

# The potential role of social transfers in the fight against HIV/AIDS in sub-Saharan Africa<sup>1</sup>

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**For many years**, poverty was largely accepted as a core driver of the HIV/AIDS epidemics in sub-Saharan Africa. This has served as the basic premise for many theories of change, which have posited that social transfer programmes could be specifically tailored to have positive impacts on the transmission and treatment of HIV and to mitigate the disease's poverty burden.

The main causal pathways through which social transfers are believed to contribute include:

- direct income effects: providing beneficiaries with basic means of consumption, therefore discouraging them from resorting to undesirable coping mechanisms against poverty and shocks, such as transactional sex and overall forms of disempowerment regarding sexual decision-making;
- indirect income effects: improving beneficiaries' access to 'social vaccines' such as health care and education, which provides them with prevention and treatment by means of biomedical services and dissemination of key messages and relevant information, and can even promote age-appropriate socialisation for children and adolescents (including delaying their sexual debut and having age-appropriate sexual partners); and
- behavioural practices: which can be further emphasised either by social assistants themselves after receiving training or by referring people to the appropriate services. Though the idea of using conditionalities to strengthen such protective habits might seem strategic, there are many cases in which this has proven too expensive and complex to monitor, while also violating privacy and ethical limits, and at times with the risk of subjecting beneficiaries and potential beneficiaries to stigma.

Although there are significant impact evaluation results showing that these outcomes can indeed affect programme beneficiaries, the relevance of these impacts on society or on the epidemic at large has yet to be better understood.

Most recent studies indicate that HIV/AIDS prevalence in sub-Saharan Africa tends to be higher among populations with higher socio-economic status. This African peculiarity mirrors the extent to which the epidemic is also driven by concurrent sexual partnerships in a generalised heterosexual environment. Wealth might be a driver of HIV, since better-off people have more mobility, time and resources to maintain concurrent partnerships.

In principle, this epidemiological profile could indicate that social transfers and the causality pathways through which they can tackle HIV are somewhat out of context for the epidemiology of sub-Saharan Africa. After all, social transfers target the poorest and most economically vulnerable populations, and in Eastern and Southern Africa most people who become infected are not the poorest and most vulnerable. Unlike socio-economic status, inequality is a less controversial driver of HIV epidemics. However, even though social transfers can reduce inequality, evidence indicates that this is often the case only for programmes with vast coverage and with large benefits, which is hardly ever the case in sub-Saharan Africa.

However, before discarding the impact of social transfers in the fight against HIV in Africa, one must consider Mann and Tarantola's (1996) proposition that HIV does not simply consist of one epidemic, but is, rather, the result of many epidemics, which are occurring in parallel, affecting different sectors of the population through different pathways and at different paces. There is no 'silver bullet' to address the issue. The dynamics of the epidemic among poor people might be very different from that among wealthy people—not to mention among those in the lesbian, gay, bisexual and transgender (LGBT) community, people who inject drugs, sex workers and other social groups.

Therefore, even if most cases of HIV are not concentrated among the poorest population, this is nevertheless a relevant epidemiological niche. And just as initiatives to tackle the HIV epidemic among poor people might not tackle the epidemic among wealthy people, the opposite can be also be true. In a sense, what works for the many might not work for the few who are HIV-positive and poor, hence the need for specific actions to reach out to this population group. Social transfers must not be presented as a panacea for the HIV epidemic, but they remain a viable option to tackle its dissemination within a niche where traditional biomedical approaches struggle to produce positive impacts. Thus, experiments to curb the spread of HIV among poor people through social transfers should be incentivised, so long as they are designed to tackle specific causes, keeping due track of their outputs and outcomes and, most importantly, without causing disinvestments in traditional medicinal interventions.

#### References:

Arruda, P. L. 2019. "HIV-inclusive and -sensitive cash transfer initiatives: evidence from high-prevalence countries in Eastern and Southern Africa." *IPC-IG Working Paper 184*. Brasília: International Policy Centre for Inclusive Growth.

Mann, J. M., and D. Tarantola. 1996. *AIDS in the World II*. New York and Oxford: Oxford University Press.

#### Note:

1. This One pager is based on: Arruda (2019). This study was undertaken between 2016 and 2017.