded at private clinics need to be reported to the authorities. Data from these and sentinel surveillance sites that cover KAP also provide good data. Estimates are made jointly by government, UNAIDS and WHO.

Monthly cash allowances (Viet Nam): A question was posed to the Vietnamese delegation as to how the monthly decentralized cash allowances delivered at the commune level to HIV-HHs are being delivered, and how leakage is prevented.

Response: The expectation is for local authorities to contribute to these cash allowances, but the government subsidizes these allowances where there is a lack of funds at the local levels, e.g. in provinces/districts/communes where there is a pronounced need (high levels of poverty) for these schemes. The selection of eligible HHs' is made by local authorities at the commune level, and local authorities monitor how HHs use this money.

State-run social establishments (Viet Nam): A number of countries have developed the idea of institutionalisation being a social protection mechanism. The questions were posed as to whether state-run social protection establishments in Viet Nam are closed or open settings, and whether they are voluntary.

Response: For key populations, these establishments can be either voluntary or forced (closed), and for OVC and poor PLHIV, these are voluntary.

Cash transfers for nomadic and indigenous people: Reaching nomadic and indigenous populations is a challenging task. In Nepal, on predefined dates, cash transfers are available for pick-up from local government authorities in areas where the beneficiaries reside that year. Increasing awareness of cash transfer schemes among the nomadic and indigenous community is important (e.g. through training teachers and health care workers).

Government support to HIV-sensitive social protection for children: There is not much information readily available on best practices on family-based and community-based rehabilitation for OVC. In Thailand, financial assistance is provided for families/ members of the extended family/foster parents to look after children (including CLHIV) at home. In addition to cash transfers, families are provided with education on child care, and equipment etc.

Need to avoid exceptionalism: Some of the programs and activities introduced/discussed have been HIV-exclusive. It is important to avoid exceptionalism and the creation of parralel systems, which has the tendency to pit groups against another as they compete over scarce resources.

Issues to consider when developing targeted HIV-sensitive social protection: A key issue to consider when developing targeted HIV-sensitive social protection (self-selection/HH-based/categorical approach) is how to address stigma and discrimination. Another issue to consider is when the government is best placed to provide social support, and when it is most effective for the civil society to provide this support.

DAY 2: HIV-SENSITIVE SOCIAL PROTECTION NEEDS: IDEAS AND ACTION

Day 2 was composed of brainstorming sessions in country groups, country presentations, and plenary discussion. Key messages that emerged during the second day included:

- There is a need to work first and foremost on ensuring existing and new social protection measures are HIV-sensitive.
- There is a need to identify and predict the costs of HIV-sensitive social protection programs.
- Services are largely in place, but there is a need to increase demand for services, promoting health-seeking behaviours among PLHIV and KAPs.
- Laws and policies are largely in place, but operationalising them – particularly at sub-national levels – needs improvement.
- The most sustainable approach to ensuring PLHIV have income is employment, and there is a need to build linkages to existing broad employment interventions, developing effective employment strategies and models for PLHIV.
- Designing effective and cost-efficient HIV-sensitive social protection requires understanding the ways HIV is being transmitted and community involvement (MIPA).
- Multisectoral and multistakeholder partnerships are key to effective social protection
- There is a need to increase domestic funding to ensure long-term sustainability.

SESSION 4: WHAT IS NEEDED?

Objective: To identify/map what is needed to improve HIV-sensitive social protection for impact mitigation

This session comprised brainstorming sessions to identify prioritity HIV impact categories in each country. All eight countries identified income and/or employment as key areas requiring action; six countries identified stigma and discrimination as requiring action[15]; five countries identified issues related to healthcare as requiring action; and one country identified strengthening the evidence base as a key area for action.

15 There was common agreement that stigma and discrimination in health settings needs to be addressed to improve access to healthcare. Actions relate to stigma and discrimination were identified under the priority area of health services by China, India, Nepal, and Viet Nam.

Selected priority impact categories

The priority impact categories are presented in summary form in the table below (see Appendix 2 for more details).

Table 3. Priority impact categories for HIV-sensitive social protection in Asia and the Pacific

HIV impact category	Cambodia	China	India	Indonesia	Nepal	PNG	Thailand	Viet Nam	Total
1. Economic									
A. Income	x	x			x		x		4
B. Assets									
C. Credit									
D. Employment	x		x	x	x	x		x	6
E. Other									
2. Food and Nutrition									
	x				x				2
3. Education									
A. School attendance									
B. Accessibility									
C. Affordability									
D. Other									
4. Health									
A. Health-seeking behavior		x	x		x			x	4
B. Accessibility									
C. Affordability						x			1
D. Other: Prov. Behavior key populations			x						1
5. Stigma and Discrimination									
A. Law and policy	x		x						2
B. Enforcement / judiciary			x			x	x		3
C. Service delivery				x			x		2
D. Cultural norms and institutions		x						x	2
6. Other									
Evidence base									1

As the table above shows, three key areas that the country groups identified as priorities requiring attention in terms of HIV-sensitive social protection were: **economic** (income and employment); **health-seeking behaviours** (which will require actions to increase demand and to ensure services are friendly and non-stigmatising); and **stigma and discrimination**. Most of the priority actions identified were built on modifying or scaling up existing programs or interventions.

Plenary discussion

The importance of employment: Employment was identified as a key priority by most groups. The experience from countries such as India demonstrates that employment is the most sustainable, effective strategy for improving the income of PLHIV. Implementation of microcredit for HIV+ entrepreneurs (SMEs) needs a lot of support from key stakeholders, including non affected partners and NA-HHs, to sustain their enterprise.

Public works programs for the chronically ill: Employment options for PLHIV – and related data and models – are limited. However, there are many public works programs, and one model of good practice is to explore opportunities to make these programs – and all other forms of employment – friendlier to the chronically ill, including PLHIV.

Importance of coverage: Providing services to all those who need them is extreme importance. For instance health service coverage incorporates three dimensions: population coverage, benefit coverage, coverage of costs.

Importance of nuanced understanding: In aiming to increase demand for services, it is important to go beyond broad trends to examine nuances. Many countries have good policies and laws in place, but are weak enforcement. While in some countries stigma and discrimination may be decreasing, marked stigma towards KAPs may be strong.

Transformative potential of HIV-sensitive social protection: Addressing stigma, discrimination, including marginalisation of MARPs, and employment can transform the lives of PLHIV in profound ways, and go beyond the conventional approach of providing social safety nets to making society more inclusive.

WHO priority for 2011 on sensitizing health sector: WHO has prioritised sensitizing the health sector for HIV access this year, and is developing related trainings and guidelines.

SESSION 5: IDEAS TO ACTION

Objectives: To brainstorm and formulate interventions on the social protection needs identified in the previous session as the country representatives find relevant to themselves; and to synthesise and generalise stakeholder responsibilities to operationalise the ideas.

This session comprised discussions in country groups to respond to the following questions for each priority impact category:

- What needs to happen to address the impact? (political will/leadership, policy, implementation, financing)
- For whom?
- Who is responsible to make it happen? (government, UN, donor, NGO, INGO, CSO and networks (local, regional and international)

The key activities identified by the groups include:

- **Income and employment:** Modifying existing schemes to make them HIV sensitive, and linking PLHIV with these schemes; developing partnerships with the private sector.
- **Health:** Increasing uptake of services through the promotion of health-seeking behaviour (particularly among KAPs); and through improving the quality of health services (addressing stigma and discrimination in healthcare settings).
- **Stigma and discrimination:** Application, enforcement and harmonisation of laws and policies; and developing social communication strategies to address stigma and discrimination among the general public.

Day 3 was composed of break-out sessions in country groups to identify follow-up actions, country presentations, and a plenary discussion to identify areas where support is needed, and to discuss and agree on common priorities. Key messages put forward /reinforced during the third day include:

- Political commitment will be key to establishing successful HIV-sensitive social protection.
- Ensuring the sustainability of current and new HIV-sensitive social protection measures will require national budget, technical support, and south–south dialogue.
- Effective and cost-efficient HIV-sensitive social protection measures in the Asia-Pacific region need to reflect the concentration of the HIV epidemic among key populations.

Preparing for action: core competencies and focus areas of UNAIDS Cosponors

ILO

Richard Howard, Senior Specialist on HIV and AIDS; ILO Decent Work Technical Support Team for East and South-East Asia and the Pacific

Labour standards for decent work: Through its tripartite structure (government, employers and workers), ILO develops and oversees labour standards to ensure decent work for all workers in the formal and informal sectors. Key objectives include fair working conditions, access to social protection, and non-discrimination.

Employment and income: ILO's HIV and the World of Work- program aims to promote national policies and legal frameworks on HIV/AIDS and the world of work, ensuring PLHIV are included in the Labour Law and that they are not discriminated; and that social protection mechanisms are strengthened in the world of work. ILO provides technical assistance to governments to assess and design social protection strategies and schemes, ensuring coverage for PLHIV. ILO works in the area of skills development, providing support to vocational training, business development, and micro-credit programs, for example.

UNDP

Pramod Kumar, Senior Program Advisor; UNDP Asia-Pacific Regional Centre

Development planning and mainstreaming: UNDP works with countries and government institutions to plan and respond to aspects of HIV that relate to development, integrating HIV into planning instruments and national social protection strategies, and facilitating South – South dialogue.

Governance: Governance of HIV responses – ensuring they address the impact of HIV on KAPs – is a key area of UNDP's work. Laws and policies, and the protection and promotion of human rights, including in the areas of gender equality and sexual diversity, are aspects of this support, as is the generation of data to inform this work (socioeconomic impact assessments).

UNICEF

Ketan Chitnis, Regional HIV/AIDS Specialist; UNICEF, Asia-Pacific Shared Services Centre

Health-seeking behaviours: UNICEF works with communities to make sure there is demand for health services, and to ensure KAPs are able to access health services (social mobilisation).

Social protection for vulnerable populations: On the service side, UNICEF works to ensure health – as well as education and social services – reach the most disadvantaged and marginalised populations. This includes strengthening the capacity of child- and social welfare workers, and support to strengthening systems to ensure social protection is child- and HIV-sensitive.

Strengthening the evidence- and resource base: UNICEF works to ensure there is data and analyses available to inform policy and program development (particularly on risk and vulnerability). UNICEF also supports fundraising, providing technical support to the development of Global Fund proposals, for instance.

UNAIDS

Robin Jackson; UNAIDS Geneva

ABC Advocating, brokering and coordination are central tasks of UNAIDS. Advocating for a range of important issues, particularly as they relate to gender and human rights is central to UNAIDS work. UNAIDS works to broker effective partnerships between governments, civil society, the UN and other actors to enhance the response to the epidemic. Coordination of the 10 cosponsors[16], catalyzing expertise and leveraging resources is a core UNAIDS function.

Access to technical support: UNAIDS has developed regional Technical Support Facilities (TSF) as a mechanism to provide technical support to countries. In Asia and the Pacific, TSFs are located in Kuala Lumpur and in Kathmandu, and technical support is also available through the HIV Alliance in Cambodia.

Strategic information and planning: Generating and analyzing strategic information (including HIV trends, structural drivers, etc.), and supporting evidence informed planning are a key part of UNAIDS' work.

SESSION 6: DEFINING PRIORITIES AND IDENTIFYING IN-COUNTRY FOLLOW-UP ACTION

Objective: To identify in-country follow-up action (next steps and milestones)

The following is a summary of the immediate follow-up actions identified by each country group:

Cambodia

- Harmonisation of laws and policies **(next 6 months)**:
  - Accelerate existing efforts to educate police and local authorities in hotspot areas to harmonise the implementation of laws and policies affecting KAPs with the HIV law (MARPs Community Partnerships Initiative)
- Social protection IWG led by CARD (**next 3 months)**:
  - Ensure inclusion of HIV sector representatives (NAA, civil society) in Social Protection IWG
  - Brief Interim Working Group on HIV sensitive SP needs (meeting outcomes), and explore establishment of a sub-TWG as required
- Economic/Income & Employment **(next 3–6 months)**
  - NAA to brief Impact Mitigation TWG on meeting outcomes
  - NAA to convene meeting with key stakeholders, including National social security fund (NSSF), Ministry of Labour and Vocational Training, and Ministry of Economy and Finance to discuss priorities, next steps & financing
  - NAA to launch findings on Stigma Index, and Socio-Economic Impact Study
  - ILO and CARD to develop proposal for pilot linking Vocational Training and social protection (that will include HIV component)
- Nutrition **(next 5 months)**
  - Accelerate roll out of existing plans to HIV & Nutrition Guidelines (June – July 2011), training of trainers (June – July 2011), and training at sub-national levels (September – October 2011)

16 ILO, UNDP, UNESCO, UNFPA, UNHCR, UNICEF, UNODC, WFP, WHO, WB

China

The following actions to take place in the next 3–6 months:

- Develop detailed measures on improving the rights and interests of PLHIV within the context of the New State Council Guidance (5 Expansion and 6 Strengthening)
- Establish a taskforce under the leadership of MOH to address stigma/health-seeking behaviour issues, including UN and other key stakeholders in the process, setting clear roles, a division of labor, and accountability for each agency, and reviewing reasons for past failures, lessons learned, and identifying a strategy for the future
- Convene a symposium on the socio-economic impact of HIV/AIDS at individual and household levels on May 4th, setting a roadmap for China in addressing the social and economic impacts on PLHIV

India

- National AIDS Control Program-4 (NACP-4) formulation of working groups (thematic including mainstreaming, gender, stigma etc.) **(Beginning in May)**
- Set up XII Plan Formulation APEX Group. **(May-June)**
- Stigma Program Framework, using data and information from pilot projects, **(Next 6 months)**
- Undertake specific consultations: Livelihoods, Gender. **(Next 3 months)**
- GIPA Policy Framework. **(Next 6 months)**
- Commission study on cost-effectiveness of different social protection measures, to ensure more informed decision-making and ensure buy-in of stakeholders. **(Next 3 months)**
- Develop a prototype for 1-2 states for implementation of more inclusive legal aid scheme **(Next 3-4 months)**
- Commence dialogue on inlusive health insurance schemes. **(Next 3-4 months)**
- Disseminate results of work underway nationally. **(Beginning in May 2011)**

Indonesia

- Inter-ministerial Meeting (**end of May 2011**) to share the results of the Technical Consultation, and to briefing to the Cabinet Meeting. **(June 2011**)
- National Coordination Meeting with key stakeholders to consolidate and strengthen existing work and to encourage government to allocate budget to strengthening and expanding HIV-sensitive social protection, and explore resources available from the private sector. **(October 2011)**
- Scale up and monitor sectoral programs on social protection at the local levels to strengthen social protection at the district and local levels. **(October 2011)**
- Develop an integrated national roadmap for social protection that is HIV-sensitive. **(November 2011)**

Nepal

- Present the findings of this workshop to National Steering Committee's National Planning Commission members, and to the Social Health protection Team under the Ministry of Health and Population. **(May 2011)**
- Review current social protection schemes to identify opportunities for HIV sensitivity (utilizing the consulting group, and organising a dissemination workshop involving civil society and other stakeholders). **(Sept 2011)**
- Incorporate HIV-sensitive schemes into the national social protection framework (service, cash transfer and safety net). **(2011)**
- Translate the provisions into various annual work-plans and budgets (MOHP, MOLD, MOLT, MOE, MOAC, DOR, MOWCSW and UN agencies under programmatic approach, NGOs, CSOs). **(2011 onwards)**

Papua New Guinea

- Consultation of participants to make a presentation to the National Social Protection Taskforce and to the National AIDS Secretariat to inform on the outcomes of this consultation, and to make recommendations on how to insert HIV-sensitive modifications into the Social Protections Policy. **(Next couple of weeks)**
- National consultation forum to occur in Papua New Guinea on HIV-sensitive social protection, and to include government, civil society, private sector, and development partners.

- HIV social protection assessment and costing exercise targeting relevant agencies and institutions. This should be integrated into the forthcoming larger social protection costing exercise.
- Greater inputs from international partners and civil society in the process of developing, implementing, and monitoring and evaluating an HIV-sensitive social protection program, especially in the area of technical support on social protection (particularly the UN and other development partners).

Thailand

- Include HIV Specialists from the government and UN to assess the HIV-sensitivities of social protection schemes to be carried out by the joint UN and government work on social protection; ensuring HIV representation in the process of developing the social protection floor. **(Next 3 months)**
- Convene HIV stakeholders to discuss Global Fund Round 10, ensuring greater understanding of social protection within the group and the workplan for globalfund reflects the social protection issues. **(June-Sept)**
- Ensure that action planning for the Joint Team (UNPAF) on social protection integrates HIV senisitivity in their plan. **(June –Dec)**
- Conduct vulnerability analysis of children infected and affected by HIV to help policy advocacy for social protection, and to inform actions for the GFATM R10 **(June –Sept)**
- Generate strategic information to be able to determine stigma and discrimination agenda and actions for Thailand. **(June 2011-2012)**
  - The following specific studies will be conducted: National Composite Policy Index on Stigma and Discrimination; Annual HIV AIDS and the Law Review for Thailand; Qualitative analyses of stigma and discrimination towards specific populations (PLHIV, SW, MSM, TG, persons who inject drugs, and children)
- Develop and strengthen national and sub-national sub-committee on stigma and discrimination so that these are in a position to advise, monitor, and implement stigma and discrimination agenda in the country. (**June 2011-2012)**
- Pilot model stigma and discrimination prevention programs in three settings: workplace, healthcare, and schools. The piloting should incorporate issues of SW, MSM, TG, people who inject drugs and children. **(June 2011-2012)**
- Strengthen AIDS Rights response through legal hotlines and counseling in several provinces, and improve the capacity of counseling centers. **(June 2011-2012)**

Viet Nam

- Ensure that the Social Protection Action Plan (2011-2015), to be developed in the **2nd semester of 2011**, is HIV-sensitive (for instance, initiatives to promote employment include PLHIV).
- On-going development of the National Strategy on HIV and action plans:
  - Bring inputs of this consultation into the1st planning workshop **(May 2011)**.
  - Collaborate closely with the Ministry of Labour, Invalids and Social Affairs (MOLISA) to integrate social protection into the HIV Strategy **(May-June 2011)**.
  - Ensure stigma and discrimination are fully considered in the development of the strategy/action plans, and remove the "social evil"-phrase from strategies and action plans.
- Develop professional social work networks to support PLHIV in community and social protection centers.
- Develop project proposal to promote health services to key populations and improve their health-seeking behaviour.

Principles for actions

Clifton Cortez, Practice Team Leader, UNDP Asia-Pacific Regional Centre

The following principles or concepts reflect common, repeated themes that emerged from the presentations and plenary discussions[17]. These principles underline strengths that drive social protection. Social protection for mitigating the impact of HIV on affecte people and their households should:

1. **Aim for HIV-sensitivity versus HIV-specificity:** For reasons of sustainability, coverage, involvement of multiple sectors and the opportunities for mainstreaming HIV into national and decentralised development plans.
2. **Involve multiple sectors and partners:** HIV-sensitive social protection requires the involvement of different ministries, the private sector, civil society and communities. Their involvement and partnership is required at every stage – from planning to implementation. This is also important for sustainability.

17 This list has been refined by key UN partners on the basis of feedback presented through plenary discussion.

3. **Engage affected individuals, networks and communities – especially key populations:** The design of HIV-sensitive social protection programs should be inclusive and participatory so as to ensure that the interventions address the specific needs and concerns of the affected people.
4. **Protect and enhance human rights:** While implementing HIV-sensitive social protection schemes, special attention must be paid to ensure that the human rights of the participants are not violated but rather are enhanced. Issues of concern are mandatory testing, disclosure of beneficiary details, breach of confidentiality and involuntary confinement.
5. **Take into account sustainability:** As in the case of ART, HIV-sensitive social protection requires long-term political and financial commitment and hence sustainability should be an integral part of the planning process.

Plenary discussion

Agreement on the principles: All participants agreed on the principles presented above.

Importance of knowing and responding to the epidemic: It is important to know how the epidemic is evolving in each country, and to ensure this informs program design and development. Countries in the Asia-Pacific have good knowledge of their epidemics, including on its concentration among particular sub-populations. The translation of the principles /concepts (above; especially principles 1 and 2) into practice should reflect the reality of the epidemic, prioritising actions targeting KAPs.

Specify sub-populations: To help target interventions, it will be good to specify which sub-populations priorities 3 and 4 relate to at the country level. Reflecting the regional scenario, a participant suggested that the third priority, "Engage affected individuals, networks and communities", be modified to include women and adolescents, who have "a lot to advise about."

Young people: Countries in the region have large youth populations, who are among the key populations most affected by the epidemic. Young people have the highest rates of HIV infection, and there is a need to address the needs of children who have been infected through their mother during pregnancy, and are entering a sexually active phase in their lives.

Importance of broad understanding of sustainability: Sustainability extends beyond financing to e.g. social sustainability. To ensure sustainability, it is important to understand what sustainability entails, and to work in the areas of e.g. policies and the legal environment.

Financial sustainability: Heavy reliance on external financing presents a threat to maintaining existing programs, and to introducing HIV-sensitive social protection schemes, particularly given the current economic crisis and its impact at global and national levels, and the decrease in ODA. Cost efficiency and mobilizing domestic budget are important, if also complex issues.

Need to approach social protection as an investment: While mobilizing funds for HIV-sensitive social protection is likely to be a challenging task, it is important to underline that HIV-sensitive social protection is an investment which yields benefits for society.

UN support to move the agenda forwards

Brian Lutz, Policy Specialist, UNDP, New York

UN counterparts present at the consultation identified the development of the following regional products by UN organisations to support HIV-sensitive social protection:

Assessment tools for country-level use (to identify HIV-sensitivity of social protection schemes);

Guidance note on HIV sensitive social protection;

Good Practices (sharing information on what works to assist in the design of HIV-sensitive social protection schemes).

Plenary discussion

Include costing and harmonisation in the principles: Costing and harmonisation are key to determining the success of HIV-sensitive social protection interventions. They should thus be included in the principles, ensuring they are congruent with each other.

Publication on good practices relevant to the region: A regional publication identifying good practices would be helpful to supporting countries to operationalise HIV-sensitive social protection. This should reflect the concentration of the epidemic among particular sub-populations. Experiences (best practices and lessons learned) from countries outside the region – with with a different HIV scenario, but e.g. similar geographic, cultural, and/or economic features – would be useful to include in the publication.

Benefit package: It would be helpful to identify good models for benefit packages offered through HIV-sensitive social protection schemes. These will look different in different countries, but an analysis of the basic elements of a benefit package would benefit governments as they develop these packages.

Guidance on harmonisation: Social protection interventions are often fragmented and individualised, which presents a challenge to harmonising these, and to making sure they are HIV-sensitive. There is a need for guidance on harmonisation, including how to ensure systems, structures, and practices are coherent.

Regional tool on costing: Given the importance of costing, specific guidance (a regional tool) on costing would be extremely useful, assisting countries advocate for, design and manage HIV-sensitive social protection schemes.

Return on social investment: Minitries of planning and financ may want to want to know the returns on social investment, and there is a need to detail expected returns (financial and social).

Monitoring and evaluation tool: Designing and implementing HIV-sensitive social protection is a complex, multisectoral process, and there is a need for a monitoring and evaluation tool.

Rapid assessment tool: Many countries in the Asia-Pacific have begun to develop social protection schemes, and a rapid assessment tool on HIV-sensitive social protection for countries with concentrated HIV epidemics would be helpful.

CLOSING REMARKS

ILO
Richard Howard, Senior Specialist on HIV and AIDS, ILO Decent Work Technical Support Team for East and South-East Asia and the Pacific

Richard Howard expressed his thanks to UNDP and all the co-organisers of the consultation, as well as the Cambodian counterparts for hosting the consultation. He shared with the audience that his thinking on HIV-sensitive social protection was provoked by the initial findings of the socioeconomic survey, which demonstrated the clear impact HIV had on HIV-HHs. He expressed his thanks also to the Asia Pacific Network of People Living with HIV/AIDS (APN+), and stated that he was impressed with the linkages established during the workshop, and called on participants to pledge to strengthen work on HIV and to ensure HIV is incorporated into work around social protection.

WAPN+
Kirenjit Kaur, WAPN+ Coordinator, Asia Pacific Network of People Living with HIV/AIDS

In her remarks, Kirenjit Kaur called on the participants to include local PLHIV local networks and KAPs in planning and implementating HIV-sensitive social protection programs and policies. "We, the community, believe we should use the term MIPA (Meangingul Involvement of People Living with HIV/AIDS), not GIPA, making sure our voices are heard and brought across." She called on all stakeholders – government, donors, community, PLHIV networks and other organisations – to work closely together, "as a family" to include HIV in social protection schemes, and to make sure all involved, at all different levels, are aware of the priorities and programs of these schemes.

Steve Kraus, Director, UNAIDS Asia-Pacific Regional Support Team

Steve Kraus began his remarks by commenting that on the basis of his observations this morning, "what I hoped might have happened, happened": participants have engaged in sharing information and experiences, and have articulated commitment to HIV-sensitive social protection. Social protection is a thematic that requires working across different ministries, different departments within ministries; and across different systems and disciplines, he noted, extending his thanks to all the

governments for engaging in the consultation, and to UNDP, ILO, and UNICEF for organising the consultation, commenting "we work together because these are important issues."

Sharing insights from a publication produced by the UN on examples of social protection programs in 18 countries, he pointed out that the evidence is overwhelming that when social protection schemes are put in place, they have positive effects on the health and well-being of communities, and contribute to vibrant economic life, increasing productivity. Many countries in the region are experiencing strong economic growth, he noted, yet the gap between their rich and poor is growing, impacting social instability. There is also strong evidence that societies that have strong equality, he noted, are best placed to compete in the global market place.

The experiences of the HIV/AIDS community and of the social protection community need to come together. He encouraged participants to continue the dialogue across sectors and agencies. It is important to engage communities in the response, he reminded. "If we have learned anything in 30 years, it is that the recipe for failure is not to talk to key populations, they are our best advisors." In Asia, most affected people include those who buy and sell sex, who use drugs, and MSM, he said, presenting participants with the challenge to get to know and befriend people from these groups. Satisfaction comes with the ability to look back and respond positively to the question "How well will we have really touched the lives of the peoples we served?" he suggested.

Asia has received considerable external funding to resource its HIV response and every country has received substantial funding from the Global Fund. This will not continue, Steve Kraus observed, pointing to the need to move from donor dependency to partnerships, increasing national budget to the HIV response, and to resourcing the development of HIV-sensitive social protection. "The issue of sustainability is not going to go away. We all are one planet, but we need to ensure government commitments are sustained." As the countries in the region move from low- to middle income, the challenge is to ensure financial sustainability to the HIV response, he stated, providing the positive example of Thailand where 95 percent of national HIV/AIDS expenditure comes from domestic sources. The economy moves faster than social protection, and experiece from many parts of the world suggests that in order to limit the negative impact of this gap and ensure maximum positive impact from economic growth, dialogue on social protection needs to take place at an early stage.

Before finishing, Steve Kraus presented one more challenge to the participants: that of thinking about the kind of changes they can make to laws and policies. The lack of a supportive, protective legal environment is the biggest single impediment holding back the HIV response, he observed. Many of the countries in Asia and the Pacific have punitive laws that have a severe impact on key populations, including laws that prohibit same sex behaviour, commercial sex, or criminalize those who take (not those who sell) drugs, and in four countries taking drugs can lead to a death penalty. "That's not the way to get from here to there; to good public health, or good social protection schemes." He commended participants for their active engagement, and called on all to "learn and work together to make the world a better, healthier, safer place for us all."

Ros Seilavath, Deputy Secretary General, NAA, Cambodia

Dr. Ros Seilavath expressed his thanks to the UNDP, ILO, UNICEF and UNAIDS for organising the consultation and for the opportunity to learn from the different experiences within the region. He noted his appreciation for all the discussion on the concept and application of HIV sensitive social protection. Cambodia faces many challenges in providing interventions to particularly MARPs (which is the term adopted in Cambodia, he noted, in place of KAPs), with cultural norms placing restrictions on the selection of appropriate interventions. Against this back-drop, Ros Seilavath drew attention to the importance of harmonising laws, and of convening interministerial discussion to raise awareness of, and seek ways to address the harmful effects of particular aspects of laws, such as the laws on anti-trafficking and drug use in Cambodia. "We can only try to live and work together to harmonise laws," he commented, noting that while changing policies and laws is possible, this takes time and requires thorough understanding of the conflicting points of laws and policies. Ros Seilavath finished his remarks by stating his commitment to involve all key partners to develop a better strategy that addresses the need in Cambodia for HIV-sensitive social protection.

APPENDIX 1: CONCEPT NOTE

Synopsis

Given its increasing importance in expanding universal access and for mitigating the impact on people and families affected by HIV, social protection has emerged as a key strategy in AIDS responses. UNAIDS in its 2009-2011 Outcome Framework lists social protection for people impacted by HIV as one of the priority areas and cross-cutting strategies. Many Asian countries have impressive records of social protection, but not adequate HIV-sensitive social protection[18] despite the impoverishment and marginalistion of people affected by HIV.

An issue of concern in the context of HIV in Asia and the Pacific is the severe and wide-ranging socio-economic impact on people living with HIV and their households. Although the prevalence is generally low and the epidemic is concentrated among the most at risk populations in the region, the impact on households is quite burdensome, often pushing them to irreversible coping mechanisms[19]. There is increasing call for social protection to help mitigate the impact as well as to prevent them from adopting irreversible coping mechanisms.

In this context, UNDP in partnership with UNICEF, ILO, UNAIDS, and APN+ is organizing a high level technical consultation in April 2011 on HIV-sensitive social protection with particular focus on impact mitigation. Besides strengthening the understanding of HIV-sensitive social protection, the consultation will arrive at a common approach to HIV-sensitive social protection for impact mitigation. It will bring together leading experts of social protection, HIV-specialists, academia, economists and leaders of PLHIV networks with participation from governments, civil society, UN and other stakeholders.

Background and rationale

Although various State-supported social welfare schemes have been in implementation in most of the countries in the Asia-Pacific region for several years, since the Asian financial crisis of 1997, there has been increasing attention to the importance of social protection to safeguard vulnerable populations from livelihood shocks. That more than a decade of unprecedented growth could not protect a large number of people in Asia from deprivation and socio-economic risks has brought to sharp focus the necessity of institutional mechanisms for social protection[20], particularly of the vulnerable groups.

As a global review of social protection[21] by the Institute of Development Studies, Sussex, notes, the risks, vulnerabilities, exclusion and inequalities that accompany the rapid economic, social and environmental changes leave millions of people exposed to livelihood insecurity. The impact of the recent economic crisis and food and fuel price shocks is a case in point. There is considerable unanimity now among international development partners that economic growth and social infrastructure alone aren't enough to fight poverty, and to protect vulnerable groups, there is an urgent need for various measures of social protection[22]. They also feel that "social protection should cover a wider set of policies and programmes than the approaches adopted in developed nations."

According to the Chronic Poverty Report 2009[23], social protection, and particularly social assistance, tackles the insecurity trap by protecting poor people from shocks and reducing their extreme vulnerability; it helps them conserve and accumulate assets so that they can improve their livelihoods and productivity; and it contributes to transforming economic and social relations in ways that strengthen the longer term livelihood prospects of the poor and the chronically poor.

Key among the people who face severe socio-economic vulnerabilities, exclusion, marginalization, poverty and livelihood shocks in the Asia-Pacific region are the people living with HIV, their households and those who are at risk of infection. People living with HIV and their households, including those who suffered AIDS-deaths, are acutely burdened by illnesses, loss of jobs and income, rising medical expenses, depletion of savings and other resources, food insecurity, psychological stress and related morbidity, discrimination, social exclusion and imminent impoverisation that is often irreversible. This socio-economic impact is also felt on the status of women as well as the education of children. The Report by the Commission on AIDS in Asia[24] estimates the annual economic cost of AIDS on Asian households at about US $ 2 billion. Each AIDS death results in a loss of at least US $ 5,000 or 14 years of productive life calculated at a modest US $ 1 a day.

Recent studies supported by UNDP in China, India, Indonesia and Cambodia, demonstrate the extreme socio-economic vulnerability of people living with HIV and their households in the Asia-Pacific region. For instance, the study in China showed that the socio-economic burden of HIV at the household and per capita levels is significant compared to the non-HIV

18 HIV-sensitive social protection refers to social protection that does not exclusively target those affected by HIV, instead targeting a more encompassing set of vulnerable group, but nonetheless is able to reach people affected by HIV and adequately address their unique needs. HIV-specific social protection refers to social protection that exclusively or predominately targets those affected by HIV.

19 Socio economic impact studies by UNDP in India (2006), Cambodia, China and Indonesia (2010), UNDP

20 Seven out of the 29 countries that will pilot the Social Protection Floor Initiative of the UN CEB are in Asia

21 Socio-economic security over the life course: A global review of social protection, Sarah Cook and Naila Kabeer, Institute of Development Studies, Sussex; July 2009

22 Social Protection Index for Committed Poverty Reduction, ADB, 2006

23 Chronic Poverty Report 2008-09

24 "Redefining AIDS in Asia", Report of The Commission on AIDS in Asia, Oxford, 2008

households across a wide spectrum of indicators ranging from loss of income to education of children. Reduced workforce participation of adults of productive age and additional burden on older people and children are substantially higher among HIV-households. Medical expenditure of HIV-households is four times higher than that of non-HIV households and the quality of food consumed, despite comparable level of expenditure, is poorer. HIV significantly compromised the ability of households, particularly in the lower quintiles, to borrow. They liquidated assets twice as many times as the non-HIV households did. HIV also has a serious impact on food security as indicated by the reduced farm activity, reduced area under cultivation as well as non-diversity of crops among HIV-households. HIV led to school drop-outs, which is higher among girls, and considerable household burden on women. Discrimination is rampant and had a wide-ranging impact including on loss of income. A major recommendation of these multi-country studies for strategic impact mitigation is targeted social protection schemes and integration of HIV into existing social protection schemes.

Despite the acute socio-economic vulnerabilities, the attention to strategically integrate HIV into appropriate social protection schemes (HIV-sensitive social protection) is very limited in the region. The recent financial crisis and the food and fuel price inflation add a more complex dimension to the situation. Already burdened by the severe socio-economic impact of HIV/AIDS, people living with HIV are among the most vulnerable to external shocks. In addition, the possibility of rollback of resources by donors in the wake of the crisis worsens the situation as the AIDS programmes in many countries in the region are largely dependent on donor funds. A World Bank/UNAIDS study[25] concludes that a majority of countries will be forced to cut their HIV programmes as they are dependent on external sources of support that will be reduced because of the crisis.

The volatile food price situation in the region is also of serious concern. Since 2000, food prices have been rising in Asia and the Pacific and throughout the world, with particularly sharp increases since 2007. Globally, food prices rose by 66 per cent between mid-2005 and August 2008[26]. The FAO Global Food Price Monitor notes that that the price of rice is at a record high in several countries of Asia[27]. A number of economists are projecting renewed high levels of food price inflation in 2011. Recent modeling work on how these increases affect the poor in developing countries shows that increases in the poverty headcount are likely to be severe, eliminating much of the progress in poverty reduction that has been made in recent years[28]. Additionally, some HIV-affected households spend a lower proportion of their total expenditure on food than their non-HIV counterparts implying that these households use for medical purposes the money that they would otherwise spend on food. Food price-rise will likely impact the quality as well as the quantity of diet of HIV-affected households.

Available examples show that social protection has significant AIDS mitigation impact. For example, cash transfer programmes piloted in countries with high HIV prevalence have a significant impact on poverty reduction in households affected by HIV and AIDS[29], while supporting livelihoods, enabling access to education and improving nutrition[30]. As the State of Evidence paper of UNICEF[31] notes, social protection, mainly through instruments such as social transfers, livelihoods, social health protection, legislation, policies & regulation, can promote Universal Access outcomes on HIV prevention, treatment, care & support.

In the East Indian state of Orissa, lowering the age limit for AIDS-widows has helped women living with HIV access monthly financial assistance from the government under the widow pension scheme[32]. Quoting relevant studies, Ann Nolan of Irish AID[33] argues that cash transfers may prevent households affected by AIDS from adopting non-reversible coping strategies such as liquidation of assets and removal of girl children from schools; labour market interventions can make amends for the erosion of skills and experience caused by illness and long periods of absence from work; increasing resources and decision-making capacity in women's hands can enhance gender equality, child survival and better food security; and transformative social protection[34][35] can support the realization of rights of women crucially required in the context of HIV/AIDS.

Some suggest that such interventions should be prioritized based on their potential contribution to reducing the impact of the epidemic, rather than on prevalence rates alone, and that such schemes could potentially contribute to prevention and treatment as well as to care and support[36].

The potential contribution of social protection to HIV prevention in concentrated epidemics and lower prevalence environments

25 The global economic crisis and HIV prevention and treatment programmes: vulnerabilities and impact, World Bank and UNAIDS, 2009

26 Table 1a, Indices of Primary Commodity Prices, 1998-2008, IMF, 2008, and quoted in The Threat Posed by the Economic Crisis to Universal Access to HIV Services for Migrants, Preliminary Findings, Joint United Nations Initiative on Mobility and HIV/AIDS in South East Asia and Southern Provinces of China (JUNIMA), 2009, Page 7

27 FAO Food Price Monitor, January 2011

28 A preliminary study of the impact of HIV on poverty and food security among HIV-affected households in Asia; Hunger briefing paper series 3; UNDP, 2009

29 UNICEF, ESARO, 2007 as quoted in "Social protection in the context of HIV and AIDS"; Ann Nolan, Irish Aid, Promoting Pro-Poor Growth; Social Protection, OECD, 2009

30 Agűero *et al.*, 2007 as quoted in quoted in "Social protection in the context of HIV and AIDS"; Ann Nolan, Irish Aid, Promoting Pro-Poor Growth; Social Protection, OECD, 2009

31 Social protection in the context of the HIV epidemic, State of the Evidence and implications for further action, Dr. Rachel Yetes, UNICEF, 2010

32 Pension Scheme for HIV-affected, UNDP India website accessed on May 19 2010 (http://www.undp.org.in/pension_scheme_hiv_affected)

33 Social protection in the context of HIV and AIDS"; Ann Nolan, Irish Aid, Promoting Pro-Poor Growth; Social Protection, OECD, 2009

34 Policies that tackle power imbalances in society that may directly or indirectly encourage, create and sustain vulnerabilities, Devereaux and Sabates-Wheeler, 2004. E.g. 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

35 Miriam Temin, HIV-sensitive social protection: What does the evidence say? UNICEF, 2010

36 Ibid 16

is much debated. Many argue that the highest priority 'structural' interventions for HIV prevention in these environments are linked to human rights protection and creating an enabling legal environment for marginalized populations, while expressing skepticism that social protection in general can significantly influence these kinds of epidemic dynamics. The Sonagachi Project of sex workers in the east Indian city of Kolkatta, which combines both transformative elements of social protection and livelihoods interventions, both designed by sex workers, is a good example in this context.

Though the common understanding and approach to social protection as well as the current systems and programmes vary considerably across the region[37], a crucial aspect is quite discernible: a vast majority of highly vulnerable people, the informal economy workers and their families, fall between the two dominant forms of social safety nets - the social welfare schemes of the formal sector and the social assistance schemes targeted for the poorest of the poor. It is important to note that social protection in developing country contexts has to deal with deficits in basic needs (basic social security), protection in times of adversity (contingent social security)[38] and an overall paradigm of inclusive growth.

Finally, it is important to understand and respond to those who are critical or skeptical about the relevance of HIV-sensitivity in social protection. Some opposition to HIV-sensitivity might be rooted in stigma or discrimination against people with HIV or against the populations disproportionately affected by HIV in this region. In addition, however, it must be noted that there are more legitimate concerns linked to the relatively modest overall burden of HIV in Asia-Pacific, and the degree to which HIV-sensitive social protection does or does not make social protection more effective and inclusive, not just for people living with or vulnerable to HIV, but also for people with other chronic or life-threatening illnesses or disabilities.

The UNAIDS Business Case for social protection[39] lists as its goal, national social protection strategies that include people living with HIV and affected by HIV, with a focus on most-vulnerable groups and contribute to universal access and achievement of MDGs by 2015. The three priority actions identified by UNAIDS in this regard are evidence-based and coherent approach to HIV sensitive social protection; building consensus around social protection and contributing to the national scale-up of HIV-sensitive social protection.

In this context, particularly given its global mandate to address the development dimensions of HIV, UNDP proposes to organize a high level technical consultation on HIV-sensitive social protection in Asia and the Pacific in April 2011, in partnership with UNICEF, UNAIDS, ILO, and APN+. It is proposed that the consultation will bring together leading experts of social protection, HIV specialists, academia, economists and leaders of PLHIV movement with participation from governments, civil society, UN and other stakeholders. Through technical papers/presentations, discussions and analytical work, it will look at the social protection situation in the region and elsewhere, with a specific focus on HIV and impact mitigation: examine the good practices; most strategic sectors that may be involved; analyse the strengths/weaknesses of the most successful social protection schemes and their adaptability in the context of HIV-related impact in relevant settings.

Objectives

- To deepen the understanding on the strategic relevance of HIV-sensitive social protection for impact mitigation in Asia and the Pacific
- To analyze/review current social protection policies and programmes in the Asia-Pacific region and elsewhere and promote South-South learning
- To strategically improve service delivery to vulnerable and affected households by identifying key programmes, policies and stakeholders to address the socio-economic impacts of HIV on households
- To formulate recommendations and a common framework to guide policies and programmes on strategic HIV-sensitive social protection schemes

Proposed Inputs

- Regional analysis of the socio-economic vulnerability of people living with HIV and their households in Asia-Pacific (based on country studies in China, India, Indonesia, Viet Nam and Cambodia - UNDP)
- The social protection floor and opportunities for HIV-sensitivity (ILO)
- Lessons learned from child and women-sensitive social protection (UNICEF)
- Draft mapping of experience to date on HIV-sensitive social protection in the region (UNICEF and UNDP)
- Draft mapping of major approaches to social protection in general in Asia-Pacific countries, with possible entry points for HIV

37 Naila Kabeer, A review of social protection in South Asia; Sarah Cook, Social Protection in East and South East Asia: A Regional Review; SPA working papers, 2009

38 Kannan quoted in ref. 2

39 UNAIDS Expanded Business Case:, Enhancing Social Protection, UNAIDS, May 2010

Expected outputs

1. Mapping and good practice documentation
2. Policy recommendations and a framework for action on HIV-sensitive social protection in Asia and the Pacific

Participating countries

Cambodia, China, India, Indonesia, Nepal, Papua New Guinea, Thailand, Viet Nam

Number of participants

61

Partners

UNDP, UNAIDS, UNICEF, ILO, APN+

APPENDIX 2: AGENDA

Objectives of meeting

- To deepen the understanding on the strategic relevance of HIV-sensitive social protection for impact mitigation in Asia and the Pacific
- To analyze/review current social protection policies and programmes in the Asia-Pacific region and elsewhere and promote South-South learning
- To strategically improve service delivery to vulnerable and affected households by identifying key programmes, policies and stakeholders to address the socio-economic impacts of HIV on households
- To formulate recommendations and a common framework to guide policies and programmes on strategic HIV-sensitive social protection schemes

Facilitators:

(1) **Paul Causey**, Consultant

(2) **Clifton Cortez**, Practice Team Leader, HIV, Health and Development, UNDP Asia-Pacific Regional Centre

(3) **Brian Lutz**, Policy Specialist, HIV, Health and Development Practice, UNDP, New York

Day 1: Social protection and HIV in Asia and the Pacific: the landscape			
Day/Time	**Description**	**Presenter/Facilitator**	**Objective**
8:30	Registration		
9:00 - 9:30	**Opening Session** Welcome Opening remarks	**Clifton Cortez**, Practice Team Leader, HIV, Health and Development, UNDP Asia-Pacific Regional Centre (APRC) **Douglas Broderick**, UN Resident Coordinator and UNDP Resident Representative, Cambodia **H.E. Ngy Chanphal**, Secretary of State, Ministry of Interior & Vice Chairman, Council for Agricultural and Rural Development (CARD)	
9:30 – 9:45	Logistics, objectives and agenda Introduction of participants	**G. Pramod Kumar**, Senior Programme Advisor, HIV, Health and Development, UNDP APRC **Facilitators**	
9:45 –10:15	**Session 1: Defining social protection** • Concepts and practice – introducing a general social protection framework and the Social Protection Floor Initiative • Discussion	**Celine Julia Felix**, ILO, Bangkok **Facilitators**	To provide a conceptual framework for social protection
10:15 – 10:30	**Coffee**		

Day 1 (cont.): Social protection and HIV in Asia and the Pacific: the landscape			
Day/Time	**Description**	**Presenter/Facilitator**	**Objective**
10:30 - 12:30	**Session 2: Social protection and HIV** • UNAIDS business case for social protection and HIV-Sensitive Social Protection: What does the evidence say? • HIV- and child-sensitive social protection: Findings from the mapping study in Asia-Pacific • Socio-economic impacts of HIV at the household levels in Asia and the Pacific and the context of social protection • Social protection from the perspectives of the HIV community • Discussion	**Robin Jackson**, UNAIDS, Geneva **Ketan Chitnis**, Regional HIV Specialist, UNICEF Asia-Pacific Shared Services Centre **G. Pramod Kumar**, Senior Programme Advisor, HIV, Health and Development, UNDP APRC **Kirenjit Kaur**, WAPN+ Coordinator, Asia Pacific Network of People Living with HIV/AIDS **Facilitators**	To understand why social protection matters for HIV, especially impact mitigation, in the region, and how to think about HIV-sensitive social protection
12.30 – 13.30	**Lunch**		
13:30 - 15:00	**Session 3: HIV-sensitive social protection for impact mitigation: lessons from Asia-Pacific** • Country case studies of social protection schemes that address HIV impacts 1. Cambodia 2. China 3. India 4. Indonesia • Discussion	**Dr. Ros Seilavath,** Deputy Secretary General, National AIDS Authority (TBC) **Dr. Oum Sopheap**, Executive Director, KHANA **Dr. Zunyou Wu,** Director, National Center for AIDS/STD Control and Prevention, China CDC **Aradhana Johri,** Additional Secretary, National AIDS Control Organisation, and **Alka Narang,** Asst. Country Director, UNDP India **Dr. Emil Agustiono,** Deputy for Population Health, and Environment, Ministry for People's Welfare, and **Dr. Haikin Rahmat,** UNDP Consultant **Facilitators**	To better understand the 'why' and 'how' of social protection for HIV impact mitigation, with country examples
15.00 – 15:15	**Coffee**		
15:15 - 16:45	**Session 3 (cont.): HIV-sensitive social protection for impact mitigation: lessons from Asia-Pacific** • Country case studies of social protection schemes that address HIV impacts 5. Nepal 6. PNG 7. Thailand 8. Viet Nam • Discussion	**Surya Prasad Acharya,** Joint Secretary, Ministry of Health and Population **Philip Tapo,** Deputy Director, National AIDS Council Secretariat **Sirirat Ayuwatana,** Deputy Permanent Secretary, Ministry of Social Development and Human Security **Dr. Do Huu Thuy,** Director, Department of BCC and Social Mobilisation, Viet Nam Administration on AIDS Control **Facilitators**	
16:45 -17:00	Re-cap of the day and closure of Day 1	**Facilitators**	

Day 2: HIV-sensitive social protection needs: Ideas and action			
Day/Time	**Description**	**Presenter/Facilitator**	**Objective**
9:00 - 9:30	Re-cap of Day 1 Objectives and agenda for Day 2	**Facilitators** **G. Pramod Kumar**	
9:30 - 12:30 (with coffee break)	**Session 4: What is needed** • Discussion: identify and map social protection needs for HIV-related impact mitigation in the region.	**Facilitators**	To identify/map what is needed to improve HIV-sensitive social protection for impact mitigation in the region
12.30 – 13.30	**Lunch**		
13:30 - 15:30	**Session 5: Ideas to action** • Break-out session: Participants are divided into break-out groups that comprise 2 country teams per group. • These can include modifying and/or scaling up existing social protection schemes or introducing new ones. These should be prioritized by impact and feasibility.	**Facilitators**	To brainstorm and formulate interventions on the social protection needs identified in Session 4 as the country-representatives find relevant to themselves To synthesize and generalize stakeholder responsibilities to operationalise the ideas
Day/Time	**Description**	**Presenter/Facilitator**	**Objective**
13:30 - 15:30	**Session 5 (cont.): Ideas to action** • Each break-out group should elect a rapporteur and then consider what needs to be done in those countries to convert the social protection needs, which were identified in the previous session, to actionable interventions • Break-out groups should be as specific as possible and should also identify which stakeholder(s) should be responsible for making the interventions work. Groups should identify opportunities and challenges as well • Each group should present the results in the plenary in a matrix (to be provided by the facilitators) containing 1) impact type and target beneficiaries, 2) corresponding interventions, 3) process, 4) key stakeholders	**Facilitators**	
15:30 - 15:45	**Coffee**		
15:45 - 17:00	**Session 5 (cont.): Ideas to action** • Report-back to plenary and discussion.	**Group representatives** **Facilitators**	
17:00 - 17:30	Re-cap of Day 2 and summary of next steps	**Facilitators**	

Day 3: Framework and recommendations for action			
Day/Time	**Description**	**Presenter/Facilitator**	**Objective**
9:00 - 9:30	Re-cap of Days 1 and 2 Objectives and agenda for Day 3	**Facilitators** **G. Pramod Kumar**	
9:30 -10:30	**Session 6: Principles of action and country plans** • Discussion	**Facilitators**	To develop recommendations and agree to a framework for action with stakeholder responsibilities and commitments identified
10:30 – 10:45	**Coffee**		
10:45-12:00	**Session 6 (cont): Principles of action and country plans** • Discussion	**Facilitators**	
12:00 -12:30	Next steps, wrap-up	**Facilitators**	
12:30 –12:45	**Closing remarks**	**Steven Kraus**, Director, UNAIDS Regional Support Team for Asia and the Pacific	

APPENDIX 3: PARTICIPANTS' LIST

Country		Organization	Title
Cambodia			
1	H.E. Ngy Chanphal	Ministry of Interior Vice Chairman of Council for Agricultural and Rural Development (CARD) responsible for the National Social Protection Strategy	Secretary of State
2	H.E. Dr. Sann Vathana	Council for Agricultural and Rural Development (CARD) Council of Ministers Russian Federation Blv., PO Box: 2470	Deputy Secretary General
3	Dr. Ros Seilavath	the National AIDS Authority	Deputy Secretary General
4	Say Ung	Council for Agricultural and Rural Development (CARD) Council of Ministers Russian Federation Blv., PO Box: 2470	member of CARD-Social Protection Coordination Unit
5	Kung Chanthy	Council for Agricultural and Rural Development (CARD) Council of Ministers Russian Federation Blv., PO Box: 2470	member of CARD-Social Protection Coordination Unit
6	Keo Chen	Cambodian People Living with HIV/AIDS Network (CPN+)	National Coordinator
7	Douglas Broderick	UNDP Cambodia Building 3, No 53, Street Pasteur, Boeung Keng Kang 1, Chamcar Morn, Phnom Penh, Cambodia	UN Resident Coordinator and UNDP Resident Representative
8	Flavia Di Marco	UNDP Cambodia Building 3, No 53, Street Pasteur, Boeung Keng Kang 1, Chamcar Morn, Phnom Penh, Cambodia	Social Protect Officer
9	Seak Hy Chay	UNDP Cambodia Building 3, No 53, Street Pasteur, Boeung Keng Kang 1, Chamcar Morn, Phnom Penh, Cambodia	Admin Officer
10	Penelope Campbell	UNICEF Cambodia	Chief, HIV/AIDS
11	Narmada Acharya	UNAIDS Cambodia 221, Street Pasteur (51), Khan Chamkar Mon Phnom Penh, Cambodia	Social Mobilization and Partnerships Adviser
12	Chuong Por	ILO, Cambodia	National HIV and AIDS Focal Point
13	Malika Ok	ILO, Cambodia	National Programme Officer, Social Protection ILO-EU/ Improving Social Protection and Promote Employment Project
14	Suntakna MengChhum	WFP Cambodia	HIV Focal point
15	Dr. Peng Vanny	World Bank, Cambodia	Social Protection Consultant
16	Dr. Oum Sopheap	KHANA #33, St 71, Tonle Bassac, Phnom Penh PO Box 2311, Cambodia	Executive Director
17	Men Sokunthea	Independent Democratic of Informal Economic Association (IDEA)	
China			
18	CHEN Xianyi	Disease Control Bureau, Ministry of Health DIC, MoH	Director General
19	WU Zunyou	National Center for AIDS/STD Control and Prevention, China CDC	Director

Country		Organization	Title
20	JIANG Xiaopeng	UNDP China 2 Liangmahe Nanlu, Beijing 100600, China	Programme Manager Democratic Governance and HIV/AIDS
21	Etienne Poirot	UNICEF China	Chief, HIV/AIDS
22	Wu Rulian	ILO, China	HIV and AIDS Program Officer
India			
23	Aradhana Johri	National AIDS Control Organisation.	Additional Secretary
24	Alka Narang	UNDP India No. 3059,New Delhi, 110 003, India	Asst. Country Director (Program)
25	Sonia Trikha	UNICEF, India 73, Lodi Estate New Delhi 110003	HIV Specialist
Indonesia			
26	Dr. Makmur Sunusi	General of Social Service and Rehabilitation, Ministry of Social Affairs	Director
27	Dr. Emil Agustiono	Coordinating, Ministry for People's Welfare	Deputy for Population Health, and Family Planning
28	Haikin Rahmat	UNDP Indonesia P.O. Box 2338 Jakarta 10001 INDONESIA	Consultant
29	Nina Tursinah	Indonesia Employers, Indonesia	Association of Indonesia Employers, Indonesia
30	Tendy Gunawan	ILO, Indonesia	Social Protection Program Officer
31	Kori Risya Ariyani	ILO, Indonesia	HIV and AIDS Program Officer
Nepal			
32	Ram Prasad Pathak	Environment and Social Unit Department of Roads Government of Nepal	Under Secretary
33	Surya Prasad Acharya	Ministry of Health and Population Member, National Steering Committee on Social Protection overnment of Nepal	Joint Secretary
34	Rafeeque A. Siddiqui	UNDP, Nepal UN House, Pulchowk G.P.O. Box 107, Kathmandu, Nepal	Local Governance Officer Governance Unit
PNG			
35	George Wrondimi	National Taskforce on Social Protection Papua New Guinea	Principle Researcher
36	Philip TAPO	National AIDS Council Secretariat P.O. Box 1345, BOROKO National Capital District Papua New Guinea	Deputy Director
37	Peterson Magoola	UNDP PNG P.O. Box 1041Port Moresby, N.C.D., Papua New Guinea	HIV Programme Specialist
38	Elaine Bainard	UNICEF PNG	Chief, Child Protection
Thailand			
39	Sirirat Ayuwathana	Ministry of Social Development and Human Security 1034 Krungkasem Rd,. Mahanak Prmprabsuttruphai, Bangkok 10100	Deputy Permanent Secretary
40	Dr. Pachara Sirivongrangson	Bureau of AIDS, TB and STIs Department of Disease Control Ministry of Public Health Tiwanond Road Nonthaburi 11000, Thailand	Director
41	Atchara Benjapong	Ministry of Social Development and Human Security 1034 Krungkasem Rd,. Mahanak Prmprabsuttruphai, Bangkok 10100	Senior Policy and Plan Analyst

Country		Organization	Title
42	Nery Ronatay	UNDP Thailand GPO Box 618 Bangkok, 10501, Thailand	HIV/AIDS Officer
Viet Nam			
43	Dr. Do Huu Thuy	Department of BCC and Social Mobilisation Viet Nam Administration on AIDS Control 135/3 Nui Truc, Ba Dinh, Hanoi, Viet Nam	Director
44	To Duc	Social Protection Department Ministry of Labour, Invalids and Social Affairs, Hanoi, Viet Nam	Head of Social Policies Division
45	Carmen Gonzalez	UNAIDS Viet Nam	
Regional UN Teams			
46	Clifton Cortez	UNDP Asia-Pacific Regional Centre	Practice Team Leader
47	Pramod Kumar	UNDP Asia-Pacific Regional Centre	Senior HIV Programme Advisor
48	Kazuyuki Uji	UNDP Asia-Pacific Regional Centre	HIV Programme Specialist
49	Ian Mungall	UNDP Asia-Pacific Regional Centre	Communications Analyst
50	Steven Kraus	UNAIDS, RST	Director
51	Ketan Chitnis	UNICEF Thailand Asia-Pacific Shared Services Centre 19 Phra Atit Road, Bangkok 10200, Thailand	Regional HIV/AIDS Specialist
52	Robert Gass	UNICEF Thailand	Chief, HIV/AIDS
53	Victoria Juat	UNICEF Thailand	Chief, Child Protection
54	Richard S. Howard	ILO Decent Work Technical Support Team for East and South-East Asia and the Pacific	Senior Specialist on HIV and AIDS
55	Celine Julia Felix	ILO	
APN+			
56	Kiren Kaur	Women of APN+ (WAPN+)	Coordinator
UNDP New York			
57	Brian Lutz	UNDP New York	Policy Specialist
ILO Geneva			
58	Lee Nah Hsu	ILO, Geneva	Asia-Pacific Regional Facilitator
UNAIDS Geneva			
59	Robin Jackson	UNAIDS, Geneva	Special Advisor, Office of Deputy Executive Director, Programme, UNAIDS
Facilitator			
60	Paul Causey	UNDP Asia-Pacific Regional Centre	Consultant
Rapporteur			
61	Silja Rajander	UNDP Asia-Pacific Regional Centre	Consultant - documentation

APPENDIX 4: GROUP PHOTO

High-level Technical Consultation on

HIV-Sensitive Social Protection for Impact Mitigation in Asia and the Pacific

27-29 March 2011 - Siem Reap, Cambodia

UNDP is the UN's global development network, advocating for change and connecting countries to knowledge, experience and resources to help people build a better life.

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