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Background Note

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Turning crisis into opportunity for children affected by HIV and AIDS: responding to the financial, fuel and food crises

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Evidence suggests that the global financial downturn has already had a negative impact on HIV and AIDS service provision and funding and increased the vulnerabilities faced by those living with the infection or caring for infected family members (UNAIDS, 2009). To date, however, there has been no comprehensive review of the impacts of the crisis on children and caregivers in this situation. This is critical, given that the mortality rate among infected children is disproportionate to that faced by adults, and that relatively fewer children have access to necessary antiretroviral therapy (ART). Moreover, many governments lack national policy strategies to address the child-specific dimensions of the HIV and AIDS epidemic, and there is, therefore, a risk that children living with the disease or highly vulnerable to infection will remain invisible in the crisis unless they receive urgent policy attention.

To understand how the macro-level changes brought about by the Triple F crisis – financial, fuel and food – translate into meso- and micro-level effects on children living with, or vulnerable to, HIV and AIDS and their caregivers, it is important to understand the pathways by which changes in the global macroeconomic environment are filtered through country-specific policy and institutional frameworks at national and sub-national levels to impact communities, households and individuals. Interviews have been conducted with UN, Government and NGO staff in Rwanda, Zambia, Mozambique, South Africa, Lesotho, Thailand, Paraguay and the Philippines. The conceptual framework that underpins this (and has been developed as part of a large research programme on crisis and children (see Harper et al., 2009a) is presented in Figure 1.

Macro-level effects: Net financial flows to developing countries may fall by as much as $300 billion in two years, equivalent to a 25% decline (Calì et al., 2008), resulting in reduced employment opportunities, including for migrants. Aid volumes have reduced, especially for major funding initiatives: the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and the US President's Emergency Plan for AIDS Relief (PEPFAR) have already suffered significant budget cuts. These effects are being compounded by a period of significant increases in food and fuel prices in 2008 and continuing high prices.

Meso-level effects: The scale of macro-level effects will determine the extent of meso-level impacts, which will vary across and within regions, but may include declining public service investment, less access to credit, growing unemployment, increased poverty and heightened social exclusion. National government policy responses will shape the extent to which communities and households are able to cope with these impacts. This is especially the case when it comes to decisions to adopt a pro-cyclical or counter-cyclical approach to investments in basic services for HIV and AIDS and to maintain or scale up targeted social protection programmes and child protection services. The role of civil society actors who champion the rights of families and children living with or vulnerable to HIV and AIDS may also play an important role in influencing policy outcomes.

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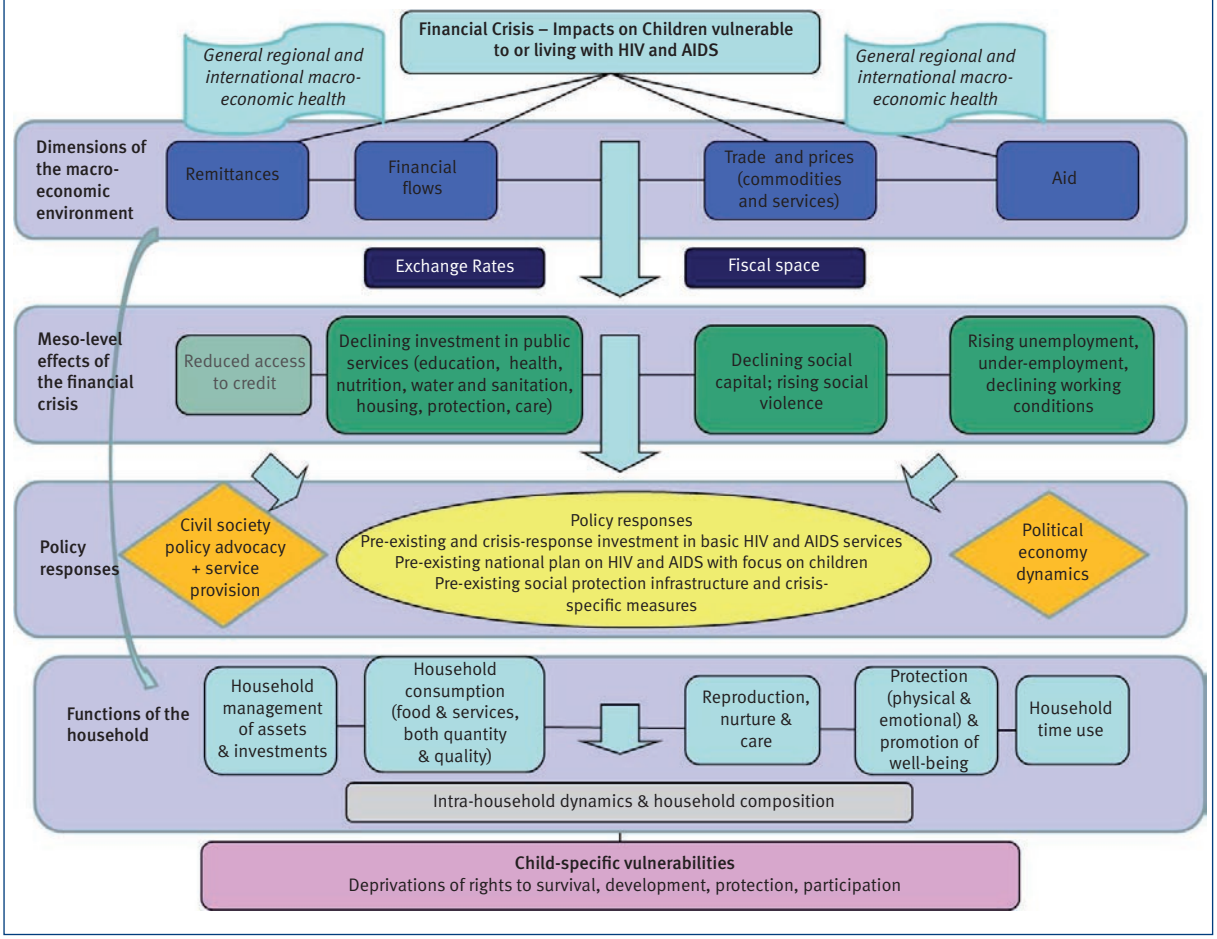
Figure 1: Linkages between macro-level shocks and impacts on children living with or vulnerable to HIV and AIDS



Micro-level experiences: Households typically respond to periods of economic turmoil by economising, reducing consumption in areas such as nutrition, education and health care. They may also resort to more negative coping strategies, such as the distress sale of assets or taking up risky and degrading forms of work. Children's time is often used as a resource, and they may be withdrawn from school. Household functions also change under economic pressure, and a range of reactions may ensue, ranging from revised resource allocations to increasing household violence and mental illness.

Although often neglected in discussions of the poverty impacts of macroeconomic shocks, **intra-household** conditions profoundly determine child wellbeing and depend on both pre-existing gender and generational dynamics, and the ways in which they are affected by the crisis and related policy responses. For example, the position of women in decision-making roles and their level of education and efficacy are important for child wellbeing, and this is a policy-sensitive arena. Cultural norms are also very important in influencing intra-household decisions, such as son preference favouring medical treatment for boys over girls.

Impact on children: current, new HIV infections

The current economic crisis is likely to affect infants, children and youth differently, through the following key variables, most of them products of the economic risk and the intensification of poverty that households affected by HIV and AIDS face in times of economic downturn.

Food consumption

The quantity and quality of food intake have suffered significantly as a result of the current crisis (Hossain et al., 2009), because of lower household income, local currency depreciations and/or food price hikes. Economic downturns aggravate the vulnerabilities of HIV-infected individuals, as they tend to suffer from more frequent and severe opportunistic infections because of their weakened immune systems (Kelly, 2000).

New infections. Even a small decline in the quantity and quality of food may increase the risk of HIV infection for children and young people, as their vulnerability to infection increases alongside malnutrition and the resulting dampening of their immune systems.

Health-seeking behaviour

Although, ART is, in principle, free in many countries, patients still need to pay other costs, including bribes for tests and services. Travel costs are cited repeatedly (interviews conducted with UN and NGOs in Rwanda, Zambia, Mozambique, South Africa, the Philippines) as hindering access to clinics and drugs. The time involved can be prohibitive for parents seeking treatment for children. Interruptions to care can occur even in 'committed' households, when unexpected or sudden shocks make planned-for treatment too expensive in terms of time or money. This can have detrimental effects in terms of responsiveness to future wellbeing as a result of the development of viral resistance to first-line drugs (UNAIDS, 2009). Furthermore, discontinuing ART treatment can increase the risk of contracting preventable HIV-connected diseases.

New infections. The effects of crisis can also result in increased HIV infections as carers cut back on seeking health care, compounded by potential cutbacks in services. For example, there are implications for both unborn and newborn babies as pregnant women and new mothers delay testing for HIV and, therefore, reduce uptake of critical prevention of mother-to-child transmission (PMTCT) interventions.

Migrants and vulnerable populations

Migrants rarely have access to subsidised ARV treatment, even if it exists in their host country. If they lose work and move into the informal economy, their links to existing HIV programmes can weaken further because of fear of detention when accessing these services (Richter, 2009).

New infections. While migration is not, in itself, a risk factor for HIV infection, migrants often face increased vulnerability to infection through exposure to exploitative situations (Richter, 2009). Under conditions of economic stress, such vulnerabilities are in danger of rising. In the context of the current crisis, marginalised groups such as sex workers, injecting drug users, prisoners, refugees and internally displaced persons can, indirectly, be more prone to HIV infection through stigmatisation by health planners (House of Commons, 2008).

The social exclusion of children

Eroding social capital and increased social violence are common outcomes of economic shocks, often with negative spill-over effects for children (Harper et al., 2009b). Marginalisation of children with HIV is already widespread, and can be expected to increase as a result of economic shocks. Violations of children's rights to care and protection, increasing exploitation and abuse, loss of homes and inheritance rights through property grabbing, the potential to become street children and child trafficking have all been highlighted as major impacts of HIV and AIDS on the lives of children (Save the Children, 2006). There is evidence, for instance, of guardians of orphans rejecting roles as protectors and instead competing with their orphan charges for scarce land and property, forcing children to support themselves and defend their property and inheritance rights (Rose, 2006). Examples of the breadth of discrimination include the abandonment of children born to mothers living with HIV and AIDS (CRIN, 2009). There are cases of infected pupils being refused admission to school in India, and in Romania, legislation hampers the attendance of older children in school while younger children living with HIV and AIDS are unable to access school because of long periods of hospitalisation. Some nurses and doctors in Ukraine have denied blood testing services to infected children (CRIN, 2009).

Loss of livelihood, risky strategies

Millions of households across the developing world are experiencing increased poverty as a result of the current crisis (World Bank, 2009). Households adopting negative or risky strategies in order to cope expose children to the vulnerabilities associated with HIV infection. Hazardous forms of labour to supplement declining household incomes include commercial sex work, transactional sex (trading sex for food or gifts), domestic work, drug peddling and internal migration to look for work, all of which increase risk of infection. Interviews suggest that an increase in transactional sex has occurred in several countries, with evidence from Zambia, Kenya, Jamaica, the Philippines, Mozambique, Cambodia and Tanzania (Hossain et al., 2009, and interviews with UN and World Bank).

Growing poverty in the context of the ongoing economic crisis is rendering people, in particular women and girls, increasingly vulnerable to both labour and sex trafficking, boosting the supply side of human trafficking worldwide. Moreover, in times of financial hardship, women working in the commercial sex industry may stop demanding that their clients use condoms, for fear of losing business, increasing their risk of contracting HIV. During the 1997-1998 Asian crisis, many vulnerable women entered commercial sex work in informal settings as a result of the loss of alternative means of income generation. As actual demand for commercial sex declined in the context of the crisis (because of declining purchasing power), so did women's bargaining power to negotiate condom use (Richter, 2009).

For girls, just being enrolled in school is protective against HIV (JLICA, 2009) by delaying sexual activity, improving knowledge on health issues and increasing control in relationships. However, there are reports that the current crisis has led to school dropouts as a result of increased poverty (Hossain et al., 2009).

Gender

Globally, there is increasing evidence of the feminisation of the HIV and AIDS epidemic. In sub-Saharan Africa, 61% of those infected are girls and women, many between 15 and 24. In the Caribbean, 43% are women, and numbers of infected women are rising gradually in Latin America, Asia and Eastern Europe (GFATM, 2009a). Given what we know about women serving as shock absorbers in crisis contexts (Holmes et al., 2009), but taking into account the additional strain of their own HIV status, this important but generally unseen buffering effect may be compromised, exacerbating impacts on children.

New infections. There is good evidence that, in times of economic crisis, gender relations shift. There tend to be higher levels of gender-based domestic violence, exacerbated by unemployment, financial stress and shifting household membership, as migrants come and go. Under such conditions, women's power within the household also shifts – sometimes strengthening, especially if they are bringing in financial resources – sometimes weakening.

Research is patchy, but women's ability to refuse sex and unprotected sex is known to be compromised when bargaining power is limited, and this could be exacerbated under domestic stress. In addition, as discussed, the bargaining power of commercial sex workers also diminishes, and women's and girls' reduced power is a factor in increased instances of trafficking.

Policy choices: pre-existing and crisis responses

Pre-existing policy. Despite a number of general commitments at the international level, policy approaches to children affected by HIV and AIDS are compromised by widespread dispersion of responsibility and lack of coordination, resulting in fragmented responses among national governments, the international community and civil society. The detrimental positioning of AIDS agencies within ministries of health leads to a neglect of policy responses related to social welfare and social protection. Additional complications arise from the fact that there is often limited agreement on funding priorities among possible child-sensitive HIV and AIDS interventions in the context of resource-poor governments, and/or spending by governments and development partners is too narrowly defined (Grainger et al., 2001).

National political commitments to scaling up HIV prevention, treatment and care have intensified in recent years, with an increasing number of countries moving to national programmes supported by domestic scale-up plans and population-based targets. As of 2008, 57% of low- and middle-income countries had implemented national plans to scale up PMTCT, and 44% had plans in place to scale up treatment and care for children, compared with 28% and 15% three years earlier, respectively (WHO et al., 2009). However, although spending today is much higher than it was before the millennium, thanks in part to the global financing mechanisms, current funding levels remain insufficient to tackle the epidemic.

Major issues undermining HIV-related spending in general, exacerbated in the context of the crisis, are: a significant funding gap; generally declining levels of donor commitment to specific HIV and AIDS funding; the expiry of committed funds (both GFATM and PEPFAR will expire in 2009 and 2010); and health sector human resource constraints (including increased demand on systems, reduced health care training opportunities and brain drains).

Pre-existing treatment/prevention programmes. In recent years, paediatric HIV treatment has benefited from the general push for access to adult treatment, UNITAID's negotiations for reduced drug prices and the World Health Organization's (WHO) user-friendly fixed-dose ART for children. This contributed to a 70% increase in the number of children receiving ART in 2004-2006 (UNICEF, 2007b). Yet, overall access to treatment, care and support services for children remains generally poor (Save the Children, 2006). Paediatric treatment has lagged behind the scale-up of access to treatment for adults (World Vision, 2008), with fewer than 4% of the total number of children exposed to HIV during gestation and birth receiving appropriate prophylaxis by two months of age (JLICA, 2009). Globally, children make up 6% of the infected population but account for 14% of HIV and AIDS-related deaths (House of Commons, 2008).

Child-focused prevention initiatives focus largely on PMTCT and preventive education. Transmission from mother to child during pregnancy, childbirth and breastfeeding can be linked to 90% of all infections in children. PMTCT reduces the risk to less than 2% (World Vision, 2008). In low- and middle-income countries, the proportion of women receiving ART to reduce the risk of transmission increased from 10% in 2004 to 45% in 2008 (WHO et al., 2009). Despite this, access to services still seems relatively limited. Take-up is generally affected by poor geographical reach, fear and stigma of being tested and weak health systems (UNICEF, 2007b), in particular human capital capacity constraints. Other health system weaknesses include: poor early infant diagnosis; limited numbers of women giving birth in hospital settings where PMTCT services are offered; poor targeting, especially among rural populations; and out-of-pocket payments at health facilities that reduce attendance by women.

Education on HIV and AIDS has generally been provided by governments, non-governmental organisations (NGOs), the media and religious leaders, with the central principle being that of helping participants behave in ways that should protect them from infection (Kelly, 2000). Prevention is limited by lack of geographic accessibility, with specific information often not reaching children in rural areas or at-risk groups, such as out-of-school and migrating children (Save the Children, 2006). Educational coverage and approaches vary enormously. In Latin America, it has been estimated that only 4% of out-of-school and 38% of in-school children have access to such programmes (ibid). In Mexico, the law stipulates that sex education must be included in the primary school curriculum, but youth do not receive any formal information on HIV and AIDS until the age of 12. In Southeast and East Asia, there seems to be a relatively higher degree of child awareness compared with that of adults on the importance of condom use, yet actual use among young people remains low (Save the Children, 2006). In South Africa, general HIV and AIDS knowledge is estimated to be adequate to high among young people, but risky sexual behaviour persists.

Post-crisis treatment and prevention programmes

Budget allocations. There is some evidence that countries have already witnessed a fall in HIV sector spending, with widespread expectations that budget cuts will be, in general, more visible in 2010 and 2011. Evidence from past crises suggests that spending on HIV may suffer disproportionately (Holmes et al., 2009). Crisis-related HIV budget cuts have already affected testing and diagnosis, treatment programmes, resistance monitoring and prevention (UNAIDS, 2009), and it is feared that promises made by world leaders to reduce the proportion of infants infected with HIV may not materialise.

Countries expect prevention programmes to be badly affected by the current crisis. The South African government recently announced that large mining companies will most likely cut their HIV prevention programmes owing to a lack of resources. In Thailand, during the earlier East Asian financial crisis, there was a 50% cut in the number of free condoms distributed in brothels and commercial sex establishments (Richter, 2009), raising concerns that prevention programmes will be among the first to suffer in the current economic downturn, particularly among marginalised groups. Other marginalised groups, such as migrants, may also be excluded from prevention initiatives, as even in good economic times they are often unreachable and excluded from prevention services (ibid).

Donor funding is an important crisis variable. There is now a widespread fear that the GFATM funding gap and the severe financial impacts of the crisis could prevent G-8 countries from delivering on their commitments. Our interviews with UN agencies and NGOs established that there was uncertainty about aid levels for HIV, with aid-dependent countries particularly vulnerable. In Rwanda, donors account for 50% of health expenditures, 80% of the HIV budget, 50% of GFATM and 20% to 40% of PEPFAR and community health insurance. The Philippines reports that only 35% of HIV funding comes from national sources. In Uganda, where 90% to 95% of the HIV budget is donor dependent, PEPFAR recently announced that there will not be an increment for the next year, and major cuts have taken place among donor players in the HIV and AIDS field.

Exchange rate devaluations make it more costly for governments to obtain imported drugs and equipment (World Bank, 2009). According to UNAIDS (2009), some East European countries currently experiencing exchange rate devaluations are struggling to cover the local currency cost of imported drugs. Exchange rate fluctuations have worked against GFATM, reducing the overall amount available for 2008-2010 by 5%, or $0.7 billion. If exchange rates had remained constant, it is estimated that contributions would have been around $10.2 billion higher (GFATM, 2009b).

Social welfare and protection programmes

Pre-existing status. Current efforts focus more on reducing children's vulnerability through nutrition, health and education, rather than investing in social services or social equity measures. Recent developments have shown how forms of social assistance and social insurance can represent a key avenue for the promotion of synergies between child protection and broader social protection programmes (Jones, 2009). However, coverage is limited, in part because of high levels of participation in the informal sector and subsistence agriculture

Social assistance initiatives supporting children affected by HIV and AIDS comprise income transfers that can be in kind (food transfers), in cash or in the form of exemptions (from school and medical fees, for instance). Social assistance can focus specifically on children affected by the pandemic or be directed more broadly, at households or children, producing positive outcomes for HIV- and AIDS-affected children. With indirect forms of social assistance outnumbering more specific efforts (and with limited understanding of whether generally targeted programmes have greater outcomes for children than those that are child-specific), one key issue is the assessment of whether indirect actions can address the challenges stemming from extremely high HIV prevalence rates and growing numbers of orphans and vulnerable children (OVC).

There are three reasons to be confident about indirect forms of social assistance, and cash transfers in particular, in addressing the vulnerabilities of HIV- and AIDS-affected children. First, general cash transfer schemes reach approximately 80% of HIV- and AIDS-affected households experiencing chronic poverty and labour constraints, and 60% of those living in these households' are children (Nolan, 2009). Second, unconditional cash transfers in Africa increase food consumption and school attendance, and conditional cash transfers in Asia and Latin America increase both health service utilisation and reduce the incidence of illness (JLICA, 2009). This suggests that cash transfers can prevent households resorting to damaging coping strategies (Nolan, 2009). Lastly, there is growing concern over the adequacy of targeting AIDS-affected families or orphaned children, rather than the most extreme-poor households or other orphans (Slater, 2004), for reasons that include equity and justice, accuracy and stigma (Adato and Bassett, 2008). It seems, therefore, that increasing attention should be paid to the context of AIDS itself, rather than to groups that are AIDS-affected or orphans (ibid). Exceptions include cases where one member of the household is undergoing ART. Because these households face significant additional expenses, the hospital providing ART could also provide cash transfers to patients, meeting their specific nutritional, health care and logistic needs (UNICEF, 2007a).

Public works programmes (PWPs). the majority of PWPs are based on food for work, although alternative forms of payments can exist, such as fertiliser and seeds. PWPs work well in providing temporary social assistance in cases of acute or cyclical problems, and continue to play a central role in social protection at large, particularly in East and Southern Africa. But the efficacy of HIV- and AIDS-focused PWPs has been limited, and PWPs may not be a cost-effective means of delivering social protection compared with alternative approaches, such as cash transfers (McCord, 2005).

Social insurance schemes can encourage individuals to save and invest in risk reduction. Social health insurance is seen as a valid alternative to user fees. Private health insurance is likely to play a minimal role in protecting the poor, let alone individuals affected by the epidemic, as they generally experience intensified income poverty as a result of HIV and AIDS. National health insurance schemes are affected, in general, by similar levels of exclusion of the poorest segments of the population, because they are available typically to formal sector employees only – although there are examples of more inclusive expansion in Mongolia and Kyrgyzstan, Ghana and Thailand. Community health insurance schemes are likely to play a significant role in addressing vulnerabilities in the context of the HIV and AIDS epidemic, owing to their stated objective of covering people outside the formal sector and being affordable to the poor. Such schemes have especially been gaining momentum in West and Central Africa, but coverage remains limited.

Microcredit is conceived as a complementary service to cash transfers programmes (Adato and Bassett, 2008). While not specifically targeted at children, expanded financial services can have positive outcomes for them, including higher rates of school enrolment and the use of microfinance infrastructure to deliver health messages. However, despite efforts to adapt microcredit schemes to suit the particular situation of HIV individuals (for instance through targeting and death benefit insurance), these initiatives have not gained momentum in HIV contexts. It remains debatable whether microfinance has a role to play in assisting HIV-affected individuals.

Social welfare services encompass governmental and non-governmental efforts to allow children to live free from abuse, violence and neglect. This includes protective legislative frameworks, government institutional agencies dealing with rights, prevention services ensuring awareness raising among the public and responsive and reintegration interventions for victims (Jones, 2009), as well as family support services. Social protection and social welfare services can be mutually reinforcing, but promoting comprehensive social protection approaches with the right balance of social protection components is not easy. The relationship between different social protection components can be competitive, leading to the crowding out of services. In South Africa, social service provision is undermined by overwhelming workloads for social workers, who find it hard to administer social protection transfers at the same time.

Social equity measures encompass efforts to address issues of stigma and discrimination and violations of rights at large. Some governments have attempted to recognise the rights of people living with HIV and AIDS. For example, pre-employment testing in Mozambique has been prohibited and Kenya's Industrial Property Act has been amended to facilitate importation of cheaper generic AIDS drugs. However, limited capacity to enforce legislation often hampers efforts. There is evidence of specific legislation addressing discrimination against children affected by HIV and AIDS, but there seems to be less concern with youth and efforts to address stigmatisation are limited. Child trafficking and property grabbing from minors are two areas where domestic laws need to be made consistent with the provisions of international frameworks.

Informal social protection and intersection with formal mechanisms are important with regard to potential synergies and the prevention of the crowd-

ing-out of one or the other. Social capital, informal circles of friends, relatives and the community at large still represent a significant source of support in regions with little government help for children and where access to treatment is often difficult (Save the Children, 2006).

Post-crisis social protection. In settings with scarce national resources and social sector ministries with weak bargaining power, economic downturns can significantly affect a government's ability to provide public services and prioritise spending on social protection programmes. In the context of the global food security crisis, there is an urgent need to implement and scale up social protection and safety nets. Given that economic crises can erode the value of income transfers to beneficiaries, the value added of food over cash transfers that are not price index linked has been recognised (Holmes et al., 2008).

The existence of governmental responses to past crises should open up more policy space for the adequate addressing of the current crisis, and the protracted nature of the current downturn and limited opportunities for quick export-oriented recovery (Jones and Holmes, 2009) mean that countries may have more time to implement effective policies. Most countries are responding indirectly through stimulus packages, growth-oriented initiatives, increased investment in infrastructure and labour market initiatives (McCord and Vandemoortele, 2009), with some considering social protection.

In Asia, current protection systems are considered very limited in coverage and range (Jones and Holmes, 2009) – the result of declines in public revenues already drained by the fuel and food crises. Responses are also determined by the degree of prioritisation governments give to social protection over other investments; the existence of debt relief funds able to ring-fence spending on social protection; and the availability of alternative sources of income, such as official development assistance. Additional reasons include generally limited knowledge of the magnitude of the impact of the crisis, leading policymakers to sideline allocation of resources for poverty alleviation (McCord and Vandemoortele, 2009).

Conclusions

The main concerns for children affected by HIV and AIDS lie in budget cutbacks, alongside contraction of specific funds, either planned or because of currency devaluation, and increased drug import costs. Some cuts to ART services (11% of countries) have already occurred, compounded by increased household difficulties in accessing services because of rising poverty, and related decreases in nutritional status and thus drug efficacy. Prevention programmes appear less affected so far, but indications suggest cuts in 2010, including on preventing vertical mother to child transmission. Social protection responses, HIV-targeted or general, have been limited by both donor and government resource restrictions stemming from the food, fuel and current financial crisis.

Pre-crisis challenges are inevitably exacerbated, especially in child-related policies and services that already lack strategic direction and priority, with poor cross-institutional coordination. An over-reliance on civil society organisations hampers large-scale interventions, and policy choices, such as the OVC focus, are not driven by reliable evidence. The lack of focus also extends to pre-existing, and daunting, funding gaps. Weak health systems and prevention services, alongside stigmatisation, social isolation and cultural barriers to changing risky behaviour, compound the long-term nature of the HIV crisis. In this context, social protection systems offer important mechanisms to counter vulnerabilities, especially in times of economic crisis, but existing systems are fragmentary. The danger is that ongoing efforts to address these issues will, at best, be stalled, but could also face reversals in progress. The economic crisis could stimulate a renewed focus on the most appropriate and cost-effective interventions, including enhancing social protection to address HIV alongside other vulnerabilities.

To prevent reversals and the long-term costly implications of infections, and turn crisis into opportunity:

Policy debates need to be far better informed, with more timely and systematic age- and gender-disaggregated data collection and crisis monitoring initiatives, paying particular attention to the differential patterning of the epidemic in diverse regional contexts and the specific patterning of child and youth infections. There also needs to be careful monitoring of children and young people, especially girls, at risk of falling into trafficking and/or commercial sex work. In addition to informing policy decisions, these data would highlight the true nature of the dilemma and stimulate action.

National responses need to be strategic and recognise the specificities of children's vulnerabilities to HIV and AIDS. Strategic responses need to work with, but not rely solely on, civil society responses, coordinating far more effectively across sectors and actors.

It is critical to take a counter-cyclical spending approach and ensure the continued provision of ART during the current crisis, given the likelihood of drug resistance developing as a result of interrupting treatment and, furthermore, the significant constraints to providing second-line treatment (which is more costly and often unavailable). Similarly, in the case of prevention services, particular attention needs to be paid to maintaining funding for PMTCT and addressing key

pre-crisis challenges, including wastage, general ineffectiveness and high scale-up costs.

Finally, capitalising on the growing international momentum around and support for social protection interventions, **a social protection focus on HIV- and AIDS-affected children and broader household vulnerability is opportune**. Social assistance measures such as child grants, social health insurance for households involved in the informal sector, enhanced social welfare services and social equity measures to address discrimination and social exclusion are all vital elements of this package.

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