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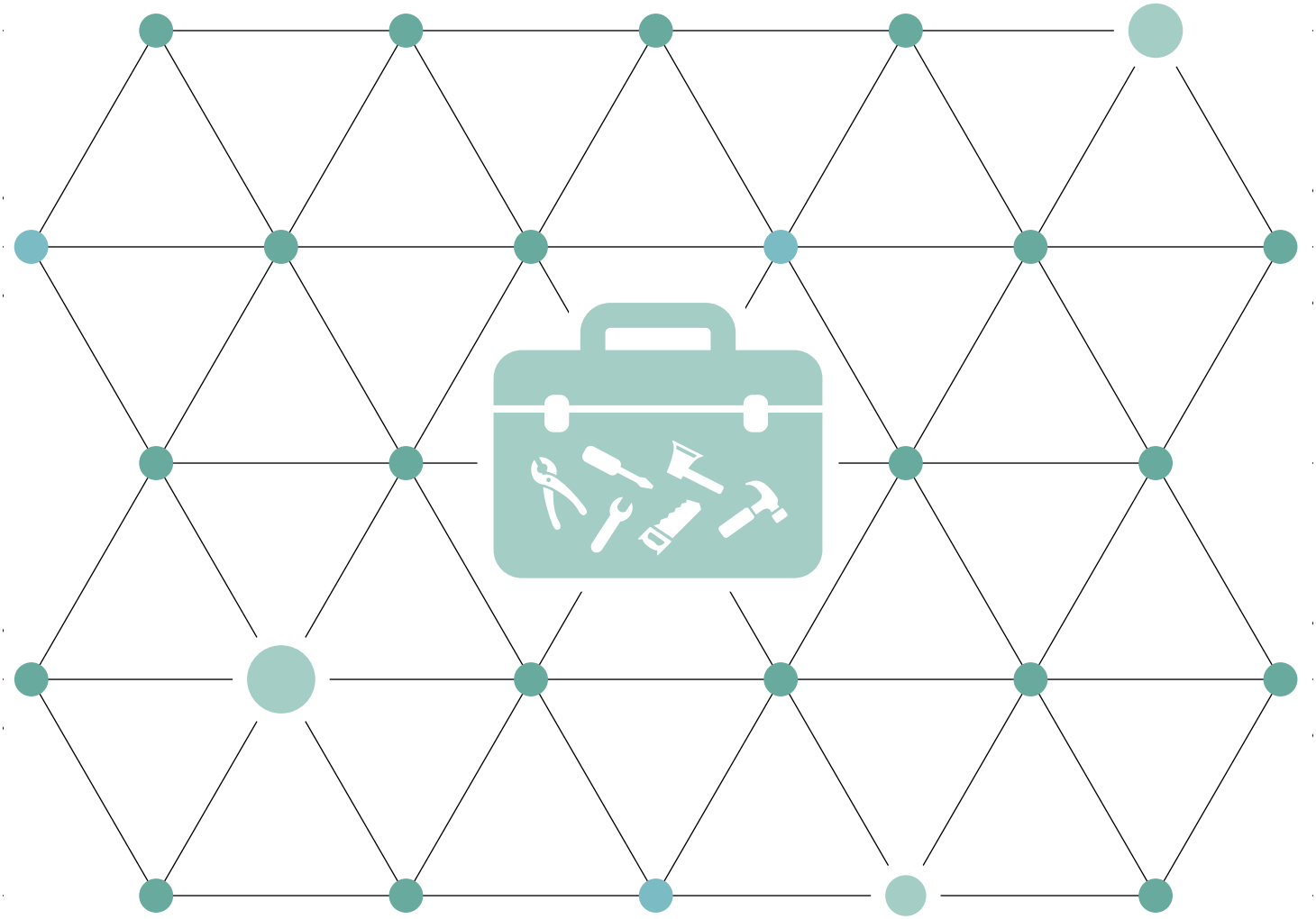
HIV and social protection assessment tool

Generating evidence for policy and action on HIV and social protection



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Executive summary

The HIV and social protection assessment tool is used for a quick scan of existing social protection programmes and their sensitivity (or lack of) to the HIV response in a given country and location. Additional follow-up and research that engages the different critical actors, including HIV programme managers, social protection administrators, beneficiaries and civil society representatives, may be necessary in some contexts. The assessment provides countries and communities with tailored analysis on HIV and social protection. The assessment seeks to gather information on:

- The social protection schemes that exist in different countries and locations, and their purpose, eligibility criteria, coverage and HIV sensitivity.
- Whether people living with HIV, adolescent girls and young women at high risk of HIV infection, key populations and others eligible to benefit from social protection benefits are accessing existing social protection schemes and, if not, the key barriers people face in accessing social protection benefits.
- What can be done to eliminate the barriers and include these populations in existing social protection programmes.

Information gathered using the assessment tool is intended to support decision-making in strengthening the HIV sensitivity of social protection schemes to better reach people living with HIV, adolescent girls and young women, key populations and others, and inform the development of national HIV-sensitive social protection portals (for example, electronic databases of existing HIV-sensitive social protection such as http://socialprotection.in/), revision of national AIDS strategies, HIV investment cases, concept notes for the Global Fund to Fight AIDS, Tuberculosis and Malaria, and other social welfare and poverty alleviation programmes. The information could also be used to catalyse cross-sector co-programming and co-financing of HIV and social protection programmes.

This document contains step-by-step guidance on how to conduct an HIV and social protection assessment, namely: preparing to conduct the assessment, including securing government ownership, leadership and commitment to conduct the assessment, and mobilizing the appropriate cadre of actors and resources; conducting the assessment, including the required training on HIV and social protection and the data collection tool and conducting appropriate data analysis, report writing, validation of findings and follow-up.

In addition, this document has annexes that contain the data collection forms and analysis format, assessment report template, a list of potential sources of data, examples of social protection, a draft agenda for an HIV and social protection assessment workshop, and a glossary of frequently used terms in the assessment.

Introduction

"Ensure that 75% of people living with, at risk of and affected by HIV benefit from HIV sensitive social protection by 2020."

UNAIDS 2016 — 2021 Strategy

There is increasing consensus that knowledge and methods exist to end the AIDS epidemic as a public health threat by 2030, although more knowledge and tools, including a cure and vaccine, are required. Political commitment and sustainable financing of the AIDS response are critically required to apply existing knowledge and methods effectively. To accelerate progress, Fast-Track Targets seek to reduce new HIV infections to fewer than 500 000, reduce AIDS-related deaths to fewer than 500 000 and eliminate HIV-related stigma and discrimination by 2020. Reducing new HIV infections to fewer than 500 000 by 2020 represents a 75% reduction in new HIV infections compared with 2010 and requires achieving a set of programmatic targets for populations at higher risk of HIV infection. A dramatic reduction in AIDS-related deaths requires that 30 million people access HIV treatment through meeting the 90–90–90 targets by 2020, whereby 90% of people living with HIV know their HIV status, 90% of people who know their HIV-positive status are accessing treatment, and 90% of people on treatment have suppressed viral loads.

The Fast-Track approach seeks to scale up proven services for populations left behind. Particular efforts are required in the 35 countries,[1] 13 of which are in eastern and southern Africa, that account for 90% of people acquiring new HIV infections and 90% of people dying from AIDS-related causes. To reach the ambitious targets, increased access and use of services is needed in key locations and by high-priority populations, including people at higher risk of HIV infection, such as sex workers, men who have sex with men, transgender people, people who inject drugs, prisoners, adolescent girls and young women, and adult men in high-prevalence countries *(1)*.

Strengthening national social and child protection systems to ensure that by 2020 75% of people living with HIV, at risk of HIV or affected by HIV benefit from HIV-sensitive social protection is a key target in the 2016 Political Declaration on Ending AIDS: The 2016 Political Declaration includes targets related to social protection, such as eliminating gender inequality and all forms of violence against women and girls, people living with HIV and key populations and empowering people living with, at risk of or affected by HIV to know their rights and access justice and legal services to prevent and challenge human rights violations, including exclusion from accessing HIV-sensitive social protection services.

The social protection target operating in synergy with other targets seeks to accelerate actions that remove barriers to accessing HIV-sensitive social protection services for:

- People living with HIV.
- People at higher risk of contracting HIV infection, including adolescent girls and young women in eastern and southern Africa and key populations.
- People affected by HIV, including orphans and vulnerable families, in particular grandmothers and caregivers.

[1] Russian Federation, United States of America, Angola, Botswana, Brazil, China, Iran (Islamic Republic of), Jamaica, Namibia, South Africa, Cameroon, Côte D'Ivoire, Ghana, India, Indonesia, Kenya, Lesotho, Myanmar, Nigeria, Pakistan, Swaziland, Ukraine, Viet Nam, Zambia, Chad, Democratic Republic of the Congo, Ethiopia, Haiti, Malawi, Mali, Mozambique, South Sudan, Uganda, United Republic of Tanzania, Zimbabwe.

Populations left behind

The populations left behind by the HIV response vary by country and context. These are populations that are more at risk, more vulnerable and more affected by HIV due to their exclusion and discrimination, highlighting the need to strengthen programmes to reach these people and meet their multiple needs, including health, education, social, economic, employment, housing, food and nutrition, psychosocial and legal. Populations left behind include people living with HIV, adolescent girls and young women, children, pregnant and lactating women living with HIV, people in prison, migrants, displaced people, people who inject drugs, sex workers, men who have sex with men, transgender people, people with disabilities, and people aged 50 years and older *(2)*.

Each country and location, given its epidemic context and relevant evidence, should prioritize and focus its programmes on populations left behind. A country has the option to choose key populations beyond the populations listed.

Social protection

Social protection is more than cash and social transfers such as food and vouchers. It encompasses economic, health financing, insurance, employment assistance and social care to reduce poverty, inequality, exclusion and barriers to accessing basic services *(3)*. The purpose, target groups, scope of benefits and coverage provided by the various social protection programmes in each country vary widely; however, the majority of social protection programmes around the world are designed to reduce poverty and vulnerability of poor people.

Social protection programmes include programmes focusing on alleviating poverty and inequality; programmes increasing access to essential services such as health and education; housing programmes; programmes targeting poor and vulnerable people, such as orphans and other vulnerable children, adolescent girls and young women, transgender people and elderly people; and programmes that transform the social, political and economic environment in which people live.

Social protection programmes seek to:

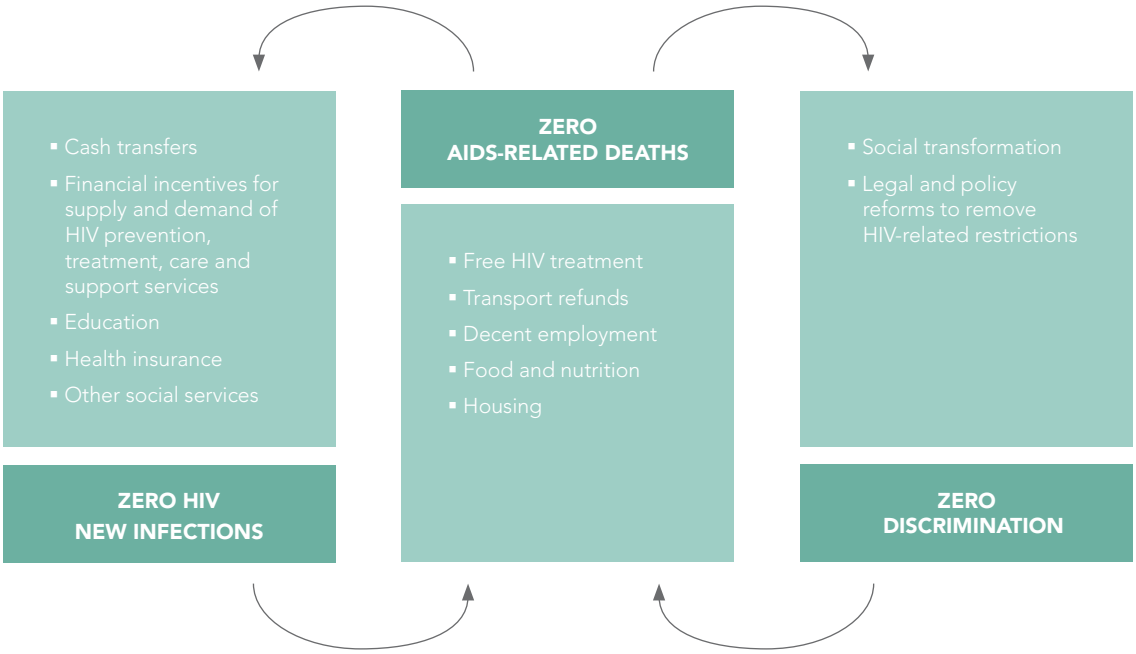
- Protect the financial streams of vulnerable individuals and households to withstand income shocks and build resilience to secure income for basic consumption necessary for care, including child care, children's education, food and nutrition, water, housing and other essentials.
- Secure and increase access to essential medical and social services for vulnerable people and households. Examples include school block grants, mentoring programmes, incentives to increase access to health care, especially for key populations, and housing and heating subsidies.
- Advocate for appropriate legal and policy reform to transform the social environment in which people live. Activities include addressing disenfranchisement of particular populations, reducing corruption in social services, reducing gender inequality, and tackling stigma and discrimination facing adolescent girls and young women and key populations.

HIV-sensitive social protection

The different functions of social protection alone and in combination contribute to advancing the AIDS response by contributing to the prevention of new HIV infections, and reducing AIDS-related deaths and stigma and discrimination. Figure 1 illustrates how HIV-sensitive social protection contributes to advancing the AIDS response.

Social protection schemes will do little for the AIDS response if they exclude or are not appropriate and accessible to people living with, at risk of or affected by HIV *(4)*. (See Social Protection: Advancing the AIDS Response *(5)* and Annex 4 for examples.) With relatively small technical and financial inputs, social protection instruments can be made HIV-sensitive. Social protection is HIV-sensitive when it is inclusive of people who are

Figure 1. How social protection advances the AIDS response



Social protection advances the AIDS response by addressing social and economic inequalities, stigma and discrimination which exacerbate HIV risk behaviors and vulnerability to HIV. Cash transfers, financial incentive, education, health insurance and other social services working prevent HIV and contribute to mitigate the impact of HIV. Free HIV treatment, transport support programmes, decent employment, Food and Nutrition and other social services also contribute to preventing HIV infection and enable people living with HIV to live long and health lives. The social transformation element of social protection make it possible for people to demand and access quality HIV services.

at risk of HIV infection or are susceptible to the consequences of HIV infection *(3)*. The term "HIV-sensitive" also refers to the degree to which people living with, at risk of or affected by HIV are considered and included in the design and implementation of social protection schemes. The degree of sensitivity in social protection can vary from no sensitivity to perfect sensitivity.

Promoting HIV-sensitive social protection entails working with programmes designed for broad population groups (such as employees, the military, orphans and other vulnerable children, households with an income below the national poverty threshold, youth, girls and women, pregnant women, people with disabilities and elderly people) and ensuring they overcome the policy and social barriers and knowledge gaps that would otherwise leave behind people living with, at risk of or affected by HIV.

Where reforming social protection programmes is too slow, inefficient or politically difficult to meet the needs of people living with, at risk of or affected by HIV, HIV-specific social protection strategies are required that focus exclusively on people living with, at risk of or affected by HIV *(6)*. HIV-specific social protection programmes are designed

specifically with and for people living with, at risk of or affected by HIV. They are essential in all countries and epidemic contexts to address pockets of vulnerability and neglect. These programmes also aim to ensure that pockets of vulnerability and neglect are covered by broader social protection schemes.

HIV-related or comprehensive social protection may be appropriate for some populations in particular contexts. For more details, see Guidance Note: HIV and Social Protection *(6)*, Annex 4, and Social Protection: Advancing the AIDS Response *(5)*.

Justification for the tool

There is increasing recognition of the role of HIV-sensitive social protection in advancing the AIDS response to increase uptake and use of HIV prevention, treatment and care services *(7–12)*. Many barriers exist, however, to people living with, at risk of or affected by HIV accessing HIV-sensitive social protection services. These barriers can be removed, though, and opportunities for HIV and social protection co-programming exist that could be exploited. This assessment tool seeks to:

- Fill the gap in country evidence on HIV and social protection.
- Identify entry points for joint action on HIV and social protection.
- Review social protection policies, programmes and schemes to make them HIV-sensitive.
- Support the development of HIV-sensitive social protection policies, programmes and schemes.
- Support the co-programming of HIV and social protection in national AIDS plans, poverty-reduction plans, development assistance plans and broader social policies.

Cross-sector co-programming

The Agenda 2030 for Sustainable Development emphasizes an approach of prioritizing the most vulnerable in leaving no one behind. It seeks to build synergies between sustainable development goals and targets. The linkage between social protection and the Sustainable Development Goals and targets, particularly target 3.3—by 2030 end the epidemics of AIDS, tuberculosis, malaria, neglected tropical diseases and combat hepatitis, waterborne diseases and other communicable diseases—presents a major opportunity for co-programming of HIV, social protection and broader development agenda *(13)*.

Deepening inequality is a predominant feature of this era. By 2020, 56% of the world's population will live in urban areas, where HIV rates are higher and poverty is growing more rapidly than in rural areas. One billion people will live in urban slums, which are typically overcrowded, polluted and dangerous; lack basic services such as clean water, food, durable housing and sanitation; and may increase vulnerability to HIV *(14)*. Social protection programmes that provide safety nets for vulnerable people across the Sustainable Development Goals (SDGs) are essential to meet the goals and advance the AIDS response. The SDGs give stakeholders a mandate for integration of efforts across all the goals, in particular on HIV and social protection, as shown in Figure 2.

Supporting scaled-up action on HIV and social protection is both the right thing to do, to improve global health and development, and a smart investment to generate efficiency and effectiveness of the HIV response. Investment in HIV, health commodities, infrastructure and human resources will not be effective unless strategic investment is made in addressing the social economic drivers of the HIV epidemic. Social protection

Figure 2. HIV and social protection related SDGs

Ensure that 75% of people living with, at risk of and affected by HIV benefit from HIV sensitive social protection by 2020.

and other behavioural and structural synergies are considered not as competing priorities to, for instance, condoms and lubricants, pre-exposure prophylaxis, antiretroviral therapy and voluntary medical male circumcision, but as components of the same response *(1)*.

Recent treatment guidelines encourage integrated approach between HIV and social protection. The 2016 World Health Organization (WHO) guidelines recommend pre-exposure prophylaxis and antiretroviral therapy to be provided with comprehensive care and support, including adherence support, counselling and testing, legal, social and economic support, mental health and emotional support, and access to contraceptive and health services *(15)*.

The needs of key populations, including adolescent girls and young women and people living with HIV, extend beyond the AIDS response and the health sector. These needs will be better met when the AIDS response effectively works with and draws on the strengths of like-minded movements, including HIV-sensitive social protection programmes backed by national laws and policies. Cross-sector linkages and complementary programmes, including access to HIV and health services, education, food and nutrition, birth registration, identity cards, transport, vocational skills training, mentoring and teacher support, agricultural development, livelihood promotion, legal support and protecting property rights, can maximize human development outcomes such as increasing access to and use of social services, including HIV health and education.

Types and purpose of social protection programmes

Although social protection programmes are grouped in categories, social protection programmes cross classification boundaries. Some conditional cash transfers may function with loosely enforced conditions, while some in-kind programmes may provide cash to beneficiaries; for example, some in-kind emergency programmes provide cash transfers to recipients in lieu of food. Regardless of the delivery mechanism, HIV actors should work to ensure that receipt and delivery of the benefits do not disadvantage people living with, at risk of or affected by HIV. For example, some public works programmes may not be appropriate for people living with HIV (who may be ill) or may impose difficulties to women (who may have caregiving roles). Social protection programmes work most effectively in combination and across different functions *(16)*; for example, fee-waivers are actively used when people have access to food and nutrition and a basic income and the means to access the social services being waived.

Table 1 illustrates the different types of social protection programmes.

Health services

Many social protection services are delivered by the health sector as part of integrated health services to increase access to and use of health services. Health services, including social protection services delivered by the health sector, are financed by different health financing mechanisms. Health financing refers to country-specific arrangements that collect and pool funds to provide nationally defined health service benefits, including HIV services. The goal of universal health coverage—access to adequate health for all at an affordable price—requires health financing systems to provide all people (including people living with, at risk of or affected by HIV) with access to needed health services and ensure that use of these services does not expose users to financial hardship *(17)*. Health financing can determine the extent of health coverage and financial protection for people from incurring catastrophic health expenditure and impoverishment associated with accessing health services.

Common health financing arrangements include mandatory systems publicly funded through the ministry of health or national health service, social health insurance, and privately funded voluntary schemes such as private and community-based health insurance *(18)*.

Publicly funded systems are the most widespread form of health financing. They collect and pool revenues on a mandatory basis to provide health services, usually free at the point of use, through a widespread network of government, private, faith-based and other nongovernmental health service providers. Countries that rely predominantly on public financing arrangements have achieved greater health coverage and financial protection of their people in accessing health services, especially for poor and vulnerable people *(19)*. These systems mobilize resources through a variety of contribution mechanisms, including taxes and domestic and external initiatives administered by governments, such as resource royalties or health equity funds.

Table 1. Types of social protection programmes.

Programme category	Programme subcategory
Conditional cash transfers	▪ Poverty-targeted cash transfers. ▪ Family and child allowance (including orphan and other vulnerable children benefits). ▪ Scholarship benefits.
Unconditional cash transfers	▪ Poverty-targeted cash transfers. ▪ Family and child allowance (including orphan and other vulnerable children benefits). ▪ Scholarship benefits in cash. ▪ Housing and utility allowance benefits in cash. ▪ Emergency support in cash. ▪ Old-age social pensions. ▪ Disability social pensions and benefits. ▪ Funeral grants and burial allowances. ▪ Public–private charity, including zakat. ▪ Other cash transfers.
Unconditional in-kind transfers	▪ Food stamps and vouchers. ▪ Food distribution programmes. ▪ Nutritional programmes (therapeutic, supplementary, and for people living with HIV or tuberculosis). ▪ In-kind emergency support. ▪ Other food or in-kind programmes.
School feeding	▪ School feeding. ▪ School gardens. ▪ School based food or food supplement distribution. ▪ School volunteer programmes to support vulnerable households (e.g. with households agriculture).
Public works	▪ Cash for work. ▪ Food for work. ▪ Workfare.
Fee-waivers	▪ Reduced medical and health fees. ▪ Educational fee waivers. ▪ Housing and utility fee waivers.
Other social safety nets	▪ Other social assistance. ▪ Social care services for children and youth. ▪ Social care services for family. ▪ Social care services for disabled people. ▪ Social care services for older people. ▪ Other social safety nets.

Sources: Adapted from State of social safety nets. Washington, DC: World Bank; 2015.

The major advantages of publicly funded health financing are that risks are pooled for the whole population nationally. Administrative efficiency, cost containment, and redistribution risks between high and low risks and between high- and low-income groups is strong in publicly funded systems. Publicly funded systems face the risks of unpredictability and underfunding due to competing public expenditure needs and political exigencies *(18)*. These systems can be inefficient if no incentives or effective supervision are provided, and they suffer from being perceived as offering low-quality services *(20)*.

Social insurance is another form of public financing. Social insurance is independent or quasi-independent health insurance that relies on mandated employee and employer payroll contributions. The benefit package is prescribed and restricted to people in formal employment, although countries are increasingly beginning to subsidize the participation of people in the informal economy, and poor, vulnerable and disadvantaged people. Social health insurance has the critical advantages of stable revenues, involvement of social partners and voice representation, strong support from the population given the perceived notion of social solidarity, equitable access to good-quality health services, and financial protection by pooling high and low health risks across different income groups. Social health insurance can be complex and difficult to manage. Payroll contributions can reduce competitiveness of firms and lead to higher unemployment *(18)*.

Voluntary health insurance is a private financing arrangement whereby contributions are paid privately and voluntarily. The health service benefits for such voluntary and private schemes, unless subsidized by governments, are accessible only for people able to pay and are prone to market failure, including adverse selection—where the people most likely to use the health services are those who pay into voluntary health schemes. A large pool of high-income, healthy subscribers is often required to balance out adversely self-selected subscribers; this is the main challenge for voluntary financing schemes *(21)*. No country has made substantial progress towards universal health coverage through voluntary health insurance. Compulsion to pay into the insurance and subsidization of the insurance are necessary conditions to achieve universal health coverage *(22)*.

Community-based health insurance is voluntary and typically established in settings with informal labour markets. The specific feature of this insurance is the community involvement in set-up, organization and management. A strong sense of local community solidarity is required. Community-based health insurance can have positive effects for the people covered if it reaches people in the informal economy and poorer segments of the population. In practice, community-based health insurance schemes face limited funding potentials and institutional capacity to cover large populations, and poor and vulnerable people are excluded unless subsidized *(23)*. Community-based health insurance may suffer from strong incentives for adverse selection and may be associated with lack of professionalism in governance and administration *(18)*.

Health sectors may also establish specific social protection and incentive programmes to increase access, use and retention in health services for particular populations, such as pregnant women living with HIV, people who inject drugs, people living with HIV, and people living with tuberculosis (TB). Examples are cash and in-kind incentives including

transport reimbursements, short-term housing, feeding programmes and fee-waivers to encourage people to access and use health services, as shown by the following two examples.

In the Democratic Republic of the Congo, a pilot programme offered women living with HIV a US$ 5 cash incentive at their first attendance at an antenatal clinic for prevention of mother-to-child transmission services, and an additional US$ 1 on top of the amount given at the previous visit at each subsequent visit. The incentive led to improved retention and uptake of services. At six weeks after delivery, 81% of women who received the cash incentives were still in the programme, compared with 72% of women who did not receive the incentive. Loss to follow-up was reduced by close to half (47%), and adherence to prevention of mother-to-child transmission services, including delivering in the health facility, increased by a third (32%) *(9)*.

HIV-sensitive social protection strategies have the potential to improve people's access to HIV/TB service access and reduce people's vulnerability to HIV/TB by improving households' socioeconomic position and food security in terms of both food availability and food diversity *(24)*. An evaluation of the role of Brazil's Bolsa Familia, one of the largest cash transfers in the world, on TB cure rates in Brazil found 82.1% TB cure rates among people exposed to the cash transfer; this was 5.2% higher than among people not exposed to the cash transfer. The association was higher among patients not on the directly observed treatment short course, suggesting the cash transfer has potentially stronger effects, especially among people who are less likely to access and be retained in standard TB care *(25)*.

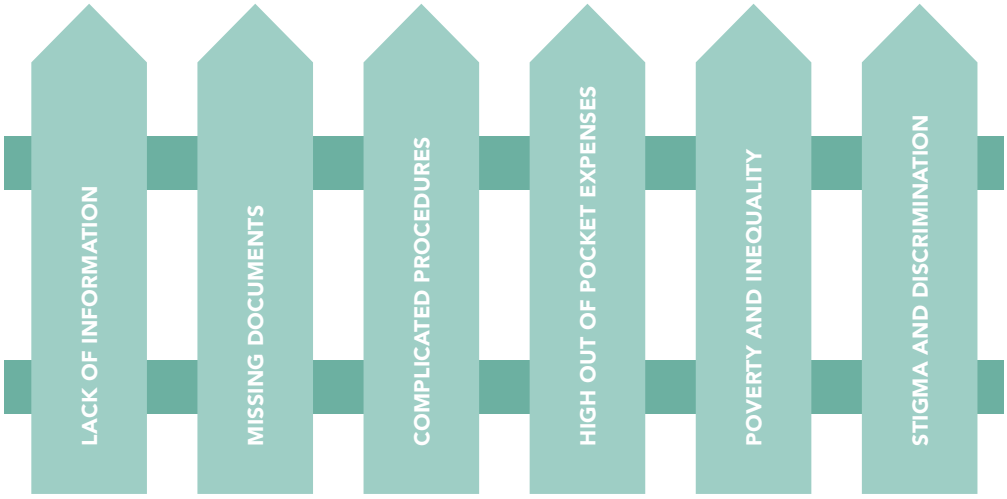
TB is the most frequent opportunistic infection in people living with HIV, whether or not they are on HIV treatment *(26)*. TB remains the leading cause of hospitalization and in-hospital deaths among adults and children living with HIV *(27)*. HIV and TB independently and collectively worsen poverty by reducing patients' physical strength and ability to work, ultimately leading to loss of income *(28)*.

Barriers to accessing HIV-sensitive social protection services

People living with, at risk of or affected by HIV face numerous barriers to accessing HIV-sensitive social protection services. These barriers may be policy or programmatic, or a combination of both. Beyond the absence of social protection programmes, barriers include nonexistence of HIV-sensitive social protection programmes, and schemes to deliver services or policies that explicitly exclude people living with, at risk of or affected by HIV. Limited coverage and benefit packages of existing schemes may also be a policy barrier to accessing HIV-sensitive social protection schemes for people living with, at risk of or affected by HIV. For example, immigrants, refugees, travellers and mobile workers often fall between the cracks, unable to access benefits at home and ineligible to access benefits in their destination country or location *(29)*.

Programme barriers include lack of information on available HIV-sensitive social protection programmes, missing documents such as national identity cards and birth certificates that confer eligibility and entitlement to services, cumbersome and complicated procedures, stigma and discrimination, and high out-of-pocket expense (Figure 3). In some cases, people living with, at risk of or affected by HIV are poor and already disadvantaged.

Figure 3. Programme barriers to accessing HIV-sensitive social protection benefits



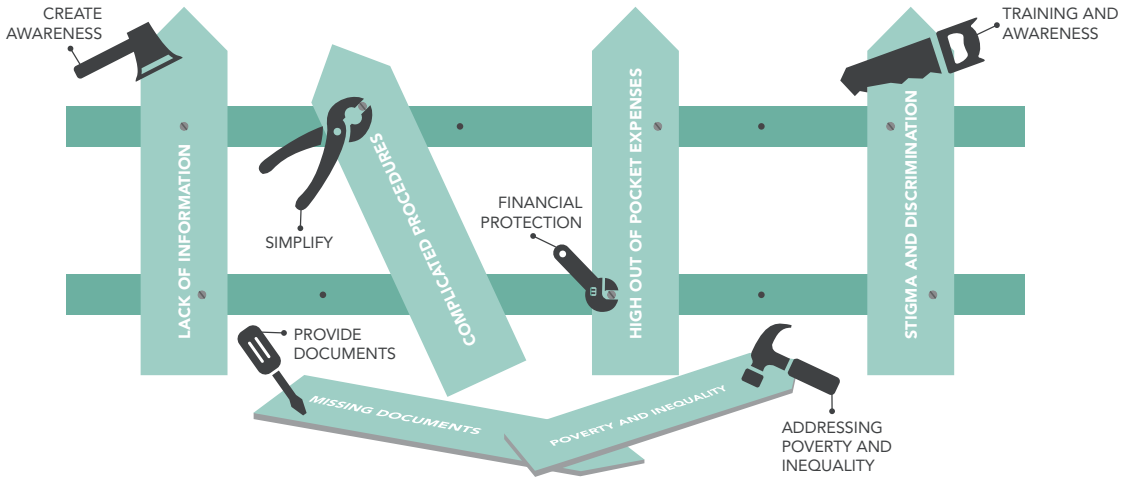
People living with, at risk of or affected by HIV may be discriminated against or may self-stigmatize and exclude themselves from accessing HIV-sensitive social protection schemes for a variety of reasons. They may belong to key populations such as sex workers, men who have sex with men, people who inject drugs or transgender people. Migrants, ethnic minorities, indigenous people, rural and urban poor people, marginalized groups, and people in or recently released from prison are often "last in line" or actively excluded from public and private services *(30)*. In some countries, only some private-sector employees, government workers and the military are covered by social protection schemes.

Although HIV-sensitive social protection services may be free at the point of use, the process of obtaining services may impose economic costs that are unaffordable to recipients; such costs include transportation to reach the service point, foregone wages and waiting times. For example, antiretroviral therapy may be free at the point of use, but recipients may have to pay for tests or buy drugs for opportunistic infections in private pharmacies due to stock-outs at public hospitals *(31)* or because these services are not exempt from fees.

Actions to remove barriers to accessing HIV-sensitive social protection programmes

Policy-makers and social protection implementers may require technical support in understanding the financial and programmatic impact of actions to remove barriers. They may require support on cross-sector co-programming, co-financing *(32)*, identification of fiscal space and other aspects to implement the actions. They may also require support for strengthening systems such as targeting, financial management, and developing credible monitoring and evaluation programmes to increase the HIV sensitivity of a social protection programme or scheme.

Figure 4. Actions to remove barriers to accessing HIV-sensitive social protection



Several activities may be undertaken to remove barriers to accessing HIV-sensitive social protection schemes for people living with, at risk of or affected by HIV, such as (Figure 4):

- Starting new schemes to fill the gaps and consolidating multiple schemes into a broader comprehensive programme.
- Revising targeting processes to more effectively reach people living with, at risk of or affected by HIV in social protection programmes.
- Expanding categorical geographical coverage of HIV-sensitive social protection programmes to meet equity needs and other considerations.
- Creating awareness among concerned populations, including people living with HIV and key populations, on existing HIV-sensitive social protection programmes and their entitlements.
- Simplifying processes to access HIV-sensitive social protection programmes including establishing one stop delivery points to enable people access comprehensive social protection benefits from one location.
- Providing national identity cards and birth certificates for government recognition of people not receiving social protection services in order to receive HIV-sensitive social protection services.
- Training of social protection administrators and providers, including insurance companies, to more effectively reach people living with, at risk of or affected by HIV where these populations are eligible, including efforts to remove stigma and discrimination around access to social protection benefits for people living with, at risk of or affected by HIV.

Efforts to remove barriers to accessing HIV-sensitive social protection schemes also require targeted institutional support for social protection administration and management, referral systems and linkages between social welfare services and health service providers. Infrastructure, staff, office equipment and vehicles for effective delivery of social protection are often in short supply at the local level where services are delivered.

Coordination and management of social protection programmes

Within a country and in a province or district, there may be a range of health services and social protection programmes containing different social protection services that are coordinated and delivered by multiple government agencies and nongovernmental actors and different levels of government. In most cases, the coordinating role is assigned to the ministry most directly linked to social protection, such as the social development ministry, the social inclusion ministry or the national authority for social security. In these cases, the coordinating ministry summons entities to participate in the implementation of the social protection strategy. For example, in Brazil, the Ministry for Social Development and Fight Against Hunger coordinates Brazil's Social Protection Strategy. In Kenya, coordination is divided between three ministries: the Ministry of Labour, the Ministry of Social Security and Services, and the Ministry of Devolution and Planning *(33)*.

Another method of coordination is through a coordinating commission or committee, often called a ministerial national committee. The committee is created specifically to coordinate the strategy. In many cases, this committee is attached to the presidency. For example, in Benin, the Comité Socle de Protection Sociale is responsible for coordination related to the social protection strategy. Because of their proximity to the president, such committees often have stronger convening and coordination powers than they would otherwise have. In many other cases, the committee may fall under a line ministry such as the ministry of finance and economic planning, the ministry of health and social welfare, or the ministry of labour *(33)*.

For effective management of social protection programmes, countries have developed management information systems of varying complexity. Social registries containing lists of individuals and households eligible to participate in a programme, beneficiary registries containing the actual list of beneficiaries of a programme, and monitoring and evaluation systems are among the most commonly used tools for administration and management of social protection systems. It is key that HIV actors ensure that eligible people living with, at risk of or affected by HIV are reflected in these management systems.

Improving coordination and management of social protection programmes across different government departments, including health, education and agriculture, across different nongovernmental implementers, such as international and bilateral agencies and donors, and within different government levels remains a key priority for successful social protection programmes *(34)*.

Three-stage process for conducting the assessment

The following three stages provide guidance to HIV and social protection actors seeking to conduct an HIV and social protection assessment. They illustrate the key points from preparation to conducting the assessment, writing reports, validation and follow-up activities that should be taken into consideration in order to conduct a useful HIV and social protection assessment.

STAGE 1

Preparing to conduct the assessment

National AIDS and social protection authorities, in particular national AIDS council directors and their designates, national social protection programme managers and other ministries concerned with the management of HIV and social protection, should lead the conduct of the HIV and social protection assessment. The government authorities should be supported by a team that includes the UNAIDS Country Director, and his or her designate and relevant representatives of UNAIDS Cosponsors.

Step 1: securing high-level commitment

High-level political commitment is key to the successful undertaking of the HIV and social protection assessment. In order to reach high-level commitment, the following tasks should be undertaken by the lead government institutions, in particular the national AIDS and social protection authorities, together with key actors:

- Map out key government decision-makers, development actors and civil society representatives to be engaged in the assessment.
- Identify challenges and opportunities for building high-level support and prepare strategies to secure this support.
- Prepare a brief one-page concept note on why it is important to conduct an HIV and social protection assessment and how it is anticipated to enhance the national AIDS response and strengthen the HIV sensitivity of social protection programmes and schemes.
- Develop a draft resource plan for the assessment. The plan may include an estimated budget and human resources requirements for conducting the assessment and funding sources for the plan.
- Share the concept note and the tool with key decision-makers. Discuss with them and seek their inputs, engagement and commitment in the process of conducting the assessment.

Step 2: establish an HIV and social protection assessment team

The national AIDS and social protection authorities with the support of UNAIDS and relevant Cosponsors should form a core team to conduct the assessment. The

authorities should identify and invite people from relevant institutions to be part of the core team to conduct the assessment. The core team should include senior staff working on HIV and social protection from the national statistics office, ministries of health, finance, agriculture, labour and key development partners such as the United States Agency for International Development (USAID), the United States President's Emergency Plan for AIDS Relief (PEPFAR), the Global Fund to Fight AIDS, Tuberculosis and Malaria, donors and civil society representatives, including networks of women living with HIV and key populations. It is important to ensure there is explicit commitment from the team members and their institutions to conduct the assessment.

Care must be taken to ensure the team is multidisciplinary, is knowledgeable and reflects the multisectoral nature of social protection. Members must have proficient expertise in and knowledge of HIV programming, including information on the national AIDS response, its strategic focus, financing, coverage, policies and measurements. Similarly, social protection authorities must be proficient in the policy, financing, programming and coverage of HIV sensitive social protection programmes and schemes nationally and subnationally.

A balance should be struck to ensure the right mix of technical know-how of HIV and social protection programmes, political ability to move the findings forward, and suitable group dynamics for productive debate in the team. The team should be limited to 10 members to ensure meaningful engagement of members and facilitate timely decision-making and action.

In line with the greater and meaningful involvement of people living with HIV (GIPA) principle, specific efforts must be made to ensure populations affected by HIV, including people living with HIV, adolescent girls and young women and representatives of key populations, are part of the team conducting the assessment and are able to participate in the entire process.

Step 3: collect, collate and store relevant documents

The team should collect the data from three sources: *(35)* desk review of existing reference documents, including social protection programme reports, national health accounts or national AIDS spending assessment reports, and monitoring and evaluation databases where these exist; *(33)* secondary analysis of existing information; *(36)* and team members' respective areas of expertise. Before conducting the desk review, the teams should conduct a documentary review to determine the set of documents that will be most relevant to the assessment.

The team may have to consider evaluating the credibility and objectivity of the documents. Where possible, the team may conduct secondary analysis of existing survey or programme data to understand different trends and patterns relating to HIV and social protection.

The potential sources of information that should be gathered in advance are given in Annexes 1 - methods of data collection and 3.

Where should the assessment be conducted?

Given that this assessment is a quick scan of existing social protection programmes and their HIV sensitivity, interface or lack of with the HIV response, the assessment should be conducted nationally. Detailed follow-up assessments where necessary and required should be conducted at the subnational (province) and sub-subnational (district) levels. In some countries, especially those with concentrated epidemics, the assessment may be conducted in a particular city or district that bears the greatest HIV burden. The subnational level should consolidate the reports in a given subnational level. A copy of the report at the subnational level should be sent to the country's national AIDS and social protection authorities. Where necessary, the subnational reports would inform the national assessment.

The advantage of this process is that, at a minimum, each country would have a national HIV and social protection assessment that, when augmented with the local epidemic situation, can inform pragmatic actions on increasing access to HIV-sensitive social protection services for the populations left behind by the AIDS response.

STAGE 2

Conducting the assessment

Organize an HIV and social protection assessment workshop

An HIV and social protection workshop should be conducted for the core team by the national AIDS and social protection authorities with the technical support of the UNAIDS Joint Team members. The workshop consists of a training and completion of the assessment. The training should cover broadly the HIV epidemic, types and functions of social protection programmes, access to social protection services in health-care settings, and the mechanics of administering the HIV and social protection assessment tool.

It is suggested that up to one week is set aside to conduct the assessment workshop. Populations not in gainful employment, including people living with, at risk of or affected by HIV, may need specific support with, for example, transport to ensure their continued participation in the workshop.

Given that group members are expected to be experts on different aspects of HIV and social protection and administration of the assessment, they could be encouraged to present aspects of the training. The training should conclude with a practical demonstration of how to complete the questionnaires and draft a report. Annex 5 contains a draft HIV and social protection assessment workshop agenda that can be adapted to the country and local context. Once the training part of the workshop is completed, the team can proceed to complete the assessment electronically.

It is essential that the information entered in the assessment is properly sourced and referenced. For example, if the assessment team indicates that migrants are excluded from receiving HIV treatment, then a source for this information should be indicated appropriately on the data collection template.

Representatives of the social protection ministry and national AIDS authorities, in collaboration with the UNAIDS Country Directors, should verify the form is completely filled and sign off on the completed data collection. Once the data are complete and submitted, a raw assessment report is made available electronically to the country or location relatively quickly for the team to write a narrative report.

STAGE 3

Data analysis, reporting and validation of findings

Analysis

Based on the information gathered, an analysis informed by the tool should be conducted and recommendations drafted. The main questions to guide analysis and the suggested analysis format are included in Annex 1. The collected data should be analysed to make social protection programmes, within their current objectives and targeting, accessible to people living with, at risk of or affected by HIV. This may require addressing the most critical barriers to accessing HIV-sensitive social protection for people living with, at risk of or affected by HIV.

Based on the analysis, a report should be written, including relevant recommendations. Since most HIV-sensitive social protection programmes are yet to reach national coverage, it may be necessary in some cases for the report to include recommendations to advocate for the expansion of existing social protection programmes, especially if these programmes cover people living with, at risk of or affected by HIV. In some cases it may be necessary to design specific and highly targeted social protection programmes to reach particularly excluded or vulnerable populations, rather than revise existing national social protection programmes put in place to achieve broader development related goals. This may require identifying new sources of financial support for implementing the recommendations. To the extent possible, recommendations should be context-specific and be adapted to national, subnational and sub-subnational contexts.

Report and validation

The report should be shared and endorsed by key HIV and social protection actors in a public event to increase the visibility and awareness of the findings and to generate political support. Relevant high-ranking government, United Nations, donor and civil society representatives, including people living with HIV and representatives of other key populations, should be invited to participate in the validation of the assessment report. Findings should be reported clearly and simply with graphics that convey the key messages. An executive summary should be extracted from the main report and made available during the validation meeting for easy assimilation of the main findings and recommendations of the research.

Follow-up

The form and duration of implementing the recommendations will vary by context, location and type of recommendations. The team should continue, however, to undertake actions to strengthen political will and ownership of the findings,

strengthening capacity for programme implementation, identifying sources of financing HIV-sensitive social protection and developing complementary programmes. Sharing evidence on progress to implement the recommendations and the broader impact of the recommendations on improving people's lives is important to sustain the political will and commitment for sustained implementation of the recommendations.

Capacity-building may involve increasing the amount of equipment and the number of staff and training staff on the different recommendations and related instruments of social protection, including removing stigma and discrimination associated with access to social protection for people living with, at risk of or affected by HIV. It may also involve creating social protection literacy of people living with, at risk of or affected by HIV to increase the quality and demand of social protection services.

Lessons learned from developing the tool

The tool was developed by members of the Inter-Agency Task Team (IATT) on social protection care and support. The IATT is co-chaired by UNICEF and the World Bank and co-ordinated by the UNAIDS Secretariat. UNICEF, UNDP, ILO, WHO, WFP, U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and USAID, AIDSFONDS previously STOPAIDS NOW!, World Vision International and Oxford University actively contributed towards the development of the tool. Additional inputs were received from participants of the UNDP led Middle East and North Africa (MENA) *Regional Consultation on HIV-sensitive social protection* held from 4-6 August, 2015 in Sham El Sheik, Egypt; ILO sponsored *HIV and AIDS and the World of Work: A prevention and social protection perspective* Training held from 12-16 October, 2015 in Turin, Italy and participants of the workshop on *Conducting an HIV and Social Protection Assessment* held on 1ST December during the 18th International AIDS Conference on AIDS/STI (ICASA) in Harare, Zimbabwe.

The tool was then piloted in Lusaka, Zambia from 4 – 5 February, 2016 followed by another pilot held in Nairobi, Kenya from 8-9 February, 2016. Each of the pilots was attended by about 36 people including senior government staff working on HIV, social protection, representatives of civil society including people living with HIV, key populations, people with disabilities and UN Joint Team members. Both pilots were strongly supported by the governments, UNICEF and UNAIDS and UNAIDS co-sponsors country offices. Suggestions from the pilots were used to strengthen the tool. Lessoned learned include:

- Ensuring the right level of government ownership and leadership in conducting the assessment. In Zambia, the NAC Director and the Minister of Community Development and Social Services were not only involved in the preparation of the pilot but actively participated in the pilot workshop. The two leaders' engagement helped to ensure the appropriate mix of key government staff and non-government staff actively participated for the duration of the pilot.
- Timing the right opportunities to undertake the assessment. The active leadership of UNICEF in both Zambia and Kenya pilots ensured that an appropriate time was chosen to conduct the assessment that fed into the right policy processes. In Zambia, the concept note for the Global Fund to Fight AIDS TB and Malaria was being developed while in Kenya Management system for social protection was being reviewed.
- Youth groups, people living with HIV, key populations and civil society representatives may require direct transport and other logistics support in order for them to participate for the entire duration of the assessment. In both countries, representatives of youths, people living with HIV and key populations attended. In Kenya these included representatives from Women Fight AIDS in Kenya (WOFAK) and Bar Hostess Empowerment and Support Programme (BHESP) while in Zambia, the Network of Zambian People Living with HIV (NZP+), National Youth Network

on Population and Development and the Zambia National Association of Persons with disabilities among others. These groups would not have participated without transport support provided by UNICEF for the Kenya pilot and UNAIDS for the Zambia pilot.

Notwithstanding the lessons learnt, both pilots showed that the tool could feasibly assist in identifying the main HIV sensitive social protection programmes that exist and generated the recommendations for actions in increasing the HIV sensitivity of the programmes identified.

Glossary

Block grant. Monetary or non-monetary grant given to a social service institution by a governmental or nongovernmental organization with general provisions on how the grant is spent. An example is money or school materials given to a school in exchange for waiving levies for identified pupils in the school for an open-ended or particular period of time. Another example is a monetary or non-monetary grant given to a health facility in exchange for a population accessing a package of health services from that health facility at no cost to the person for an open-ended or particular period of time *(35)*.

Cash transfer. Regular, predictable noncontributory cash payments given to poor and vulnerable people to reduce poverty and vulnerability. Cash transfers encompass a range of instruments, including social pensions, child grants and public works programmes, and have a range of design features:

- Conditional cash transfers require recipients to fulfil specified behavioural conditions, such as increasing children's enrolment and school attendance to at least 80% of classes, having up-to-date vaccinations, or regular visits to antenatal health-care facilities by pregnant women.
- Conditional in-kind transfers involve forms of compliance such as ensuring a level of monthly school attendance in return for receiving food or other in-kind transfers.
- Unconditional cash transfers do not attach particular behavioural requirements to receiving the transfer.
- Unconditional in-kind transfers encompass the distribution of in-kind transfers without any form of condition or co-responsibility *(33)*.

Fast-Track. Approach introduced and promoted by UNAIDS to accelerate the implementation of essential HIV prevention, treatment and human rights approaches that will enable the AIDS response to outpace the HIV epidemic, to be attained by 2020, to set the world on course to ending the AIDS epidemic by 2030 *(36)*.

Gender equality. Equal consideration, value and favour of different behaviours, aspirations and needs of women and men. Gender equality signifies there is no discrimination on the grounds of a person's gender in the allocation of resources or benefits or in access to services. Gender equality may be measured in terms of whether there is equality of opportunity or equality of results *(36)*.

Global Fund concept note. Format of a proposal introduced by the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) to define an application to request new funds from the Global Fund for any one of the three diseases or for cross-cutting support for health and community system strengthening *(36)*.

Health care. Diagnostic, preventive, curative and palliative services and interventions delivered to individuals or populations to maintain and improve health *(36)*.

Health financing. Country-specific arrangements that collect and pool funds to provide nationally defined health service benefits. Common health financing arrangements include mandatory systems publicly funded through the ministry of health or national health service, social health insurance, and privately funded voluntary schemes such as private and community-based health insurance *(18)*.

Health sector. Encompasses a number of health-related organizations and services such as public and private health services (including those for health promotion, disease prevention, diagnosis, treatment and care), ministries of health, health-related nongovernmental organizations, health-related community groups, and health-specific professional organizations. It also includes institutions that provide direct input into the health-care system, such as the pharmaceutical industry and teaching institutions *(36)*.

Investment case. Document that makes the case for optimized HIV investments. The case is a description of returns on investment in a country's optimized HIV response over the long term (typically more than 10 years). It summarizes the state of the HIV epidemic and response, describes the prioritized programmes to be implemented, and the populations and geographical areas that should be focused on in order to achieve the greatest impact, and indicates the resources required *(36)*.

Key populations. UNAIDS considers men who have sex with men, sex workers, gay men and other, and people who inject drugs as the main key population groups. These populations suffer from punitive laws or stigmatizing policies, and they are among the most likely to be exposed to HIV. Their engagement is critical to a successful AIDS response everywhere: they are key to the epidemic and key to the response. Countries should define the specific populations that are key to their epidemic and response based on the epidemiological and social context *(36)*.

Lesbians. Women attracted to other women. A lesbian may or may not be having sex with women, and a woman having sex with women may or may not be a lesbian. The term "women who have sex with women" should be used unless individuals or groups self-identify as lesbians *(36)*.

Men who have sex with men. Males who have sex with males, regardless of whether or not they also have sex with women or have a personal or social gay or bisexual identity. This concept is useful because it also includes men who self-identify as heterosexual but who have sex with other men *(36)*.

Migrant worker. Person who is or has been engaged in a remunerated activity in a state of which he or she is not a national. Internal migration, including for seasonal work, may also be important in the context of HIV epidemics in some countries *(36)*.

Modes of transmission. Abbreviation for the study of HIV incidence by modes of transmission. It refers to an epidemiological model developed by UNAIDS to help countries calculate HIV incidence by mode of transmission. The model incorporates biological and behavioural inputs, such as HIV and sexually transmitted infection prevalence, risk behaviours and transmission probabilities *(36)*. Modelling tools for HIV programme planning such as Allocative Efficiency Models (AEM), Goals and Optima can also be used in the study of HIV incidence by modes of transmission.

Person with disabilities. Person with long-term physical, mental, intellectual or sensory impairments that, in interaction with various barriers, may hinder his or her full and effective participation in society on an equal basis with others *(36)*.

Public works programme. Form of social protection in which participants engage in manual labour-oriented activities such as building or rehabilitating community assets and public infrastructure. Examples include seasonal labour-intensive works for poor and food-insecure populations *(33)*.

Sex worker. Female, male or transgender adult over the age of 18 years who receives money or goods in exchange for consensual sexual services, either regularly or occasionally, and who may or may not self-identify as a sex worker *(37)*.

Social protection. Set of policies and programmes aimed at preventing or protecting vulnerable groups of people against poverty, vulnerability and social exclusion throughout their life cycle. Social protection can be provided in cash or in kind, through noncontributory schemes, providing universal, categorical or poverty-targeted benefits such as social assistance or social safety nets. Contributory schemes with social insurance are the most common form; they build human capital and productive assets, and increase access to productive jobs *(33)*.

Social safety net. Noncontributory measure designed to provide regular and predictable support to poor and vulnerable people. Social safety nets are also referred to as safety nets, social assistance and social transfers. They are a component of larger social protection systems *(33)*.

Transgender. Umbrella term describing people whose gender identity and expression do not conform to the norms and expectations traditionally associated with their sex at birth. Transgender people include individuals who have received gender reassignment surgery, individuals who have received gender-related medical interventions other than surgery (such as hormone therapy), and individuals who identify themselves as having no gender, multiple genders or alternative genders *(36)*.

Annexes

Annex 1. HIV and social protection assessment data collection tool

1.0 Identification

The purpose of this section is to collect data on the location of the country in which the assessment is conducted, who is responsible for the assessment and who was involved in the assessment. This information will be the key identifier of the data set and will assist in understanding country and regional specificities of the data collected.

Identification				
01. Location ID	1. Geographical classification		2. Name of country	
02. Names of people responsible for the assessment				
1. Name	2. Gender	3. Organization affiliation	4. Function/title	5. Email
1. 2.				
03. Data collection team members				
1. Name	2. Gender	3. Organization affiliation	4. Function/title	5. Email
1. 2. 3. 4. 5. 6. 7. 8. 9. 10.				

1.1 Social protection strategy and HIV sensitivity

This subsection looks at whether a social protection policy/strategy/framework/policy exists and, if it does, whether it is HIV-sensitive.

Does the country have a social protection strategy? (Yes/No) If yes, is the social protection strategy HIV-sensitive? (Yes/No) HIV sensitivity score (automatic calculation based on answers entered)

2.0 Health services

Given the critical role the health sector plays in the AIDS response, a section on health services is included to understand the different health schemes that exist to increase access to health care and identify opportunities for increasing access to health care for people living with, at risk of or affected by HIV. This section seeks to understand the different schemes available, their focus and which populations have the most barriers in accessing these schemes.

2.0 In your country list populations that face the most barriers in accessing schemes			
1.	2.	3.	4.
5.			

2.10 Are any of the following health schemes operational in your country? (Mark all that apply)	**2.11 Is the scheme operational?**		**2.12 If yes in 2.11 write the name of the scheme. Otherwise skip to next row.**	**2.13 What is the target population of the scheme?** (select all that apply) Children, orphans and vulnerable children, men, women, pregnant women, pensioners, homeless people, poor and vulnerable people, rural populations, widows, transgender people, people living with HIV, people with TB, refugees, displaced people, migrants, formally employed workers, informal employed workers, other, NA.	**2.14 What is the age group of the target population?** (list all that applies). x in years 1. (<4) 2. (5<x<9) 3. (10<x<14) 4. (15<x<19) 5. (20<x<24) 6. (25<x<29) 7. (30<x<34) 8. (35<x<40) 9. (40<x<59) 10. (x>60) 11. All age groups	**2.15 Where applicable, what is the amount of the benefit, period and time frame of the scheme?**		**2.16 What is the name of the implementing agence(s)?**
	2.11a Yes	2.11b No				2.15a Local currency	2.15b US dollars	
1. Taxation/ government financing that offers free health services at point of use								
2. Mandatory/ social insurance that targets specific population groups								
3. Voluntary health insurance								
4. Community-based health insurance								
5. Other health-care financing (specify)								
In-kind schemes								
6. Short-term housing								
7. Feeding programme								
8. Transport scheme								
9. Other in-kind support (specify)								

2.10-2.16 continued

Sources (Please fill in the source of your information for each scheme below):	
1. Taxation/ government financing that offers free health services at point of use	
2. Mandatory/ social insurance that targets specific population groups	
3. Voluntary health insurance	
4. Community-based health insurance	
5. Other health-care financing (specify)	
In-kind schemes	
6. Short-term housing	
7. Feeding programme	
8. Transport scheme	
9. Other in-kind support (specify)	

Recall period is the past six months for all the data.

Checklist for analysis for questions 1.1–2.16: availability of health schemes

Questions	Checklist for analysis	Methods of data collection	Basic analysis and presentation of findings
1.1 Indicate whether or not the programme is HIV-sensitive **2.0–2.05 List the populations that face the most barriers in accessing health services**	▪ Indicate the identifiers of the country where the assessment is being conducted ▪ Indicate whether or not strategy or framework is HIV-sensitive ▪ List the populations that face the most barriers in accessing Health services ▪ Absolute number of population groups that face the most barriers in accessing health services	**Methods:** ▪ Desk review ▪ Secondary analysis of existing data ▪ Group discussion **Sources:** ▪ National health accounts ▪ National health insurance policies ▪ Health insurance schemes ▪ National social protection administrative reports and documents ▪ Reports and documents from nongovernmental organizations and people living with HIV ▪ Private-sector social protection administrative documents ▪ Gender assessment reports of the AIDS response ▪ National HIV plan ▪ PEPFAR country operational plans ▪ Institute of Social Security Administration regional reports ▪ HIV and Social Protection Assessment Team (members of United Nations Joint Team on AIDS, people living with HIV, key populations)	▪ Indicate whether or not strategy is HIV-sensitive ▪ For each question, if appropriate conduct frequency tabulations and correlations, and illustrate the results
2.10–2.12 Are any of the following schemes operational in your country?	▪ List schemes that are operational ▪ Absolute number of schemes that are operational		
2.13–2.14 What is the target and their age groups?	▪ Names of the schemes that are operational, their target group and the age groups of the target populations. Specify the age group of the target populations (years): (<4), 2; (5–9), 3; (10–14), 4; (15-19), 5; (20–24), 6; (25–29), 7; (30–34), 8; (35–40), 9; (40–59), 10; (>60), 11. All age groups ▪ Absolute number of different populations groups targeted		
2.15 What is the amount of the benefit?	▪ Specify the amount of funds spent, period and timeframe on provision of health service benefits in local currency and in US dollars at the prevailing exchange rate under each scheme and indicate it as a percentage of total health spending in your district; where the benefit is in-kind, translate the cost of the benefit in local currency into US dollars using the current exchange rate ▪ Absolute value of the local currency and US dollar value of the benefit and the percentage of the total		
2.16 What is the name of the implementing agency?	▪ Names of implementing agencies (identifying the implementing agencies assists in locating the points of influence)		

2.2 Accessibility of health services

This subsection focuses on population 1 identified in 2.0.

2.20 This section relates to the health schemes you identified as operational in 2.10 (mark all that apply; if not go to question 3)	**2.20 Is population (1) identified in 2.0 facing the most barriers in accessing particular health schemes?** (Write name of scheme and check all barriers)								**2.21 What can be done to include this population in health finacing schemes?**				
	2.20a Yes	2.20b No	2.20c Name of scheme	2.20d Barrier 1	2.20e Barrier 2	2.20f Barrier 3	2.20g Barrier 4	2.20h Any other barrier	2.21a What (Activity 1) can be done to remove barrier 1?	2.21b What (Activity 2) can be done to remove barrier 2?	2.21c What (Activity 3) can be done to remove barrier 3?	2.21d What (Activity 4) can be done to remove barrier 4?	2.21e What (Activity 5) can be done to remove barrier 5?
1. Taxation/ government financing that offers free health services at point of use													
2. Mandatory/ social insurance that targets specific population groups													
3. Voluntary health insurance													
4. Community-based health insurance													
5. Other health-care financing (specify)													
In-kind schemes													
6. Short-term housing													
7. Feeding programme													
8. Transport scheme													
9. Other in-kind support (specify)													

2.20-2.21 continued

Sources (Please fill in the source of your information for each scheme below):	
1. Taxation/ government financing that offers free health services at point of use	
2. Mandatory/ social insurance that targets specific population groups	
3. Voluntary health insurance	
4. Community-based health insurance	
5. Other health-care financing (specify)	
In-kind schemes	
6. Short-term housing	
7. Feeding programme	
8. Transport scheme	
9. Other in-kind support (specify)	

Recall period is the past six months for all the data.

This subsection focuses on population 2 identified in 2.0.

2.30 This section relates to the health schemes you identified as operational in 2.10 (mark all that apply; if not go to question 3)	**2.30 Is population identified in 2.0 facing the most barriers in accessing particular health schemes?** (Write name of scheme and check all reasons for barriers)								**2.31 What can be done to include this population in health schemes?**				
	2.30a Yes	2.30b No	2.30c Name of scheme	2.30d Barrier 1	2.30e Barrier 2	2.30f Barrier 3	2.30g Barrier 4	2.30h Any other barrier	2.31a What (Activity 1) can be done to remove barrier 1?	2.31b What (Activity 2) can be done to remove barrier 2?	2.31c What (Activity 3) can be done to remove barrier 3?	2.31d What (Activity 4) can be done to remove barrier 4?	2.31e What (Activity 5) can be done to remove barrier 5?
1. Taxation/ government financing that offers free health services at point of use													
2. Mandatory/ social insurance that targets specific population groups													
3. Voluntary health insurance													
4. Community-based health insurance													
5. Other health-care financing (specify)													
In-kind schemes													
6. Short-term housing													
7. Feeding programme													
8. Transport scheme													
9. Other in-kind support (specify)													

2.30-2.31 continued

Sources (Please fill in the source of your information for each scheme below):	
1. Taxation/ government financing that offers free health services at point of use	
2. Mandatory/ social insurance that targets specific population groups	
3. Voluntary health insurance	
4. Community-based health insurance	
5. Other health-care financing (specify)	
In-kind schemes	
6. Short-term housing	
7. Feeding programme	
8. Transport scheme	
9. Other in-kind support (specify)	

Recall period is the past six months for all the data.

This subsection focuses on population 3 identified in section 2.0.

2.40 This section relates to the health schemes you identified as operational in 2.10 (mark all that apply; if not go to question 3)	**2.40 Is population (3) identified in 2.0 face the most barriers in accessing particular Health schemes?** (Write down name of scheme and check all reasons for barriers)								**2.41 What can be done to include this population in health schemes?**				
	2.40a Yes	2.40b No	2.40c Name of scheme	2.40d Barrier 1	2.40e Barrier 2	2.40f Barrier 3	2.40g Barrier 4	2.40h Any other barrier	2.41a What (Activity 1) can be done to remove barrier 1?	2.41b What (Activity 2) can be done to remove barrier 2?	2.41c What (Activity 3) can be done to remove barrier 3?	2.41d What (Activity 4) can be done to remove barrier 4?	2.41e What (Activity 5) can be done to remove barrier 5?
1. Taxation/ government financing that offers free health services at point of use													
2. Mandatory/ social insurance that targets specific population groups													
3. Voluntary health insurance													
4. Community-based health insurance													
5. Other health-care financing (specify)													
In-kind schemes													
6. Short-term housing													
7. Feeding programme													
8. Transport scheme													
9. Other in-kind support (specify)													

2.40-2.41 continued

Sources (Please fill in the source of your information for each scheme below):	
1. Taxation/ government financing that offers free health services at point of use	
2. Mandatory/ social insurance that targets specific population groups	
3. Voluntary health insurance	
4. Community-based health insurance	
5. Other health-care financing (specify)	
In-kind schemes	
6. Short-term housing	
7. Feeding programme	
8. Transport scheme	
9. Other in-kind support (specify)	

Recall period is the past six months for all the data.

This subsection focuses on population 4 identified in 2.0.

2.50 This section relates to the health schemes you identified as operational in 2.10 (mark all that apply; if not go to question 3)	**2.50 Is population (4) identified in 2.0 facing the most barriers in accessing particular health schemes?** (Write name of scheme and check all reasons for barriers)								**2.51 What can be done to include this population in health finacing schemes?**				
	2.50a Yes	2.50b No	2.50c Name of scheme	2.50d Barrier 1	2.50e Barrier 2	2.50f Barrier 3	2.50g Barrier 4	2.50h Any other barrier	2.51a What (Activity 1) can be done to remove barrier 1?	2.51b What (Activity 2) can be done to remove barrier 2?	2.51c What (Activity 3) can be done to remove barrier 3?	2.51d What (Activity 4) can be done to remove barrier 4?	2.51e What (Activity 5) can be done to remove barrier 5?
1. Taxation/ government financing that offers free health services at point of use													
2. Mandatory/ social insurance that targets specific population groups													
3. Voluntary health insurance													
4. Community-based health insurance													
5. Other health-care financing (specify)													
In-kind schemes													
6. Short-term housing													
7. Feeding programme													
8. Transport scheme													
9. Other in-kind support (specify)													

2.50-2.51 continued

Sources (Please fill in the source of your information for each scheme below):	
1. Taxation/ government financing that offers free health services at point of use	
2. Mandatory/ social insurance that targets specific population groups	
3. Voluntary health insurance	
4. Community-based health insurance	
5. Other health-care financing (specify)	
In-kind schemes	
6. Short-term housing	
7. Feeding programme	
8. Transport scheme	
9. Other in-kind support (specify)	

Recall period is the past six months for all the data.

This subsection focuses on the population indicated in "any other" in section 2.0.

2.60 This section relates to the health schemes you identified as operational in 2.10 (mark all that apply; if not go to question 3)	**2.60. Is population (any other) identified in 2.0 face the most barriers in accessing particular Health schemes?** (Write down name of scheme and check all barriers)								**2.61 What can be done to include this population in health schemes?**				
	2.60a Yes	2.60b No	2.60c Name of scheme	2.60d Barrier 1	2.60e Barrier 2	2.60f Barrier 3	2.60g Barrier 4	2.60h Any other barrier	2.61a What (Activity 1) can be done to remove barrier 1?	2.61b What (Activity 2) can be done to remove barrier 2?	2.61c What (Activity 3) can be done to remove barrier 3?	2.61d What (Activity 4) can be done to remove barrier 4?	2.61e What (Activity 5) can be done to remove barrier 5?
1. Taxation/ government financing that offers free health services at point of use													
2. Mandatory/ social insurance that targets specific population groups													
3. Voluntary health insurance													
4. Community-based health insurance													
5. Other health-care financing (specify)													
In-kind schemes													
6. Short-term housing													
7. Feeding programme													
8. Transport scheme													
9. Other in-kind support (specify)													

2.60-2.61 continued

Sources (Please fill in the source of your information for each scheme below):	
1. Taxation/ government financing that offers free health services at point of use	
2. Mandatory/ social insurance that targets specific population groups	
3. Voluntary health insurance	
4. Community-based health insurance	
5. Other health-care financing (specify)	
In-kind schemes	
6. Short-term housing	
7. Feeding programme	
8. Transport scheme	
9. Other in-kind support (specify)	

Recall period is the past six months for all the data.

Checklist for analysis 2.20–2.61: accessibility of health schemes

Questions	Checklist for analysis	Methods of data collection	Basic analysis and presentation of findings
2.20–2.61 These questions relate to the populations identified in 2.0 as facing the most barriers in accessing health schemes **For each population, a list of the schemes to which they face barriers in accessing is indicated, followed by the reasons for the barriers and what can be done to remove each corresponding barrier** **Is population identified in 2.0 facing the most barriers in accessing particular health schemes that are operational, what are those barriers, and what can be done to remove the barriers?** **Note:** This section has forms that need to be completed fully—one for each of the populations. Additional electronic forms will be made available.	**For each population:** ▪ List and names of schemes in which the population identified faces the most barriers in accessing health services ▪ Absolute number of health schemes that the population has the most barriers in accessing ▪ Barriers faced by each population ▪ Number of barriers faced by each population ▪ Activities that can be done to remove the barriers ▪ Number and types of activities that can be done to remove the barriers	**Methods:** ▪ Desk review ▪ Secondary analysis of existing data ▪ Group discussion **Sources:** ▪ National health insurance policies ▪ Health insurance schemes ▪ National social protection administrative reports and documents ▪ Reports and documents from nongovernmental organizations and people living with HIV ▪ National social protection strategy ▪ Gender assessment reports of the AIDS response ▪ National HIV plan ▪ PEPFAR country operational plans ▪ Institute of Social Security Administration regional reports ▪ HIV and Social Protection Assessment Team (members of United Nations Joint Team on AIDS, people living with HIV, key populations)	▪ For each question, if possible conduct frequency tabulations, cross-tabulations by different variables and correlations, and illustrate the results ▪ Determine patterns and trends ▪ Identify gaps in access of health services, reasons for these gaps and what can be done to close the gaps ▪ Describe good practices ▪ Identify unexpected effects (positive and negative)

3.0 Availability of HIV-sensitive social protection schemes (excluding health schemes)

This section seeks to gather data to establish the focus and coverage of existing HIV-sensitive social protection programmes. It looks at what kinds of HIV-sensitive social protection programmes are available, their names, target populations and ages, the amount of the benefit, and the names of the implementing agencies. Data collection team members should complete this table together and indicate the sources of the information. For clarity on the terminology, please refer to the glossary of the terms.

3.10 Are any of the following programmes operational in your country? (Mark all that apply)	**3.10 Is the programme operational?**		**3.11 If yes in 3.10, write the name of the programme; otherwise skip to next row**	**3.12 What is the target population of the programme?**	**3.13 What is the age group of the target population** (list all that apply) (years) 1. (<4); 2. (5-9); 3. (10-14); 4. (15-19); 5. (20-24); 6. (25-29); 7. (30-34); 8. (35-39); 9. (40-59); 10. (>60); 11. All age groups	**3.14 What is the amount of the benefit of the programme per month?**		**3.15 What is the name of the implementing agency(ies)?**
	3.10a Yes	3.10b No				3.14a Local currency	3.14b US dollars	
1. Conditional cash transfer								
2. Unconditional cash transfer								
3. Scholarships								
4. Fee waivers								
5. Food and nutrition programmes								
6. Public works programmes								
7. Emergency support								
8. Non-contributory pensions								
9. Other regular cash payment								
In-kind schemes								
10. Housing subsidies								
11. In-school feeding								

3.10-3.15 continued

12. School block grants								
13. Teacher support								
14. Other in-kind support								
Sources (Please fill in the source of your information for each scheme below):								
1. Conditional cash transfer								
2. Unconditional cash transfer								
3. Scholarships								
4. Fee waivers								
5. Food and nutrition programmes								
6. Public works programmes								
7. Emergency support								
8. Non-contributory pensions								
9. Other regular cash payment								
In-kind schemes								
10. Housing subsidies								
11. In-school feeding								
12. School block grants								
13. Teacher support								
14. Other in-kind support								

Recall period is the past six months for all the data.

Checklist for analysis for questions 3.10–3.15: availability of HIV-sensitive social protection programmes

Questions	Checklist for analysis	Methods of data collection	Basic analysis and presentation of findings
3.10 Are any of the following programmes operational in your country?	▪ List the programmes that are operational in your country ▪ Absolute number of programmes that are operational ▪ Absolute number (and/or %) of the different categories of populations targeted	**Methods:** ▪ Desk review ▪ Secondary analysis of existing data ▪ Group discussion **Sources:** ▪ National social protection floor dialogue assessment reports ▪ National social protection policy ▪ National social protection strategy ▪ National social protection administrative reports and documents ▪ Nongovernmental organization social protection reports and documents ▪ Private-sector social protection administrative documents ▪ Gender assessment reports of the AIDS response ▪ National poverty eradication plan ▪ National HIV plan ▪ National concept note for the Global Fund to Fight AIDS, Tuberculosis and Malaria ▪ PEPFAR country operational plans ▪ Institute of Social Security Administration regional reports	▪ For each question, conduct frequency tabulations and illustrate the results ▪ Identify gaps in availability of social protection reach of the 5 populations ▪ For question 3.15, value of the benefits that can be used for secondary analysis ▪ For question 3.16, write the types, name and implementing agencies of the social protection programme; this information is relevant to understand what exists and who is implementing the programmes
3.11–3.14 What is the target population and their age group?	▪ List names of target populations and their age groups ▪ Specify the target population, e.g. men who sex with men, children, transgender people, adults, people living with HIV, migrants, adolescents, pregnant and lactating women, etc ▪ Specify the age group of the target population (years): 1. (<4); 2. (5–9); 3. (10–14); 4. (15–19); 5. (20–24); 6. (25–29); 7. (30–34); 8. (35–40); 9. (40–59); 10. (>60); 11. All age groups ▪ Absolute number (and/or %) of different population groups targeted		
3.14b What is the amount of the benefit?	▪ Specify the amount of the benefit in local currency and in US dollars at the prevailing exchange rate; where the benefit is in-kind, the group should translate the cost of the benefit in local currency and US dollars ▪ Absolute value in local currency and US dollar value of the benefit		
3.15 What is the name of the implementing agency(ies)?	▪ Names of the social protection programmes		

3.2 Access to HIV-sensitive social protection programmes excludes access to health services

This section looks at access to existing HIV-sensitive social protection programmes by five populations. It looks at most barriers encompassing policy, legal and socioeconomic that impede access to HIV-sensitive social protection programmes by the five populations. This section also looks at what can be done to remove the barriers to accessing HIV-sensitive social protection programmes for these populations.

3.2 In your country list populations that face the most barriers in accessing HIV-sensitive social protection services			
1.	2.	3.	4.
5.			
3.2b For each of the populations listed in 3.2, indicate the number of people in the population group accessing HIV-sensitive social protection benefits			
1.	2.	3.	4.
5.			
3.2c For each population listed in 3.2 and 3.2b, indicate the estimated population of this group in your country or area. (These data should be available from Modes Of Transmission (MOT) studies, census surveys, household surveys etc.)			
1.	2.	3.	4.
5.			

This subsection focuses on population 1 identified in 3.2.

3.30 This question relates to the programmes that you marked in 1.00 (mark all that apply; if none, go to question 2)	**3.30 Is population 1 indicated in 3.20 facing the most barriers in accessing programmes?** (Write the name of the population and indicate the barriers)							**3.31 What can be done to remove barriers facing population 1 identified in 3.20 in accessing HIV-sensitive social protection programmes** (list from the pull-down menu what can be done to include population 1 in social protection services)				
	3.30a Yes	3.30b No	3.30c If yes in 3.30a, list barrier 1	3.30d If yes in 3.30a, list barrier 2	3.30e If yes in 3.30a, list barrier 3	3.30f If yes in 3.30a, list barrier 4	3.30g If yes in 3.30a, list barrier 5	3.31a What (Activity 1) can be done to remove barrier 1?	3.31b What (Activity 2) can be done to remove barrier 2?	3.31c What (Activity 3) can be done to remove barrier 3?	3.31d What (Activity 4) can be done to remove barrier 4?	3.31e What (Activity 5) can be done to remove barrier 5?
1. Conditional cash transfer												
2. Unconditional cash transfer												
3. Scholarships												
4. Fee waivers												
5. Food and nutrition programmes												
6. Public works programmes												
7. Emergency support												
8. Non-contributory pensions												
9. Other regular cash payment												
In-kind schemes												
10. Housing subsidies												
11. In-school feeding												
12. School block grants												
13. Teacher support												
14. Other in-kind support												

3.30-3.31 continued

Sources (Please fill in the source of your information for each scheme below):	
1. Conditional cash transfer	
2. Unconditional cash transfer	
3. Scholarships	
4. Fee waivers	
5. Food and nutrition programmes	
6. Public works programmes	
7. Emergency support	
8. Non-contributory pensions	
9. Other regular cash payment	
In-kind schemes	
10. Housing subsidies	
11. In-school feeding	
12. School block grants	
13. Teacher support	
14. Other in-kind support	

Recall period is the past six months for all the data.

This subsection focuses on population 2 identified in 3.2.

3.40 This question relates to the programmes that you marked in 1.00 (mark all that apply; if none, go to question 2)	**3.40 Is population 2 indicated in 3.20 facing the most barriers in the programme?** (Write the name of the population and choose the barriers)							**3.41 What can be done to remove barriers facing population 1 identified in 3.20 in accessing HIV-sensitive social protection programmes** (list from the pull-down menu what can be done to include population 1 in social protection programmes)				
	3.40a Yes	3.40b No	3.40c If yes in 3.40a, list barrier 1	3.40d If yes in 3.40a, list barrier 2	3.40e If yes in 3.40a, list barrier 3	3.40f If yes in 3.40a, list barrier 4	3.40g If yes in 3.40a, list barrier 5	3.41a What (activity 1) can be done to remove barrier 1?	3.41b What (Activity 2) can be done to remove barrier 2?	3.41c What (Activity 3) can be done to remove barrier 3?	3.41d What (Activity 4) can be done to remove barrier 4?`	3.41e What (activity 5) can be done to remove barrier 5?
1. Conditional cash transfer												
2. Unconditional cash transfer												
3. Scholarships												
4. Fee waivers												
5. Food and nutrition programmes												
6. Public works programmes												
7. Emergency support												
8. Non-contributory pensions												
9. Other regular cash payment												
In-kind schemes												
10. Housing subsidies												
11. In-school feeding												
12. School block grants												
13. Teacher support												
14. Other in-kind support												

3.40-3.41 continued

Sources (Please fill in the source of your information for each scheme below):	
1. Conditional cash transfer	
2. Unconditional cash transfer	
3. Scholarships	
4. Fee waivers	
5. Food and nutrition programmes	
6. Public works programmes	
7. Emergency support	
8. Non-contributory pensions	
9. Other regular cash payment	
In-kind schemes	
10. Housing subsidies	
11. In-school feeding	
12. School block grants	
13. Teacher support	
14. Other in-kind support	

Recall period is the past six months for all the data.

This subsection focuses on population 3.

3.50 This question relates to the programmes that you marked in 1.00 (mark all that apply; if none, go to question 2)	**3.50 Is population 3 indicated in 3.20 facing the most barriers in accessing the programmes?** (Write the name of the population 3 and choose the barriers)							**3.51 What can be done to remove the barriers facing population 3 identified in 3.20 in accessing HIV-sensitive social protection programme** (list from the pull-down menu what can be done to include population 3 in social protection programmes)				
	3.50a Yes	3.50b No	3.50c If yes in 3.50a, list barrier 1	3.50d If yes in 3.50a, list barrier 2	3.30e If yes in 3.50a, list barrier 3	3.50f If yes in 3.50a, list barrier 4	3.50g If yes in 3.50a, list barrier 5	3.51a What (activity 1) can be done to remove barrier 1?	3.51b What (Activity 2) can be done to remove barrier 2?	3.51c What (Activity 3) can be done to remove barrier 3?	3.51d What (Activity 4) can be done to remove barrier 4?	3.51e What (Activity 5) can be done to remove barrier 5?
1. Conditional cash transfer												
2. Unconditional cash transfer												
3. Scholarships												
4. Fee waivers												
5. Food and nutrition programmes												
6. Public works programmes												
7. Emergency support												
8. Non-contributory pensions												
9. Other regular cash payment												
In-kind schemes												
10. Housing subsidies												
11. In-school feeding												
12. School block grants												
13. Teacher support												
14. Other in-kind support												

3.50-3.51 continued

Sources (Please fill in the source of your information for each scheme below):	
1. Conditional cash transfer	
2. Unconditional cash transfer	
3. Scholarships	
4. Fee waivers	
5. Food and nutrition programmes	
6. Public works programmes	
7. Emergency support	
8. Non-contributory pensions	
9. Other regular cash payment	
In-kind schemes	
10. Housing subsidies	
11. In-school feeding	
12. School block grants	
13. Teacher support	
14. Other in-kind support	

Recall period is the past six months for all the data.

This subsection focuses on population 4.

3.60 This question relates to the programmes that you marked in 1.00 (mark all that apply; if none, go to question 2)	**3.60 Is population 4 indicated in 3.20 facing the most barriers in accessing the programmes?** (Write the name of the population 4 and choose the barriers)							**3.61 What can be done to remove the barriers facing population 4 identified in 3.20 in accessing HIV-sensitive social protection programme** (list from the pull-down menu what can be done to include population 4 in social protection programmes)				
	3.60a Yes	3.60b No	3.60c If yes in 3.60a, list barrier 1	3.60d If yes in 3.60a, list barrier 2	3.60e If yes in 3.60a, list barrier 3	3.60f If yes in 3.60a, list barrier 4	3.60g If yes in 3.60a, list barrier 5	3.61a What (Activity 1) can be done to remove barrier 1?	3.61b What (Activity 2) can be done to remove barrier 2?	3.61c What (Activity 3) can be done to remove barrier 3?	3.61d What (Activity 4) can be done to remove barrier 4?	3.61e What (activity 5) can be done to remove barrier 5?
1. Conditional cash transfer												
2. Unconditional cash transfer												
3. Scholarships												
4. Fee waivers												
5. Food and nutrition programmes												
6. Public works programmes												
7. Emergency support												
8. Non-contributory pensions												
9. Other regular cash payment												
In-kind schemes												
10. Housing subsidies												
11. In-school feeding												
12. School block grants												
13. Teacher support												
14. Other in-kind support												

3.60-3.61 continued

Sources (Please fill in the source of your information for each scheme below):	
1. Conditional cash transfer	
2. Unconditional cash transfer	
3. Scholarships	
4. Fee waivers	
5. Food and nutrition programmes	
6. Public works programmes	
7. Emergency support	
8. Non-contributory pensions	
9. Other regular cash payment	
In-kind schemes	
10. Housing subsidies	
11. In-school feeding	
12. School block grants	
13. Teacher support	
14. Other in-kind support	

Recall period is the past six months for all the data.

This subsection focuses on the population indicated in "any other" in 3.20.

3.70 This question relates to the programmes that you marked in 1.00 (mark all that apply; if none, go to question 2)	**3.70 Is population 5 indicated in 3.20 facing the most barriers in accessing the programmes?** (Write the name of the population 5 and check the applicable reasons for exclusion)							**3.71 What can be done to remove the barriers facing population 5 identified in 3.20 in accessing HIV-sensitive social protection schemes** (list from the pull-down menu what can be done to include population 5 in social protection programmes)				
	3.70a Yes	3.70b No	3.70c If yes in 3.70a, list barrier 1	3.70d If yes in 3.70a, list barrier 2	3.70e If yes in 3.70a, list barrier 3	3.70f If yes in 3.70a, list barrier 4	3.70g If yes in 3.70a, list barrier 5	3.71a What (Activity 1) can be done to remove barrier 1?	3.71b What (Activity 2) can be done to remove barrier 2?	3.71c What (Activity 3) can be done to remove barrier 3?	3.71d What (Activity 4) can be done to remove barrier 4?	3.71e What (Activity 5) can be done to remove barrier 5?
1. Conditional cash transfer												
2. Unconditional cash transfer												
3. Scholarships												
4. Fee waivers												
5. Food and nutrition programmes												
6. Public works programmes												
7. Emergency support												
8. Non-contributory pensions												
9. Other regular cash payment												
In-kind schemes												
10. Housing subsidies												
11. In-school feeding												
12. School block grants												
13. Teacher support												
14. Other in-kind support												

3.70-3.71 continued

Sources (Please fill in the source of your information for each scheme below):	
1. Conditional cash transfer	
2. Unconditional cash transfer	
3. Scholarships	
4. Fee waivers	
5. Food and nutrition programmes	
6. Public works programmes	
7. Emergency support	
8. Non-contributory pensions	
9. Other regular cash payment	
In-kind schemes	
10. Housing subsidies	
11. In-school feeding	
12. School block grants	
13. Teacher support	
14. Other in-kind support	

Recall period is the past six months for all the data.

Checklist for analysis for questions 3.30–3.7: access to social protection programmes

Questions	Checklist for analysis	Methods of data collection	Basic analysis and presentation of findings
3.30–3.71e These questions relate to the populations identified in 3.20 as facing the most barriers in accessing particular social protection schemes **For each population, a list of the schemes to which they face barriers in accessing is indicated, followed by the reasons for the barriers and what can be done to remove each corresponding barrier** **Is population identified in 2.0 facing the most barriers in accessing particular social protection schemes that are operational, what are those barriers and what can be done to remove the barriers?** **Note:** This section has forms that need to be completed fully—one for each of the populations. Additional electronic forms will be made available.	**For each population:** ▪ Number of each population accessing social protection benefits ▪ Estimated number of each population in country or area ▪ Proportion of each population accessing schemes ▪ Schemes that the population faces the most barriers in accessing ▪ Number and names of social protection schemes that the population has the most barriers in accessing ▪ Barriers faced by each population ▪ Number of barriers faced by each population ▪ Activities that can be done to remove the barriers ▪ Number of activities that can be done to remove the barriers	**Methods:** ▪ Desk review ▪ Secondary analysis of existing data ▪ Group discussion **Sources:** ▪ National social protection floor dialogue assessment reports ▪ Modes of Transmission (MOT) studies, Demographic and Health Surveys, household surveys, etc. ▪ UNAIDS Spectrum ▪ National social protection strategy ▪ National social protection administrative reports and documents ▪ Nongovernmental organization social protection reports and documents ▪ Private-sector social protection administrative documents ▪ Gender assessment reports of the AIDS response ▪ National HIV plans ▪ PEPFAR country operational plans ▪ Institute of Social Security Administration regional reports ▪ HIV and Social Protection Assessment Team (members of United Nations Joint Team on AIDS, people living with HIV, key populations)	▪ For each question, if possible conduct frequency tabulations, cross-tabulations and correlations and illustrate the results ▪ % of each population group accessing social protection benefits (where possible, disaggregate by gender) ▪ Identify gaps in access of social protection schemes, the reasons for these gaps and what can be done to close the gaps

4.0 Coordination, management and accountability mechanisms

For social protection programmes to operate sustainably, government ownership and effective aid coordination and harmonization are critical. Different government agencies and ministries implement various aspects of social protection programmes requiring strong collaborative relationships and coordination. Where opportunities for direct representation of people working on HIV exist in social protection coordination agencies, these people should be represented in appropriate fora where they can advocate for the strengthening of the HIV sensitivity of social protection programmes. People working on the AIDS response should also be represented in health schemes under social health protection, which is often run by the ministry of health separate from other national social protection programmes. Similarly, social protection actors should be represented in national AIDS mechanisms to ensure coordination and co-programming of social protection and HIV.

4.00 Are there coordinating mechanisms for social protection in your district for social protection and health services?	**4.1 Are coordinating mechanims operational?**		**4.2 If yes in 4.1, write the name of the coordinating mechanism; otherwise skip to Health services. If no coordinating mechanism for health services exists, stop**	**4.3 If yes in 4.1, is the AIDS response represented in the coordinating mechanism?**		**4.4 If no, what can be done to include the AIDS response in the coordinating mechanism?**
	4.1a Yes	4.1b No		4.3a Yes	4.3b No	
1. Social protection						
2. Social protection						
3. Social protection						
4. Social protection						
5. Social protection						
6. Social protection						
Health services						
7. Health schemes						
8. Health schemes						
9. Health schemes						
10. Health schemes						

4.00-4.4 continued

Sources (Please fill in the source of your information for each scheme below):	
1. Social protection	
2. Social protection	
3. Social protection	
4. Social protection	
5. Social protection	
6. Social protection	
Health services	
7. Health schemes	
8. Health schemes	
9. Health schemes	
10. Health schemes	

Recall period is the past six months for all the data.

Checklist for analysis for questions 4.0–4.40: coordination, management and accountability

Questions	Checklist for analysis	Methods of data collection	Basic analysis and presentation of findings
4.00 Are coordinating mechanisms for social protection, including health financing, in your country operational?	▪ List and names of coordination and governance mechanisms of social protection, including health schemes ▪ Absolute numbers of coordinating and governance mechanisms of social protection, including health schemes	**Methods:** ▪ Desk review ▪ Secondary analysis of existing data ▪ Group discussion **Sources:** ▪ National social protection floor dialogue assessment reports ▪ National social protection policy ▪ National social protection strategy ▪ National social protection administrative reports and documents ▪ Nongovernmental organization social protection reports and documents ▪ Private-sector social protection administrative documents ▪ Gender assessment reports of the AIDS response ▪ National HIV plan ▪ PEPFAR country operational plans ▪ Institute of Social Security Administration regional reports ▪ HIV and Social Protection Assessment Team (members of United Nations Joint Team on AIDS, people living with HIV, key populations)	▪ For each question, conduct frequency tabulations and illustrate the results in a format that best conveys the information ▪ If possible, determine trends
4.2 Is the AIDS response represented in the coordinating and governance mechanisms?	▪ Names of coordinating and governance mechanisms of social protection, including health schemes, that include representation from the AIDS response ▪ Absolute number (and/or %) of coordinating and governance mechanisms of social protection that includes representation from the AIDS response		
4.4 If the AIDS response is not represented, what can be done for the AIDS response to be represented in the coordinating and governance mechanisms of social protection programmes?	▪ Actions to be done to have the AIDS response represented in the coordination and governance mechanisms		

Annex 2. HIV and social protection assessment report outline

Front page

- Title of assessment, geographical classification, name of country, name of province, name of district
- Names of people responsible for research
- Names of the HIV and Social Protection Assessment team
- Executive summary (brief summary of report, including assessment questions, methodology used, key findings, conclusions and recommendations)

Body of report

- Introduction
- Background and context
- Assessment questions
- Composition of the HIV and Social Protection Assessment team
- Methodology used
- Limitations

Main findings

- Highlight the most important findings
- Organize the findings around the assessment questions
- Use graphics, charts and tables to highlight the main findings

Conclusion

- Provide an assessment of the findings as related to the assessment questions

Recommendations

- Identify key actions emerging from the assessment that should be taken forward given the context of the district/province or country and the knowledge of the HIV and Social Protection Assessment team

References

- Indicate the documents and works that were consulted

Annex 3. Potential sources of data

- Size estimation of key populations
- Multiple Indicator Cluster Survey—women and children
- Modes of HIV transmission studies
- HIV estimates and projections
- Gender assessment reports of the national AIDS response
- National social protection floor dialogue assessment reports
- Institute of Social Security Administration regional reports (with descriptions of country-specific national social security programmes, including eligibility, funding sources, and so on)
- National social protection policy
- National social protection strategies
- National poverty eradication plans
- National HIV strategic plans
- National HIV concept notes for the Global Fund to Fight AIDS, Tuberculosis and Malaria
- Most recent Demographic and Health Survey
- AIDS Indicator Surveys
- Sentinel surveillance
- Integrated Bio-behavioural Surveillance Surveys
- Routine programme data
- Cohort studies on HIV incidence and survival
- Country research in peer-reviewed journals
- Joint programme monitoring system reports
- HIV investment cases
- Target programme evaluations
- Stigma Index
- Population census
- National Information Systems for Social Assistance
- Household budget surveys/living conditions surveys

Annex 4. Examples of social protection programmes

Country	Name of social protection scheme	Objective of scheme	Target population of programme	Entitlement of programme	Implementing agency of scheme
Brazil[2]	Bolsa Familia	Reduce poverty among poor people through conditional cash transfers targeted at developing human capital	Families with monthly per capita income less than R$ 140 (US$ 44) or less than R$ 70 (US$ 22) regardless of household composition	Families with monthly per capita income less than R$ 140 (US$ 44) receive R$ 22 (US$ 22) per child aged 14 years or younger, up to a maximum of 3 children, and another R$ 33 (US$ 10) for each child aged over 15–16 years, up to a maximum of 2 children Families with monthly per capita income less than R$ 70 (US$ 22) receive an additional R$ 68 (US$ 21) conditional on sending children to school and accessing vaccinations and other health and social services	Citizenship Income Secretariat in the Ministry of Social Development and Fight against Hunger
Cambodia[3]	Buddhist Leadership Initiative	Improve social protection for specific poor and vulnerable groups	People living with and most affected by HIV, and orphans and vulnerable children	For children: cash and in-kind transfers, and cash for transport for children living with HIV to collect antiretroviral therapy For adults: cash and in-kind transfers, and cash for transport to collect antiretroviral therapy	Ministry of Culture and Religion
China	Five Guarantees	Improve living conditions of extremely poor people (living below poverty line of 2300 RMB/month (US$ 360) in 2011)	Three "no populations"—no ability to work, no savings or income, no relatives	Subsistence expenses, health care and housing; benefits vary across regions	County civil affairs bureaus and village councils

[2] Poverty and shared prosperity in Brazil's metropolitan regions. Washington, DC: World Bank Group; 2015.
[3] A review of Cambodia's social protection schemes for incorporating HIV sensitivity. New York: United Nations Development Programme; 2013.

Country	Name of social protection scheme	Objective of scheme	Target population of programme	Entitlement of programme	Implementing agency of scheme
Ethiopia	Productive Safety Net Programme	Empower chronically food-insecure people to resist shocks, build assets and become food-sufficient	Rural people facing food insecurity and hunger	Combination of food and cash transfers are given conditional on participation of able-bodied members of the household in livelihood-strengthening activities such as land and waterways rehabilitation and infrastructure development	Disaster Risk Management and Food Security Sector in the Ministry of Agriculture
India	Indira Ghandi National Widow Pension Yojanna	Provide a minimum level of social assistance as stipulated in Article 41 of the constitution of India	Widows below the poverty line aged 40–64 years (now modified to include widows aged 18–39 years)	Monthly transfer of R 400	Ministry of Rural Development through Municipalities and Panchayats
Mexico[4]	System for Social Protection in Health ("Seguro Popular")	Reduce inequality in health and financial protection between Mexicans who have and do not have social security	Open to all Mexicans without social security; made up of 4 schemes for different benefits and targeting specific populations; Fund for Protection Against Catastrophic Expenditures, including tertiary care for childhood illnesses	1. Seguro Popular offers comprehensive primary health care and most secondary health care 2. Fund for Protection of Catastrophic Expenditures finances selected high-cost tertiary care interventions, including cancers and cardio- and neurovascular diseases 3. Health Insurance for a New Generation targets children born after 1 December 2006 4. *Embarazo Saludable* ("healthy pregnancy") targets pregnant women to access free point-of-use services for antenatal care, hospital-based, skilled birth attendance, and postpartum care	Public health facilities managed by the networks provide the benefits

[4] Mexico's social protection system in health and the financial protection of citizens without social security. Washington, DC: Human Development Department, World Bank Latin America and the Caribbean Regional Office; 2012.

Country	Name of social protection scheme	Objective of scheme	Target population of programme	Entitlement of programme	Implementing agency of scheme
Nigeria[5]	Girls Education Programme	Encourage enrolment and retention in primary and junior secondary schools and improve learning outcomes for target girls in the 10 northern states of Nigeria		Conditional cash transfers to poor families; advocacy work with traditional leaders, parents and Islamic teachers; female teacher scholarships and school-based management committees	Federal Ministry of Education and UNICEF (State Ministry of Education and State Universal Basic Education Board)
South Africa	Child Support Grant	Addresses high levels of poverty and inequality post-apartheid	All children aged 0–18 years whose families meet minimum means-tested eligibility criteria		South African Social Security Agency in the Department of Social Development
United Republic of Tanzania[6]	Public Works Programme	Provides cash income to beneficiaries through employment in approved infrastructure construction and rehabilitation projects	Labour-able poor households	A wage that is 20% below prevailing market wage for unskilled labour (self-selection targeting criteria)	Public Works Programme Division of the Tanzania Social Action Fund Management Unit

[5] Samuels F, Blake C, Akinrimisi B. HIV vulnerabilities and the potential for strengthening social protection responses in the context of HIV in Nigeria. London: Overseas Development Institute; 2012.
[6] Tanzania Social Action Fund (TASF) Public Works Programme Handbook. Dar es Salaam: Tanzania Social Action Fund; 2003.

Annex 5. Draft HIV and social protection assessment workshop agenda

[venue and city of assessment]
Day 1: [date]

Time (hours)	Activity
09.00–09.30	**Remarks—national AIDS council** ▪ Welcome and remarks by national AIDS council. ▪ Remarks from civil society organization representing people. living with HIV and key populations. ▪ Remarks from UNAIDS Country Director. ▪ Opening remarks by minister of social services.
09.30–10.30	**Workshop objectives—national AIDS council** ▪ Country situation of HIV/AIDS and monitoring and. evaluation—national AIDS council. ▪ Country situation of social protection—ministry of social protection. ▪ Country situation of people living with HIV and key. populations—representative of people living with HIV. ▪ **Questions and discussion**
10.30–11.00	**Coffee break**
11.00–12.30	▪ Global and regional perspective on social protection and HIV and evidence and policy implications for Fast-Track—UNAIDS Co-sponsor. ▪ Examples of good practice on HIV and social protection—civil society organization. ▪ Examples of good practice on HIV and social protection—UNAIDS. ▪ **Questions and discussion**
12.30–14.00	**Lunch**
14.00–15.30	**Evidence of social protection for HIV prevention and treatment** ▪ Social protection cash + care for adolescents. ▪ HIV-sensitive social protection for key populations. ▪ Social protection and emerging evidence on HIV prevention and treatment—UNAIDS Co-sponsors.
15.30–16.00	**Coffee break**
16.00–16.45	Introduction to HIV and Social Protection Assessment Tool.
16.45–17.00	Hand out printed tool for familiarization and information collection—homework.

Day 2: [date]

Time (hours)	Activity
09.00–09.30	**Recap of day 1**
09.30–10.30	**Group work** ▪ **Completing the HIV and Social Protection questionnaire electronically.**
10.30–11.00	**Coffee break**
11.00–12.30	**Group work** ▪ **Continue completing the questionnaire electronically.**
12.30–14.00	**Lunch**
14.00–15.30	**Group work** ▪ Continue completing the questionnaire electronically.
15.30–16.00	**Coffee break**
16.00–16.30	**Presentation of summary report** (Summary report will be generated automatically once completed questionnaire is electronically submitted). ▪ Questions and discussion. ▪ Way forward—UNAIDS/Ministry of Social services /national AIDS council/civil society organization.
16.30–17.00	**Closing remarks** ▪ Civil society organization representative. ▪ UNAIDS Country Director. ▪ Ministry of social services. ▪ National AIDS council director.

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