

Meeting Report

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Action on Social Drivers to End AIDS and Extreme Poverty

An expert consultation on HIV/AIDS and the global health and development agendas.

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Action on Social Drivers to End AIDS and Extreme Poverty

Meeting Report and Issue Brief

Overview: Structural Responses to HIV/AIDS, Poverty and Inequities

After more than three decades of struggle against HIV, the world is witnessing unprecedented returns from its investments in HIV prevention, treatment and care. The annual number of new HIV infections has declined, with especially dramatic reductions in the number of newborns who acquire HIV, fewer people living with HIV are dying as a result of scaled-up antiretroviral therapy (ART) and effective ART has been demonstrated to significantly reduce the rate of ongoing HIV transmission.¹ As a result of scientific advances, treatment and prevention methods now exist to end the HIV epidemic.

Despite this unprecedented progress in the global HIV response, economic inequality, social marginalization and other structural factors continue to fuel the HIV epidemic – with 35.3 million people living with HIV worldwide and 1.6 million dying from AIDS every year. In high-, middle- and low-income countries alike, HIV/AIDS is increasingly concentrated among persons marginalized by poverty, inequities and stigma – young people, women and girls, men who have sex with men, people who use drugs, sex workers, transgender and gender non-conforming persons, prisoners and the formerly incarcerated, refugees and migrants, homeless and displaced persons. Social, economic and legal disadvantages increase vulnerability to HIV, worsen the epidemic's impact, and undermine the effectiveness of biomedical tools. Gender inequalities, discrimination, social marginalization, and lack of access to housing and food, education and stable livelihood are what keep many people at risk of HIV infection, deprive them of access to effective treatment, and keep them from living fulfilling lives even when HIV is under control.

The continuing impact of HIV/AIDS, in turn, is a barrier to global efforts to reduce economic and social inequities and promote shared prosperity. Just as the devastation caused by HIV galvanized unprecedented global action to address the epidemic, an emerging worldwide mobilization is focusing on the eradication of extreme poverty. Under the leadership of President Jim Yong Kim, the World Bank is reorienting its work to help ensure the elimination of extreme poverty by 2030 and a boosting of shared prosperity for the poorest 40% in all developing countries. The ongoing HIV epidemic poses a significant challenge to these efforts. HIV deepens poverty and increases inequalities at every level, from household to country to global, undermining progress on poverty reduction, economic growth and other development goals. HIV—and its related stigma and discrimination—exacerbate social and economic inequalities, diminish opportunities for economic and social advancement, and cause profound human hardship.

As the global AIDS response continues to evolve, increasing attention is focused on combination prevention and care strategies that incorporate social/structural interventions – both HIV-specific (i.e., social protections as critical enablers of effective HIV prevention, care and treatment) and non HIV-specific (i.e., gender equity and human rights protections) – interventions usually associated with development goals. Empirical evidence supports a wide range of structural interventions to address social drivers of the AIDS pandemic, from economic empowerment (including education, livelihood building and protection of property rights), to

social protection (cash, food or housing), to transformative approaches (decriminalization, anti-discrimination laws and campaigns to change social norms). The available research evidence links greater social security, gender equality and improved economic opportunities to HIV treatment adherence, reduced mortality and lower rates of HIV acquisition and transmission. Progress toward ending the epidemic will therefore have significant positive implications for a range of development and human rights challenges

Indeed, action at the social/structural level is a “natural” space for the confluence of efforts to address the interrelated challenges of HIV/AIDS, extreme poverty and inequalities/inequities in opportunity, health and wellbeing. Although often conceptualized and organized as distinct components of the international development field, it is time to more consciously integrate efforts to end the HIV epidemic and eliminate poverty and inequality, to achieve more effective synergies and maximize gains towards both global goals.

A UNAIDS and World Bank Expert Consultation

In January 2014, UNAIDS and the World Bank co-convened a two-day expert consultation in Washington D.C. on *Action on Social Drivers to End AIDS and Extreme Poverty*. Through presentations of data, interdisciplinary discussion and development of recommendations for action, participants explored the interconnection of HIV/AIDS and social and economic inequities, reviewed evidence on effective social and structural responses, and worked to identify barriers that may currently impede effective intersectoral approaches. This report reflects the key themes, findings and recommendations that emerged from the meeting.

As observed by World Bank President Kim in his opening remarks, “Despite all of the progress we’ve made, AIDS continues to ravage the poorest, most marginalized and excluded communities – including the homeless, intravenous drug users, sex workers, and sexual minorities. They remain more likely to contract HIV, less likely to access or maintain treatment, and have far shorter life expectancy.” Dr. Kim reminded participants that the extraordinary gains to date against HIV have been achieved against considerable skepticism and resistance, and urged participants to take action regardless of similar doubts, stating “There is no doubt in my mind that we can achieve the end of AIDS and the end of extreme poverty.”

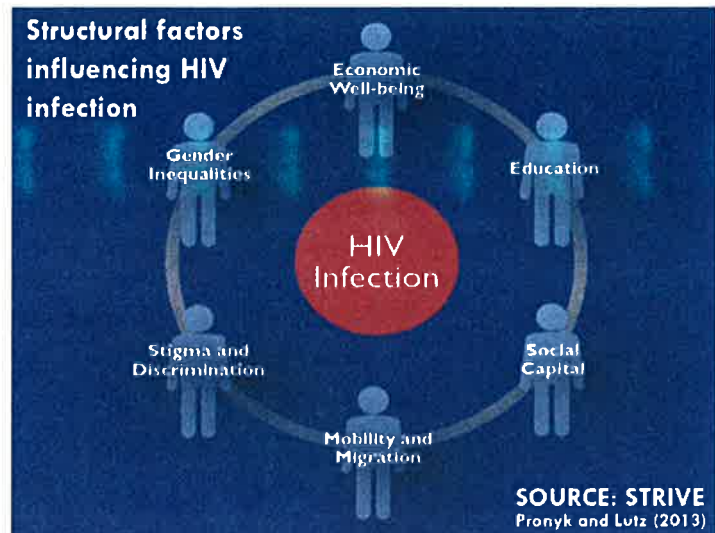
In welcoming participants to the Washington meeting, UNAIDS Executive Director Michel Sidibé said that placing “people at the center of our approach” will help us recognize the natural links between the HIV response and the global initiative to end extreme poverty and promote shared, equitable prosperity. “The time has come to combine our efforts, to work across sectors and to avoid fragmentation or working in isolation. We need to leverage our capacity to build a new movement to achieve our common dreams to end AIDS and to end extreme poverty.”

Social Drivers and Social/Structural Interventions: What They Are

Social drivers are the “core social processes and arrangements – reflective of social and cultural norms, values, networks, structures and institutions – that operate around and in concert with individual behaviors and practices to influence HIV epidemics in particular settings.”¹¹ Social drivers address broader contextual factors that are largely beyond the individual’s power to control, such as social attitudes regarding groups to which the individual belongs, laws and

policies that govern behavior and resources, and larger economic or social patterns that encourage particular behaviors or limit the range of possible behaviors.

These broader contextual issues are often referred to as “structural factors.” Structural factors or “determinants” have been variously defined but generally refer to “physical, social, cultural, organization, community, economic, legal or policy aspects of the environment that impede or facilitate efforts to avoid HIV infection” or to access and adhere to HIV treatment.ⁱⁱⁱ



Efforts that aim to change or leverage social or environmental factors to promote HIV prevention, treatment and care are commonly known as “structural interventions” or as “social-structural interventions.” According to Carlos F. Cácares of the International AIDS Society governing council and Peru’s Cayetano Heredia University, structural approaches for the HIV response typically address factors that depend on the state of the social environment (e.g., law or policy change), affect the larger economy or political system (e.g., global agreements), seek to alter individuals’ life conditions (e.g., economic and educational opportunities, basic subsistence needs, community support), or affect individuals’ options (e.g., changes in social norms affecting human sexuality or affecting an individual’s capacity to negotiate individual practices).

Structural interventions may operate close to individuals – for example, by altering the physical environment in which an individual lives, works or congregates with others – or quite distant from them – for example, by changing laws, increasing economic opportunities, or forging new social norms. Proximal strategies (including some forms of social protection) may have an immediate impact to improve the feasibility/effectiveness of biomedical strategies, while more “upstream” strategies (such as addressing stigma or discrimination) often have a longer time horizon. Changing harmful gender norms, for example, is unlikely to occur overnight, necessitating years of work and investment.

The Critical Role of Social Drivers in the HIV Epidemic

Physiological, behavioral and structural factors affect both the risk that an individual will acquire HIV and the capacity of individuals and communities to access life-saving treatment services. The health challenge posed by HIV underscores the critical role of biomedical research and health technologies. The antiretroviral medications that dramatically improve quality of life for persons with HIV both suppress viral load and prevent transmission to others. Whether taken as treatment by a person with diagnosed HIV, or as post- or pre-exposure antiretroviral prophylaxis (nPEP or PrEP) by an uninfected individual, studies evaluating the prevention impact of antiretrovirals show clear benefits in stopping the spread of HIV. But to realize the full benefit of new HIV prevention and care technologies, and to ensure that no one is left behind,

social/structural and biomedical strategies must be implemented in a complementary, synergistic and mutually-enabling manner.

Recognizing the multi-faceted nature of HIV risks, UNAIDS and other experts have long recognized the need to strategically combine biomedical, behavioral and structural factors to minimize the number of new HIV infections. This approach is known as “combination prevention.”

A combination prevention approach is hardly unique to HIV, having been used effectively in myriad public health efforts. Initiatives to minimize automobile fatalities, for example, have combined technological (e.g., development of seatbelts, airbags the like), behavioral (e.g., communications campaigns to encourage seat belt use) and structural (e.g., laws mandating seat belt use, regulations requiring auto makers to include seatbelts and airbags) interventions. Likewise, tobacco control programs use technological (e.g., nicotine replacement therapy), behavioral (e.g., mass media, one-on-one and group counseling) and structural (e.g., tobacco taxes, laws banning smoking in public spaces) approaches to prevent tobacco-related deaths. In national vaccination campaigns, conditional cash transfer programs implemented in combination with education and other health promotion strategies have proven effective in increasing vaccination rates.^{iv}

Although evidence shows that a combination approach to HIV prevention is highly effective, it has yet to be widely implemented. While multiple behavioral and biomedical tools and strategies have been identified and implemented to prevent HIV transmission, no coordinated effort has focused on addressing the broader underlying social, economic and legal conditions that contribute to the continued spread of HIV.

EFFECTIVENESS OF PREP – THE ROLE OF ADHERENCE

Study	Efficacy	Estimated Adherence by Drug Concentration
PinP-TDF/FTC	75%*	75-80%
PinP- TDF	67%*	67-80%
TDF2 – TDF/FTC	62%*	80%
BKK- TDF	49%*	67%
iPrEX – TDF/FTC	44%*	51%
CAPRISA –Gel BAT24	39%*	38% - 98%
VOICE- Gel Daily	14.7%	22%
FemPrEP – TDF/FTC	6%	37%
VOICE- TDF/FTC	-4%	29%
VOICE- TDF	-49%	28%

As Dr. Wafaa El-Sadr, director of ICAP at Columbia University, noted, “Every biomedical intervention is a combination intervention.” This is especially evident in results from the numerous efficacy trials of PrEP, which have found that the preventive effects of PrEP are directly correlated with the degree to which users adhere to the daily regimen. Unless factors that affect an individual’s ability to accept an intervention and adhere to

it are addressed – such as unstable living conditions, stigma associated with use of an HIV-specific intervention, or an ability to obtain ongoing access to the prophylactic regimen – the potential promise of PrEP will never be realized. These principles apply to other biomedical interventions such as use of ART for prevention or voluntary medical male circumcision.

The need to address the social and structural factors is equally evident with respect to HIV treatment and care. Although numerous studies have consistently found HIV treatment to be highly effective in preventing HIV-related mortality and HIV transmission, the public health impact of treatment is undermined by the fact that only a fraction of people living with HIV achieve the therapeutic goal of durable viral suppression. Due to patient loss across the HIV treatment cascade, only an estimated 25% of people living with HIV in the U.S.^v and 24% in sub-Saharan Africa have a suppressed viral load.^{vi}

Our inability to fully capture the therapeutic and preventive benefits of treatment can be traced to our failure to effectively address social and structural barriers. People living in extreme poverty often cannot afford the inevitable out-of-pocket costs associated with HIV treatment, people who are homeless or unstably housed lack the means to adhere to treatment, and many people whose behaviors are criminalized or highly stigmatized avoid mainstream health settings due to fear that they will be mistreated or reported to law enforcement authorities. In the U.S., where Black men who have sex with men (MSM) were roughly half as likely as other HIV-positive MSM to have viral suppression, HIV-positive Black MSM were 3.4 times more likely to have low income (i.e., less than US\$20,000 per year) than other MSM living with HIV and substantially less likely to visit a clinic.^{vii}

The HIV Investment Framework, developed by UNAIDS in collaboration with a number of international partners, recognizes the importance of structural approaches to maximize the effectiveness of HIV prevention and treatment programs. Critical enablers enhance the reach, relevance and impact of HIV programs, while development synergies use social protection, education, gender equality and other broader development aims to strengthen the foundations of the HIV response.

AIDS investment framework



Structural approaches strengthen the HIV response in three ways, as outlined by the Social Drivers Working Group of the aids2031 Consortium.^{viii} First, structural interventions build social, legal and physical environments that enable risk reduction behaviors and encourage the use of essential health and supportive services. Second, by addressing the factors that undermine healthy living, structural approaches foster individual agency to reduce risk, adhere to

prescribed remains and remain engaged in continuous HIV care. Third, structural approaches create and support AIDS-competent communities that prioritize community engagement and communication to promote better health outcomes.

Poverty, Inequality and HIV: The Need for a Comprehensive, Integrated Response

Ending AIDS as a pandemic will also require a shift in the focus of the HIV response to include and prioritize persons among whom most new HIV infections are occurring. People living in severe poverty, key affected populations, women and girls, and young people often face barriers to accessing HIV prevention, treatment that prevent them from benefiting from HIV biomedical breakthroughs. As a result of escalating infection rates among drug users and other marginalized populations, new HIV infections continue to rise in Eastern Europe and Central Asia, in the Middle East and North Africa, and in many parts of Asia. These lessons are underscored by experiences in high-income countries. During the nearly two decades of the HIV treatment era, even as antiretroviral therapy has been universally offered in high-income countries, limited progress has been made in reducing new HIV infections^x; in the U.S., for example, the pace of new HIV infections has remained steady for more than two decades.^{x xi} The increasing concentration of new HIV infections among the poorest and most marginalized in high-income countries reflects both the limits of biomedical tools to end the HIV epidemic on their own and the pivotal importance of addressing the underlying economic, social and structural factors that help perpetuate the epidemic.

Poverty and Income Inequity

The relationship between HIV and socioeconomic status can be complicated. As the early spread of HIV in many sub-Saharan African countries often occurred among the wealthier segments of society, many previous household studies in the region found little correlation between income and HIV prevalence.^{xii}

Over the last decade, however, an epidemiological shift appears to have occurred in parts of sub-Saharan Africa, with HIV incidence rising fastest among the least educated and most impoverished groups, especially in urban centers.^{xiii xiv xv} These findings mirror trends seen earlier in high-income countries, where epidemics that began among more affluent communities eventually became concentrated among the more economically and socially marginalized, such as low-income people, immigrants and indigenous people.^{xvi} In the European region, new HIV infections are rising most rapidly among poor and marginalized communities of drug users in eastern Europe countries and in southern European countries hit hardest by the global recession.^{xvii} Among Black MSM disproportionately affected by HIV in the U.S., unemployment independently predicts HIV infection.^{xviii} Likewise, poverty is the single most powerful demographic associated with HIV infection among heterosexual, urban-dwelling adults in the U.S.^{xix}

“As a person living with HIV, I know that we will never truly end AIDS until we do have a vaccine and a cure. But I am also quite confident that we will have both of those in due course. What I am not at all confident about is that we will ever have a cure for our own inhumanity. And that inhumanity is the true social driver at the heart of the AIDS epidemic. And that same inhumanity is also the social driver behind much of the rest of the misery in the world around us, whether we call it social marginalization, extreme poverty or inequality.”

*Charles King, President and CEO
Housing Works, New York USA*

The increasing HIV burden on the poorest and most marginalized is what was predicted in the epidemic’s early years by Dr. Jonathan Mann, former head of the WHO Global Programme on AIDS, who noted that epidemics inevitably visit their harshest effects on those with the fewest

financial and social resources.^{xx} Wealthier, more socially advantaged cohorts have the greatest access to prevention information and health services, while poverty and social marginalization place people in environments and situations that often promote risky behaviors and diminish access to health services.^{xxi} Conditions associated with poverty, such as homelessness, unstable housing or migration, are also associated with increases in HIV risk behaviors, sub-optimal rates of health care utilization, and poorer medical outcomes.^{xxii xxiii} According to a longitudinal study in rural South Africa, household socioeconomic status is significantly related to adult mortality.^{xxiv}

Although the global economy is growing at a more robust pace as the recovery from the global financial and economic downturn quickens^{xxv}, income inequality within and among countries is rising, as the fruits of economic growth disproportionately accrue to the wealthiest segments of society.^{xxvi} Evidence from across the world indicates that the most economic inequitable societies – as measured by benchmarks such as the Gini coefficient – also have the highest HIV prevalence.^{xxvii}

While poverty and income inequality increase HIV-related risks, the epidemic itself deepens poverty and exacerbates inequalities.^{xxviii} A household study in Swaziland found that HIV in the family has profound economic effects, reducing household income as a result of diminished productivity while increasing outlays for medical care.^{xxix} Research suggests that investment in ART for maintaining 3.5 million people on treatment would save 18.5 million life-years and return US\$ 12–34 billion mainly through increased labour productivity and averted orphan care over 2011–2030.^{xxx} A recent systematic review of the literature on economic and quality of life outcomes of antiretroviral therapy for HIV/AIDS in developing countries concluded that ending AIDS would lead to better-skilled, productive workforces, and stronger economies.^{xxxi}

Given the powerful links between poverty, economic inequality and HIV, policies and programs that reduce poverty and promote shared prosperity have a potentially important role to play in efforts to end the HIV epidemic. Likewise, HIV prevention and treatment programs that improve health outcomes promote poverty reduction. Findings from a prospective cohort tracking economic outcomes of HIV treatment in Africa suggest significant, sustained improvements in productivity and economic wellbeing of persons maintained on long-term antiretroviral treatment, confirming the sustained economic benefits of providing effective large-scale treatment.^{xxxii} A special commission on health convened by *The Lancet* concluded that additional life-years due to health improvements were responsible for 24% of the growth in income in low- and middle-income countries from 2000 to 2011.^{xxxiii}

Social Inequity and Marginalization

Economics is not the only form of inequity that is driving the HIV epidemic. Gender inequities and social marginalization increase HIV-related risks and worsen the epidemic's effects. These social inequities, which also often have important economic consequences, are typically rooted in long-held prejudices, social norms and cultural values.

Inequitable gender norms limit women's capacity to reduce their sexual risk and diminish their access to health information and services.^{xxxiv} Globally, women account for 52% of all people

living with HIV, including 57% in sub-Saharan Africa. In sub-Saharan Africa, young women (ages 15-24) are more than twice as likely to be living with HIV than young men their own age due to such factors as early sexual debut and a reliance on transactional sex with older men to lessen their economic vulnerability.^{xxxv} Gender disparities also intensify HIV-related stigma, with surveys indicating that women living with HIV are more likely to be the targets of verbal abuse and physical violence than HIV-positive men.^{xxxvi}

The link between sexual violence and HIV risk is potentially significant for understanding the epidemic's disproportionate impacts on young women and girls, particularly in sub-Saharan Africa, other hyperendemic areas, and conflict-affected regions.^{xxxvii} According to national surveys catalyzed by the Together for Girls consortium, 52.9% of women ages 18-24 years in Swaziland and 40.7% in Zimbabwe reported their first sexual intercourse was forced or coerced. Studies in Uganda and South Africa have found that women who have experienced intimate partner violence are more than 50% more likely to be living with HIV.^{xxxviii xxxix xl}

Failing Our Young People

Everyone – from politicians to average citizens – profess to care about young people. In reality, the response to HIV is largely failing them.

Adults who are eligible for HIV treatment are about twice as likely to receive antiretroviral therapy than treatment-eligible children. While AIDS-related deaths overall fell by 30% from 2005 to 2012, AIDS-related mortality among adolescents actually *increased by 50%* during the same period due to failure to recognize the diverse HIV-related needs of young people and to ensure access to adolescent-friendly health services. Today, young people ages 15-24 account for more than 40% of new HIV infections.

Young people who belong to key affected populations are especially affected by HIV, as studies have found that HIV-related risk behaviors in these groups often begin at a very early age. "When we talk about our successes with regard to children and young people, the results are appalling," said Craig McClure, chief of the HIV/AIDS program division at UNICEF. "We throw them in prison if they use drugs. We bully and beat up LGBT young people and put them in jail. We might well use children and young people as our lens for measuring how well we are doing in investing in a future that is AIDS-free."

A multi-dimensional approach that addresses the numerous sources of children's vulnerability is required – one that lodges HIV in a broader discussion of child wellbeing. According to a recent analysis, 39% of children's risk outcomes can be explained by abuse, AIDS in the family and hunger. (Cluver et al., forthcoming.) A UNICEF 2012 expert consultation on *The Structural Determinants of Child Well-Being* called for inter-sectoral and comprehensive approaches which recognize the interplay of structural factors that influence children's lives and seek to build synergies across program areas. (<http://www.unicef-irc.org/publications/678>).

"Even doctors are kind of drawing the line where gay people or female sex workers are concerned. They find it disgusting, you see."

*39-year-old MSM
Iringa, Tanzania (2012)*

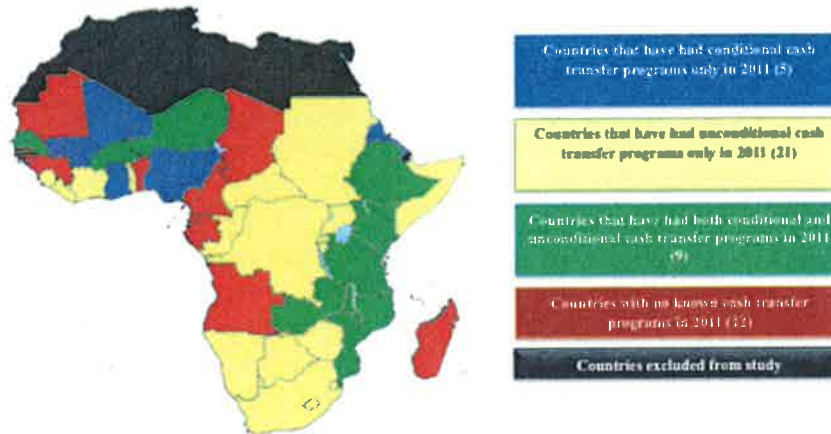
Key affected populations also experience social marginalization, abuse and discrimination, which increase their risks for acquiring HIV and reduce their access to essential health and social services. Female sex workers are 13.5 times more likely to be living with HIV than other reproductive-age women^{xli}; HIV prevalence is 49 times higher

among transgender women compared to other people of reproductive age^{xlii}; and people who inject drugs are at least 22 times more likely to be living with HIV than the general population in at least 49 countries and at least 50 times more likely in at least 11 countries.^{xliii} Globally, HIV prevalence among MSM is 19 times higher than for men generally^{xliv}, and there is evidence that HIV incidence among MSM has accelerated in recent years.^{xlv}

Even taking account of the intrinsically greater transmission risks associated with certain behaviors common to these key populations, the epidemic's disproportionate burden in these groups cannot be disentangled from broader social mores, discriminatory patterns and



Cash transfers growing rapidly in SSA



Source: Garcia, M. and C. Moore, 2013. Cash Transfer Programs: The Emerging Safety Net in Sub-Saharan Africa

institutionalized abuse. Fearful that biased health care workers will withhold care, treat them poorly, or report them to law enforcement authorities, many members of key affected populations actively avoid seeking health services, such as HIV testing, biomedical HIV prevention, or antiretroviral therapy. According to a survey of 600 MSM in

Malawi, Botswana and Namibia, few (17%) reported ever disclosing same sex practices to a health professional, 19% reported ever being afraid to seek health care, and those who feared seeking health care were 2.6 times less likely to have accessed health services.^{xlvi}

The deterrent effects of stigma, discrimination and social marginalization undermine health outcomes for key affected populations. A 2006 review of the evidence found that injection drug users accounted for over 80% of HIV cases in Eastern European and Central Asia but only approximately 14% of people with HIV in antiretroviral therapy.^{xlvii} In Moscow, the capital city of a high-income country, only 9% of MSM living with HIV are currently receiving antiretroviral therapy^{xlviii}, while only 15% of female sex workers in Lome, Togo who had tested HIV-positive were on HIV treatment in 2013.^{xlix}

Evidence for Social/Structural Interventions

Although work is urgently needed to build the evidence base for action on structural interventions, available evidence already demonstrates the effectiveness of numerous structural approaches in simultaneously strengthening HIV prevention and treatment while bolstering other development aims (e.g., poverty elimination, hunger elimination, gender equality, etc.).

Cash Transfers and HIV-Sensitive Social Protection

A growing number of African countries are implementing cash transfer programs.¹ Although most cash transfer programs in low- and middle-income countries provide funds without conditions, more recently established programs generally condition cash transfer on certain behaviors by the recipient, such as attending school or ensuring that children are vaccinated.

In recent years, studies in three African countries have assessed the effectiveness of cash transfer programs to encourage safer sexual behavior and prevent HIV acquisition among young women. Although both the cash transfer programs and the research methodology differed among the studies, all found that cash transfer programs promote HIV prevention aims. In Lesotho, participation in a lottery open to individuals who remained free of HIV or STIs was associated with a 27% reduction in HIV incidence compared to the control arm.^{li} A cash transfer scheme to keep girls in school in Malawi was associated with a 60% and 76% reduction in prevalence of HIV and herpes simplex virus type 2, respectively.^{lii} In Tanzania, STI prevalence was 25% lower among people who received up to US\$60 per year to remain STI-free than among non-participants.^{liii} Cash transfer programs appear to operate in multiple ways to reduce sexual risk behavior; for example, in addition to having less sex, the school-age girls who received the Malawi cash transfer chose younger, safer partners due to a lessened perceived need for gifts or money from older, wealthier men.

Evidence suggests that other forms of social protection have similarly positive effects on sexual risk behaviors. In Kenya, for example, a cash transfer program for orphans and vulnerable children was associated with significant reductions in early sexual debut, unprotected sexual activity among young people, and the proportion of young women having multiple sex partners – results that have encouraged similar programming in Ghana, Lesotho, Malawi and Zimbabwe.^{liv} Likewise, a qualitative and quantitative assessment by UNICEF determined that South Africa’s child support grant improved educational outcomes and reduced risky sexual activity among young people.^{lv}

Microfinance and HIV

Although additional research is needed, there are signs that targeted microfinance programs may help reduce women’s vulnerability to HIV. The IMAGE study found that the combination of a microfinance initiative with a learning and action model focused on gender equality and HIV prevention was associated with a 55% reduction in intimate partner violence over two years and with women’s empowerment within the household. The two-year study did not detect an effect on HIV incidence. Source: Pronyk P et al. (2006). *Lancet* 368:1973-1983.

Currently, social protection programs reach more than 110 million households in low- and middle-income countries.^{lvi} As of 2012, 41 African countries had social protection programs in place.^{lvii} Appropriately tailored, these initiatives offer the opportunity to reduce poverty while improving HIV and other health outcomes.

National Health Insurance

Recognizing the inability of patchwork health systems to address the myriad health needs of people in resource-limited settings, a global movement has developed to advocate for universal health coverage.^{lviii} Health insurance schemes complement cash transfers, which may help households manage out-of-pocket costs associated with routine medical care but cannot protect against catastrophic illness. According to a World Bank review of experience in 22 countries, health insurance schemes improve health care access, provide financial protection, and in some cases increase health outcomes.^{lix}

Universal Education

In rural South Africa, every additional year of educational attainment is associated with a 7% reduction in the risk of HIV infection.^{lx} Moreover, there is evidence that the protective effect of education may be increasing over time, with a shift over the last decade toward notably higher HIV infection rates among less-educated people in sub-Saharan Africa.^{lxi} Clearly, there are potentially powerful synergies between the HIV response and the global movement to ensure Education for All by 2015.

Housing Assistance

An overwhelming body of evidence indicates that homelessness and housing instability is fundamentally inconsistent with sound medical management of a complex disease such as HIV. There is a strong association between homelessness or housing instability and inadequate utilization of HIV treatment and care, sub-optimal medication adherence, high viral load and premature death.^{lxii lxiii} Homelessness and housing insecurity are also independently associated with increased risk of acquiring and transmitting HIV infection.^{lxiv lxv} In the recent outbreak of HIV infection among injection drug users in Greece, those who were homeless were 2.3 times more likely to become HIV infected than housed injection drug users, after adjusting for risky behaviors.^{lxvi}

Provision of safe housing (through such means as housing placement, subsidies or ongoing assistance) to HIV-positive individuals at risk of homelessness has been shown to more than double the odds that the individual will have an undetectable viral load and reduces AIDS-related mortality by 80% over five years.^{lxvii} Studies have also found that housing support substantially reduces HIV-related risk behaviors.^{lxviii}

Food Assistance

Hunger or food insecurity reduces rates of HIV medication adherence, with one study finding that food-insecure individuals living with HIV were 66% less likely than food-secure individuals to adhere to prescribed antiretroviral regimens and 85% less likely to have viral suppression.^{lxix} Food supplementation for food-insecure individuals living with HIV improves medication adherence^{lxx} at the same time that it advances the global goal (Millennium Development Goal 1) of halving the proportion of people suffering from hunger by 2015.

Legal Reform

Discriminatory and scientifically unsound laws reflect and reinforce stigma and deter individuals and communities from seeking life-saving HIV prevention and treatment services. Removal of such laws is an important step toward reducing stigma, encouraging service uptake and mobilizing the resources across the entire society to respond effectively to the epidemic.

Although United Nations Secretary-General has warned that laws that criminalize HIV exposure, transmission or non-disclosure lack scientific basis and reduce the effectiveness of HIV prevention efforts,^{lxxi} 63 countries have such HIV-specific legal provisions in place in at least one jurisdiction.^{lxxii} In 2012, 60% of national governments reported having laws, regulations or policies in place that impede effective delivery of HIV services to key affected populations.^{lxxiii}

Roughly 40% of United Nations Member States criminalize same-sex relations^{lxxiv}; most countries criminalize one or more aspects of sex work^{lxxv}; and punitive policies regarding drug use are common, including mandatory drug detention regimes in many countries.^{lxxvi} According to People Living with HIV Stigma Index surveys in diverse regions, key affected populations experience higher levels of HIV stigma than other people living with HIV.^{lxxvii}

Homelessness has also been linked with increases in unsafe sexual and drug injecting behaviors.^{lxxviii}

"There is a need to reform legal and policy environments to support HIV and health outcomes. We [at UNDP] believe that bad laws fuel the epidemic. The majority of national governments report that there are laws on their books that are still discriminatory. Often, law reform in these areas involves sensitive issues, but we must remember that we are dealing with a deadly disease. Today, UNDP in partnership with UN entities, government officials and civil society partners is engaging in more than 80 countries to advance the recommendations of the Global Commission on HIV and the Law and to assist UN Member States to meet commitments made at the 2011 High Level Meeting on AIDS."

Helen Clark
UNDP Administrator

Community Mobilization

Providing opportunities and capacity for communities to organize to address their own needs has been shown to generate improved outcomes not only for health but also for broader development aims. For example, sex workers in Kolkata, India, joined together to form the Sonagachi Project, a collective enterprise focused on poverty, sexuality and gender. Although the embedded condom programming represented a modest component of the project's activities, the health results were considerable, with condom use increasing and HIV prevalence among Sonagachi sex workers remaining substantially lower than infection levels reported among sex workers in other urban settings in India.^{lxxix lxxx} Although Sonagachi's compelling HIV prevention results have attracted considerable worldwide attention, Sonagachi members place a greater value on the project's work in providing safe and secure housing and working conditions.^{lxxxi} The project has succeeded in large measure because it is owned and driven by community members themselves and because it is oriented around the real-life needs of its members.^{lxxxii}

Policy reform may help boost the health impact of community mobilization campaigns. In Puerto Plata, Dominican Republic, the combination of a community solidarity approach with changes in government policy resulted in a doubling of sex workers' condom use with regular clients, declines in STIs (from 28.8% to 16.3%) and a substantial increase in sex workers' verbal rejection of unsafe sex (from 50.0% to 79.4%).^{lxxxiii}

Barriers to Structural Approaches to HIV Prevention, Treatment and Care

Despite clear evidence that poverty, inequities and HIV are deeply interconnected, and the demonstrated effectiveness of a range of interventions designed to address social barriers to HIV prevention and treatment, the AIDS response has yet to fully incorporate structural interventions that target extreme poverty and other social drivers. There are several reasons why social and structural approaches have yet to be prioritized and brought to scale in the response to the epidemic.

Questions about the Evidence Base

Evaluating the effectiveness of structural approaches is challenging, in part due to the fact that structural interventions are not generally intended to generate the kinds of immediate, short-term results that clinical trials are typically designed to measure.^{lxxxiv} As a result, the evidence base on structural interventions remains limited^{lxxxv}, although it is worth noting that policy-makers have frequently failed to implement strategies that have been rigorously evaluated and found to be effective (as described below in the following section).^{lxxxvi} Moving forward, countries should urgently implement proven structural interventions, apply rigorous implementation science to ‘learn by doing’ through implementation of other innovative strategies, and prioritize research to expand and strengthen evidence for action. In particular, decision-makers should recognize that randomized controlled trials, the gold standard for scientific research, are often inappropriate for structural approaches, which aim to influence the context for sexual behaviors or program utilization and which may require a longer time to generate change. Quasi-experimental designs, community randomization, social science research techniques and observation of real-world experiences offer opportunities to expand understanding of the pathways by which structural approaches can best help prevent new infections and enhance the effectiveness of prevention and treatment programs.

Disenfranchisement of key populations

On the most fundamental level, it is sometimes easy for decision-makers to ignore or give short shrift to communities and populations with the least financial resources or political clout. For example, where national legal and policy frameworks on drug use are primarily oriented around a law enforcement approach, societies are encouraged to view people who use drugs as criminals, not as people with a human right to the highest attainable standard of health. Likewise, in many societies, the poorest parts of society are least able to effect political change. A key step in addressing the social drivers of HIV is the development of a political and social culture that values solidarity, compassion and inclusion and that takes account of the needs of the most vulnerable.

Official Discomfort

Implementing social and structural interventions requires that decision-makers grapple with difficult questions, such as gender norms, paid sex, gender identity, same-sex relations, and drug use. Political courage is required to lead on such issues and support unpopular structural interventions. Social change also challenges extant power arrangements, which can be threatening to policy-makers and officials. In addition, given the fact that some structural approaches require a re-thinking of long-held cultural traditions, engaging cultural leaders and institutions plays a critical role in paving the way for a holistic response that addresses the root causes of HIV vulnerability.

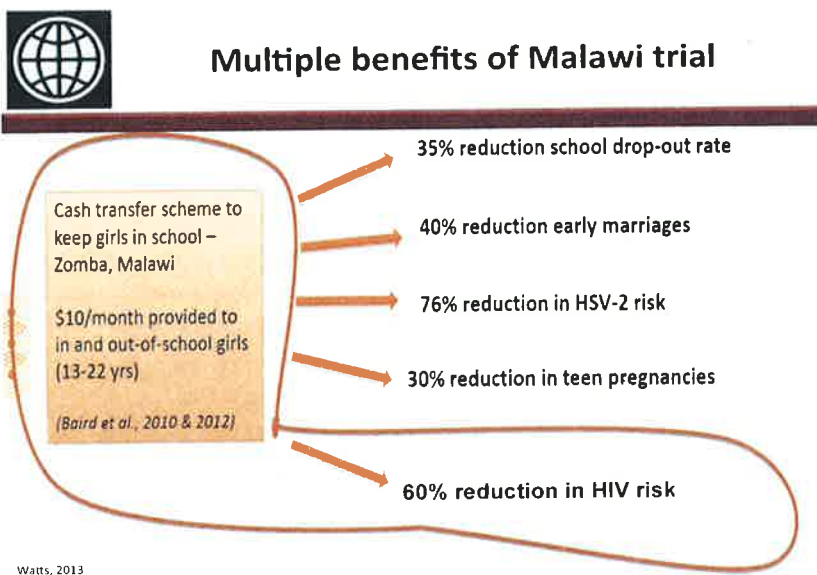
Longer Time Horizons

The basic contours of the HIV response, forged during the early stages of the epidemic, conceptualized the HIV enterprise as an ‘emergency’ that required swift results. While understandable, the singular focus on short-term results dooms the HIV response to long-term

disappointment, as efforts to prevent new HIV infections and AIDS-related deaths will never be optimally effective unless critical structural issues are effectively addressed.^{lxxxvii}

Perceived Costs

Policy-makers may understandably regard the costs of eradicating extreme poverty, ensuring safe and affordable housing, or providing universal education as prohibitive. However, what wise policy-makers will also take into account is the cost of *failing* to address extreme poverty,



inequities and other structural factors. As one example, providing housing for people living with HIV reduces risk behaviors, thereby averting substantial future medical spending and representing a prudent HIV prevention investment.^{lxxxviii} The returns from investments in structural approaches are multi-faceted, in that structural interventions affect multiple outcomes^{lxxxix xc}; for

example, as demonstrated by the results of the Malawi cash transfer program described above, a well-designed conditional cash transfer program for young women can increase school attendance, prevent new HIV infections, promote poverty reduction, and contribute to more equitable gender norms – generating co-benefits in a number of areas and supporting cross-sector financing.

A Call to Action: Meeting Outcomes and Recommendations for Action

Action points endorsed by UNAIDS and World Bank Group

At the January 2014 expert consultation UNAIDS and the World Bank Group endorsed four areas of “action to accelerate efforts that address the interrelated challenges of AIDS, inequality and extreme poverty.” Noting that “investing in health also means investing in equity,” a joint statement outlined “essential elements of a human rights-based response to HIV to include: enabling laws, policies and initiatives that protect and promote access to effective health and social services, including access to secure housing, adequate nutrition and other essential services.” The World Bank group and UNAIDS committed to work closely with UNDP and other international partners to address the social and structural drivers of the HIV epidemic that put people at greater risk of HIV and deny them access to services, including gender inequality, stigma and discrimination, lack of access to education and unstable livelihoods, including

advocacy for:

1. *Aligning health and development efforts around country-led time-bound goals towards ending extreme poverty and AIDS, with special attention to the inclusion of the poorest and most marginalized populations. Areas of focus will include: supporting countries to adopt progressive legal systems that remove discriminatory laws, especially among populations most vulnerable to HIV infection; increasing access to income, adequate housing and safe working conditions; and accelerating reforms towards universal health coverage and universal access to HIV services and commodities.*
2. *Urging the post-2015 development agenda to include targets towards ending AIDS alongside the goal of universal health coverage, so that no one falls into poverty or is kept in poverty due to payment for AIDS treatment or health care.*
3. *Promoting national and global monitoring and implementation research. Actions will include: working closely with global partners and countries to innovate and monitor service delivery, including for HIV, especially to the poorest and the most marginalized; and intensify implementation research to capture and codify innovative approaches to address the linkages between efforts towards ending extreme poverty and ending AIDS. As part of this effort, the World Bank Group will launch a major new trial to better understand how social protection systems reduce HIV infection, particularly among young women in the highest burden hyper-endemic countries.*
4. *Convening two high-level meetings in 2014 with national policy leaders and experts on ending AIDS and extreme poverty. The first meeting will be convened in Southern Africa to share current research and discuss how it can be translated into practice. The second meeting will be held during the International AIDS Conference in July 2014 in Melbourne.*

UNAIDS and the World Bank Group pledged to “work to ensure that these efforts feature prominently in the post-2015 global development agenda, and are integral elements in ending AIDS, achieving universal health coverage, ending extreme poverty and inequality and building shared prosperity.”^{xci}

Working group findings and recommendations

In addition to the barriers already described in this report and the above priorities outlined by the World Bank and UNAIDS, participants in the high-level meeting distilled the following challenges, principles for action and recommendations from the two-day discussion, working in small groups focused on structural HIV prevention and care interventions, the potential for development synergies, and resource issues. The following synthesis of the working groups’ efforts is intended as a “kick-off” for an ongoing and broadened consideration of action on social drivers of the HIV epidemic and related social and economic marginalization. Meeting participants hope that their work can inform the development of concrete strategies, mechanisms and partners’ roles in renewed efforts to realize the potential of synergies in health and development responses, towards the goal of a multisectoral, evidence-based systems approach to social and structural drivers of HIV and poverty – adopted, prioritized and implemented at the country and global level.

Challenges

- “Vertical” thinking, donor streams, programmes, institutions, and planning processes can create silos that act as a barrier to more innovative, integrated approaches to address the social and structural determinants of health.
- The centrality of the biomedical paradigm in the HIV response (and the health care architecture more generally) and associated unfamiliarity with social and structural strategies among HIV programme planners and implementers impedes effective integration of social/structural and biomedical strategies in a complementary, synergistic and mutually-enabling way.
- Lack of shared understanding and coordinated action between those charting policy/legal strategies and those implementing community and individual-level interventions – including the failure to consider the particular context of social and structural barriers and to tailor interventions for the particular time and place.
- Resistance to the concept of HIV-sensitive social policies/programs and co-benefit with other sectors, with its implications for resource and power sharing.
- The lack of tested and scaled intervention models grounded in real world contexts and governance structures.

Principles for action

- Articulate a broader understanding of the aim to end extreme poverty and reduce inequities – one that expands the notion of inequality to include not only economic inequities but also inequities based on gender and social marginalization, with a focus on key populations including LGBTQ communities, women and girls, people who use drugs, sex workers, prisoners and formerly incarcerated persons and other groups disparately affected by HIV/AIDS, extreme poverty and/or inequalities/inequities based on race, ethnicity, country or other contextual factors.
- Employ language of integration and avoid verticality in speech and actions, to gain the advantages of multisectoral integration in ways that do not weaken but rather maximize the effectiveness of HIV-specific strategies and interventions.
- Recognize, both at the country level and globally, the relevance to an effective and equitable HIV response of:
 - Wider social protection system development, including social welfare workforce development, and
 - Evidence-informed work that tackles gender inequities – legal reform, reducing gaps in educational and livelihood opportunities, addressing gender based violence, and changing harmful gender norms/practices.
- Speak directly to development actors and discourse, ensuring inclusion of action on social drivers as a core component of the Human Development Index (HDI)/ Millennium Development Goals (MDGs)/Sustainable Development Goals (SDGs), and objectives related to development, poverty reduction, inequality reduction and economic growth.
- Promote joint understanding, and the need to translate into action, the realities that:
 - First, development is not only about economic growth, but about reducing economic and social inequalities as a critical part of growth; and
 - Second, health is a sound investment in development, and that effective investments in health must include addressing social and structural drivers to facilitate inclusion and wellbeing, as an integral component of health interventions.

Recommendations – Critical next steps

- Maximize the use of investment approaches for HIV to ensure that critical enablers and development synergies are being appropriately addressed and play a central role in addressing HIV/AIDS and poverty.
- Ensure joint action by international agencies (on diagnostics, costings, planning, intersectoral coordination) to identify co-benefits and synergies between national social protection plans and national strategic HIV/health plans (with all instruments – protective, preventive, promotive, transformative – to be included, to account for regional and country contexts).
- Collect and disseminate the existing evidence base for social/structural interventions and fund new field studies to assess how structural barriers or interventions affect treatment (or other biomedical) cascades, since:
 - Treatment outcomes are easier to monitor than prevention outcomes and will help to keep structural factors part of dominant HIV agenda and discourse; and
 - More research is needed to clarify the pathways and mechanisms for operation of social/structural interventions within and across public and private stakeholders.

Recommendations – Policy and planning

- All public and private HIV stakeholders (global and country-level) should foster greater internal cross-fertilization among relevant divisions (e.g. social protection, health group, and gender) and actively pursue internal and external analyses of potential inconsistencies within policy agendas (e.g. trade negotiations and goals of poverty and HIV reduction).
- Based upon evidential findings explore innovative public private partnerships models to support sustainable interventions at all levels.
- Provide leadership and necessary technical assistance so that development planning and policy decisions at every level are informed by and integrate action on HIV in order to maximize efforts to reduce extreme poverty, reduce inequality and reduce HIV/AIDS.
- Specifically, co-sponsors of the UN Joint Programme and development partners should, using existing structures, support governments to develop more integrated planning, financing and implementation platforms that fully consider social and structural drivers and effective interventions to realize health and development synergies at a country level.
- Promote universal health coverage planning that is deliberately inclusive of, and built around HIV services and structures (in hyper endemic contexts), employing HIV as a driver of efficient UHC planning and roll out.

Recommendations – Finance and investments

- Actively collaborate with international partners to provide technical and financial support in a coherent manner to assist countries to develop, finance and implement HIV/health plans and social protection strategies in synergy and in a manner that optimizes co-funding and co-benefits.

- Make public and private investments in capacity building in order to strengthen an integrated civil society platform that retains a focus on emerging issues in specific agendas, with a view on common goals around equality and wellbeing.

Recommendations – Program development and implementation

- Encourage stakeholders to continue and accelerate efforts to incentivize national plans and priorities that track how structural factors impact on HIV interventions and treatment outcomes as part of required program monitoring for public and private stakeholders (overall and for key populations).
- Promote joint action by global HIV stakeholders to support scale up of cash transfer work with at least one other structural intervention to test the potential of a cash transfer-plus model to magnify gains across sectors/outcomes and to better understand cash transfer models and their potential synergies with other structural strategies (operational research in at least three settings).

Recommendations – Building the evidence base

- Advocate for monitoring multiple endpoints/outcomes in HIV programming and interventions aimed at reducing poverty and inequities, to build the evidence base for development synergies and to better assess the impact of categorical health interventions on economic outcomes and vice versa.
- Make evidence frameworks around social interventions more demand-driven (to answer policy-makers' questions), and advocate for an expanded scope of evaluation approaches considered credible evidence, with stakeholders championing both randomized control trials and rigorous evidence from other robust interdisciplinary studies.
- Fund research designed to strengthen causal theory on social and structural drivers and interventions and to develop measures of incremental progress that can be tracked effectively and in a manner that does not rely exclusively on HIV incidence as the sole measure of success.
- Encourage funding for a program of work to advance understanding of how structural factors drive epidemics in different settings (starting with analyses of existing data), and operationalize this work within the rollout of investment approaches.
- Fill gaps in the evidence, including funding and evaluating demonstration projects on the impacts of housing interventions on HIV vulnerability and treatment outcomes (especially in middle- and low-income settings).

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