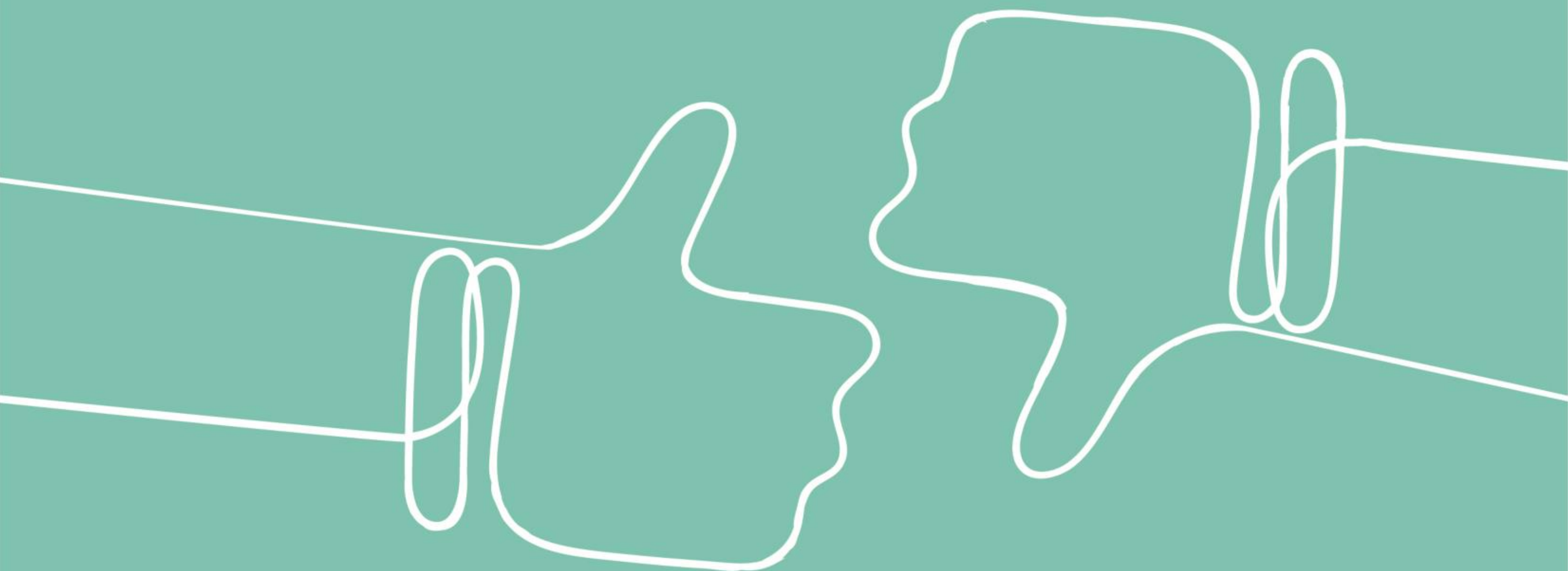
UNAIDS

An Evaluation of the work of the Joint Programme on HIV and Social Protection

Report



December 2023 | UNAIDS Evaluation Office

Disclaimer

This report has been authored by Ampersand Creative Laboratory. The views expressed in this report are those of the evaluators. They do not represent those of UNAIDS Secretariat or of any of the individuals or organisations referred to in the report. This is an independent publication by the UNAIDS Evaluation Office.

Any enquiries about this evaluation should be addressed to: Evaluation Office, UNAIDS; Email: evaluation@unaids.org

The report and related evaluation products are available at http://www.unaids.org/en/whoweare/evaluation

Copyright © 2023
Joint United Nations Programme on HIV/AIDS (UNAIDS)
All rights reserved.

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of UNAIDS concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. UNAIDS does not warrant that the information published in this publication is complete and correct and shall not be liable for any damages incurred as a result of its use.

UNAIDS/JC2996

Acknowledgements

The UNAIDS Evaluation Office would like to express its gratitude to the evaluation team for conducting the evaluation of the work of the UNAIDS Joint Programme on social protection. The Evaluation Office extends its appreciation to all stakeholders who provided inputs to the evaluation. The Office would particularly like to acknowledge the contributions of colleagues and partners in the eight countries where data was collected – Benin, China, the Dominican Republic, Fiji, Ghana, Malawi, Morocco and Peru.

The evaluation covered the work of the UNAIDS Joint Programme to promote HIV-sensitive social protection and was jointly managed by the evaluation offices of UNAIDS, WFP, ILO and UNICEF. Findings point to several challenges that hinder the efficient and effective delivery, monitoring, and scale-up of HIV-sensitive social protection programmes.

Key recommendations highlight the need (i) to strengthen the collaboration between the UNAIDS Secretariat and the Cosponsors on advocacy, data generation, knowledge translation and training related to HIV-sensitive social protection, and; (ii) to enhance efforts to increase access of key populations – especially sexual and gender minority populations and people who use or inject drugs – to social protection services.

We hope that the findings and recommendations will be helpful in guiding continued efforts to integrate HIV into social protection programmes.

UNAIDS Evaluation Office

Evaluation management (UNAIDS Evaluation Office)

Elisabetta Pegurri, UNAIDS Evaluation Office
Alexandra Chambel, WFP Evaluation Office
Craig Russon, ILO Evaluation Office
Beth Ann Plowman, UNICEF Evaluation Office

Evaluation Reference Group

Kofi Amekudzi, ILO
Helene Badini, UNAIDS
Ludo Bok, UNDP
Georgina Caswell, GNP Plus
David Chipanta, UNAIDS
Corinna Csaky, Children and HIV
Charlotta Feitscher, UNAIDS
Kenny Kintu Ivan, African Young Positives Network
Juan Jaramillo, WFP
Rikke Le Kirkegaard, UNICEF
Cedric Nininahazwe, Y+ Global
Bettina Schunter, UNICEF
Michael Smith, WFP
Omar Syarif, GNP Plus
Aditia Taslim, International Network of People who Use Drugs
Katherine Ward, World Bank
Rachel Yates, Accelerate Hub

Country Evaluation Leads/Team Members

Benin, Agnès Fiamma Papone and Lisa M. Butler
China, Jinglin He
Dominican Republic, Julia Hasbún and Lisa M. Butler
Fiji, Leaine Robinson
Ghana, Marian Honu
Malawi, Lusizi Kambalame and Hasina Ndeketa
Morocco, Aitor Pérez
Peru, Soledad Gallego and Ignacio Garay

Evaluation Team

Lisa M. Butler, Aitor Pérez, Greg Szekeres

Evaluation Social Protection Advisors

Lucie Cluver, Oxford University
Michael Samson, Economic Policy Research Institute

Evaluation Team Assistants

Brooke Hunsacker, Bailey Milne, Mackenzie Powell, Raksha Rajeshmohan, Jennifer Sarche, Phoebe Yang

Table of Contents

Executive Summary 6
1. Introduction 14
2. Methods 23
2.1. Evaluation approach 23
2.2. Evaluation criteria and questions 24
2.3. Data collection at the global level 26
2.4. Country studies 27
Asia and the Pacific 28
Eastern and southern Africa 29
Latin America and the Caribbean 29
Middle East and North Africa 30
Eastern Europe and central Asia 30
West and Central Africa 31
In-country data collection 31
2.5. Quality control, analysis and reporting 32
3. Main findings 34
3.1. Relevance and coherence 34
3.2. Effectiveness 38
3.3. Efficiency 46
3.4. Equity 47
3.5. COVID-19 50
4. Conclusions 52
5. Recommendations 57
References 59
Annexes 66
Annex I: Matrix 66
Annex II: Tools 70
Tool 1. Field mission questionnaire: UNAIDS and Cosponsors 70
Tool 2. Field mission questionnaire: National counterparts 71
Tool 3. Field mission questionnaire: CSOs, key population representatives and other partners 72
Tool 4. Global and regional document review: Operationalization of evaluation questions 74
Tool 5. Country document review: Operationalization of evaluation questions 75
Tool 6. Global and regional key informant interviews: Operationalization of evaluation questions 76
ANNEX III: List of interviews 77
ANNEX IV: Social protection indicators and legal barriers 85
IV.1 Social protection indicators 85
IV.2 Development indicators and legal barriers to HIV-sensitive social protection 86
Annex V: Revisiting UNAIDS ToC on HIV-sensitive social protection 87

Acronyms and abbreviations

AGYW	Adolescent girls and young women
AIDS	Acquired immunodeficiency syndrome
AMO	Assurance Maladie Obligatoire – Morocco
ART	Antiretroviral therapy
CAFNGO	China AIDS Fund for Non-Governmental Organizations
CHeRA	Community Health Rights Advocacy – Malawi
CONAMUSA	La Coordinadora Nacional Multisectorial en Salud – Peru
CONAVIHSIDA	Consejo Nacional para el VIH y el SIDA – Dominican Republic
COWLHA	Coalition of Women Living with HIV – Malawi
CSO	Civil society organization
DREAMS	Determined, Resilient, Empowered, AIDS-free, Mentored and Safe
EMTCT	Elimination of mother-to-child transmission
EQ	Evaluation question
FAO	Food and Agriculture Organization
FSWA	Female Sex Workers Association – Malawi
GAC	Ghana AIDS Commission
HIV	Human immunodeficiency virus
HSSS	HIV Sentinel Surveillance System
ILO	International Labour Organization
IOM	International Organization for Migration
ISPA	Inter-agency Social Protection Assessments
JPMS	Joint Programme Monitoring System
KI	Key informant
KII	Key informant interview
LGBTQIA+	Lesbian, gay, bisexual, transgender, queer, intersex, asexual and other extensions
LI	Low income
LITE	Lesbian, Intersex, Transgender and other Extensions - Malawi
LMI	Lower middle income
LMIC	Low- and middle-income country
MANASO	Malawi Network of Aids Service Organisations
MANET+	Malawi Network of People Living with HIV
MNSSPII	Malawi National Support Programme II
MoH	Ministry of Health
MOHRSS	Ministry of Human Resources and Social Security – China
MOHSP	Ministry of Health and Social Protection – Morocco
NACS	Nutrition assessment, counselling and support
NEEF	National Economic Empowerment Fund – Malawi
NGO	Nongovernmental organization
OGAC	Office of the Global AIDS Coordinator and Health Diplomacy
PAHO	Pan American Health Organization
PEPFAR	US President’s Emergency Action Plan for AIDS Relief

PNAPS	National Psychological and Social Support Programme – Morocco
PNSF	Programme National de Solidarité Famille – Djibouti
PPS+VIH	Programme for Social Protection of People Living with HIV/AIDS – Dominican Republic
PROSA	Programma de Soporte a la Autoayuda de Personas Seropositivas – Peru
RAMED	Regime d'Assistance Medicale – Morocco
RBM	Results-based management
SCTP	Social Cash Transfer Programme – Malawi
SDG	Sustainable Development Goals
TB	Tuberculosis
ToC	Theory of change
ToR	Terms of reference
UBRAF	Unified Budget, Results, and Accountability Framework
UCO	UNAIDS Country Office
UMI	Upper middle income
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNCT	UN Country Team
UNDAF	UN Development Assistance Frameworks
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNSDCF	United Nations Sustainable Development Cooperation Frameworks
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
USAID	United States Agency for International Development
WB	World Bank
WFP	World Food Programme
WHO	World Health Organization
WNAC	Women's Network Against AIDS – China

Executive Summary

Social protection is defined as the system of policies and programmes designed to reduce and prevent poverty, vulnerability and social exclusion across the life cycle. Social protection encompasses social assistance interventions, including cash and in-kind transfers, public works and fee waivers; social insurance, including contributory pensions and other social insurance; and labour market interventions, including training, wage subsidies and unemployment benefits.

HIV-sensitive social protection measures help mitigate the social and economic impacts of HIV on households and individuals, and increase access to prevention, treatment, care and support for people affected by or vulnerable to HIV.[1] There is now strong evidence that social protection measures can reduce vulnerability to HIV infection, improve and extend the lives of people living with HIV, and support individuals and families.[2–19]

Consequently, the *Global AIDS Strategy 2021–2026*[20] prioritizes resourcing and sustaining HIV responses that are integrated into systems for social protection (Strategic Priority 3).[20] *The 2022–2026 Unified Budget, Results and Accountability Framework* (UBRAF) operationalizes HIV-sensitive social protection under Result Area 9 and foresees support to country stakeholders to strengthen inclusive systems for social protection. Such support includes knowledge production and dissemination, capacity building, community engagement and advocacy.

As part of the 2022–2023 United Nations Programme on HIV/AIDS (UNAIDS) evaluation plan approved by UNAIDS Programme Coordinating Board (PCB) in December 2021, this area of work has been assessed by an external independent evaluation team against standard evaluation criteria (relevance, coherence, effectiveness, efficiency and equity). The assessment has covered activities related to HIV-sensitive social protection conducted by the UNAIDS Secretariat and Cosponsors (referred to as the Joint Programme) from 2018 to December 2022, with a focus on nine countries selected for their broadness and diversity of the UNAIDS geographic scope. This document is the result of this evaluation process. It starts by further defining the evaluation subject and providing a visual overview of its rationale by means of a theory of change (ToC) diagram (section 1). Then, the report presents the evaluation methodology, including its overall approach, criteria and questions, as well as details of the design and implementation of the various evaluation methods (section 2). The evaluation findings are presented by criteria and questions (section 3). Finally, the report concludes with an assessment of the work of the Joint Programme on HIV-sensitive social protection and a series of actionable recommendations for future work.

Evaluation approach and methodology

Theory-based evaluation

As part of the Theory of Change (ToC) development process, the evaluation team developed a series of assumptions about how change is expected to happen. The assumptions were tested in different country settings, using a mixed-methods approach. The ToC represents the evaluation's overarching analytical framework, and informs the evaluation matrix (assumptions, indicators and data sources, as well as tools for data collection, question guides and case study reporting). The finalized evaluation questions (see Annex I) were mapped to the ToC.

It is recognized that the role played by the Joint Programme in any country must be tailored to the social and political context, and the nature of the epidemic in each setting. Therefore, the contribution of the Joint Programme is expected to differ by country—for example, the Joint Programme may support different types of activities, engage with different partners and focus on different key populations or other groups, but always within the programming bounds established in the overall ToC. This awareness was important during data collection, as well as in the interpretation and reporting of findings.

The reconstructed ToC depicts the overall ToC for Joint Programme support for HIV-sensitive social protection. The ToC illustrates the collaboration and mutually reinforcing nature of the Joint Programme's work in HIV-sensitive social protection. In developing the ToC, the evaluation team considered the activities and outputs of the Strategy and associated UBRAF:

- Intermediate outcomes aligned to the Strategic Results Areas of the *2016–2021 Strategy* and UBRAF and Results Areas of the new *2021–2026 Strategy* and 2022–2026 UBRAF.
- The 2021–2026 Strategic Priority Outcome areas, to help identify gaps influencing progress towards the new outcomes and, ultimately, impact.
- Activities from the *2016–2021 Strategy* and UBRAF were compared to those in the more recent versions of these documents to ensure the activity areas are relevant.
- Strategic priorities from the *2016–2021 Strategy* and UBRAF were compared to those in the more recent versions to ensure general alignment of priorities.
- The assumptions of change that the evaluation examined are not included in the ToC but are articulated and presented in the evaluation matrix (Annex I).
- The evaluation questions (Annex I) are mapped to the ToC to demonstrate linkages between the evaluation questions and the ToC.

Utilization-focused evaluation

The results of this evaluation are expected to be used by the Joint Programme to inform decisions regarding HIV-sensitive social protection initiatives and programmes globally, regionally and nationally. It is a utilization-focused evaluation that will enable global, regional and country-based stakeholders to reflect on the relevance, coherence, effectiveness, efficiency and equity of the work of the Joint Programme on HIV-sensitive social protection.

In this evaluation, the primary users of the evaluation are members of the Joint Programme and partners that play a significant role in the international response of scaling up HIV-sensitive social protection and comprehensive care and support. The evaluation management and reference groups were involved in the design of the evaluation from the development of the ToR, and reviewing and commenting on iterations of the inception report and informing key methodological decisions, such as the choice of countries for inclusion in in-country data collection. Some other evaluation users were also consulted via individual interviews and discussions throughout the inception stage.

Evaluation Criteria and Questions

Criteria

The evaluation examined the strategic priorities and work of the Joint Programme based on a prioritized selection of ten questions against standard evaluation criteria:[21]

Relevance: Examines the extent to which the Joint Programme of support is consistent with country needs.

Coherence: Examines the extent to which the Joint Programme's work supports or undermines other actors' interventions and vice versa. Coherence includes complementarity, harmonization and coordination within and beyond the Joint Programme.

Effectiveness: Assessment of the extent to which Joint Programme's interventions have achieved or are expected to achieve objectives and intended results. Special attention was paid to this criterion, focusing on outcomes and impacts in line with results-based management (RBM) principles applied in UN agencies.

Efficiency: Assessment of how well the Joint Programme is using available resources.

Equity: The evaluation also considered the cross-cutting issues of equity, gender equality and human rights, following guidance provided by the United Nations Evaluation Group, and the analysis

assessed the extent to which Joint Programme-supported interventions contribute to addressing inequalities.

Questions

Following the development of the ToC, evaluation questions (EQs) were prioritized and refined from the list provided in the ToR.

Relevance and coherence:

- EQ1 To what extent is the role of the Joint Programme in social protection aligned with its overall mandate and strategy?
- EQ2 How relevant are the Joint Programme guidance and efforts to integrating HIV into national social protection systems, and how connected to national systems are they?

Effectiveness:

- EQ3 To what extent are partners involved in the advancement of HIV-sensitive social protection; what roles do partners play; and how can partnerships with and the capacity of stakeholders (civil society, government, others) be strengthened further?
- EQ4 What models or instruments for HIV-sensitive social protection are feasible and available in resource-constrained environments, and what are the gaps relevant to the Joint Programme's work?
- EQ5 To what extent has the Joint Programme contributed to HIV (and, to a certain extent, TB) integration into national social protection programmes? What are the contributing and/or hindering factors for this integration?

Efficiency:

- EQ6 How well equipped is the Joint Programme to effectively contribute to HIV-sensitive social protection and what should its role be going forward?
- EQ7 How effectively is the (UNAIDS) HIV and Social Protection Assessment Tool (and related tools by other agencies) used to link people living with, at risk of or affected by HIV to social protection services?
- EQ8 How effective is the Joint Programme in supporting the regional initiatives on HIV-sensitive social protection?

Equity:

- EQ9 What are the main contributions of the Joint Programme to increasing access and coverage of HIV-sensitive social protection, including for key populations?

COVID-19:

- EQ10 What key lessons have emerged from government- and community-led COVID-19-related social protection services supported by the Joint Programme?

Matrix

A full evaluation matrix was developed and is presented in Annex I. The matrix includes: (1) evaluation questions; (2) the corresponding evaluation criteria; (3) assumptions underlying the evaluation questions; (4) indicators; and (5) sources of data and information, both quantitative and qualitative. The evaluation was conducted with the aim of contributing to the strategic assessment and future planning of HIV-sensitive social protection initiatives, programmes and/or activities to strengthen their reach and the inclusion of people living with, at risk of or affected by HIV, including key populations. In this respect, the assessment ends with a series of actionable recommendations to the Joint Programme for maximizing the contribution to HIV-sensitive social protection, taking stock

of what is working well (best practices), what the Joint Programme should stop doing or do less of, and where efforts are needed to address existing gaps.

The evaluation assesses the work of the Joint Programme in HIV-sensitive social protection over the period 2018 to 2022, in the framework of the *UNAIDS 2016–2021 strategy* and 2016–2021 UBRAF. It covers the work of the Joint Programme at the global level by drawing on information available in reports published on its overall work by UNAIDS, its Cosponsors, or as the Joint Programme, interviews with key informants at the global level, and conducting data collection in countries in several world regions that, together, represent the broadness and diversity of the work of the Joint Programme.

Conclusions

Assessment against evaluation criteria

Relevance and coherence

I. The rationale of HIV-sensitive social protection from the perspective of the AIDS global response remains unquestioned: social protection programmes help to mitigate the social and economic impacts of HIV on individuals, their families and households, as well as to reduce HIV-infection risk, particularly for the most vulnerable populations. Therefore, such programmes are an essential part of the response to HIV and AIDS in all countries, independent of HIV prevalence or incidence. Effective and inclusive HIV-sensitive social protection programmes help to keep prevalence and incidence low (by reducing inequalities that exacerbate vulnerabilities), and help to mitigate the social and economic impacts when HIV prevalence and/or incidence are high.

II. However, people living with, at risk of and affected by HIV, including key populations, often face additional barriers to accessing social benefits that are already scarce in low- and middle-income countries. In this light, the Joint Programme has been assigned the responsibility of promoting and supporting the implementation of policies, programmes and activities to increase access for people living with, at risk of and affected by HIV to social protection. Despite the complexity of this responsibility**, it can be concluded that the Joint Programme is in a unique position to work towards this goal**. The collaboration and coordination of efforts among these organizations are essential in ensuring that HIV-sensitive social protection programmes are integrated into national health, education and social protection systems, adapted to social and policy contexts of each country.

III. In global and country-level key informant interviews, stakeholders reported positive perceptions about the multisectoral approach of the Joint Programme and its contributions to the advancement of programmes, strategies and policies relevant to the needs of people living with, at risk of and affected by HIV, including key populations**. It was recognized that the Secretariat has historically played an effective and visible role, though was not viewed as being at the forefront of social protection. ILO, UNICEF and WFP were recognized as lead agencies in social protection activities at the global and country level. And further, it was recognized that the World Bank also has an extensive portfolio of relevant social protection programming around the globe.** That said, Cosponsors themselves demand involvement of the UNAIDS Secretariat as a coordinator and to help ensure that general social protection programmes are HIV-sensitive. Additionally, relevant global KIs emphasized that **the absence of staff at the global-level office of the UNAIDS Secretariat dedicated to social protection signifies that UNAIDS is not prioritizing this agenda** and may not be able to continue to play such a role. **The UNAIDS Secretariat can play a key catalytic role in ensuring the investments of Cosponsors are inclusive of people affected by HIV.**

Additionally, the lack of awareness and ownership at country level on methodologies and data provided by UNAIDS Secretariat at HQ level undermine their relevance and effectiveness. Methodological developments like the HIV and Social Protection Assessment Tool[22] need to be balanced with efficient training and timely dissemination of results. Similarly, the indicators and data used to monitor progress towards HIV-sensitive social protection at the global level are not

known by UCOs and have not guided their planning and monitoring of social protection activities.

IV. In general, the work of the Joint Programme aligns well with national priorities, plans and strategies related to HIV prevention, care and treatment. This alignment is facilitated by close collaboration among UN agencies, national governments and donors. However, in most cases, **national social protection systems do not explicitly indicate people living with, at risk of or affected by HIV as populations that should have equitable access to social protection benefits, despite evidence of and confirmation by country informants of the existence of stigma-related barriers for people living with HIV and key populations to access social protection**. This highlights an important gap in broader social protection services.

V. At the same time, country missions revealed that the UNAIDS Secretariat and its Cosponsors have important relationships with governments and experience in providing technical assistance to strengthen national capacity to deliver health and social services for people living with, at risk of or affected by HIV. The UNAIDS Secretariat in particular is found to be uniquely placed to engage with CSOs and to coordinate efforts between those organisations, governments and other partners to build strong national social protection systems. Multisectoral partnerships are essential to the development and implementation of HIV-sensitive social protection programmes. **The UNAIDS Secretariat and its Cosponsors, researchers and civil society are uniquely organized to produce new evidence, to understand vulnerability in the context of HIV, to use evidence to define norms and standards, and to bridge evaluation and research findings with policy and practice.**

Effectiveness

VI. Progress towards HIV-sensitive social protection worldwide reported in the JPMS Monitoring System was not validated by the evaluation. More precisely, the target established in the 2016–2021 UBRAF (70% of reporting countries with HIV-sensitive social protection strategies by 2020) was met, according to country government self-reporting data provided to the Joint Programme. However, evaluation field missions revealed that data on their effective coverage is generally lacking, and Joint Programme monitoring data are not consistently used as a basis to plan and follow up at the country level in terms of social protection. Moreover, HIV-sensitive social protection is not a well-established area of the Secretariat's work at country level, nor is its conceptual definition and scope clear to all key stakeholders.

VII. This said, in many countries reporting to the JPMS and in all countries where field missions were conducted, evidence was found on how the **Joint Programme members have been effective in addressing concrete discriminatory practices, as well as barriers that exclude people living with, at risk of or affected by HIV, often by means of joint initiatives and collaboration across agencies.** Through advocacy, the programme has promoted fair employment practices in some settings and supported livelihoods and food security interventions to reduce the multiple impacts of poverty. Indeed, several initiatives have been proposed as models for HIV-sensitive social protection in resource-constrained environments, including a chronic illness marker in cash-transfer programmes in Malawi; an assessment of food security and vulnerability of HIV-affected households in Ghana; a country-wide psycho-social support programme acting as a social mediation network in Morocco; and analyses of employment, income and social protection focused on discriminatory employment-related practices for people living with HIV in poverty-stricken areas of China.

VIII. Positive feedback on the UNAIDS Secretariat's advocacy work on HIV-sensitive social protection was collected in all field missions, although such work was described in very different ways. In some countries, it was related to general advocacy on human rights and addressing discrimination and criminalization of key populations. In other countries, it consisted of seeking connections between food security and HIV programmes, or in advocating for effective coverage of free HIV treatment. This may reflect different needs and understanding of HIV-sensitive social protection in the very different country contexts in which people living with, at risk of and affected by HIV, including key populations, live.

IX. Despite promising advances, reports from stakeholders, especially country-level Joint Programme members and those from CSOs, indicate that there is room for improvement, particularly in terms of explicitly including HIV-sensitive social protection in national policies and programmes. In particular, there is strong agreement on the need to revisit the UNAIDS HIV and Social Protection Assessment Tool. **The tool was completely unknown by KIs in most countries; alternative tools and methods are used to assess HIV-sensitivity of social protection programmes**. Moreover, in countries where the tool was used, most respondents representing national stakeholders were unaware of the assessment tool. Respondents who were familiar with the tool described it as cumbersome, and indicated that the training is too lengthy and costly; it requires adaptation by national experts before use. Effective free access to ART cannot be taken for granted. Monitoring of such access is not only relevant for the Joint Programme's work on HIV treatment, but it can also improve its strategic positioning in HIV-sensitive social protection, and thus, improve overall effectiveness.

X. The UNAIDS Secretariat and its Cosponsors have established partnerships and collaborations with organizations, networks and civil society groups in all regions. However, across country-level informants, there was **little to no awareness of regional activities related to HIV-sensitive social protection.**

Efficiency

XI. Mixed evidence was found on the capacity of the Joint Programme to effectively enhance HIV sensitivity in social protection systems across countries. In some countries, it was highlighted that **UNAIDS Country Offices lack the resources to effectively engage in national social protection systems while in other countries, informants noted that capacities distributed across the Cosponsors have a great potential**.

XII. According to global informants, the potential for a significant impact in the area of HIV-sensitive social protection has been compromised by reductions in available funding to the Joint Programme globally, regionally and nationally. **Staff reductions across agencies, including the UNAIDS Secretariat, has compromised the potential influence of the Joint Programme in this area**. Further, it has affected the general outlook of staff, especially at global and regional levels, as they valued the expertise in HIV-sensitive social protection that was previously provided by staff at the UNAIDS Secretariat. In more general terms, lack of data and conceptual precision hinders planning and monitoring of HIV-sensitive social protection work at country level.

Equity

XIII. From an equity perspective, at global and country level, respondents indicated a strong commitment to promoting social protection for marginalized and other vulnerable populations. Further, it was emphasized that there must be a continued focus on ensuring that strategies are inclusive of key populations—including youth, sexual and gender minority populations, adolescent girls and young women, and people who use or inject drugs—and are responsive to country-specific challenges (e.g., recurrent climate-related emergencies, legalized oppression of certain groups). On this note, it must be emphasized that the **key populations most often cited in country reports as being left behind were sexual- and gender-minority populations, especially transgender people. To note, HIV-sensitive measures found in this evaluation referred broadly to people living with HIV and did not put a concrete focus on these population groups.**

COVID-19

XIV. The COVID-19 crisis added pressure to Joint Programme resources, public finances and livelihood strategies, but it also put social protection on many governments' agendas and improved governments' knowledge about and partnerships on social protection services. In this context, opportunities for social protection reform arise and such opportunities could also be taken to advocate for an explicit focus and increased sensitivity to HIV. The COVID-19 crisis has forced governments and international partners to improvise concrete social protection

measures, while providing momentum to broader expansions. However, many COVID-19-responsive social protection programmes are not being continued.

Recommendations

Based on the evaluation conclusions, good practices and lessons learnt, a series of recommendations are provided below to the Joint Programme (UNAIDS and Cosponsors) for maximizing its contribution to HIV-sensitive social protection. These recommendations are meant to be actionable and include indications of responsibilities and suggested timelines and are expressed in such a way that they can be costed by the Joint Programme.

Global level

1. Clarify the future of the **social protection position** at the UNAIDS Secretariat and consider its inclusion in a broader area of work of the Secretariat, such as in eliminating stigma and discrimination, and its connection with the data department (Linked to conclusions I, II, IV, XI, XII and XII).
2. Articulate a **common understanding** of HIV-sensitive social protection as an area of work of the Joint Programme, and reinforce the roles of the UNAIDS Secretariat and each of its Cosponsors in the implementation and evaluation of efforts in supporting all HIV-vulnerable groups through sustained linkage to available social protections (Linked to conclusions III, IV, XII).
3. In collaboration with UCOs and national stakeholders, promote ownership of the monitoring of HIV-sensitive social protection, and the use of the related data for planning and monitoring actions at the country level. Identify and leverage existing survey mechanisms to extract or embed **monitoring indicators**; utilise these data to provide evidence of the Joint Programme's impact on HIV-sensitive social protection. Where possible, disaggregate data by key population and other priority populations. Disaggregation will provide insights into the inequalities faced by different groups and their level of access to different social protections (Linked to conclusion VI).
4. In collaboration across Joint Programme organisations, **review the UNAIDS Social Protection Assessment Tool** and revise guidance for its implementation to optimise efficiency, as well as guidance for data analysis and use. For the sake of sustainability and considering implementation challenges in the past, the review should consider integration in other tools designed and systematically applied by Joint Programme Cosponsors or more broadly across relevant UN agencies (Linked to conclusions VI, and IX).
5. In collaboration with Regional Support Teams, establish geographic priorities for the work of the Joint Programme in HIV-sensitive social protection on the basis of challenges (e.g., high prevalence, criminalization) and opportunities (e.g., social protection reform and expansion). Enhance **collaboration** across Joint Programme agencies in those regions and/or countries (Linked to conclusions III, IV, V and X).
6. The Joint Programme must explore all opportunities to engage with social protection programmes, policies, schemes, conferences, etc., to ensure that HIV concerns are highlighted. This recommendation is applicable at the global, regional and country levels. (Linked to conclusions III, IV, V, X and XIV).

Regional level

7. Once concepts and tools have been revised, tap into opportunities at the regional level (facilitated by the Regional Support Teams) to provide training in HIV-sensitive social protection, with a view **to strengthening existing HIV and social protection expertise at the country level among UCOs, CSOs, government and other partners, including the development of various skillsets required, and the matching of skills to contexts and programme aims** (Linked to conclusions IX, VI, IX and X).

National level

8. UCOs should concentrate efforts in **advocacy** on improved accessibility of social protection and provision of appropriate and adequate benefits and programmes for people living with, at risk of or affected by HIV, including key population groups (including sexual- and gender-minority populations, people who use or inject drugs, and youth), in connection with broader advocacy work on universal social protection (Linked to conclusions IV and VIII).
9. UCOs, in collaboration with Joint Programme agencies in country, should engage national social protection programmes and advocate for the voices of key and vulnerable populations to be included at all stages in the conceptualization, design, analysis, planning, implementation, monitoring and evaluation of social protection schemes at the country level (Linked to conclusion XIII).
10. UCOs, in collaboration with Joint Programme agencies in country, should engage representatives of key and other vulnerable populations, including groups that are most neglected in the country, to identify barriers to accessing available social protections and to collaborate in finding appropriate solutions (Linked to conclusions IV, V, XIII and XIV).
11. UCOs should provide **technical support and other resources to CSOs** to enhance their role in documenting coverage and access to social protection programmes and to removing barriers among community members across the life course (Linked to conclusions IV, V, VI and XIV).

1. Introduction

Social protection is defined as the system of policies and programmes designed to reduce and prevent poverty, vulnerability and social exclusion across the life cycle. Social protection encompasses social assistance interventions, including cash and in-kind transfers, public works and fee waivers; social insurance, including contributory pensions and other social insurance; and labour market interventions, including training, wage subsidies and unemployment benefits.

HIV-sensitive social protection measures help mitigate the social and economic impacts of HIV on households and individuals, and increase access to prevention, treatment, care and support for people affected by or vulnerable to HIV.[1] There is now strong evidence that social protection measures can reduce vulnerability to HIV infection, improve and extend the lives of people living with HIV, and support individuals and families.[2–19]

Consequently, the *Global AIDS Strategy 2021–2026* [20] prioritizes resourcing and sustaining HIV responses that are integrated into systems for social protection (Strategic Priority 3).[20] The 2022–2026 Unified Budget, Results and Accountability Framework (UBRAF) operationalizes HIV-sensitive social protection under Result Area 9 and foresees support to country stakeholders to strengthen inclusive systems for social protection. Such support includes knowledge production and dissemination, capacity building, community engagement and advocacy.

As part of the 2022–2023 UNAIDS evaluation plan approved by UNAIDS Programme Coordinating Board in December 2021, this area of work has been assessed by an external independent evaluation team against standard evaluation criteria (relevance, coherence, effectiveness, efficiency and equity). The assessment has covered activities related to HIV-sensitive social protection conducted by the UNAIDS Secretariat and Cosponsors from 2018 to date, with a focus on nine countries selected for their broadness and diversity of the UNAIDS geographic scope. This document is the result of this evaluation process. It starts by further defining the evaluation subject and providing a visual overview of its rationale by means of a theory of change (ToC) diagram (section 1). Then, the report presents the evaluation methodology, including its overall approach, criteria and questions, as well as details of the design and implementation of the various evaluation methods (section 2). The evaluation findings are presented by criteria and questions (section 3). Finally, the report concludes with an assessment of the UNAIDS work on HIV-sensitive social protection and a series of actionable recommendations for future work.

Evaluation subject

Social protection

Social protection refers to the system of policies and programmes that aim to minimize and prevent poverty, vulnerability and social exclusion throughout all stages of life. Social protection includes nine main areas: benefits for children and families, protection during pregnancy, unemployment support, employment injury benefits, sickness benefits, health protection, benefits for the elderly, disability benefits and survivors' benefits.[23] Social protection systems address all of these policy areas by a mix of contributory schemes (primarily social insurance) and noncontributory, tax-financed schemes (universal/categorical schemes and social assistance).

HIV-sensitive social protection

HIV-sensitive social protection measures help to mitigate the social and economic impacts of HIV on households and individuals, and increase access to prevention, treatment, care and support for people affected by or vulnerable to HIV.[1] HIV-sensitive social protection can be grouped into three broad categories of interventions.[1]

Financial protection through transfers of cash, food or other transfers for those affected by HIV. Cash transfers, for example, can mitigate the adverse impact of income fluctuation that otherwise could lead people living with, at risk of or affected by HIV to negative coping mechanisms.

Programmes supporting access to affordable quality services, including treatment, health and education services. Examples include social health insurance and school-fee exemption.

Policies, legislation and regulations to meet the needs and uphold the rights of the most vulnerable and excluded. For example, legislation protecting people living with, at risk of or affected by HIV from workplace discrimination can not only protect individuals financially, but also have a transformative effect on institutions and relationships within those institutions to recognize the rights of a potentially marginalized and stigmatized groups.

Outcomes across the HIV cascade are influenced by many factors at individual, community and societal levels, including poverty, gender inequality, unemployment and economic vulnerability. Social protection is often used as an entry point to address these deeply rooted social vulnerabilities and not only decrease HIV risk, but also the factors contributing to the risk.[21] The impacts of social protection can be significant, particularly in settings where people face multiple threats to their health and well-being.

Social protection impacts HIV-prevention and -treatment outcomes through multiple pathways, enabling people to withstand life shocks, and increases the capacity of individuals and households to cope with and respond to risks. Social protection schemes can cushion the economic and social impacts of HIV by reducing financial strain, social stigma and barriers to treatment. There is strong evidence that HIV prevention, treatment and care outcomes are affected by the social determinants of health (e.g., socioeconomic status, transportation, housing, access to services, discrimination due to social grouping, as well as social and environmental stressors). Social protection mechanisms that mitigate the adverse effects of poverty, discrimination and other stressors can have a positive impact on health—including for people living with, at risk of or affected by HIV.

Evidence on HIV-sensitive social protection

There is a substantial body of evidence on the impacts of social protection on HIV prevention and HIV care outcomes.

There is now extensive evidence from randomised trials[3,8,24] and quasi-experimental[9,25,26] studies of positive associations between access to social protection – primarily government-provided cash transfers – and HIV prevention, ART adherence and reduced mortality. These include studies of high-risk population groups such as pregnant women and girl.[27,28] The most recent meta-analysis of effects of cash transfers on HIV prevention and care, published in The Lancet HIV in 2023,[29] found 16 randomised trials, all but one in sub-Saharan Africa. Receipt of a cash transfer was associated with

lowered HIV incidence (RR 0·74, CI 0·56–0·98), increased retention in care for pregnant women (RR 1·14, 95% CI 1·03–1·27) (although no impacts on testing or ART adherence).

Some complexities and methodological challenges with this evidence have challenged the progress of social protection programming, and it is valuable to unpack these. Two individual randomised trials of conditional cash transfers on education attendance, both published in South Africa in 2016, gave inconsistent evidence that resulted in hesitation among key donors. CAPRISA 007 gave cash incentives for participation in a sustainable livelihood programme and passing exams,[29] and found no effects on HIV incidence – which was much lower than anticipated - but showed effects on reduction of HSV-2 incidence. Also in South Africa, HTPN068, among girls aged 13-20 years, found no differences in HIV-incidence,[29] although girls receiving the cash transfer had less intimate partner violence, sexual activity and unprotected sex. However, the study was limited to girls who were currently attending school, were not married or pregnant, were able to read, who were able to open a bank account and whose guardian was able to open a bank account. This meant that the most vulnerable to HIV-infection (for example those who were not in school or had a child) were likely to have been excluded from the trial.

Since then, an evaluation of the effects of government cash transfers in 42 countries, published in Nature in 2022,[29] found that cash transfer programmes were associated with a lower probability of STIs among females (OR 0.67; CI, 0.50–0.91; $P = 0.01$), a higher probability of recent HIV testing among females (OR 2.61; 95% CI, 1.15–5.88; $P = 0.02$) and among males (OR 3.19; 95% CI, 2.45–4.15; $P < 0.001$), a reduction in new HIV infections (IRR 0.94; 95% CI, 0.89–0.99; $P = 0.03$), improvements in antiretroviral therapy (ART) coverage (3%; 95% CI, 0.3–5.7 at year 2; $P = 0.03$) and AIDS-related deaths (IRR 0.91; 95% CI, 0.83–0.99 at year 2; $P = 0.03$).

There is also strong evidence for impacts of social protection in reducing proximal risk pathways to HIV-infection. These include reductions in sexual violence, transactional sex and age-disparate sex,[25] which have been shown in phylogenetic studies to be primary causes of HIV-infection for adolescent girls in Sub-Saharan Africa.[30]Multiple studies show that social protection increases education enrolment and retention,[31] another pathway to HIV-prevention.[13] Studies with adolescents living with HIV show increases in condom use associated with social protection.[32]

There are a number of considerations to note in the evidence-base. First, that the evidence for the preventative effects of cash transfers is primarily among countries with generalised epidemics in Sub-Saharan Africa. However, a particularly notable study in Brazil, published in the Lancet HIV in 2022, found that the national social protection programme was associated with reduced HIV-incidence of 5.1% (CI 0·9–9·1), reduced HIV/AIDS hospitalisations of 14·3% (7·7–20·5), and reduced AIDS mortality of 12·0% (5·2–18·4).[33] There is less availability of rigorous evidence regarding key populations of gay men and other men who have sex with men and people who sell sex, and in countries with concentrated epidemics. Second, evidence also suggests – particularly for adolescent girls – that combining social protection with provisions that improve parenting, provide psychosocial support or income generation support results in increased protective impacts on HIV-incidence, sexual violence and HIV risk behaviors such as transactional sex. For example, a study of the 4-year follow-up of the HTPN068 trial, found that girls who received cash transfers and good parenting with positive mental health had reductions in HIV incidence (RD-3.0%, CI -5.1 - -0.9).[34] This was reflected in quasi-experimental studies in South Africa,[35] as well as in trials in Sierra Leone,[36] Tanzania,[12] Zimbabwe,[37] and Uganda.

In summary, there is very strong evidence for benefits of social protection on HIV prevention and reduction of mortality among PLHIV within Sub-Saharan Africa and particularly within high-prevalence countries. The evidence-base for the impacts of social protection on key populations of gay men and other men who have sex with men and people who sell sex is less well developed. There is growing evidence that combining social protection with additional supports has substantial benefits for HIV-prevention.

The work of the Joint United Nations Programme on HIV/AIDS on social protection

The *Global AIDS Strategy 2021–2026*[20] sets out priority actions and targets to end AIDS globally by 2030 as a public health threat. Aligned with the Sustainable Development Goals (SDGs), the strategy aims to reduce the inequalities that drive the AIDS epidemic, and specifically calls for an intensified effort to encourage meaningful, equitable investments by diverse sectors to create adequate, inclusive, HIV-sensitive social protection safety nets and systems. The goal is to strengthen and help sustain the HIV response; enhance access to HIV prevention and treatment programmes; address drivers of HIV risk; contribute to delivering broad-based benefits to society at large; and drive the development of health-inclusive social protection strategies and systems. The strategy stipulates that by 2025, 45% of people living with, at risk of and affected by HIV and AIDS should have access to one or more social protection benefits. The strategy also calls for the Joint United Nations Programme on HIV/AIDS (hereafter referred to as the Joint Programme) to advance its leadership role in the global HIV response.[21]

The terms of reference (ToR) for this evaluation note that the HIV burden on poorer households has increased in recent years, exacerbated by the COVID-19 pandemic, which has led to challenges in meeting essential needs and coping with risk, especially for households of people living with, at risk of or affected by HIV and AIDS. The *Global AIDS Strategy 2021–2026*[20] prioritizes social protection interventions for people living with HIV, key populations (i.e., gay men and other men who have sex with men, sex workers, transgender people, people who inject drugs) and priority populations, including adolescent girls and young women (AGYW), to reduce gender and income inequalities and eliminate social exclusion, thereby diminishing the risk of HIV due to poverty. It also prioritizes integrated food and nutrition programming and social protection interventions to address the root causes of poverty and hunger by promoting robust national systems that are broad in their reach and inclusive across diverse population groups and by tackling structural deprivations, inequalities and vulnerabilities within communities and at scale.

Among actions that are relevant to social protection and HIV, the *Global AIDS Strategy 2021–2026*[20] prioritizes the following:

- Strengthen institutions and technical capacity to ensure that systems are equipped to link people at risk of HIV with social protection, and to ensure that social protection responses address the needs of people living with HIV, key populations and other priority populations.
- Scale up intersectoral linkages to poverty reduction platforms and cofinancing for people living with HIV, key populations and priority populations to inclusive social protection.
- Create HIV-specific programming that leverages social protection tools and so-called cash-plus options that have been shown to significantly improve HIV outcomes.
- Strengthen the capacity of communities affected by HIV to participate in the governance of social protection systems and deliver community-led social protection services.
- Ensure that existing social protection initiatives, such as the social protection floors, address the needs of people living with, at risk of and affected by HIV.
- Scale up social protection interventions to enroll and retain AGYW in schools and to provide pathways for economic and sexual and reproductive health empowerment.
- Promote integrated health data systems (including with social protection) and conduct assessments, research, monitoring and evaluations of social protection programmes.

Social protection and the
Sustainable Development Goals

Social protection is a primary strategy for governments to make progress towards the United Nations' Sustainable Development Goals. Below are examples of how social protection programmes relate to these goals:

- No poverty (SDG1). Programmes that provide financial assistance or resources, such as cash transfers, unemployment benefits and pensions, can directly reduce poverty by providing the necessary resources.
- Zero hunger (SDG2). Programmes that increase food security, including school feeding programmes or agricultural support systems, can reduce hunger by ensuring that people have access to sufficient nutritious foods.
- Good health and well-being (SDG3). Universal health coverage or subsidized healthcare services contribute to this goal.
- Quality education (SDG4). Social protection programmes related to education, including cash transfers tied to school attendance or performance and scholarships for children in certain groups, can help to support inclusive and equitable access to education.
- Gender equality (SDG5). Programmes that economically empower women, including microfinance programmes, can improve economic participation and opportunities for women.
- Decent work and economic growth (SDG8). Programmes that provide skills training or job placement services can help promote inclusive and productive employment for all.
- Reduced inequalities (SDG10). Social protection programmes can offer support to the most vulnerable and marginalized populations.

The 2022–2026 UBRAF operationalizes the *Global AIDS Strategy 2021–2026*[20] for the Joint Programme under Result Area 9. The Joint Programme's high-level actions to achieve results include:

- Support country stakeholders to strengthen inclusive systems for social protection.
- Build high-level support at global, regional and country levels for action to ensure that people living with, at risk of and affected by HIV, including key populations, have adequate access to social protection services and programmes.
- Leverage in-country capacity to ensure that HIV is reflected in national universal health coverage and social protection agendas, including building capacity in planning, financing, implementation, monitoring and evaluation.
- Support HIV and social protection equity assessments and advocate for laws, policies and programmes to reduce barriers to housing, education and employment and to protect the rights of workers living with HIV to retain their employment.
- Provide tailored support to countries, focusing on identifying and removing barriers to the uptake of social protection services, such as lack of information, documentation challenges, complicated procedures, stigma and discrimination.

The UN Joint Programme on AIDS

UNAIDS is a partnership of 11 UN Cosponsor entities with different mandates, thematic experiences and national counterparts, which are all relevant for a multidimensional AIDS response. UNAIDS allows for a division of labour among Cosponsors and the Secretariat based on each UN entity's experience and strengths, while adopting a UBRAF, and reporting through a Joint Programme Monitoring System (JPMS).

A recently published paper, published by the International Labour Organization (ILO), the Food and Agriculture Organization (FAO) and the United Nations Children's Fund (UNICEF) on UN collaboration on social protection acknowledges that social protection is beyond the mandate and capacity of any single agency, and that One UN is easier to apply to social protection by drawing on pre-existing collaborations. The paper advocates the adoption of joint frameworks with shared ownership and the enhancement of joint initiatives, such as the Inter-agency Social Protection Assessment (ISPA) tools, while highlighting the effects of coordinated UN action on coherent national systems.[38]

Joint Programme's work in social protection

The work of each Joint Programme organization in social protection (and HIV, where applicable) is briefly described in the table below.

Table 1. Joint Programme organizations' work in social protection

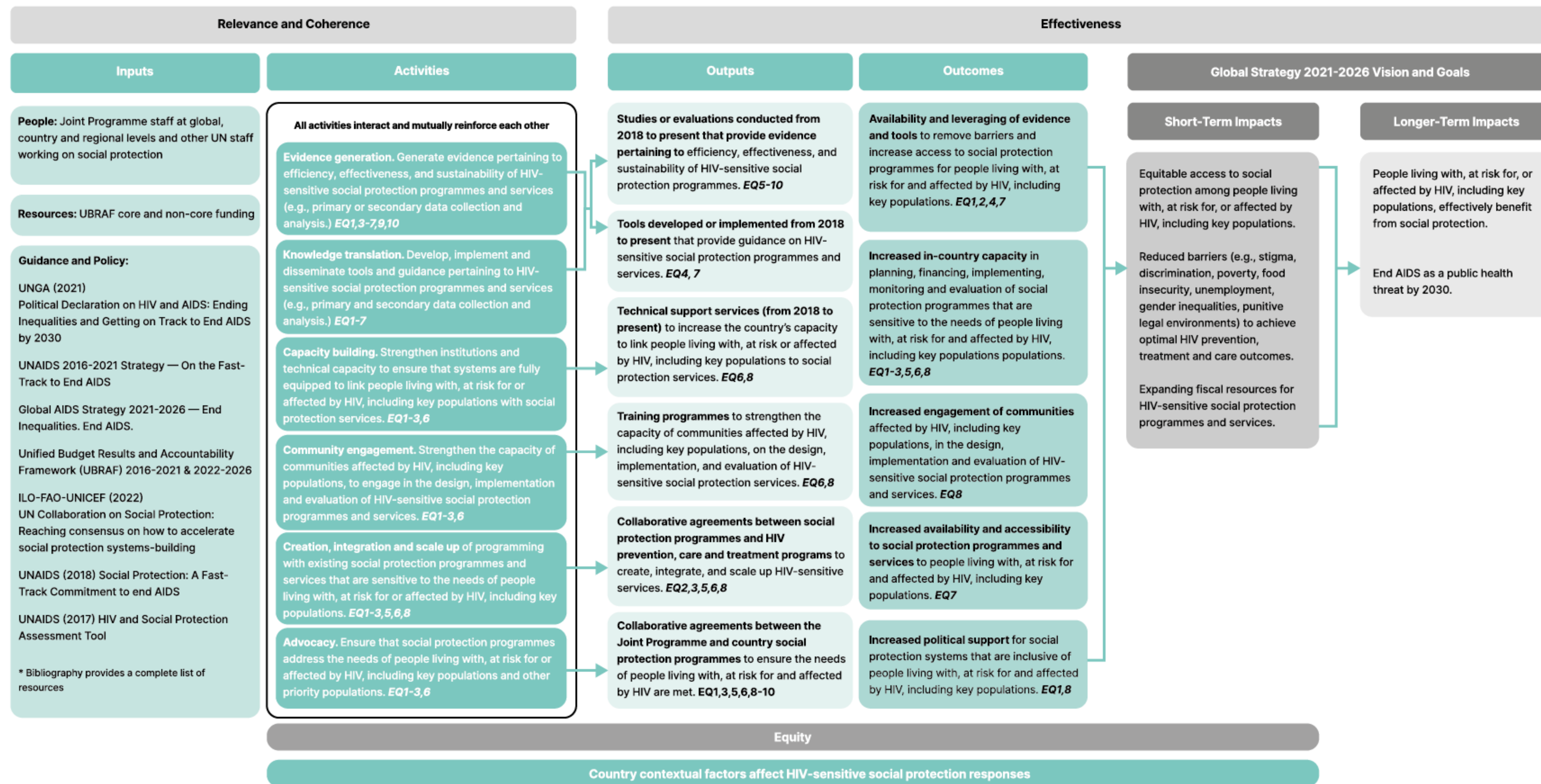
Programme	Definition	Focal Populations	Social Protection Activities and Roles
UNAIDS[39]	All public and private initiatives that provide income or consumption transfers to the poor, protect the vulnerable against livelihood risks and enhance the social status and rights of the marginalized with the overall objective of reducing the economic and social vulnerability of poor, vulnerable and marginalized groups	People living with, at risk of or affected by HIV, including key populations	▪ Advocate with local governments on expanding and increasing the HIV sensitivity of social protection programmes ▪ Support the generation and application of evidence on HIV and social protection to achieve Fast-Track Targets ▪ Track progress in attaining the Fast-Track commitments to strengthen national social and child protection systems ▪ Coordinate and guide partners working on social protection for a coherent engagement in the AIDS response
ILO[40]	The set of policies and programmes designed to reduce and prevent poverty and vulnerability across the life cycle	Governments, employers and workers	▪ Provide recommendations to governments, employers and workers on ILO social security standards
WFP[41]	Policies and programmes designed to protect people from shocks and stresses throughout their lives	Poor and marginalized groups	▪ Help people to meet their food security and nutrition needs ▪ Help people to manage risks and shocks
UNICEF[42]	The set of public and private policies and programmes aimed at preventing, reducing and eliminating economic and social vulnerabilities to poverty and deprivation	Children and families with children	▪ Generate evidence on child poverty and vulnerability ▪ Promote responsive and disability-inclusive social protection systems ▪ Enhance shock responsiveness ▪ Promote case management approaches and connect families to social protection
IOM[43]	All measures providing contributory and non-contributory benefits to secure protection meant	Migrants, trafficked persons and rejected asylum seekers	▪ Migrant resource centres ▪ Migrant-friendly health assessments ▪ Pre-departure orientation and training

	to prevent poverty and vulnerability throughout the life cycle and in relation to key identifiable social risks		▪ Awareness campaigns ▪ Reintegration assistance
UNDP[44]	A set of nationally owned policies and instruments that provide income and support and facilitate access to goods and services	Governments and decision-makers	▪ Support countries to implement social protection systems ▪ Promote higher spending on social protection ▪ Encourage countries to expand existing social protection systems to be more inclusive ▪ Promote the social, political and economic inclusion of all people[45]
UNESCO[46]	A range of policies that explicitly aim to reduce poverty and vulnerability, and which have the potential to be redistributive	Educational systems, children and young people	▪ Support countries to scale up education ▪ Develop policies and programmes on HIV and health ▪ Create safe learning environments
UNHCR[47]	A set of policies and programmes aimed at preventing or protecting people against poverty, vulnerability and social exclusion throughout their life-course, with emphasis on vulnerable groups	Refugees	▪ Aid governments in making social protection programmes more inclusive ▪ Support shock-responsive mechanisms that are inclusive of refugees in time of disaster ▪ Ensure coherent action across humanitarian-development space ▪ Ensure continued assistance where governments cannot meet needs of displaced people
UN Women[48]	A set of minimum guarantees, including basic income security for children, working-age adults, older people and people with disabilities, as well as essential healthcare for all.	Women	▪ Integrate gender equality into the governance of the HIV response ▪ Amplify voice and leadership of women and girls to meaningfully engage in decision-making ▪ Upscaling what works in transforming unequal gender norms to prevent HIV and mitigate its impact
WHO-PAHO[49]	A broad concept encompassing all governmental measures to achieve the universalization of priority services and benefits, such as housing, work, education, pensions and healthcare	Population groups that have been neglected or marginalized	▪ Support health policy related to social protection ▪ Provide technical cooperation for the development of security systems ▪ Support the production of evidence by evaluating policies on social protection
World Bank[50]	Systems that help individuals and families, especially the poor and vulnerable, cope with crises and shocks, find jobs, improve productivity, invest in the health and education of their children and protect the ageing population	The poorest and vulnerable groups including youth, and women and girls; also a focus on contexts affected by fragility, conflict and violence	▪ Develop and design programmes that support individuals and household effectively ▪ Address the fiscal gap through pension reform and promoting fiscal sustainability ▪ Address the opportunity gap through labour and economic inclusion programmes

Reconstructed theory of change

Based on the information extracted from the *Global AIDS Strategy 2021–2026*[20] and the 2022–2026 UBRAF, the evaluation team, in consultation with the evaluation management and reference groups, reconstructed a ToC describing the work of the Joint Programme in social protection, its expected effects and underlying assumptions.[20,51] The ToC diagram is presented below (see Figure 1) and further information on its use in the evaluation is provided in section 2.

Figure 1



2. Methods

2.1. Evaluation approach

Objective and purpose

The objective of the joint independent evaluation was to assess the relevance, coherence, effectiveness, efficiency and equity of the Joint Programme's work in HIV-sensitive social protection. As part of the 2022–2023 UNAIDS evaluation plan, approved by UNAIDS Programme Coordinating Board in December 2021, the evaluation was designed both for accountability and organizational learning purposes.

The evaluation was conducted with the aim of contributing to the strategic assessment and future planning of HIV-sensitive social protection initiatives, programmes and/or activities to strengthen their reach and the inclusion of people living with, at risk of or affected by HIV, including key populations. In this respect, the assessment ends with a series of actionable recommendations to the Joint Programme for maximizing the contribution to HIV-sensitive social protection, taking stock of what is working well (best practices), what the Joint Programme should stop doing or do less of, and where efforts are needed to address existing gaps.

Scope

The evaluation assesses the work of the Joint Programme in HIV-sensitive social protection over the period 2018 to 2022, in the framework of the *UNAIDS 2016–2021 strategy* and 2016–2021 UBRAF. It covers the work of the Joint Programme at the global level by drawing on information available in reports published on its overall work by UNAIDS, its Cosponsors, or as the Joint Programme, interviews with key informants at the global level, and conducting data collection in countries in several world regions that, together, represent the broadness and diversity of the work of the Joint Programme.

Theory-based evaluation

As part of the ToC development process, the evaluation team developed a series of assumptions about how change is expected to happen. The assumptions were tested in different country settings, using a mixed-methods approach. The ToC represents the evaluation's overarching analytical framework, and informs the evaluation matrix (assumptions, indicators and data sources, as well as tools for data collection, question guides and case study reporting). The finalized evaluation questions (see Annex I) have been mapped to the ToC.

It is recognized that the role played by the Joint Programme in any country must be tailored to the social and political context, and the nature of the epidemic in each setting. Therefore, the contribution of the Joint Programme is expected to differ by country—for example, the Joint Programme may support different types of activities, engage with different partners and focus on different key populations or other groups, but always within the programming bounds established in the overall ToC. This awareness was important during data collection, as well as in the interpretation and reporting of findings.

The reconstructed ToC is shown in Figure 1. The figure depicts the overall ToC for Joint Programme support for HIV-sensitive social protection. The ToC illustrates the collaboration and mutually reinforcing nature of the Joint Programme's work in HIV-sensitive social protection. In developing the ToC, the evaluation team considered the activities and outputs of the *UNAIDS 2016–2021 strategy* and associated UBRAF:

- Intermediate outcomes aligned to the Strategic Results Areas of the *2016–2021 Strategy* and UBRAF and Results Areas of the new *2021–2026 Strategy* and 2022–2026 UBRAF.
- The 2021–2026 Strategic Priority Outcome areas, to help identify gaps influencing progress towards the new outcomes and, ultimately, impact.

- Activities from the *2016–2021 Strategy* and UBRAF were compared to those in the more recent versions of these documents to ensure the activity areas are relevant.
- Strategic priorities from the *2016–2021 Strategy* and UBRAF were compared to those in the more recent versions to ensure general alignment of priorities.
- The assumptions of change that the evaluation examined are not included in the ToC but are articulated and presented in the evaluation matrix (Annex I).
- The evaluation questions (Annex I) are mapped to the ToC to demonstrate linkages between the evaluation questions and the ToC.

Utilization-focused evaluation

The results of this evaluation are expected to be used by the Joint Programme to inform decisions regarding HIV-sensitive social protection initiatives and programmes globally, regionally and nationally. It is a utilization-focused evaluation that will enable global, regional and country-based stakeholders to reflect on the relevance, coherence, effectiveness, efficiency and equity of the work of the Joint Programme on HIV-sensitive social protection.

In this evaluation, the primary users of the evaluation are members of the Joint Programme and partners that play a significant role in the response of scaling up HIV-sensitive social protection and comprehensive care and support. The evaluation management and reference groups were involved in the design of the evaluation from the development of the ToR, and reviewing and commenting on iterations of the inception report and informing key methodological decisions, such as the choice of countries for inclusion in in-country data collection. Some other evaluation users were also consulted via individual interviews and discussions throughout the inception stage.

2.2. Evaluation criteria and questions

Criteria

The evaluation examined the strategic priorities and work of the Joint Programme based on a prioritized selection of ten questions against standard evaluation criteria:[21]

Relevance: Examines the extent to which the Joint Programme of support is consistent with country needs.

Coherence: Examines the extent to which the Joint Programme's work supports or undermines other actors' interventions and vice versa. Coherence includes complementarity, harmonization and coordination within and beyond the Joint Programme.

Effectiveness: Assessment of the extent to which Joint Programme's interventions have achieved or are expected to achieve objectives and intended results. Special attention was paid to this criterion, focusing on outcomes and impacts in line with results-based management (RBM) principles applied in UN agencies.

Efficiency: Assessment of how well the Joint Programme is using available resources.

Equity: The evaluation also considered the cross-cutting issues of equity, gender equality and human rights, following guidance provided by the United Nations Evaluation Group, and the analysis assessed the extent to which Joint Programme-supported interventions contribute to addressing inequalities.

Questions

Following the development of the ToC, evaluation questions (EQs) were prioritized and refined from the list provided in the ToR.

Relevance and coherence:

EQ1 To what extent is the role of the Joint Programme in social protection aligned with its overall mandate and strategy?

EQ2 How relevant are the Joint Programme guidance and efforts to integrating HIV into national social protection systems, and how connected to national systems are they?

Effectiveness:

EQ3 To what extent are partners involved in the advancement of HIV-sensitive social protection; what roles do partners play; and how can partnerships with and the capacity of stakeholders (civil society, government, others) be strengthened further?

EQ4 What models or instruments for HIV-sensitive social protection are feasible and available in resource-constrained environments, and what are the gaps relevant to the Joint Programme's work?

EQ5 To what extent has the Joint Programme contributed to HIV (and, to a certain extent, TB) integration into national social protection programmes? What are the contributing and/or hindering factors for this integration?

Efficiency:

EQ6 How well equipped is the Joint Programme to effectively contribute to HIV-sensitive social protection and what should its role be going forward?

EQ7 How effectively is the (UNAIDS) HIV and Social Protection Assessment Tool (and related tools by other agencies) used to link people living with, at risk of or affected by HIV to social protection services?

EQ8 How effective is the Joint Programme in supporting the regional initiatives on HIV-sensitive social protection?

Equity:

EQ9 What are the main contributions of the Joint Programme to increasing access and coverage of HIV-sensitive social protection, including for key populations?

COVID-19:

EQ10 What key lessons have emerged from government- and community-led COVID-19-related social protection services supported by the Joint Programme?

Matrix

A full evaluation matrix was developed and is presented in Annex I. The matrix includes:

1. evaluation questions;
2. the corresponding evaluation criteria;
3. assumptions underlying the evaluation questions;
4. indicators; and sources of data and information,
5. both quantitative and qualitative.

2.3. Data collection at the global level

Given the global scope of the evaluation, data collection started by reviewing documents and data provided by the Secretariat and covering the overall work of UNAIDS in HIV-sensitive social protection. This review was completed with a series of interviews with key informants of the Joint Programme with global responsibilities on social protection.

Document review

Data collection for this evaluation started with a document review. Among other documentary sources, the evaluators reviewed the JPMS for planning and reporting,[52] the *UNAIDS 2016–2021 strategy*,[20] and the 2016–2021 UNAIDS UBRAF.[53] These were used as the primary source for the description of the evaluation subject, while the new *Global AIDS Strategy 2021–2026*[20] and 2022–2026 UBRAF[54] were consulted to enhance the relevance of the recommendations.

Additionally, reports, data repositories and web resources were reviewed. These included ILO Flagship reports on social protection,[23,55] web presentations on Cosponsors' activities in social protection and data repositories, including the ILO social protection database,[56] UNAIDS country factsheets,[57] and World Bank development indicators.[58] These resources aided in the preparation of country analyses and the development of evidence-informed recommendations and were used in conjunction with feedback from key informants.

Global and regional key informant interviews

The evaluation team conducted key informant interviews (KIIs) at the global and regional level, including key informants (KIs) who are internal and external to the Joint Programme. The interviews were conducted by one or more members of the core evaluation team, using a semi-structured interview guide, audio recorded (where permission was granted) and transcribed (using auto-transcription software).

The transcripts were reviewed and coded, and the findings were triangulated with those from data collection from other sources. The purpose of these interviews was to elicit input to inform the overall findings of the evaluation through increasing understanding of the:

- Role, positioning and contribution of the Joint Programme in relation to other partners.
- Main contributions of the Joint Programme in increasing access and coverage across population groups and epidemic profiles.
- Successful partnerships that have been established to support the advancement of HIV-sensitive social protection.
- Coverage of and access to HIV-sensitive social protection across population groups and epidemic profiles.
- Type of support provided at the global or regional level that is most needed at the country level going forward.
- Experience using the UNAIDS assessment tool for social protection systems.
- Impact of the COVID-19 crisis on achievements in HIV-sensitive social protection.

KIs included UNAIDS Secretariat and Cosponsor representatives involved in any HIV and social protection activity (e.g., evidence generation, knowledge translation, capacity building, community engagement, programming, advocacy); UN staff involved mainly in social protection (not necessarily HIV); some TB partners; members of the evaluation reference group and evaluation management group, members of UNAIDS global partners collaborating on social protection in any activity (as listed above), and civil society organizations (CSOs) and/or networks representing key populations, including youth, people who use drugs, sexual and gender minority populations, and migrant populations.

The global KIs provided valuable insight into their organizations' activities and perspectives on social protection. They included officers at ILO and World Food Programme (WFP) involved social

protection; specialists in gender equality and inclusion from ILO; and specialists in HIV and AIDS from the ILO, UNICEF, and WFP. The breakdown of Joint Programme institutions and gender of global KIs is outlined in the table below.

Table 2. Global KI participants by institution and gender

	UNAIDS	UNICEF	WFP	WB	ILO	USAID and OGAC	Total
Female	2	3	0	1	1	1	8
Male	1	0	2		4	0	7
Total	3	3	2	1	5	1	15

Source: Annex II 'List of Informants'

2.4. Country studies

A major share of evaluation efforts was put into data collection at the country level, based on field missions conducted by members of the core evaluation team and national consultants. The goal was to capture the actual contribution of the Joint Programme to HIV-sensitive social protection systems, identifying enabling and limiting factors of such contributions, and reflecting on the current and future role of the Joint Programme in national social protection systems.

To this end, following indications of the evaluation management group, 12 countries were selected on the basis of the following criteria:

- Coverage of six UNAIDS regions (two countries per region): Asia and the Pacific, eastern and southern Africa, Latin America and the Caribbean, Middle East and North Africa, eastern Europe and central Asia, West and central Africa.
- Presence of a UNAIDS Country Office.
- Presence of Cosponsors specialized in social protection: ILO, WFP and/or UNICEF.
- No record of a UNAIDS evaluation in the prior two years.
- Inclusion of countries where the UNAIDS Social Protection Tool has been used (this criterion applied to West and Central Africa, following a suggestion of the evaluation reference group).
- In eastern Europe and central Asia, only one country met the criteria. However, in most regions more than two countries were preselected and the final selection was made randomly. The process resulted in the following countries: Benin, China, Djibouti, Dominican Republic, Djibouti, Peru, Fiji, Ghana, Malawi, Morocco, Uganda, and Uzbekistan. Of these 11 countries, UNAIDS and the evaluation team succeeded in organizing field missions in all countries except Djibouti and Uganda.
- In total, nine field missions were conducted in a selection of countries that reflected the breadth and diversity of UNAIDS' geographic scope. Table 3 below and the following paragraphs outline key features of the evaluated countries with respect to HIV and social protection. More detailed tables regarding HIV indicators, TB indicators, social protection indicators and legal barriers are provided in Annex IV.

Table 3. Condensed key country indicators

Country	HIV prevalence[i]	Income group[ii]	SDG 1.3.1[iii]	SDG 3.8.1[iv]
Benin	0.80 [0.7-1.0]	LMI	8%	40%
China	0.1 [0.9-1.1]	UMI	71%	79%
Dominican Republic	0.90 [0.7-1.1]	UMI	54%	74%
Fiji	0.20 [0.2-0.5]	UMI	59%	64%
Ghana	1.70 [1.6-1.7]	LMI	25%	47%
Malawi	7.70 [7.1-8.0]	LI	21%	46%
Morocco	<0.10 [<0.1-<0.1]	LMI	21%	70%
Peru	[0.3-0.4]	UMI	29%	77%
Uzbekistan	0.20 [0.2-0.3]	LMI	43%	73%

[i] % (ages 15-49 years, 2021) [59]
[ii] LI = low income, LMI = lower middle income, UMI = upper middle income[58]
[iii] SDG Target 1.3.1 = Population covered by at least one social protection benefit (excluding health) [40]
[iv] SDG Target 3.8.1 = Universal health coverage[40]

Asia and the Pacific

China

China is a country in east Asia that has a population of 1.4 billion and is classified as an upper-middle-income country, with a GDP per capita of US$12 720 and a Gini index of 38.2. In 2021, 1.14 million people living with HIV knew their HIV status, 92.6% of people were on antiretroviral therapy (ART), and 96.4% of people living with HIV receiving ART have a suppressed viral load. The key populations affected by HIV and AIDS in China are gay men and other men who have sex with men (HIV prevalence 5.4%), people who inject drugs (HIV prevalence of 4.3%) and female sex workers (prevalence <0.1%) and their partners. To monitor the HIV epidemic across key populations, China established the HIV Sentinel Surveillance System (HSSS) to monitor and record changes in HIV prevalence. From 2010 to 2016, China spent 1.2% of its GDP on social protection programmes, with much of this funding going towards cash transfers, fee waivers, public works and social pensions. China's social security programme has achieved universal legal coverage and health insurance. China is still facing challenges, however, such as maintaining coverage for the increasing number of urban residents and ageing population. The government's current priorities are to build a social assistance programme for both urban and rural areas, expand the coverage of unemployment insurance, improve the delivery of social protection through digital technology, and enhance the public health and education systems.

Fiji

Fiji is an island country in the Pacific with a population of 900 000 and is classified as an upper-middle-income country, with a GDP per capita of US$5 316 and a Gini index of 30.7. In 2021, the overall HIV incidence rate for all ages was 0.19 per 1 000 population. HIV prevalence was 0.20% for those aged 15–49. Data for Fiji in 2022 show that 51% of people living with HIV know their status and 28% of people with HIV are on ART. The number of people living with HIVHIV who are virally suppressed was not reported. The key populations affected by HIV and AIDS in Fiji are migrants, sex workers (HIV prevalence 0.7%), gay men and other men who have sex with men (HIV prevalence 0.5%), transgender people (HIV prevalence 0.4%) and prisoners. While Fiji is on the lower end of social protection spending in the Pacific, the country spent 0.7% of its GDP on social protection programmes from 2014 to 2016, with much of this funding going towards cash transfers, fee waivers and social pensions. Fiji has a social welfare family assistance programme that provides cash transfers to the poorest individuals and has an informal social protection system known as *solesolevaki* that spreads the risks and benefits among the community collective. Fiji, Cook Islands and Kiribati have the most extensive social protection programmes in the Pacific.

Eastern and southern Africa

Malawi

Malawi is a south-eastern African country with a population of 18 million. Malawi is classified as a low-income country and has a GDP per capita of US$645.2 and a Gini index of 38.5. Malawi's overall HIV incidence rate of all ages in 2021 was 1.13 per 1 000 population. The HIV prevalence was 7.7% for those aged 15–49. Ninety-three % of people living with HIV know their status, 91% of people with HIV are on ART, and 85% of people with HIV have a suppressed viral load. In 2021, the key populations for HIV in Malawi are female sex workers (HIV prevalence 49.9%), prisoners (HIV prevalence 19%), and gay men and other men who have sex with men (HIV prevalence 12.9%). Malawi spent 1.5% of its GDP on social protection during 2013 to 2016 and this budget is primarily spent on public works and school feeding. The Malawi National Support Programme II (MNSSPII) was adopted in 2018 and provides noncontributory social protection, cash transfers, social security and an occupational injury scheme. The MNSSPII focuses on three pillars: consumption support (through timely and adequate cash and/or in-kind transfers to poor and vulnerable people throughout their life cycles), promoting resilient livelihoods (through tailored packages based on individual, household and community needs), and shock-sensitive social protection (reducing vulnerability and enhancing the resilience of the population to disasters and socioeconomic shocks).

Latin America and the Caribbean

Dominican Republic

The Dominican Republic, a Caribbean nation, has a population of 10.6 million and is classified as an upper-middle-income country. Most recent data shows it has a GDP per capita of US$10 120 and a Gini index of 38.5. In 2021, the HIV incidence for all ages was 0.39 per 1 000 population. The HIV prevalence was 0.9% for those aged 15–49. For the Fast-Track Targets, 85% of people living with HIV know their status, 55% of people with HIV are on ART, and 47% of people with HIV have a suppressed viral load. Key populations for HIV in the Dominican Republic are transgender people (HIV prevalence 27.7%), prisoners (HIV prevalence 4.8%), sex workers (HIV prevalence 4.2%) and gay men and other men who have sex with men (HIV prevalence 4%). The Dominican Republic allocated 1.6% of its GDP between 2017 and 2018 to go towards cash and in-kind transfers, school feeding programmes and social assistance. The government created programmes supporting people with HIV, such as the National Programme for the Prevention and Control of HIV/AIDS which provides comprehensive care, testing, counseling, and assistance with housing, education, and job training. The Programme for Social Protection of People Living with HIV/AIDS (PPS+VIH) aims to provide financial assistance to people living with HIV and their families for basic needs and in turn to reduce poverty through

financial and nonfinancial support. The National Plan for STIs and HIV/AIDS targets vulnerable, key and general populations, aiming to control the AIDS epidemic and other sexually Transmitted Diseases (STIs). . Collaboration with civil society and international partners helps raise awareness and combat stigma.

Peru

This South American country has a population of 33.72 million and is classified as an upper-middle-income country, with a GDP per capita of US$7,125 and a Gini index of 40.2. In 2021, the overall HIV incidence for all ages in Peru was 0.17 per 1 000 population. The HIV prevalence among people aged 15–49 was 0.4%, and 80% of people living with HIV were on treatment. The number of people living with HIV who know their status and who are virally suppressed was not reported. The key populations for HIV in Peru are transgender people (HIV prevalence 31.8%), gay men and other men who have sex with men (HIV prevalence 10%), female sex workers (HIV prevalence 1.3%), and prisoners (prevalence 0.5%). No data were reported on people who inject drugs. Only 26% of the working population participates in social security, necessitating the growth of non-contributary initiatives. Most of the population is covered by either state-subsidised comprehensive health insurance (SIS) and the social health insurance (EsSalud).

Middle East and North Africa

Morocco

Morocco is a low-prevalence country in North Africa, with a GDP of US$3,527 and a Gini index of 39.5. Morocco has managed to reduce new HIV infections by 42% in the last decade, while the average decline in the region was 4%. With an estimated 21 500 people living with HIV, the country's statistics on the Fast-Track Targets are as follows: 78% of people living with HIV know their status, 95% are on ART and 93% have suppressed viral loads. The key populations for HIV in Morocco are people who inject drugs (HIV prevalence 7.1%), gay men and other men who have sex with men (HIV prevalence 4.1 %), sex workers (HIV prevalence 2.3 %), and prisoners (prevalence 0.3%). The Morocco social protection system comprises a pension system and a series of social assistance programmes. The former consists of different regimes for the private and public sectors and the latter comprises a wide array of social safety needs, including price subsidies for basic goods and services, cash transfers, livelihood support and health insurance. The system has been historically defined as fragmented and presenting numerous gaps but is currently undergoing a vast reform. Following the COVID-19 pandemic, a Framework Law on Social Protection was adopted, and the following milestones were set: extending compulsory health insurance by 2023 (achieved), extending family allowances to 7 million school-age children by 2024, broadening the coverage of the pension schemes to 5 million working people and generalizing unemployment subsidies by 2025.

Eastern Europe and central Asia

Uzbekistan

Uzbekistan is a country located in central Asia with a population of 32 million. Uzbekistan is classified as a lower-middle-income country and has a GDP per capita of US$2,255 and a Gini index of 35.3. In 2021, the overall HIV incidence for all ages in Uzbekistan was 0.11 per 1 000 population. The HIV prevalence was 0.20% for those aged 15–49. For the Fast-Track Targets, 77% of PLHIV know their status and 51% of people with HIV are on ART. The number of people living with HIV who have suppressed viral loads was not reported. The key populations for HIV in Uzbekistan are people who inject drugs (HIV prevalence 5.1%), gay men and other men who have sex with men (HIV prevalence 3.7%), female sex workers (HIV prevalence 3.2%), and prisoners (prevalence 0.5%). Uzbekistan spent 0.8% of its GDP on social protection in 2017 and most of that funding went towards cash transfers, social pensions and other social assistance. The social protection system in Uzbekistan moved from a social insurance-based system to a greater focus on social assistance and employer's liability. The current goals of the government to improve the social protection system include improving the

pension system, developing a policy for the transition from informal to the formal economy, designing a national social protection strategy, and strengthening national social protection coordination mechanisms.

West and Central Africa

Benin

Benin is a lower-middle-income country in West Africa with a population of 11 million. Benin has a GDP per capita of US$1,303 and a Gini index of 37.8 The country had an overall HIV incidence rate of 0.14 per 1 000 population in 2021 (all ages), with a prevalence of 0.8% among individuals aged 15–49. For the Fast-Track Targets, 85% of people living with HIV in Benin are aware of their status, 84% are receiving ART and 66% have a suppressed viral load. The key populations at higher risk include transgender individuals (with an HIV prevalence of 21.9%), sex workers (8.5%), gay men and other men who have sex with men (7%), prisoners (4.1%) and people who inject drugs (2.2%). Benin allocated 0.40% of its GDP from 2017 to 2020 towards social protection expenditures, primarily focused on fee waivers, in-kind transfers and other forms of social assistance. The country has social insurance laws covering work injury, sickness, maternity and unemployment.

Ghana

Ghana is a country in West Africa with a population of 25.5 million. Ghana is classified as a lower-middle-income country, with a GDP per capita of US$2,175 and a Gini index of 43.5. The overall HIV incidence rate for all ages in Ghana was 0.57 per 1 000 population in 2021. HIV prevalence was 1.7% for those aged 15–49 in 2021. For the Fast-Track Targets, 71% of people living with HIV know their status, 71% of people with HIV are on ART and the number of people with HIV who have a suppressed viral load is unreported. The key populations for HIV are gay men and other men who have sex with men (prevalence 4.9%), and prisoners (0.4%). It was not possible to collect data for sex workers, people who inject drugs, or transgender people due to stigma and criminalization of sex work and same-sex sexual acts. Key populations remain the main drivers of the epidemic in Ghana. HIV prevalence among female sex workers, estimated in 2019, was 4.6%, significantly higher than the national prevalence of 1.7%. [60]The 2017 *Ghana* Men's Study *II* revealed the HIV prevalence among gay men and other men who have sex with men increased from 17.5% in 2011 to 18.1%.[61] By 2021, it had reduced considerably to 4.9%. ART coverage in 2021 was 99% for female sex workers and 95.1% for gay men and other men who have sex with men.[60] Ghana spent 0.4% of its GDP on social protection between 2011 and 2016 and most of that funding went towards fee waivers, school feeding and other social assistance.[58]

In-country data collection

As part of case studies, national consultants conducted country-specific document reviews that covered some of the previously cited sources of data and reports produced by national governments, CSOs and UN agencies.[52,58,62] The latter sources included national plans and policies on AIDS and social protection,[61,63–84] UNAIDS and Cosponsors' plans and reports,[85–95] policy papers,[96–102] published[93,103,104] and grey [105–109] literature, and strategies on social protection and HIV.

Country studies were guided by a country report template and standard interview questionnaires (see tools 1, 2, 3, and 7 in Annex II). These tools were intended to provide the national consultants with an analytical framework for the assessment of the Joint Programme's work on social protection in each country, and to gather data in a way that allowed for aggregation of findings and comparison across countries.

The preparation of country studies was supported by the UNAIDS Evaluation Office and Country Offices for document gathering, stakeholder mapping and identification of informants. Then, a country-specific desk review was conducted, which consisted of extracting available secondary evidence against the assumptions and evaluation questions and mapping the Joint Programme activities and reported results on social protection. This allowed for the identification of specific

themes of interest, data gaps and issues for exploration during the country visit and ensured that the time allocated to primary data collection was optimized. As can be seen in the following table, the country studies collected inputs from a balanced group of country informants.

Table 4. Type of stakeholder interviewed in each country with total gender breakdown

Country	JP	Government	CSO	Development Partner	Total
Benin	7	8	15	8	38
China	9	–-	10	–	19
Dominican Republic	7	6	5	–	18
Fiji	7	–-	7	–	14
Ghana	6	6	11	–	23
Malawi	9	10	9	4	32
Morocco	6	6	13	1	26
Peru	7	2	13	–	22
Total	58	38	83	13	192
Of which, female	32	15	43	8	98
					51 %

2.5. Quality control, analysis and reporting

Review and triangulation

The evaluation was conducted according to a methodology and workplan described in an inception report that was discussed and agreed with the Evaluation Reference and Management groups. The reliability of the evaluation was ensured by using triangulation; that is, the combination of findings from a document review, global KIIs and country studies to respond to each evaluation question. Country studies, in turn, triangulated findings from data sets, country-specific documents and interviews with different types of stakeholders (see Table 4).

The country reports were elaborated by national consultants and reviewed by the core evaluation team and UNAIDS Country Offices. Country reports were then consolidated with the support of comparative analysis tables that allowed for the identification of commonalities and differences across countries, and a consolidated country report was in turn consolidated with findings from the document review and global KIIs.

Analysis and reporting

The analysis and reporting process focused on the evaluation questions and criteria defined in the inception report, and connected to each evaluation task by means of an evaluation matrix (see Annex I). Preliminary recommendations were developed based on the evaluation conclusions with a view to further refine them through discussion with the Evaluation Reference and Management groups. To enhance the learning perspective of the evaluation, lessons learnt and good practices were also extracted from key findings and conclusions. To this end, a lesson learnt was defined as knowledge gained on specific design, activity, process or decision that provides either a positive or negative influence on effectiveness, efficiency, impact or sustainability; a good practice was defined as a positive lesson learnt that corresponds to a strategy likely to be replicated elsewhere.

Limitations

The evaluation process faced a series of challenges and limitations.

As per the evaluation findings on relevance and coherence, HIV-sensitive social protection is not always a well-established area of work and often lacks conceptual clarity, as well as adequate and robust indicators. Moreover, some of the details of the work of the Joint Programme (e.g., participants in regional and global activities, repositories of assessments conducted, reports backing up indicators on countries' progress towards HIV-sensitive social protection, etc.) were not available

to the evaluators. These issues, together with the broad geographic scope of the evaluation and the limited budget available for field missions, were addressed with more time dedicated to preparing field missions with national consultants and UNAIDS Country Offices (UCOs); and to review national consultants' findings and reports to ensure consistency in country reports.

The longer time dedicated to the nine field missions and their reports also impeded the evaluation team from conducting a global survey to further triangulate data. In some countries, key informant interviews (KIIs) were completed over several weeks, instead of a single week as planned, due to competing demands on the KIs (e.g., participating in COP 2023 or Global Fund meetings, or, in the case of Malawi, a devastating cyclone that made travel and communications challenging, if not impossible, for two weeks, as well as challenges in contacting KIs whose attention was called to necessary emergency responses). Not all key informants were reached or accepted invitations to be interviewed despite multiple attempts to make contact. For example, in both China and Fiji, no government representative accepted.

However, it must be noted that the country missions and global KIIs collected inputs from over 200 informants (see Annex II). Finally, it must be stated that the findings from the Uzbekistan mission were not incorporated into this report, as contact with the national consultant was lost right before the country report was due and all attempts to re-establish communication and clarify the status of the report made by the core evaluation team and the UCO were unsuccessful.

Limitations related to country selection and social protection.

HIV-sensitive social protection was conceptualised with a strong emphasis on countries that experience both high levels of poverty, and high prevalence and incidence of HIV infection. These are primarily in Southern and Eastern Africa, and have prevalence rates ranging from Lesotho at 20.9%, eSwatini at 27.9% to Kenya at 4.0% and Uganda at 5.2%.[61] In these countries, women and girls in the general population account for 63% of new HIV infections. It is in these contexts that national social protection programmes – especially when combined with effective psychosocial interventions – have the potential to alleviate severe poverty and overall poverty, with benefits for HIV prevention and treatment. For example, reduction of food insecurity among poor families can interrupt risk pathways such as adolescent girls having transactional sex in order to access basic needs. In addition, national social protection programmes can improve access of all people in poverty – including people living with HIV who are at higher risk of poverty – to food, transport and positive mental health, thus promoting treatment success and quality of life.

The countries included in this review were Benin, China, Dominican Republic, Fiji, Ghana, Malawi, Morocco, Peru and Uzbekistan. It is important to note that-- of these countries-- only one (Malawi) is among the high HIV-prevalence and incidence countries globally. The others have much more concentrated and smaller epidemics, primarily among key populations. All countries except for Malawi have HIV-prevalence <2%.[61] In these contexts, it would not be expected that HIV-specific national social protection programmes would be a focus of UNAIDS or wider UN social protection advocacy or programming, and this is reflected in the KIIs. However, inclusive HIV-sensitive social protection programmes are important everywhere.

Table 5. HIV prevalence in countries participating in the evaluation

Selected country	Adult prevalence (15-49 yrs)	Number of adults & children living with HIV	Source
Benin	0.8%	69,000	UNAIDS Data 2022[61]
China	<0.1%	1.25m	Government data 2018
Dominican Rep.	0.9%	78,000	UNAIDS Data 2022[61]
Fiji	0.2%	1,400	UNAIDS Data 2022[61]
Ghana	1.7%	350,000	UNAIDS Data 2022[61]
Malawi	7.7%	990,000	UNAIDS Data 2022[61]
Morocco	<0.1%	21,500	UNAIDS Data 2023[61]
Peru	0.4%	110,000	UNAIDS Data 2023[61]
Uzbekistan	0.2%	59,000	UNAIDS Data 2022[61]

3. Main findings

3.1. Relevance and coherence

To what extent is the role of the Joint Programme in HIV-sensitive social protection aligned with its overall mandate and strategy (EQ1)?

Globally, the activities of the Joint Programme are aligned with the *Global AIDS Strategy 2021–2026*[20] Strategic Priority Area 3, and reflective of the mandate outlined in the 2022–2026 UBRAF under Result Area 9. Overall, the roles of Programme members are clear in the UBRAF workplan and budget.[110] The activities of the Joint Programme include support for country stakeholders to strengthen inclusive systems for social protection; to advocate for high-level support for inclusive access to social protection services and programmes; to leverage in-country capacity to ensure that HIV is reflected in national universal health coverage and social protection agendas, including building capacity in planning, financing, implementation, monitoring and evaluation; to support HIV and social protection equity assessments and advocate for laws, policies and programmes to reduce barriers to housing, education and employment and to protect the rights of workers living with HIV to retain their employment; and to provide tailored support to countries, focusing on identifying and removing barriers to the uptake of social protection services, such as lack of information, documentation challenges, complicated procedures, stigma and discrimination.

Perceptions of global key informants

There was considerable agreement among global and country-level KIs with respect to the perceived importance of HIV-sensitive social protection activities, and alignment to the Joint Programme's work globally and nationally. However, some questions were raised about the adequacy of inserting this area of work within the UNAIDS Secretariat and Country Offices. Some Cosponsors (e.g., WFP, ILO, UNICEF and the World Bank) have considerable expertise in social protection, in addition to well-established partnerships with relevant social protection authorities at national levels. They are very well placed to integrate different goals and approaches in their support to member states on social protection systems and programmes. However, informants from Cosponsor agencies indicated that the involvement of UNAIDS Secretariat is needed to ensure that the general work of the UN in social protection systematically considers the unique needs of people living with, at risk of or affected by HIV, including key populations, as well as capitalizing on the experience of the various agencies in the specifics of HIV-sensitive social protection, and linking to CSOs representing people living with, at risk of or affected by HIV, including key populations.

Perceptions at country level

During field missions, it was found that the work of the Joint Programme in HIV-sensitive social protection is perceived as part of its role in creating an enabling environment for the inclusion of people living with, at risk of or affected by HIV, in different policy domains. This role is described as a combination of high-level advocacy, resource mobilization, technical support and facilitation of CSO–government dialogue. On this last note, some country informants also highlighted the importance of the global normative and strategic frameworks provided by the UN system as a lever for CSOs' advocacy vis-à-vis national governments, which includes the Human Rights framework, the Fast-Track strategy and the SDGs, with HIV- and AIDS-related targets, and its basic principle of leaving no one behind.

At country level, HIV-sensitive social protection is not a well-established and stand-alone area of work, but rather a component of UNAIDS' work on broad issues, such as gender equality, stigma and discrimination, employment, human rights, psycho-social support, etc. In general terms, country informants had difficulties in precisely describing the role of UNAIDS in social protection.

Moreover, in some countries, the term "HIV-sensitive social protection" was used in relation to the effective free access to HIV treatment, including ART, while the Joint Programme's work on this issue

is usually positioned under “treatment”. In Morocco, for instance, the historical role played by CSOs and UNAIDS in ensuring free access by people living with HIV to services related to HIV and TB, in a general context of limited health coverage, was considered the best example of their work in HIV-sensitive social protection. In this instance, this particular issue is still on the UNAIDS agenda due to risks arising during the ongoing reform of the national health system. In Malawi, UNAIDS advocacy for increased access to ART for all through the Test and Treat policy, was also presented as part of its work on HIV-sensitive social protection. In Benin, considering the gaps found between the government discourse and the reality, there was a gap in effective free access to ART that could be addressed by advocacy work of UNAIDS on HIV-sensitive social protection.

Finally, the role of the Joint Programme in HIV-sensitive social protection was also described as the consideration of the specific needs of people living with, at risk of or affected by HIV in different interventions supported by Cosponsors like ILO, UNICEF and WFP in the various domains of social protection, including livelihoods, cash transfers or food aid. This is perceived as fully consistent with the Cosponsors’ mandate and scope. In Ghana, for instance, this materializes in the assessment of the needs of people living with HIV in the framework of the financial and technical support provided by UNICEF to the Livelihood Empowerment Against Poverty programme.

How relevant are the Joint Programme’s guidance and efforts to integrating HIV into national social protection systems, and how connected to national systems are they (EQ2)?

General approach

The general approach of the Joint Programme’s work to social protection is based on collaboration with national governments and their social protection agencies. The approach is to eliminate discriminatory practices and key barriers that exclude people living with HIV, as well as key and other vulnerable populations from existing social protection benefits provided by the public system.

Examples of Joint Programme work connected to national systems are outlined below.

In 2020, the Joint Programme developed a government-focused social protection call to action and a subsequent global webinar, highlighting the urgent need to support refugees, asylum seekers and migrants with social protection systems.[111]

The 2021 report by the Joint Programme on HIV-sensitive social protection in East and southern Africa,[112] covering 15 countries in the region, focuses on national social protection legislation, policies and programmes, namely cash-based programmes, and how they reflect HIV-sensitive priorities. Within this region, HIV-sensitive social protection mechanisms took the form of cash transfers for specific populations.

The WFP reported technical assistance to 21 national governments and regional workshops aimed at integrating food and nutrition services with national HIV responses. WFP’s support included assisting governments in developing national guidelines on nutrition assessment, counselling and support (NACS), the analysis of nutrition and food security vulnerability assessment for people living with HIV, and training for health personnel. WFP also implemented the nutritional support aspect of NACS (formerly known as “food by prescription”) in 12 countries across three regions. In parallel, regional workshops on social protection organized in 2018 with UNAIDS’ collaboration in West Africa and southern Africa were aimed at strengthening national capacities for social protection programming that meets the needs of people living with HIV.

Support for livelihood strategies is also included in this area of work, and related advocacy activities of the Joint Programme have also sought to promote fair employment and eliminate poverty among people living with HIV. This includes evaluating attitudes of employers and employees towards people living with HIV to better understand the challenges faced in the workplace. Another area of focus has been social protection and livelihood strategies for women and girls—an area of particular focus for UN Women and the World Bank.

Alignment with national priorities and development strategies

In all country studies, it was found that the general work of UCOs and Cosponsors is well aligned with national priorities, policies, plans and strategies. Indeed, such work is often framed under national AIDS plans, and elaborated and followed up with support from UCOs and Cosponsors. Additionally, all countries count on participatory institutions that act as coordination mechanisms for the channeling of the Global Fund and provide the space for national ministries and international agencies to coordinate efforts in the overall fight against HIV and AIDS.

In Peru, for instance, the national coordinating body, La Coordinadora Nacional Multisectorial en Salud (CONAMUSA), was the platform for UNAIDS to conduct advocacy in liaison with CSOs on laws seeking to expand rights, especially for people living with HIV and key populations. Similarly, in Fiji, the Joint Programme conducts advocacy in relevant areas of national plans, such as gender equality, addressing discrimination, employment opportunities and access to health services, but the explicit focus is not on HIV-sensitive social protection.

In some countries, informants also referred to the working groups of United Nations Country Teams (UNCTs), UN Sustainable Development Cooperation Frameworks (UNSDCFs) and Development Assistance Frameworks (UNDAFs) as factors enabling harmonization and alignment to national strategies. For instance, in Ghana, all of the Joint Programme's work is framed under Outcome 2 of the UNSDCF, which is in turn aligned to national priorities; in China, the Joint Programme's work in human rights, antidiscrimination and gender equality in the framework of a component of the UNSDCF, and through a UNCT working group on "Leaving no one behind". In this framework, ILO conducted work on combating unfair employment practices and discrimination against people living with HIV, which is further described in other sections of this report.

This said, country studies revealed that the overall rationale of HIV-sensitivity does not always reflect governments' stated priorities on social protection. People living with HIV and key populations are only explicitly mentioned in official documents on social protection in China, Dominican Republic and Ghana, and according to interviews with government informants in the rest of the countries, it is often taken for granted that extending the outreach of social protection systems to poor households and enhancing their focus on vulnerable groups leads to increased coverage of people living with HIV. In Malawi and Morocco, it was highlighted that ILO and UNICEF usually play a leading role in the coordination of social protection working groups under UNCTs, and that such collaborations can help integrate HIV-sensitivity in social protection systems to align with national government plans and reforms.

Connections of UNAIDS to national social protection actors

During interviews with global informants, it was highlighted that UNAIDS' national counterparts and networks primarily include stakeholders whose work focuses on populations living with, affected by or at risk of HIV and in the health sector, and are not always connected to key social protection institutions, which may sit under the ministries of labour or finance. However, according to the same informants, ILO, UNICEF and WFP do have the connections needed to establish a high-level dialogue on country-wide social protection systems and their inclusion of people living with HIV.

To what extent are partners involved in the advancement of HIV-sensitive social protection, what roles do partners play and how can partnerships with and the capacity of stakeholders (civil society, government, others) be strengthened further? (EQ3)

Partnerships within the Joint Programme were found in Ghana and Malawi. In Ghana, WHO and UNAIDS partnered to conduct the Enabler's Package programme, which received funding from the Global Fund and focused on people living with HIV and TB and involved the distribution of blended fortified food. In Malawi, UNICEF collaborated with the World Bank and leveraged funding from Germany, Ireland and the European Union for the Social Cash Transfer Programme (SCTP). The SCTP reaches out to poor households in general terms, but its targeting includes a chronic illness marker that covers HIV.

Many other successful partnerships indirectly connected to social protection were found in field missions. These concerned the implementation of Fast-Track programmes and community-led monitoring to achieve HIV targets, advocacy for better representation and enhanced coverage of people living with HIV and key populations, legal reforms for key population-inclusive programmes, creation of employment for adolescent girls, young women, and other vulnerable groups, and inclusion of women in digital financial systems. These partnerships involved different ministries of governments (Health, Women and Child Development, Education, etc.); CSOs and international agencies (UNAIDS, UNICEF, UNFPA, WHO, WFP).

In Malawi, UNAIDS has developed successful partnerships with CSOs for people living with HIV (e.g., the Malawi Network of People Living with HIV and AIDS (MANET+), the Malawi Network of AIDS Service Organizations (MANASO), the Coalition of Women Living with HIV and AIDS (COWLHA)) and key populations (e.g., lesbian, intersex, transgender and other extensions (LGBTQIA+)), the organization known as LITE (Lesbian, Intersex, Transgender and other Extensions), Community Health Rights Advocacy (CHeRA), Female Sex Workers Association (FSWA)). These partnerships have led to better representation, inclusivity and advocacy for better access to public services by people living with HIV and key populations. UNAIDS has also collaborated with UN Women to reduce gender-based violence and mitigate the risk of HIV among girls and women. UNAIDS has partnered with the Ministry of Health for Fast-Track follow-up, including a community-led monitoring initiative. UNDP has also set up a successful partnership with the Ministry of Health to push for legal reforms to avoid criminalization of key populations.

In China, UNAIDS Joint Programme supports planning and monitoring of the implementation of the China AIDS Fund for Non-Governmental Organizations (CAFNGO), established by the National Health Commission, the Ministry of Finance and the Ministry of Civil Affairs. CAFNGO is a national public welfare special fund that supports CSOs involved in AIDS plans by providing livelihood support to people living with HIV, among other activities related to HIV prevention, treatment and care. Other partnerships involving UNAIDS and Cosponsors in China include annual academic conferences, the development of a community network and advocacy on employment discrimination.

Additionally, in some countries, the links established between UNAIDS and CSOs, together with their involvement in the governance of national AIDS plans and their liaison with health authorities, were described as a broad-based partnership directly or indirectly contributing to HIV-sensitive social protection.

As previously indicated, this is the case of CONAMUSA in Peru, where UNAIDS is praised for engagement with key populations in advocacy and decision-making. The Joint Programme has a close relationship with grassroots community organizations working for the benefit of the most vulnerable population. Between 2020-2023, UNAIDS with WFP, Partners in Health and the CCM (CONAMUSA) implemented a cash-based transfer programme for migrants and Peruvians living with HIV and key populations that reached almost 3,000 beneficiaries and disbursed more than USD 3 million to attend food insecurity. UNAIDS worked with WFP to ensure the system and protocols for beneficiary selection was sensitive to HIV and key populations, and sensitized NGO implementers to better understand vulnerabilities of key populations, particularly transgender women, sex workers and migrants. Similarly, in Morocco, UNAIDS has joined efforts with national and international partners at the National Council of Human Rights, which has led to a National Strategy on Human Rights and HIV and AIDS.

In all the countries analysed in depth, with the exception of Fiji, the feedback collected about the capacity of UCOs to establish relevant partnerships was unanimously positive, and related to the links established with CSOs, which in turn represent or connect to people living with HIV and key populations. In Fiji, mixed views were collected on this point. Country progress reports highlighted UNAIDS' collaboration with the Ministry of Health and Medical Services, but some country informants indicated that communication between UNAIDS and CSOs representing key populations was limited to planning around specific events (e.g., World AIDS Day).

3.2. Effectiveness

To what extent has the Joint Programme contributed to HIV (and to a certain extent TB) integration into national social protection programmes? What are the contributing and/or hindering factors for this integration? (EQ5)

Progress towards output 8.2 target of UBRAF 2016–2021 and result area 9 of UBRAF 2022–2026

Output 8.2 target of the UNAIDS 2016–2021 UBRAF report indicates that the Joint Programme will support national social protection to ensure HIV-sensitive social protection programmes targeted to vulnerable populations, including eligible HIV-affected households, communities and vulnerable children. In doing this, UNAIDS proposed to work with Cosponsors and various partners to build an evidence-informed reporting that looks at the socioeconomic drivers of the HIV epidemic and contributes to ensuring that social protection programmes, including cash transfer programmes, address the needs of people living with HIV and those affected by or at risk of HIV.

To this end, the 2016–2021 UBRAF established a target of 70% of countries with HIV-sensitive social protection strategies. The work of the Joint Programme was to be measured through strategic information, high-level advocacy, technical support and mobilization of affected communities.[113] For the Fast-Track Target to integrate HIV and health services in ways that strengthen national social and child protection systems, the aim was to reach 75% of people at risk of and affected by HIV. Actionable steps to actualize this goal through partnership with contributing agencies include building an evidence base for social protection interventions and support for countries in the form of social protection assessment; research and evaluation efforts; scale-up of sustainable HIV-sensitive and evidence-informed social protection programmes such as cash and in-kind transfers; strengthening the ability of health systems and education sector to serve vulnerable children and adolescents; and, lastly, advocating for increased investment and cofinancing to support the implementation of HIV-sensitive measures for orphans, vulnerable children and key populations.[53]

As outlined in the UBRAF 2018 report, the percentage of countries with social protection strategies and systems in place that address HIV increased marginally from 85% in 2017 to 86% in 2018, surpassing the 2019 milestone of 60%. However, there was a reduction to 82% and 83% in 2019 and 2020, respectively. In 2020, 75% of these countries were considered to have social protection programmes, such as safety nets and livelihood interventions, which supported people living with and affected by HIV, compared to 71% reported in 2018. More precisely, of the 113 countries with approved social protection programmes, 75% had at least one of the six measures of HIV-sensitivity. Progress against some indicators was not general—for instance, only 44 countries recognized adolescent girls and young women as key populations, and unpaid care work in the context of HIV was recognized in the national social protection strategies of only 35 countries—but UBRAF reporting informs of general progress towards HIV-sensitive social protection.

How are the Joint Programme's social protection targets followed up?

The Joint Programme performance monitoring is based on the UBRAF indicators, drawing on quantitative data collected through the JPMS and complemented by qualitative narratives from various data sources and validation processes that are subjected to critical evaluation. The ILO and other Cosponsors supported 94 countries in Africa, Asia and Latin America in developing their social protection systems using tools and guidelines prepared by the Secretariat. Working in 15 countries, the Joint Programme also continued to collaborate with the US President's Emergency Plan for AIDS Relief (PEPFAR)'s Determined, Resilient, Empowered, AIDS-free, Mentored and Safe (DREAMS) initiative by combining social protection interventions with HIV activities aimed at adolescent girls and young women; and the World Bank supported various similar measures aimed at adolescent girls and women, such as a multiyear project in Zambia operating during the timeframe of this evaluation (with school fees covered for over 90 000 girls and livelihoods support to over 96 000 women as of late 2022).

In the 2020 UBRAF performance report, the Joint Programme reported that progress was made in four of the five sub-indicators that measured HIV-sensitive social protection for people living with, at risk of or affected by HIV. Progress remained slow in the area of unpaid care work for HIV services while key populations continue to face many barriers to inclusion in social protection services, including stigma and discrimination, lack of information on available programmes, complex programme procedures, lack of documentation on eligibility, higher personal expenses and prohibitive laws to prevent access.

In the 2020 reporting of the Joint Programme, activities on HIV-sensitive social protection were measured based on six themes: (1) normative guidance; (2) capacity development; (3) mapping and assessments; (4) extension of HIV-sensitive protection; (5) funding; and (6) strengthening national social protection programmes and partnerships. The other aspects of the Joint Programme reporting include addressing the impact of COVID-19 on access to prevention for key populations, addressing legal and structural barriers and access to services, service delivery support through Global Fund partnership, and providing capacity development knowledge. In the *UNAIDS 2020 performance monitoring report*,[114] released in June 2021, a more structured evaluation of HIV-sensitive social protection by the activities of each of the 11 Cosponsors was presented.

Feedback from the field on HIV-sensitive social protection

In contrast with the data provided by the Joint Programme at the global level, field studies revealed that social protection systems do not always explicitly specify the inclusion of people living with or affected by HIV and data on their effective coverage is generally lacking. Moreover, UCOs did not indicate during field missions how their countries are positioned in such indicators, nor did their scores seem to be used as a basis to guide action at the country level.

In Fiji, for instance, the national social protection system, despite being considered one of the more comprehensive systems in the Pacific, has neither an explicit social protection scheme targeting people living with or affected by HIV, nor does the Social Assistance Policy describe how social assistance is HIV sensitive. Moreover, due to confidentiality, doubts were raised about the possibility of providing differentiated assistance to people living with, at risk of or affected by HIV from social protection services. A lack of disaggregated data on coverage also hinders the possibility of doing an ex-post assessment of the inclusion of people living with HIV in existing services. This was also the case in Benin, the Dominican Republic, Malawi and Morocco. Based on the impact of the WFP-UNAIDS cash-based transfer programme and food basket provided by the MoH to people affected by TB (PANTB), UNAIDS is advocating with the Ministry of Social Inclusion and Development and MoH to ensure similar social protection benefits reach PLHIV and key populations in Peru.

The lack of specific inclusion of people living with, at risk of or affected by HIV does not mean that programmes are not HIV sensitive. In Malawi, for instance, people living with or affected by HIV are not specifically targeted in the National Social Support Programmes, a guiding policy for all the social protection programmes in the country. However, as previously mentioned, those living with HIV or affected by it (e.g., orphans) are marked with a vulnerability marker that refers to chronic illnesses and therefore does not raise confidentiality issues, nor does it put users at risk of discrimination. Markers of vulnerability are used to select participants into different social protection programmes.

In Ghana, Dominican Republic and China, the policies and official documents on social protection include people living with HIV. In Ghana, the National Social Protection Policy, drafted in 2015, does identify people living with HIV and TB as “socially vulnerable” groups. However, this has not been further operationalized to provide some differentiated support.

In China, the social protection system includes a package of benefits specifically dedicated to people living with or affected by HIV. The "Four Frees and One Care" grants people living with HIV and their families with life assistance, medical care, education, employment and other benefits. Additionally, the Ministry of Civil Affairs issued a "Notice on strengthening relief work for AIDS patients, family members and orphans with difficult living", which proposed to implement the current social assistance policies and provide necessary living assistance for people living with HIV and their

families, and a concrete plan for assistance to people affected by HIV in poverty-stricken areas is in place. Healthy Poverty Alleviation, as this programme is called, offers not only free HIV testing, treatment and prevention measures, but also poverty-alleviation measures.

In Dominican Republic, the scope of social programmes had broadened, extending coverage to vulnerable children. CONAVIHSIDA (Consejo Nacional para el VIH y el SIDA) worked in identifying affected or orphaned children and referring them to social protection programmes. UNICEF further supported a network of people living with HIVPLWHIV to offer psychological support and follow-up to children of HIV-positive parents.

The Joint Programme's contribution according to Joint Programme internal reporting

Joint Programme reports indicate that the Programme has played a central role in integrating HIV services more fully with social protection programmes. Several lines of work and concrete examples supporting this statement can be found in UNAIDS files.

Collaborative efforts between the Secretariat and Cosponsors, technical assistance and stakeholder engagement to improve the understanding of HIV-sensitive social protections. Such efforts are reported in Lesotho, Namibia, Tanzania and Uganda.

UNHCR and UNAIDS collaboration to address the specific needs of social protection and health of refugees living with HIV. This collaboration materialized in Botswana, Malawi, Nigeria, the Philippines, Tanzania, Uganda and Zimbabwe. The social protection support provided in each country was based on specific needs and context, including support for data collection on social protection, cash transfer national initiatives, creating an outpatient HIV and AIDS treatment package to improve financial status, access to health services by people living with HIV and marginalized groups, and the establishment of peer-support groups.

UNICEF technical support to expand HIV-sensitive social protection services in national systems with a focus on access to social and health services by adolescents that are at risk of HIV in eligible households. Specific approaches to achieve success include providing comprehensive information on health and HIV, supporting sexual and reproductive health education, collaboration on educational assistance and financial literacy, identifying job opportunities and supporting access to protective social assets. Coordination and implementation of these programmes have centred on adolescent and gender case management that involves multisector linkages in areas such as health, social welfare, justice, child protection and social development.

UNAIDS and WFP collaboration in food aid and cash aid in emergencies. This includes previously cited work conducted by WFP in 18 African countries, and a UN to UN agreement in Peru for a cash-based transfer programme targeting key populations, migrants, and Peruvians living with HIV In the area of providing high-level advocacy support, the UBRAF 2018 report indicated that the WFP has focused on its advocacy on behalf of adolescents by partnering with agencies such as the Coalition for Children Affected by AIDS.

Feedback from the field on the contribution of the Joint Programme

Field missions have found that HIV-sensitive social protection is not a clearly established area of work in all countries, although relevant activities can be found in overall advocacy on social protection, livelihoods and food security interventions, as well as in UNAIDS advocacy and support related to HIV treatment and healthcare for people living with HIV and key populations.

In Ghana, for instance, WFP and UNAIDS conducted advocacy for integration of people living with HIV in the 2019 Food Security Assessment. They also advocated for capacity strengthening in livelihoods for people living with HIV to promote their nutrition and food security. Additionally, ILO conducted advocacy on the benefits and opportunities of health insurance coverage for people living with HIV, among other groups, and provided technical and financial support to identify CSOs that could expand the existing livelihood pilot programmes for people living with HIV and other key

populations. Ghana was also one of the countries where UNAIDS used its tool for assessing HIV sensitivity of social protection systems, as explained in the following section.

In Benin, the UNAIDS tool was also applied, and several livelihood opportunities were supported. These included support of four associations of people living with HIV to improve their livelihoods and food security, and financial support to orphans and vulnerable children, particularly girls, as well as cash transfer programmes targeting out-of-school girl mothers.

In Peru, the social protection assessment tool was applied by WFP in 2020 and the findings informed the development and implementation of the cash-based transfer programme implemented with UNAIDS until 2023.

In Malawi, the UNAIDS social protection tool has not been used, but UNDP, UN Women, UNICEF and UNAIDS itself are engaged in other assessments and tools intended to enhance HIV sensitivity in social protection systems. Additionally, UNICEF and WFP are integrating HIV needs in the nutrition cluster, while UNICEF is working on the United Beneficiary Registry and the issue of markers that allow for targeting people living with HIV.

In China, several joint activities were conducted in HIV prevention, care and treatment, and advocacy. ILO has been supporting the Ministry of Human Resources and Social Security (MOHRSS) and the China Academy of Labour and Social Security in conducting an in-depth analysis of employment, income and social protection for people living with HIV and AIDS in poverty-stricken areas of China. This analysis has been an important step towards identifying and addressing the key barriers that prevent people living with HIV from accessing employment opportunities and social protection measures. Based on a study, MOHRSS and the ILO have developed guidance on fair employment for people living with HIV. This guidance aims to combat employment discrimination against people living with HIV and ensure that they have equal access to employment opportunities, including vocational training, job placement services and social protection measures. Other key areas of support from the ILO have been to improve the employment and vocational skills of people living with HIV, particularly women facing multiple challenges such as poverty, being from minority groups and gender-based discrimination. The ILO has supported the Women's Network Against AIDS (WNAC) in carrying out training workshops to upgrade digital skills, such as livestreaming selling, to enable people living with HIV to enhance their employability and earn a living.

In Morocco, UNAIDS has been advocating for effective free access to HIV treatment at the national centre. In the 2020–2021 planning within Priority Area 2 on "HIV testing and treatment", a goal was set on the integration of people living with HIV in social protection programmes. A survey on the food and nutritional status of people living with HIV was carried out in Morocco. The UCO and WFP provided technical assistance to the Ministry of Health and Social Protection (MOHSP) in conducting the survey. During the COVID-19 crisis, UNAIDS provided financial support to nongovernmental organizations (NGOs) to deliver food aid and medicines to people living with HIV.

Morocco informants also highlighted as a successful contribution to HIV-sensitive social protection the National Psychological and Social Support Programme (PNAPS). Part of the AIDS National Strategic Plan, this programme does not grant any additional benefits to people living with HIV but provides assistance for them to access different schemes of social protection and livelihood support. With support from social workers and CSOs, the programme is believed to help people living with HIV and key populations overcome barriers such as lack of information and discrimination by public officials.

Additional information on the advocacy work of the Joint Programme is provided under EQ9.

What are the contributing and/or hindering factors for integration of HIV in social protection systems? (EQ5)

Factors enabling HIV-sensitive social protection systems (EQ5)

UNAIDS' advocacy work on HIV-sensitive social protection was positively assessed in all countries. The focus of such work included integration of HIV sensitivity in ongoing social protection strategies

and initiatives, and effective coverage of free HIV treatment. Such advocacy work tends to draw on studies previously conducted by the Joint Programme. Advocacy work on human rights is often cited as conducive to HIV-sensitive social protection, as it tackles discrimination and criminalization of key populations.

Although HIV was not fully integrated into the national social protection system in Malawi, efforts are being made in that direction. Social protection systems were considered as key elements in HIV impact mitigation. An assessment carried out by UNAIDS in collaboration with the Ministry of Gender revealed how social protection systems were some of the key strategies that ought to be implemented to reduce the socioeconomic impact of COVID-19 among people living with HIV. Key policy frameworks of social protection and HIV (i.e., MNSSPII, NSP I, HIV management and prevention framework) provided the environment for integration of the two sectors, even though it was not explicitly mentioned.

A hugely successful social protection intervention in Ghana was recommended for mainstreaming. For example, the agricultural loan intervention in the eastern region has women make up 80% of shareholders with the rural banks because of how successful they were at servicing the loans. Because the Ministry of Gender, Children and Social Protection was at the helm of social protection, it was relatively easy to collate data and initiate social protection interventions across the country. However, lack of data on HIV-vulnerable populations was considered a barrier for providing HIV-sensitive social protection interventions. Consistent donor support was also regarded as one of the contributing factors to the integration of HIV in the national social protection system. The inclusion of social protection in the HIV National Strategic Plan and the role of Ghana Aids Commission (GAC) in leadership and coordination had a positive influence.

The participation of activists and people affected by HIV through political advocacy allowed progress in accessibility of ART in Peru. Organizations such as Programa de Soporte a la Autoayuda de Personas Seropositivas (PROSA) and community led monitoring GIVAR (Grupo Impulsor de Vigilancia en Abastecimiento de Medicamentos Antirretrovirales) remain vigilant and work for the rights of key populations. UNAIDS works to strengthen the voices of the communities to demand their rights by ensuring their active participation at the national multisectoral coordinating committee on health, CONAMUSA.

China was committed to providing services to people living with HIV and to eliminating discrimination toward people living with HIV. There were several factors that contributed to the integration of HIV in the national social protection system, including advocacy with authorities, publicity through the media, capacity building of CSOs, overall socioeconomic development, and international organizations and UN agencies sharing international experiences, guidelines and measures.

In Morocco, effective partnership between civil society and the MOHSP, supported by the king, was considered a key factor contributing to success. Collaboration and dialogue among the national and international actors, including the financial assistance of the Global Fund and technical support of UNAIDS, provided an enabling environment for international aid to be effective. The importance of ensuring access to HIV treatment and ART was understood by all the key actors of the AIDS National Strategic Plan and the MOHSP, with Global Fund support, ad hoc financial coverage of such treatment and the engagement of NGOs.

Factors hindering HIV-sensitive social protection systems (EQ5)

Stigma and discrimination against key population groups, coupled with processes and systems that were not sensitive to the needs of people living with HIV, were the key barriers to the integration of HIV in the national social protection system. Key populations and people living with HIV suffered stigma and discrimination in healthcare settings and workplaces. Several other factors hindered integration, including lack of national HIV strategies; barriers and limitations of social registries; lack of surveillance data; and lack of awareness about social protection measures among the key populations. In addition, lack of policy and legal support to key populations, discriminatory civil laws against single mothers and dependent children/orphans were considered to hinder the integration of HIV in the national social protection system.

In Fiji, there were significant barriers to people living with HIV accessing support services, including social protection schemes. Stigma and discrimination toward key populations, coupled with processes and systems that were not sensitive to the needs of people living with HIV, created barriers for the uptake of social protection services by people living with HIV. At the policy level, the lack of a national HIV strategy was also a factor limiting a multistakeholder response to HIV. Lack of appropriate surveillance data was also considered a barrier to assess the extent of the issue and the needs of affected groups. Based on the available information (documentation, interviews and data collection), there was no evidence of the extent to which HIV was integrated into the national social protection system in Fiji. While Fiji had a comprehensive social protection system that adopted a life-cycle approach and had a strong focus on reaching the poorest and vulnerable, as evidenced by documentation and interviews, currently the social assistance may not be reaching some population groups, including people living with HIV.

In Malawi, the United Beneficiary Registry did not have an explicit HIV marker in its assessment; rather HIV was categorized under chronic illnesses. At the national level, HIV and social protection were not properly integrated, which made it difficult for the populations in need. Stigma, discrimination and a lack of policy and legal support to key populations were also barriers. After the significant achievement of reaching the 95–95–95 targets, there was a sense of complacency. HIV-response programmes were supposed to “treat, care, and support”, but only the treatment was provided. The care and support stages, where social protection ought to be brought in, have not been properly conceptualized and advocated for.

In Ghana, several limiting factors were identified, including lack of adequate data on vulnerable HIV populations, poor involvement of CSOs, inadequate funding, stigma and discrimination, lack of awareness about the social protection measures among key populations, and lack of policy prioritization for HIV-sensitive social protection.

Despite the fact that universal health coverage in Peru includes HIV treatment, free of charge, to all people living with HIV in the country, including migrants, a high level of stigma and discrimination hinders improvement in social protection policies for people living with HIV. No sector seems to have a clear responsibility for HIV care. The qualitative analysis of social protection programmes in Peru conducted by WFP in 2021, showed that no policies nor social programmes which are sensitive to HIV were found beyond the health sector. In China, stigma and discrimination in health settings and workplaces, lack of awareness about services, and the requirement of proof of three-month residency were considered hindrances to the integration process. Imbalances in development in different regions made it difficult to implement minimum protection packages, types of HIV drugs in medical insurance and the access to some surgeries. The difficulties faced by people living with HIV were not well recognized and addressed by some local governments. LGBTIQA+ individuals and sex workers were still not well accepted by the public and some policymakers. In recent years, the CSOs’ voice has weakened and the channels of communication between CSOs and the government have also weakened, leading to limited capacity-building and advocacy activities.

In Morocco, social protection for people living with HIV and key populations has encountered structural challenges related to the overall coverage and inclusivity of the social protection system. Such challenges included financial shortcomings related to informality in labour markets and a narrow foundation of the pension system in terms of contributors, as well as fragmentation and lack of coordination of regimes and programmes, resulting in gaps in coverage. The laws of the country that criminalized key populations, including people who inject drugs, gay men and other men who have sex with men and female sex workers exacerbated stigma. The discriminatory civil law weakened single mothers’ and dependent children’s independence by making them rely on men to fulfil public registry requirements that give access to basic services and social protection benefits.

How effectively is the (UNAIDS) HIV and Social Protection Assessment Tool (and related tools by other agencies) used to link people living with, at risk of, or affected by HIV to social protection services? (EQ7)

The UNAIDS HIV and Social Protection Assessment Tool

The UNAIDS HIV and Social Protection Assessment Tool was published in 2017 as an instrument to gather information on existing social protection schemes in different countries and locations in terms of their purpose, eligibility criteria, coverage and sensitivity to HIV.[22] The Tool also assesses whether people living with HIV, adolescent girls and young women at high risk of HIV infection, key populations and others are accessing social protection programmes, and identifies the barriers faced in accessing social protection benefits. Finally, the assessment tool was also designed to suggest actions that can be taken to eliminate barriers that exclude key populations in social protection programmes.

The *UNAIDS summary report 2018–2019*[118] suggests that the Assessment Tool was used to better understand the reasons why key populations were being excluded from access to social protection schemes. This was relevant for the studies undertaken by the ILO, UNAIDS and WFP and partners to understand the barriers facing people living with HIV and other key populations in terms of access to social protection services. The lessons learnt from these evaluations informed the design and review of social protection schemes at country levels.[114] The report outlines that over 25 HIV-sensitive country assessments were conducted using the Assessment Tool through support from the WFP, ILO and UNAIDS Secretariat.

Feedback on the UNAIDS Assessment Tool from the field (EQ7)

The Assessment Tool was completely unknown to country informants in most field missions. These included China, Fiji, Malawi, Morocco and Peru.

In Morocco, the tool was referred to in the plan for 2022–2023 as part of the advocacy support to CSOs. However, neither the UCO nor any other country informants were aware of the tool. In addition, there were no adequate data on the inclusion of people living with HIV and key populations in the social protection system. Additionally, the target of the Political Declaration of the AIDS National Strategic Plan that refers to social protection (ensure that 75% of people living with HIV, affected by HIV or at risk enjoy social protection) was not indicated in the annual reports. The low HIV-prevalence rate was considered a possible reason for lack of increased focus on social protection reforms among people living with HIV.

In Malawi, the UNAIDS Assessment Tool of social protection systems was also not known among all the government agencies and personnel interviewed. Among UN Cosponsors, only one reported to have used some elements of the tool while they were in the process of developing a different social protection assessment tool of their own with UN Women. Indeed, these two Cosponsors are seeking a way to rapidly identify individuals' needs for social services and HIV care and treatment during emergencies. UNAIDS is also collaborating with the Ministry of Gender to assess HIV sensitivity of social protection policies and programmes in the country, but the Tool is not being used for that purpose.

In Ghana, where the tool was used in 2021 to develop the 2021 HIV and Social Protection report by the GAC and WFP, most respondents representing national stakeholders were unaware of the UNAIDS Assessment Tool. Those who knew of it described it as cumbersome and indicated that it required adaptation by national experts before use.

In Peru, as explained above, WFP conducted a qualitative diagnosis using the social protection assessment tool in 2021, but the report was not published nor socialized. UNAIDS in Peru and the WFP focal point of the Joint Team used the findings of this report to develop a UN-to-UN agreement with UNAIDS to implement the cash-based transfer programme for migrants and Peruvians living with HIV and key populations, that reached 3,000 beneficiaries and disbursed more than USD three million in 3 years.

How effective is the Joint Programme supporting the regional initiatives on HIV-sensitive social protection? (EQ8)

No country informant has reported awareness of regional activities directly related to HIV-sensitive social protection. However, respondents in most countries made reference to regional activities in other areas of work.

The interest in regional activities for experience sharing and knowledge transfer was highlighted in China. In this country, support is provided to CSOs to participate in regional or global events and understand the differences and similarities of the work of different countries, create channels of communication and connect with and set up regional and global networks.

What models or instruments for HIV-sensitive social protection are feasible and available in resource-constrained environments? (EQ4)

As outlined in the previous sections on relevance and effectiveness, the following successful experiences can be considered as models or sources of inspiration for developing HIV-sensitive social protection programmes in resource-constrained environments.

The chronic illness marker in cash transfer programmes in Malawi

As already mentioned in references to country studies, governments tend to extend the coverage of social protection programmes while enhancing their focus on poverty and vulnerability, and it is generally understood that people living with HIV and key populations who are poor benefit from more expansive and inclusive social protection programmes. However, people living with HIV (or affected or at risk of HIV) do not often form part of government-stated priorities on social protection.

Indeed, different views were expressed during interviews on the issue of the prioritization of people living with HIV in social protection systems. On the one hand, some informants argued that people living with HIV should not be prioritized over other groups, such as people with disabilities. Additionally, it is not clear how such priority could be operationalized without revealing the confidential information on HIV status and adding to stigmatization. On the other hand, country informants agree that key populations find additional barriers to public services, and it cannot be taken for granted that they will benefit from general expansion of social protection on an equal basis.

In Malawi, the SCTP, supported by UNICEF, is the country's flagship social protection programme. Since 2018, it has increased its coverage from 14 to all 28 districts, strategically targeting ultra-poor households, or households that live on US$1.90 or less per day. In this programme, people living with HIV is one of the conditions that falls into the category of chronic illness. While HIV status is not a specific criterion for inclusion in the SCTP, the programme criteria ensure that poor households affected by HIV are included.

In general terms, CSOs in Malawi indicate that people living with HIV are being left behind in many social protection programmes, and they have advocated a similar marker to be introduced in the United Beneficiary Registry, a registry put in place in the framework of the ongoing national plan on social protection and meant to be used for targeting purposes under different social protection initiatives.

In more general terms, a chronic illness marker in social protection registries could help to better integrate people living with HIV in social protection programmes while preserving confidentiality and avoiding additional stigmatization risks.

Assessment of food security and vulnerability of HIV-affected households in Ghana

In Ghana, WFP has conducted a food security assessment of people living with HIV. This survey, conducted in 2018, assessed food insecurity and vulnerability status of HIV-affected households in four regions of Ghana. The assessment concluded that 21% of ART users are food insecure and highlighted the role of optimal nutrition in treatment success.

The report led to several recommendations for providers of food and cash aid on targeting criteria for aid delivery, as well as beneficiary registries, and phasing-out strategies based on livelihood support. The assessment contributed to increasing awareness on the relevance of HIV-sensitive food security interventions in Ghana and can be considered a model for contexts in which social protection concentrates on food security.

A country-wide social mediation network in Morocco

The PNAPS is a psychological and social support programme that forms part of the Moroccan national plan against AIDS. The whole plan is led by the Ministry of Health and Social Protection, developed with support from UNAIDS and the Global Fund. It intends to have a countrywide scope and has been gradually extended to the various referral centres on HIV treatment with the involvement of CSOs.

The programme consists of a training framework and an operational guide on the continuum of care, which includes socioeconomic support. To ensure the quality of the services, it includes an accreditation system for participants, including CSOs, and sets criteria for services inside and outside the hospital. Inside the hospital, the service package includes psycho-social support, and outside the hospital it includes social mediation, legal support, and even economic support, including cash, food and transport aid, as well as linkage with livelihood programmes.

As indicated previously in this report, the PNAPS does not grant social protection benefits, but it puts in place a network of social workers that link people living with HIV to social protection benefits. This helps users to overcome barriers.

The potential of the PNAPS is obviously limited by the social protection measures in place in Morocco and their gaps and shortcomings, but it may be greater as the different phases of the ongoing social protection reform unfold. In any case, a support network like this helps vulnerable people living with HIV to access whatever benefits are available for vulnerable people in Morocco.

Analyzing employment, income and social protection for people living with HIV in areas of China characterized by widespread poverty.

Over the past few years, the ILO has supported the Chinese Ministry of Human Resource and Social Security (MoHRSS) and the China Academy of Labour and Social Security in conducting an in-depth analysis on employment, income and social protection of people living with HIV in poor regions of China. The analysis has been used to identify the key barriers that prevent people living with HIV from accessing employment opportunities and social protection measures, and has led to further studies, such as an assessment of the attitudes of employers and employees towards people living with HIV in selected companies.

As a result of this research, a guide on fair employment for people living with HIV has been produced, awareness on the harmful effects of employment discrimination against people living with HIV has been raised, and several pilot activities with people living with HIV have been supported. These included vocational training, job placement services and social protection measures.

3.3. Efficiency

How well equipped is the Joint Programme to effectively contribute to HIV-sensitive social protection in the country and what should be its role going forward? (EQ6)

Feedback from country informants

Mixed evidence was found at country level on the capacity of the Joint Programme to contribute effectively to HIV-sensitive social protection. Some country reports highlight a lack of resources, while others report an effective use of the capacities distributed across Joint Programme offices and Cosponsors.

There were mixed views about the capability of the Joint Programme to contribute effectively to the HIV response, including HIV-sensitive social protection in Fiji. Concerns were expressed about the lack of adequate resources available to UNAIDS, as a lead agency with an HIV mandate, to effectively support government and civil society in their efforts. There was a need for more coordination and resourcing to ensure agencies under the Joint Programme had appropriate capacity and capability to undertake this role. In moving forward, the Joint Team should explore ways of including people living with HIV into the social protection programmes.

The Joint Programme has successfully fostered partnerships with government and civil society organizations and supported the implementation of HIV-sensitive programmes in Malawi. The Joint Programme was considered to be in a strong position. Several factors strengthened it to lead in the future as it has membership in several technical working groups/clusters on social protection, HIV prevention, treatment and care. In addition, it has the technical capacity to support the government in the implementation of HIV-sensitive social protection programmes.

In Peru, the Joint Programme contributed through emergency aid and technical assistance in coordination with CONAMUSA members to address food insecurity of PLHIV and key populations affected by national weather and political crises and emergencies ("El Niño" and military coup in 2022).. It was felt that the role of the Joint Programme should be strengthened to have more structured planning and programmatic involvement. The Peruvian Government should carry out the social protection programmes, but with the assistance and participation of the Joint Programme, as well as academia, private enterprise and CSOs.

Although the Joint Programme's funding has decreased in China, the joint activities seemed to be more efficient and effective. With the elimination of mother-to-child transmission (EMTCT) programme being multi-departmental in operation, more agencies were expected to come together—for example, UNICEF, WHO, UNAIDS and other UN agencies, partners of women's and children's health, disease control, CAFNGO, CSOs and women's groups. It was felt that the EMTCT model in China could become the best practice to emulate. The Joint Programme was expected to continue providing legal assistance to LGBTQIA+ and other groups and promote the availability of high-quality treatment to key population groups.

In Morocco, the UN partners were fully engaged with the national government in the fight against AIDS by way of providing technical assistance to institutions like MOHSP and the National Council on Human Rights. For the team to fill in the data gap on HIV-sensitive social protection, more resources were needed. UNICEF was coleading the UN work on social protection with dedicated staff and budget. However, the coverage of people living with HIV was not included in their social protection work. The way forward could be a collaboration of UN entities to commission a study on HIV-sensitive social protection, with data on coverage to inform advocacy work related to the ongoing reform of the social protection system and to strengthen the availability of data for key populations.

3.4. Equity

What are the main contributions of the Joint Programme in increasing access and coverage of HIV-sensitive social protection, including for key populations? (EQ9)

During the COVID-19 pandemic, the role of the Joint Programme was largely in providing supporting systems to sustain key population responses by strengthening COVID-19 service delivery initiatives and inclusive emergency social protection systems. Social protection support in some cases, such as in Peru and Thailand, was directed towards migrants, the LGBTQIA+ community and sex workers through cash transfers and small grants from WFP and UNDP.[115]

The UNICEF Cash Plus programme promoted inclusive HIV-sensitive social protection programming by strengthening linkages between national cash transfer schemes and HIV social services for vulnerable children and adolescents. WFP implemented a similar cash-based transfer programme for

households affected by HIV and also advocated for an inclusive and reliable social protection system that extends to people living with HIV.[111]

The *UNAIDS 2020 performance monitoring report*[114] further describes the specific key population groups targeted in its HIV-sensitive social protection advocacy and activities to include young people, women and girls, people with disabilities, refugees, asylum seekers, migrants, populations in a state of food insecurity, people experiencing malnourishment, and in humanitarian settings. These also include people living with HIV, people affected by conflict or violence, people with disabilities, low-income workers, orphans, vulnerable children, as well as those who have lost income or employment due to COVID-19.

UNAIDS' *In danger: Global AIDS update*[116] refers to the need for more data on access to social protection benefits among persons living with, at risk of or affected by HIV in order to better estimate their social protection coverage.[116] Social protection advocacy carried out by Cosponsors varies and depends on the focus and interest of the agency as well as the epidemic profile in the countries where they are in operation.

Coverage and access across population groups

In response to the COVID-19 pandemic, WFP aided people living with and affected by HIV by offering safety net transfers such as cash, vouchers and in-kind support. They also partnered with the UNAIDS Secretariat to implement a pilot cash-based transfer programme in Burkina Faso, Cameroon, Côte d'Ivoire and Niger that assisted 19 500 individuals in 4 000 households. The beneficiaries used the cash transfers to buy food and invest in income-generating activities.

In the Gambia, WFP supported vulnerable households through the established Lean Season Response Transfer Programme, via which 380 households with people living with HIV received monthly cash assistance.

During the COVID-19 pandemic's socioeconomic impacts on the most marginalized and vulnerable populations in Djibouti, WFP supported households affected by HIV with a cash-based transfer programme, in addition to the Programme National de Solidarité Famille (PNSF), an unconditional cash transfer programme for the most vulnerable people. Mitigating the socioeconomic impacts of the COVID-19 pandemic on the most vulnerable groups was also a key area for the World Bank, including through ongoing projects and as part of its US$6 billion Fast-Track Response Facility. Examples of this work in 2021 examples included a package in Uzbekistan, including cash support to vulnerable families, and a pandemic response project in Pakistan that had delivered cash transfers to 15 million vulnerable beneficiaries by December 2021.[117]

Additionally, UNDP has assisted in reforming discriminatory laws and policies on HIV, TB and other health issues in 89 countries to combat exclusion and marginalization and improve health outcomes. For instance, Belarus created a working group to propose changes to HIV criminalization and Sudan repealed a punitive public order law.[118]

In all the countries assessed, it was found that key populations commonly experience difficulties in accessing social protection benefits due to stigma and discrimination. The key populations most often cited in country reports were sexual- and gender-minority populations, especially transgender people.

In Fiji, it was felt that the current social protection assistance may not be reaching the intended beneficiaries, especially poor and vulnerable households and those requiring assistance because of extra costs associated with their status (such as disability). Stakeholder representatives highlighted that people living with HIV and at-risk populations were left behind when it came to coverage and access to formal social protection assistance, due to stigma and discrimination, services not being accessible and a lack of data to identify where the vulnerable groups existed.

In Malawi, people living with HIV had access to government social protection programmes only if they were extremely poor, as HIV was categorized under chronic illness in the United Beneficiary Registry which provides benefits to ultra-poor citizens with a chronic disease. The government social

protection programmes (such as the social cash transfer programme) did not target individuals, but rather targeted households. Therefore, if a household included a member who was living with HIV, that household also received the benefits. However, a significant number of people living with HIV were still left behind because of the lack of an explicit HIV marker in the assessment criteria and poor HIV-sensitive targeting of social protection programmes. Young people living with HIV also had limited access to social protection programmes. It was believed that almost all the key population groups were left behind in their ability to access to social protection because of discriminatory laws in the country. Female sex workers were not included as beneficiaries of the social cash transfer programme even though they were poor and vulnerable. In 2021, female sex workers mobilized themselves to apply for the benefit of the National Economic Empowerment Fund (NEEF) initiative, but they were denied because they were sex workers. Non-binary and transgender persons were also left out, as the country did not have a third gender marker and could not register them into the government social protection programme.

Ghana’s HIV and social protection report of 2021 stated that the lack of disaggregated data on the estimated sizes of groups identified as vulnerable was a barrier in assessing social protection interventions at both the national and sub-national level. Civil society representatives indicated that several vulnerable groups were left behind in acquiring social protection, including young people living with HIV, young people with TB, caregivers of young people living with HIV, older people living with HIV, persons with disabilities living with HIV, transgender people, prisoners and prisoners living with HIV, lesbians and children of female sex workers.

In Peru, the Ministry of Development and Social Inclusion is responsible for implementing social protection plans for people in extreme poverty or who are at risk of falling into extreme poverty. The ministry implemented seven targeted social programmes. They also assisted vulnerable groups, such as transgender women. The MoH provides food baskets for people affected by TB, but not living with or affected by HIV. UNAIDS advocated with CONAMUSA, WFP, and IOM to provide food baskets to sex workers that work on the streets and were not able to go out to work due to the prevailing violence.. UNAIDS, NGOs and other organizations work on the legal regularization of migrants, so that they could receive the resources and aid offered by the programme.

In general, the social protection system in China was characterized as low-level universal coverage. Certain subgroups were considered to be at risk of being left behind, including people living with HIV with other risk factors and comorbidities, senior groups without stable income, transgender individuals, sex workers, minors and foreigners not covered by local social protection. In 2016, the State Council successively promulgated the "Opinions on Strengthening the Care and Protection of Left-Behind Children in Rural Areas" and "Opinions on Strengthening the Protection of Children in Difficulties" after the UNICEF initiative on AIDS orphans and children in difficulties in rural areas. In April 2019, China issued the "Document on Further Improving the Care and Service System for Left-behind and Children in Difficulties in Rural Areas", specifying that the members of village (residential) committees, village officials or professional social workers were responsible for childcare and protection services, and female members of village (residential) committees were given priority.

The representatives of CSOs in Morocco indicated that female sex workers, widows and single mothers and their children were in a disadvantaged position in terms of access to social protection programmes. Migrants had difficulty accessing social protection due to mobility. CSO representatives reported that HIV treatment and quality healthcare was adequately provided to prisoners. It was felt that the social protection system did not provide any solution to the most vulnerable children living with HIV, who were sometimes orphans or dependents of a widow or single mother. The ongoing transition from Regime d’Assistance Medicale (RAMED) to Assurance Maladie Obligatoire (AMO) and the generalization of family allowances announced for 2023 and 2024, which puts a specific focus on vulnerable children, were considered to be good opportunities for increased coverage for children, including those depending on widows and single mothers.

The Joint Programme's contribution to inclusive access

The Joint Programme has helped improve inclusive access in several ways, including mapping of vulnerable groups and people living with HIV/TB, developing nondiscriminatory policies for LGBTQIA+, strengthening CSOs supporting key populations, integrating social protection schemes with HIV services, and conducting HIV behavioural and biological surveys among key populations and migrants.

Although UNFPA in Fiji was focused on institutional capacity-building in the health sector in the context of integrated sexual and reproductive health, they did not have a specific programme for people living with HIV and HIV/AIDS. Before 2018, ILO had advocated for access that was more inclusive of people living with HIV to social insurance in the Fiji National Provident Fund and supported the assessment for a national health insurance scheme. Although UNICEF did not have a people living with HIV focused programme for people living with HIV, they worked with the government on developing a newborn and new parent support scheme to support new parents. WHO had advocated for surveillance to map vulnerable groups, including people living with HIV/TB. UNAIDS provided the strategic direction, advocacy, coordination, and technical support needed to catalyze and connect leadership from governments, the private sector and communities to deliver life-saving HIV services.

In Malawi, UNDP has been working with the Ministry of Health put forward a bill that explicitly bars discrimination based on gender identity and sexual orientation among LGBTQIA+ individuals. UNAIDS has provided support to strengthen CSOs led by key population groups. During the COVID-19 pandemic, UNAIDS worked on raising awareness on HIV and COVID-19. UNAIDS also provided technical support in conducting the stigma index study/assessment in Malawi. UNAIDS supported Y+ Malawi to register as a CSO and to come up with strategic action plans.

In Ghana, WFP has worked closely with GAC to advocate for integration of national social protection interventions and policies for people living with HIV and vulnerable populations. Beyond developing the 2017 Food Security Assessment and the 2021 Social Protection and HIV report, WFP has supported GAC in conducting a dissemination and advocacy roadshow across all regions of Ghana to highlight the findings of these reports. UNICEF has supported young people living with HIV organizations to establish their organizational frameworks and improve on their governance structures. UNAIDS supported GAC to voice concerns about Ghana's anti-LGBTQIA+ Bill.

In Peru, UNAIDS, IOM and the Joint Programme provide technical assistance and support addressing food insecurity of PLHIV and key populations, including migrants during the recent complex political scenario in the country, since it is not easy to influence changes in policies at the highest level accompanied by a budget.

In Morocco, UNAIDS has conducted an integrated bio-behavioral surveys report with specific references to female sex workers, men who have sex with men, people who inject drugs and migrants.

As previously mentioned, relevant advocacy work on human rights has been conducted by UNAIDS at country level, and this has been found to be conducive to HIV-sensitive social protection, as it addresses discrimination and criminalization of key populations. However, the lack of data production on HIV-sensitive social protection in general terms hinders second layers of analysis that could provide information on populations left behind by the social protection system.

3.5. COVID-19

What key lessons have emerged from government and community-led COVID-19-related social protection services supported by the Joint Programme? (EQ10)

COVID-19 has added pressure to social protection systems and people living with HIV livelihood strategies of people living with HIV. For instance, in Malawi, government and its key partners in social

protection failed to implement the national strategy programme in 2020. The pandemic also increased the operational costs of the SCTP. At the onset of the pandemic, people living with HIV defaulted from treatment and care, as they failed to access healthcare services. In Ghana, the funds were diverted to fight the pandemic, which affected social protection and other interventions during the height of COVID-19. Services to people living with HIV, including registration with the National Health Insurance Scheme, were severely delayed due to the epidemic. Health service points/centres were avoided due to the restrictions and the fear of contracting COVID-19. In China, COVID-19 affected medical services for people living with HIV, such as testing, treatment and following-up services. For example, testing capacities were reduced, leading to higher rates of under surveilled HIV in China, which impacted treatment accessibility and follow-up care. The pandemic had a significant impact on the economy, resulting in many job losses and affecting vulnerable populations, including people living with HIV.

At the same time, the COVID-19 pandemic enhanced the focus of governments and agencies on social protection. In Malawi, UNICEF supported COVID-19 cash top-ups to SCTP beneficiaries. As reported by a CSO representative in Malawi, UNAIDS supported people living with HIV and key population CSOs with COVID-19 safety kits (masks, sanitizers). Fiji expanded its social protection and the Joint Programme adapted to focus its support on addressing the impact of the COVID-19 pandemic by ensuring livelihood recovery and continuity of HIV services to the vulnerable key populations. In Morocco, a survey on nutrition needs of people living with HIV was conducted as part of the adaptation of the UNAIDS work during COVID-19. The purpose was to make strategic information available to guide appropriate actions in terms of nutrition, food security and social protection for people living with HIV and other key populations.

In Peru, the epidemic highlighted the fragility of the existing social programmes in terms of targeting adequately, and vulnerability during the COVID-19 pandemic caused UNAIDS to reflect on the problems surrounding HIV, which pushed the agencies involved in the humanitarian response to integrate people living with HIV into social protection programmes, and WFP to integrate these populations in the cash-based transfer programme. For Cosponsors in Peru, the issue of social protection was placed on the public agenda mainly because of the COVID-19 pandemic. Similarly, in Morocco, a comprehensive reform of the overall social protection system was announced after the COVID-19 crisis, which has already resulted in the integration of health insurance regimes and universalization of social protection systems. This was followed by the creation of a special fund dedicated to the management of the COVID-19 pandemic, endowed with more than US$900 000, mainly devoted to upgrading medical infrastructure.

In Ghana, it was highlighted that lessons were drawn on HIV-differentiated service delivery for people living with HIV as an adaptation to crises, and providers learned to engage virtually with beneficiaries through social media and other virtual platforms. It was also emphasized that government worked more closely with CSOs than ever before, something that was also assessed as a promising achievement by informants in Morocco.

It can be concluded that despite added pressure on social protection systems, the COVID-19 pandemic led to better systems and produced opportunities for learning and enhanced partnerships, and triggered reforms. UCOs’ focus on livelihoods was also enhanced during the pandemic.

4. Conclusions

Assessment against evaluation criteria

Relevance and coherence

I. The rationale of HIV-sensitive social protection from the perspective of the AIDS global response remains unquestioned: social protection programmes help to mitigate the social and economic impacts of HIV on individuals, their families and households, as well as to reduce HIV-infection risk, particularly for the most vulnerable populations. Therefore, such programmes are an essential part of the response to HIV and AIDS in all countries, independent of HIV prevalence or incidence. Effective and inclusive HIV-sensitive social protection programmes help to keep prevalence and incidence low (by reducing inequalities that exacerbate vulnerabilities) and help to mitigate the social and economic impacts when HIV prevalence and/or incidence are high.

II. However, people living with, at risk of and affected by HIV, including key populations, often face additional barriers to accessing social benefits that are already scarce in low- and middle-income countries. In this light, the Joint Programme has been assigned the responsibility of promoting and supporting the implementation of policies, programmes and activities to increase access for people living with, at risk of and affected by HIV to social protection. Despite the complexity of this responsibility**, it can be concluded that the Joint Programme is in a unique position to work towards this goal**. The collaboration and coordination of efforts among these organizations are essential in ensuring that HIV-sensitive social protection programmes are integrated into national health, education and social protection systems, adapted to social and policy contexts of each country.

III. In global and country-level key informant interviews, stakeholders reported positive perceptions about the multisectoral approach of the Joint Programme and its contributions to the advancement of programmes, strategies and policies relevant to the needs of people living with, at risk of and affected by HIV, including key populations**. It was recognized that the Secretariat has historically played an effective and visible role, though was not viewed as being at the forefront of social protection. ILO, UNICEF and WFP were recognized as lead agencies in social protection activities at the global and country level. And further, it was recognized that the World Bank also has an extensive portfolio of relevant social protection programming around the globe.** That said, Cosponsors themselves demand involvement of the UNAIDS Secretariat as a coordinator and to help ensure that general social protection programmes are HIV-sensitive. Additionally, relevant global KIs emphasized that **the absence of staff at the global-level office of the UNAIDS Secretariat dedicated to social protection signifies that UNAIDS is not prioritizing this agenda** and may not be able to continue to play such a role. **The UNAIDS Secretariat can play a key catalytic role in ensuring the investments of Cosponsors are inclusive of people affected by HIV, as done in Peru. This would be possible if a dedicated consultant is hired to design and implement the HIV component of the cash-based transfer programme under UNAIDS guidance.**

Additionally, the lack of awareness and ownership at country level on methodologies and data provided by UNAIDS Secretariat at HQ level undermine their relevance and effectiveness. Methodological developments like the HIV and Social Protection Assessment Tool[22] need to be balanced with efficient training and timely dissemination of results. Similarly, the indicators and data used to monitor progress towards HIV-sensitive social protection at the global level are not known by UCOs and have not guided their planning and monitoring of social protection activities.

IV. In general, the work of the Joint Programme aligns well with national priorities, plans and strategies related to HIV prevention, care and treatment. This alignment is facilitated by close collaboration among UN agencies, national governments and donors. However, in most cases, **national social protection systems do not explicitly indicate people living with, at risk of or affected by HIV as populations that should have equitable access to social protection benefits,**

despite evidence of and confirmation by country informants of the existence of stigma-related barriers for people living with HIV and key populations to access social protection. This highlights an important gap in broader social protection services.

V. At the same time, country missions revealed that the UNAIDS Secretariat and its Cosponsors have important relationships with governments and experience in providing technical assistance to strengthen national capacity to deliver health and social services for people living with, at risk of or affected by HIV. The UNAIDS Secretariat in particular is found to be uniquely placed to engage with CSOs and to coordinate efforts between those organisations, governments and other partners to build strong national social protection systems. Multisectoral partnerships are essential to the development and implementation of HIV-sensitive social protection programmes. **The UNAIDS Secretariat and its Cosponsors, researchers and civil society are uniquely organized to produce new evidence, to understand vulnerability in the context of HIV, to use evidence to define norms and standards, and to bridge evaluation and research findings with policy and practice.**

Effectiveness

VI. Progress towards HIV-sensitive social protection worldwide reported in the JPMS Monitoring System was not validated by the evaluation. More precisely, the target established in the 2016–2021 UBRAF (70% of reporting countries with HIV-sensitive social protection strategies by 2020) was met, according to country government self-reporting data provided to the Joint Programme. However, evaluation field missions revealed that data on their effective coverage is generally lacking, and Joint Programme monitoring data are not consistently used as a basis to plan and follow up at the country level in terms of social protection. Moreover, HIV-sensitive social protection is not a well-established area of the Secretariat's work at country level, nor is its conceptual definition and scope clear to all key stakeholders.

VII. This said, in many countries reporting to the JPMS and in all countries where field missions were conducted, evidence was found on how the **Joint Programme members have been effective in addressing concrete discriminatory practices, as well as barriers that exclude people living with, at risk of or affected by HIV, often by means of joint initiatives and collaboration across agencies.** Through advocacy, the programme has promoted fair employment practices in some settings and supported livelihoods and food security interventions to reduce the multiple impacts of poverty. Indeed, several initiatives have been proposed as models for HIV-sensitive social protection in resource-constrained environments, including a chronic illness marker in cash-transfer programmes in Malawi; an assessment of food security and vulnerability of HIV-affected households in Ghana; a country-wide psycho-social support programme acting as a social mediation network in Morocco; and analyses of employment, income and social protection focused on discriminatory employment-related practices for people living with HIV in poverty-stricken areas of China.

VIII. Positive feedback on the UNAIDS Secretariat's advocacy work on HIV-sensitive social protection was collected in all field missions, although such work was described in very different ways. In some countries, it was related to general advocacy on human rights and addressing discrimination and criminalization of key populations. In other countries, it consisted of seeking connections between food security and HIV programmes, or in advocating for effective coverage of free HIV treatment. This may reflect different needs and understanding of HIV-sensitive social protection in the very different country contexts in which people living with, at risk of and affected by HIV, including key populations, live.

IX. Despite promising advances, reports from stakeholders, especially country-level Joint Programme members and those from CSOs, indicate that there is room for improvement, particularly in terms of explicitly including HIV-sensitive social protection in national policies and programmes. In particular, there was strong agreement on the need to revisit the UNAIDS HIV and Social Protection Assessment Tool. **The tool was completely unknown by KIs in most countries; alternative tools and methods are used to assess HIV-sensitivity of social protection programmes**. Moreover, in countries where the tool was used, most respondents representing

national stakeholders were unaware of the assessment tool. Respondents who were familiar with the tool described it as cumbersome and indicated that the training is too lengthy and costly; it requires adaptation by national experts before use. Effective free access to ART cannot be taken for granted. Monitoring of such access is not only relevant for the Joint Programme's work on HIV treatment, but it can also improve its strategic positioning in HIV-sensitive social protection, and thus, improve overall effectiveness.

X. The UNAIDS Secretariat and its Cosponsors have established partnerships and collaborations with organizations, networks and civil society groups in all regions. However, across country-level informants, there was **little to no awareness of regional activities related to HIV-sensitive social protection.**

Efficiency

XI. Mixed evidence was found on the capacity of the Joint Programme to effectively enhance HIV sensitivity in social protection systems across countries. In some countries, it was highlighted that **UNAIDS Country Offices lack the resources to effectively engage in national social protection systems while in other countries, informants noted that capacities distributed across the Cosponsors have a great potential**.

XII. According to global informants, the potential for a significant impact in the area of HIV-sensitive social protection has been compromised by reductions in available funding to the Joint Programme globally, regionally and nationally. **Staff reductions across agencies, including the UNAIDS Secretariat, has compromised the potential influence of the Joint Programme in this area**. Further, it has affected the general outlook of staff, especially at global and regional levels, as they valued the expertise in HIV-sensitive social protection that was previously provided by staff at the UNAIDS Secretariat. In more general terms, lack of data and conceptual precision hinders planning and monitoring of HIV-sensitive social protection work at country level.

Equity

XIII. From an equity perspective, at global and country level, respondents indicated a strong commitment to promoting social protection for marginalized and other vulnerable populations. Further, it was emphasized that there must be a continued focus on ensuring that strategies are inclusive of key populations—including youth, sexual and gender minority populations, adolescent girls and young women, and people who use or inject drugs—and are responsive to country-specific challenges (e.g., recurrent climate-related emergencies, legalized oppression of certain groups). On this note, it must be emphasized that the **key populations most often cited in country reports as being left behind were sexual- and gender-minority populations, especially transgender people. To note, HIV-sensitive measures found in this evaluation referred broadly to people living with HIV and did not put a concrete focus on these population groups.**

COVID-19

XIV. The COVID-19 crisis added pressure to Joint Programme resources, public finances and livelihood strategies, but it also put social protection on many governments' agendas and improved governments' knowledge about and partnerships on social protection services. In this context, opportunities for social protection reform arise and such opportunities could also be taken to advocate for an explicit focus and increased sensitivity to HIV. The COVID-19 crisis has forced governments and international partners to improvise concrete social protection measures, while providing momentum to broader expansions. However, many COVID-19-responsive social protection programmes are not being continued.

Review of the ToC

As should be clear from the conclusions above, the ToC of the work of UNAIDS on HIV-sensitive social protection needs to be revisited by the Joint Programme, as data show that the following assumptions of the ToC are not correct (for a full list of assumptions and its review, see Annex V):

- The Joint Programme's mandate clearly defines its role in HIV sensitive social protection.
- UNAIDS guidance and policies adequately cover social protection issues.
- Social protection sensitivity to HIV is properly analysed and followed up by the Joint Programme.
- Evidence of the need/priorities of populations living with, at risk of or affected by HIV is available to guide the Joint Programme's design and implementation.
- Evidence is used to inform the design and choice of country activities.
- The assessments produced with the Tool have been shared with and are available to key stakeholders.
- Patterns and models of HIV and TB integration with national social protection programmes are analysed and documented by UNAIDS.
- The focus and data of the Joint Programme allows for differentiated analysis of access and coverage across population groups and epidemic profiles.
- Countries are receptive to information and knowledge from Joint Programme on HIV-sensitive social protection.
- Focus on national systems, political buy-in and national ownership favour the effectiveness and sustainability of the UNAIDS Secretariat's work in social protection.
- Regional collaborations and activities inform and support activities at country level.
- The UNAIDS HIV and Social Protection Assessment Tool has been implemented in a significant number of countries.
- Concrete collaborations are established at regional level.
- The Joint Programme's overall allocation of resources is appropriate to enable the implementation of the activities.

Good practices

As per the previous conclusions and responses to evaluation question 4 on models of HIV-sensitivity integration in social security systems, the following practices can be showcased as inspiring examples in different country contexts:

The assessment of food security and vulnerability of HIV-affected households conducted in Ghana can be considered a good practice in contexts of food insecurity and emergency, where food aid, cash aid and livelihoods support represent a major share of the available social protection programmes.

The joint UNAIDS-WFP cash-based transfer programme conducted from 2020-2023 targeting 3,000 families with people living with HIV and key populations living under the line of poverty, including migrants were benefited and more than USD 3 million disbursed.

The PNAPS, a psychological and social support programme that forms part of the Moroccan national plan against AIDS, is a country-wide social mediation network that facilitates access of people living with HIV to existing social protection benefits. It is a good practice that may inspire other countries where different social protection services exist, but are not accessible to people living with HIV and key populations due to various barriers, including stigmatization.

The chronic illness marker in cash transfer programmes used in Malawi can be considered a good practice in all settings, for ensuring that HIV is considered within vulnerability factors and targeting criteria, while preserving confidentiality and avoiding additional stigmatization risks.

Analysing employment, income and social protection for people living with HIV in poor areas and addressing discrimination, as in China, is a good practice likely to be replicated in contexts where formal jobs and income opportunities arise, but people living with HIV and key populations are discriminated against in job selection and workplaces.

Additionally, another successful connection between social protection services and HIV services has been found in Malawi (also showcased in a UNICEF report covering several high-HIV-prevalence countries in southern and eastern Africa):

Development of a linkages and referral programme in Malawi. Like the PNAPS, the UNICEF programme for linkages and referral in Malawi aims to strengthen the linkages between HIV services and national social protection programmes. Unlike the PNAPS, beneficiaries in Malawi are referred by social protection services (the SCTP) to HIV services, focusing on adolescent girls. Finally, the partnership approach of UNAIDS in most countries analysed can also be considered a promising practice for advocacy on HIV-sensitive social protection.

Broad-based advocacy partnerships. In most countries, UNAIDS is found to play a key advocacy role as a bridge between the government and CSOs that represent and support people living with HIV and other key populations. Through the high-level advocacy of UNAIDS and its insertion in participatory coordinating bodies, such connections are enhanced and institutionalized, and they have been described as broad-based partnerships for advocating the rights of people living with HIV and other key populations. Concrete materialization of such partnerships includes the organization of the Stigma Index Study and related advocacy in Morocco and opposition against laws criminalizing gender minorities in Ghana. Although these examples have only an indirect relationship with HIV-sensitive social protection, more concrete advocacy work in this domain could build upon this experience.

5. Recommendations

Based on the evaluation conclusions, good practices and lessons learnt, a series of recommendations are provided below to the Joint Programme (UNAIDS and Cosponsors) for maximizing its contribution to HIV-sensitive social protection. These recommendations are meant to be actionable and include indications of responsibilities and suggested timelines and are expressed in such a way that they can be costed by the Joint Programme.

Global level

1. Clarify the future of the **social protection position** at the UNAIDS Secretariat and consider its inclusion in a broader area of work of the Secretariat, such as in eliminating stigma and discrimination, and its connection with the data department (Linked to conclusions I, II, IV, XI, XII and XII).
2. Articulate a **common understanding** of HIV-sensitive social protection as an area of work of the Joint Programme and reinforce the roles of the UNAIDS Secretariat and each of its Cosponsors in the implementation and evaluation of efforts in supporting all HIV-vulnerable groups through sustained linkage to available social protections (Linked to conclusions III, IV, XII).
3. In collaboration with UCOs and national stakeholders, promote ownership of the monitoring of HIV-sensitive social protection, and the use of the related data for planning and monitoring actions at the country level. Identify and leverage existing survey mechanisms to extract or embed **monitoring indicators**; utilise these data to provide evidence of the Joint Programme's impact on HIV-sensitive social protection. Where possible, disaggregate data by key population and other priority populations. Disaggregation will provide insights into the inequalities faced by different groups and their level of access to different social protections (Linked to conclusion VI).
4. In collaboration across Joint Programme organisations, **review the UNAIDS Social Protection Assessment Tool** and revise guidance for its implementation to optimise efficiency, as well as guidance for data analysis and use. For the sake of sustainability and considering implementation challenges in the past, the review should consider integration in other tools designed and systematically applied by Joint Programme Cosponsors or more broadly across relevant UN agencies (Linked to conclusions VI, and IX).
5. In collaboration with Regional Support Teams, establish geographic priorities for the work of the Joint Programme in HIV-sensitive social protection on the basis of challenges (e.g., high prevalence, criminalization) and opportunities (e.g., social protection reform and expansion). Enhance **collaboration** across Joint Programme agencies in those regions and/or countries (Linked to conclusions III, IV, V and X).
6. The Joint Programme must explore all opportunities to engage with social protection programmes, policies, schemes, conferences, etc., to ensure that HIV concerns are highlighted. This recommendation is applicable at the global, regional and country levels. (Linked to conclusions III, IV, V, X and XIV).

Regional level

7. Once concepts and tools have been revised, tap into opportunities at the regional level (facilitated by the Regional Support Teams) to provide training in HIV-sensitive social protection, with a view **to strengthening existing HIV and social protection expertise at the country level among UNAIDS Country Office civil society organizations (CSOs), government and other partners, including the development of various skillsets required, and the matching of skills to contexts and programme aims** (Linked to conclusions IX, VI, IX and X).

National level

8. UCOs should concentrate efforts in **advocacy** on improved accessibility of social protection and provision of appropriate and adequate benefits and programmes for people living with, at risk of or affected by HIV, including key population groups (including sexual- and gender-minority

populations, people who use or inject drugs, and youth), in connection with broader advocacy work on universal social protection (Linked to conclusions IV and VIII).

9. UCOs, in collaboration with Joint Programme agencies in country, should engage national social protection programmes and advocate for the voices of key and vulnerable populations to be included at all stages in the conceptualization, design, analysis, planning, implementation, monitoring and evaluation of social protection schemes at the country level (Linked to conclusion XIII).
10. UCOs, in collaboration with Joint Programme agencies in country, should engage representatives of key and other vulnerable populations, including groups that are most neglected in the country, to identify barriers to accessing available social protections and to collaborate in finding appropriate solutions (Linked to conclusions IV, V, XIII and XIV).
11. UCOs should provide **technical support and other resources to CSOs** to enhance their role in documenting coverage and access to social protection programmes and to removing barriers among community members across the life course (Linked to conclusions IV, V, VI and XIV).

References

1. ILO. *Social Protection Assessment-Based National Dialogue: A Global Guide*.; 2016. Accessed May 1, 2023. https://www.ilo.org/global/topics/dw4sd/WCMS_568693/lang--en/index.htm
2. al Mamun F, Hosen I, Mamun MA. Sexual violence and rapes' increment during the COVID-19 pandemic in Bangladesh. *EClinicalMedicine*. *2021*;34. doi:10.1016/j.eclinm.2021.100817
3. Baird SJ, Garfein RS, McIntosh CT, Özler B. Effect of a cash transfer programme for schooling on prevalence of HIV and herpes simplex type 2 in Malawi: a cluster randomised trial. *The Lancet*. 2012;379(9823):1320-1329. doi:10.1016/S0140-6736(11)61709-1
4. Cluver LD, Orkin FM, Boyes ME, Sherr L. Cash plus care: social protection cumulatively mitigates HIV-risk behaviour among adolescents in South Africa. *AIDS*. 2014;28(Supplement 3):S389-S397. doi:10.1097/QAD.0000000000000340
5. Cluver LD, Orkin FM, Campeau L, et al. Improving Lives by Accelerating Progress towards the UN Sustainable Development Goals for Adolescents Living with HIV: A Prospective Cohort Study. *The Lancet Child & Adolescent Health,* 2019;3(4):245-254.
6. Devereux S, Sabates-Wheeler R, Institute of Development Studies. *Transformative Social Protection*. Institute of Development Studies; 2004. Accessed May 1, 2023. https://opendocs.ids.ac.uk/opendocs/bitstream/handle/20.500.12413/4071/Wp232.pdf?sequence=1
7. Drimie S, Casale M. Multiple stressors in Southern Africa: The link between HIV/AIDS, food insecurity, poverty and children's vulnerability now and in the future. *AIDS Care - Psychological and Socio-Medical Aspects of AIDS/HIV*. 2009;21(SUPPL. 1):28-33. doi:10.1080/09540120902942931
8. Handa S, Halpern CT, Pettifor A, Thirumurthy H. The government of Kenya's cash transfer program reduces the risk of sexual debut among young people aged 15-25. *PLoS One*. Published online 2014. doi:10.1371/journal.pone.0085473
9. Heinrich C, Hoddinott J. Reducing Adolescent Risky Behaviors in a High-Risk Context: The Effects of Unconditional Cash Transfers in South Africa † Running Title: Reducing Adolescent Risky Behaviors.; 2016. Accessed May 1, 2023. https://my.vanderbilt.edu/carolynheinrich/files/2016/06/CSG-effects-on-adolescent-risky-behavior-Heinrich-Hoddinott-Samson.pdf
10. Leclerc-Madlala S. "We will eat when I get the grant": negotiating AIDS, poverty and antiretroviral treatment in South Africa. *African Journal of AIDS Research*. 2006;5(3):249-256. doi:10.2989/16085900609490386
11. Palermo T, Peterman A, Handa S, Seidenfeld D. Impacts of Zimbabwe's harmonised social cash transfer (HSCT) on violence against youth. *SVRI Forum 2015*. 2015. Accessed May 1, 2023. https://transfer.cpc.unc.edu/wp-content/uploads/2021/08/Violence_Against_Youth_Zim.pdf
12. Palermo T, Prencipe L, Kajula L. Effects of Government-Implemented Cash Plus Model on Violence Experiences and Perpetration Among Adolescents in Tanzania, 2018-2019. *Am J Public Health*. 2021;111(12):2227-2238. doi:10.2105/AJPH.2021.306509
13. Pettifor AE, Levandowski BA, Macphail C, Padian NS, Cohen MS, Rees H V. Keep them in school: The importance of education as a protective factor against HIV infection among young South African women. *Int J Epidemiol*. 2008;37(6):1266-1273. doi:10.1093/ije/dyn131
14. Toska E, Gittings L, Hodes R, et al. Resourcing resilience: social protection for HIV prevention amongst children and adolescents in Eastern and Southern Africa. *African Journal of AIDS Research*. 2016;15(2):123-140. doi:10.2989/16085906.2016.1194299
15. Ulrichs M, Slater R, Costella C. Building resilience to climate risks through social protection: from individualised models to systemic transformation. *Disasters*. 2019;43(S3):S368-S387. doi:10.1111/disa.12339
16. UNICEF. *UNICEF's Global Social Protection Programme Framework Executive Summary*.; 2019. Accessed May 1, 2023. https://www.unicef.org/media/61026/file/UNICEF-social-protection-programme-framework-exec-summry.pdf

17. Watts C, Seeley J. Addressing gender inequality and intimate partner violence as critical barriers to an effective HIV response in sub-Saharan Africa. *Journal of International AIDS Society*. Published online 2014. doi:10.7448/IAS.17.1.19849

18. WFP. *World Food Programme Strategy for Support to Social Protection: Summary Version*.; 2021. Accessed May 1, 2023. https://www.wfp.org/publications/world-food-programme-strategy-support-social-protection-2021

19. Zulaika G, Bulbarelli M, Nyothach E, et al. Impact of COVID-19 lockdowns on adolescent pregnancy and school dropout among secondary schoolgirls in Kenya. *BMJ Glob Health*. 2022;7:7666. doi:10.1136/bmjgh-2021-007666

20. UNAIDS. Global AIDS strategy 2021-2026. End inequalities. End AIDS. Published online 2021. Accessed May 1, 2023. https://www.unaids.org/sites/default/files/media_asset/global-AIDS-strategy-2021-2026_en.pdf

21. ILO, WFP, UNAIDS. *HIV-Sensitive Social Protection in East and Southern Africa: Fast Track Countries*.; 2021. Accessed May 5, 2023. https://www.childrenandaids.org/sites/default/files/2022-06/ILO_UNAIDS_WFP%20Joint%20Mapping%20Report%20on%20HIV-s%20SP.pdf

22. UNAIDS. *HIV and Social Protection Assessment Tool*.; 2017. Accessed May 17, 2023. https://www.unaids.org/sites/default/files/media_asset/HIV-social-protection-assessment-tool_en.pdf

23. ILO. *ILO Flagship Report World Social Protection Report*.; 2020. Accessed May 1, 2023. https://www.ilo.org/global/research/global-reports/world-social-security-report/2020-22/lang--en/index.htm

24. Schaefer R, Thomas R, Robertson L, et al. Spillover HIV prevention effects of a cash transfer trial in East Zimbabwe: evidence from a cluster-randomised trial and general-population survey. *BMC Public Health*. 2020;20(1). doi:10.1186/s12889-020-09667-5

25. Cluver L, Boyes M, Orkin M, Pantelic M, Molwena T, Sherr L. Child-focused state cash transfers and adolescent risk of HIV infection in South Africa: A propensity-score-matched case-control study. *Lancet Glob Health*. 2013;1(6). doi:10.1016/S2214-109X(13)70115-3

26. Cluver LD, Toska E, Orkin FM, et al. Achieving equity in HIV-treatment outcomes: can social protection improve adolescent ART-adherence in South Africa? *AIDS Care - Psychological and Socio-Medical Aspects of AIDS/HIV*. 2016;28:73-82. doi:10.1080/09540121.2016.1179008

27. Saleska JL, Turner AN, Gallo MF, et al. Role of temporal discounting in a conditional cash transfer (CCT) intervention to improve engagement in the prevention of mother-to-child transmission (PMTCT) cascade. *BMC Public Health*. 2021;21(1). doi:10.1186/s12889-021-10499-0

28. Liu JX, Shen J, Wilson N, Janumpalli S, Stadler P, Padian N. Conditional cash transfers to prevent mother-to-child transmission in low facility-delivery settings: Evidence from a randomised controlled trial in Nigeria. *BMC Pregnancy Childbirth*. 2019;19(1). doi:10.1186/s12884-019-2172-3

29. Guimarães NS, Magno L, de Paula AA, et al. The effects of cash transfer programmes on HIV/AIDS prevention and care outcomes: a systematic review and meta-analysis of intervention studies. *Lancet HIV*. 2023;10(6):e394-403. doi:10.1016/S2352-3018(22)00290-9

30. de Oliveira T, Kharsany ABM, Gräf T, et al. Transmission networks and risk of HIV infection in KwaZulu-Natal, South Africa: a community-wide phylogenetic study. *Lancet HIV*. 2017;4(1):e41-e50. doi:10.1016/S2352-3018(16)30186-2

31. Hallfors D, Cho H, Rusakaniko S, Iritani B, Mapfumo J, Halpern C. Supporting adolescent orphan girls to stay in school as HIV risk prevention: Evidence from a randomized controlled trial in Zimbabwe. *Am J Public Health*. 2011;101(6):1082-1088. doi:10.2105/AJPH.2010.300042

32. Toska E, Cluver LD, Boyes ME, Isaacsohn M, Hodes R, Sherr L. School, Supervision and Adolescent-Sensitive Clinic Care: Combination Social Protection and Reduced Unprotected Sex Among HIV-Positive Adolescents in South Africa. *AIDS Behav*. 2017;21(9):2746-2759. doi:10.1007/s10461-016-1539-y

33. Sampaio Morais GA, Magno L, Silva AF, et al. Effect of a Conditional Cash Transfer on AIDS Incidence, Hospitalizations and Mortality in Brazil: A Nationwide Observational Longitudinal Study.; 2022. https://www.sciencedirect.com/science/article/pii/S2352301822002211

34. Stoner MCD, Edwards JK, Westreich D, et al. Modeling Cash Plus Other Psychosocial and Structural Interventions to Prevent HIV Among Adolescent Girls and Young Women in South Africa (HPTN 068). *AIDS Behav*. 2021;25:133-143. doi:10.1007/s10461-021-03158-3

35. Cluver LD, Orkin FM, Boyes ME, Sherr L. Cash plus care: Social protection cumulatively mitigates HIV-risk behaviour among adolescents in South Africa. *AIDS*. 2014;28(SUPPL. 3). doi:10.1097/QAD.0000000000000340

36. Bandiera O, Buehren N, Goldstein M, Rasul I, Smurra A. *The Economic Lives of Young Women in the Time of Ebola Lessons from an Empowerment Program*.; 2019. Accessed May 1, 2023. http://www.worldbank.org/research.

37. Dunbar MS, Kang Dufour MS, Lambdin B, Mudekunye-Mahaka I, Nhamo D, Padian NS. The SHAZ! Project: Results from a pilot randomized trial of a structural intervention to prevent HIV among adolescent women in Zimbabwe. *PLoS One*. 2014;9(11):e113621. doi:10.1371/journal.pone.0113621

38. FAO, ILO, UNICEF. *UN Collaboration on Social Protection: Reaching Consensus on How to Accelerate Social Protection Systems-Building*.; 2023. Accessed May 1, 2023. https://www.ilo.org/secsoc/information-resources/publications-and-tools/books-and-reports/WCMS_845757/lang--en/index.htm

39. UNAIDS. *HIV and Social Protection Guidance Note*.; 2014. Accessed May 5, 2023. http://www.unaids.org/en/ourwork/programmebranch/

40. ILO. Social protection. Published 2023. Accessed May 2, 2023. https://www.ilo.org/global/topics/social-security/lang--en/index.htm

41. WFP. *WFP's Work in Enabling Social Protection around the Globe*.; 2021. Accessed May 5, 2023. https://docs.wfp.org/api/documents/WFP-0000124163/download/?_ga=2.50730671.723853143.1685757121-220850412.1683631664

42. UNICEF. Social protection. Accessed May 4, 2023. https://www.unicef.org/social-policy/social-protection#:~:text=UNICEF's%20response&text=Our%20social%20protection%20activities%20include,programmes%20on%20children%20and%20communities.

43. IOM, Dafuleya G, N, Mahil N, Olivier M. *Social Protection: An Operational Tool for the Humanitarian Development and Peace Nexus*.; 2022. Accessed May 5, 2023. http://rocairo.iom.int/

44. UNDP. Social protection. Published 2023. Accessed May 5, 2023. https://www.undp.org/eurasia/social-protection-0

45. UNDP. *Leaving No One behind: A Social Protection Primer for Practitioners*.; 2016. Accessed May 5, 2023. https://www.undp.org/sites/g/files/zskgke326/files/publications/Leaving%20No%20One%20Behind-%20A%20Social%20protection%20Primer%20for%20Practitioners%20FINAL.pdf

46. UNESCO. *Social Protection, Inequality and Social Justice*.; 2016. Accessed May 5, 2023. https://en.unesco.org/inclusivepolicylab/sites/default/files/analytics/document/2019/4/wssr_2016_chap_55.pdf

47. UNHCR. Social protection. Accessed May 1, 2023. https://www.unhcr.org/us/what-we-do/build-better-futures/livelihoods-and-economic-inclusion/social-protection#:~:text=UNHCR%20identifies%20with%20social%20protection,Social%20Protection%20Interagency%20Coordination%20Board

48. UN Women. *Making National Social Protection Floors Work for Women*.; 2015. Accessed May 1, 2023. https://www.unwomen.org/en/digital-library/publications/2015/12/making-social-protection-floors-work-for-women

49. WHO, PAHO. Social protection in health. Accessed May 3, 2023. https://www3.paho.org/hq/index.php?option=com_content&view=article&id=4180:2007-proteccion-social-salud&Itemid=0&lang=en#gsc.tab=0

50. The World Bank. The World Bank in social protection. Published 2023. Accessed May 1, 2023. https://www.worldbank.org/en/topic/socialprotection/overview

51. UBRAF. 2022-2026 UBRAF. Published online 2021. Accessed May 8, 2023. https://www.unaids.org/sites/default/files/media_asset/PCB_SS_2022_2026_UBRAF_Framework_EN.pdf

52. UNAIDS. Joint Evaluation of the UN Joint Programme on AID's Work with Key Populations. 2022. Accessed May 1, 2023. https://www.unaids.org/en/resources/documents/2022/joint-evaluation-un-joint-programme-aids-work-key-populations

53. UNAIDS, PCB. *Unified Budget, Results and Accountability Framework: On the Fast-Track to End AIDS*.; 2016. Accessed May 1, 2023. https://www.unaids.org/en/resources/documents/2015/UNAIDS_PCB37_15-19

54. UNAIDS. 2022–2026 Unified Budget, Results and Accountability Framework: Annex 5 - UBRAF Indicators and Specific Outputs.; 2021. Accessed May 1, 2023. https://www.unaids.org/en/resources/documents/2021/PCB49_Decisions

55. ILO. *World Social Protection Report 2020-22*.; 2020. Accessed January 4, 2023. https://www.ilo.org/wcmsp5/groups/public/@ed_protect/@soc_sec/documents/publication/wcms_817572.pdf

56. ILO. ILO World Social Protection Database (WSPDB). Accessed May 10, 2023. https://www.social-protection.org/gimi/WSPDB.action?id=15

57. UNAIDS. *Factsheet 2022*.; 2022. Accessed May 1, 2023. https://www.unaids.org/en/resources/fact-sheet

58. World Bank. World Bank Open Data. Published 2023. https://data.worldbank.org/

59. UNAIDS. UNAIDS data 2022. Published online 2022. Accessed May 11, 2023. https://www.unaids.org/sites/default/files/media_asset/data-book-2022_en.pdf

60. UNAIDS. *Ghana Country Report*.; 2020. Accessed May 1, 2023. https://www.unaids.org/en/regionscountries/countries/ghana

61. Ghana Aids Commission. *National HIV and AIDS Strategic Plan 2021-2025*.; 2020. Accessed May 5, 2023. https://www.ghanaids.gov.gh/mcadmin/Uploads/GAC%20NSP%202021-2025%20Final%20PDF(4).pdf

62. ILO. ILO world social protection database (WSPDB). Accessed January 4, 2023. https://www.social-protection.org/gimi/WSPDB.action?id=15

63. 50 Million African Women Speak. Social protection in Benin. Published 2013. Accessed May 10, 2023. https://www.womenconnect.org/web/benin/social-services

64. Republic of Benin, UNICEF. Holistic Social Protection Policy in Benin.; 2013.

65. UN, Republic of Benin. *Benin 2022-2026 Joint Plan*.

66. WFP. *Benin Annual Country Report 2021: Country Strategic Plan*.; 2019. Accessed May 1, 2023. https://www.wfp.org/operations/bj02-benin-country-strategic-plan-2019-2023

67. UN, ILO. *Coordination and Implementation of Social Protection Systems in China*. Accessed May 5, 2023. https://social.desa.un.org/sites/default/files/migrated/22/2021/04/Research-on-Coordination-and-Implementation-of-Social-Protection-Systems-in-China.pdf

68. Joint Programme. Delivering as One UN: The Report of UN Joint Programme on AIDS in China (2018-2019).

69. UNAIDS. Biennial Report for UN Joint Programme on AIDS in China. 2020. Accessed May 1, 2023. http://www.unaids.org.cn/?_l=en

70. WHO. Validation of elimination of mother-to-child transmission of HIV, syphilis and hepatitis B. Accessed May 23, 2023. https://www.who.int/initiatives/triple-elimination-initiative-of-mother-to-child-transmission-of-hiv-syphilis-and-hepatitis-b/validation

71. UNAIDS. *UNAIDS Data 2021*.; 2021. Accessed May 1, 2023. https://www.unaids.org/en/resources/documents/2021/2021_unaids_data

72. UNICEF. A Fair Start for Every Child: How Six Governments in East Asia and the Pacific Solved Some of the Most Stubborn Problems Facing Marginalized Children.; 2016. Accessed May 1, 2023. www.iniscommunication.com

73. Gajate-Garrido G, Owusua R, International Food Policy Research Institute. *The National Health Insurance Scheme in Ghana: Implementation, Challenges and Proposed Solutions*.; 2013. Accessed May 5, 2023. https://ebrary.ifpri.org/utils/getfile/collection/p15738coll2/id/127958/filename/128169.pdf

74. World Bank, Wang H, Otoo N, Dsane-Selby L. *Ghana National Health Insurance Scheme*.; 2017. Accessed May 1, 2023. https://ebrary.ifpri.org/utils/getfile/collection/p15738coll2/id/127958/filename/128169.pdf

75. Ministry of Health R of F. National strategic plan on HIV and STIs, 2012- 2015. Published online 2014. Accessed May 1, 2023. https://www.gov.za/sites/default/files/gcis_document/201409/national-strategic-plan-hiv-stis-and-tb0.pdf

76. Fiji Government. *A Beijing Declaration and Platform for Action Beijing Declaration*.; 2019. Accessed May 1, 2023. http://digitallibrary.un.org/record/1648092

77. Fiji Government. *Social Assistance Policy: Protecting the Poor and Vulnerable*.; 2021. Accessed May 5, 2023. https://wrd.unwomen.org/sites/default/files/2023-02/Fiji_Social_Asssitance_Policy.pdf

78. Ministry of Labour IRT and E. National code of practice for HIV/AIDS in the workplace. Published online 2007. Accessed May 1, 2023. https://www.ilo.org/dyn/natlex/docs/ELECTRONIC/77676/82552/F2140837405/FJI77676.pdf

79. Ghana Aids Commission. The Ghana AIDS Commission (GAC) Assessment of Food Security and Vulnerability of HIV-Affected Households in Selected Regions Of Ghana.; 2019. Accessed May 5, 2023. https://docs.wfp.org/api/documents/WFP-0000108069/download/?_ga=2.48087719.1660366059.1696887083-1387424611.1696887083

80. Republic of Malawi. *Malawi National Social Support Programme II (MNSSP II)*.; 2018. Accessed May 1, 2023. https://socialprotection.org/discover/legal_policy_frameworks/malawi-national-social-support-programme-mnssp-ii

81. The Government of Malawi. *National Social Welfare Policy Promoting Social Inclusion and Human Dignity*.; 2018. Accessed May 1, 2023. www.gender.gov.mw

82. National Aids Commission Malawi. National strategic plan for HIV and AIDS 2020-25 final. Published online 2020. Accessed May 1, 2023. https://www.prepwatch.org/resources/national-strategic-plan-for-hiv-and-aids-2020-25/

83. Ghana AIDs Commission. *HIV and Social Protection Assessment in Ghana: Evidence for Policy and Action on HIV and Social Protection*.; 2021. Accessed May 1, 2023. https://ghanaids.gov.gh/mcadmin/Uploads/HIV%20AND%20SOCIAL%20PROTECTION.pdf

84. Ministère de la Santé et de la Protection Sociale. *Rapport National SIDA 2022 Royaume Du Maroc*.; 2022. Accessed May 1, 2023. https://www.sante.gov.ma/Publications/Documents/RAPPORT_NS_19.12.2022_VF_SG.pdf

85. UNAIDS. *Miles to Go - The Response to HIV in the Caribbean*.; 2018. Accessed May 1, 2023. https://www.unaids.org/sites/default/files/media_asset/miles-to-go_caribbean_en.pdf

86. The World Bank. *Implementation Completions and Results Report*.; 2016. Accessed May 1, 2023. https://documents.worldbank.org/en/publication/documents-reports/documentdetail/375311468326426795/Implementation-completion-and-results-report-guidelines#:~:text=Implementation%20Completion%20and%20Results%20reports,and%20being%20accountable%20for%20results.

87. UNDP Pacific Centre. *HIV, Ethics and Human Rights Review Of Legislation of Pacific Island Countries Regional Summary*.; 2009. Accessed May 1, 2023. https://www.undp.org/sites/g/files/zskgke326/files/migration/asia_pacific_rbap/Pacific_regional_summary_HIV_Ethics_and_HR_reviev.pdf

88. ILO, Government of Fiji. HIV/AIDS Decree. Published online 2011. Accessed May 1, 2023. https://www.ilo.org/dyn/natlex/natlex4.detail?p_isn=86222&p_lang=en

89. PEPFAR. *Malawi Country Operational Plan 2022 Strategic Direction Summary*.; 2022. Accessed May 1, 2023. https://www.state.gov/wp-content/uploads/2022/09/Malawi-COP22-SDS.pdf

90. WFP. WFP Malawi - 2022 Annual Country Reports. Published online 2023. Accessed May 1, 2023. https://docs.wfp.org/api/documents/WFP-0000148012/download/#:~:text=WFP%20Malawi%20had%20less%20resources,however%2C%20most%20activities%20were%20sustained.

91. UNICEF. *UNICEF Annual Report - 2021*.; 2021. Accessed May 1, 2023. https://www.unicef.org/reports/unicef-annual-report-2021

92. UNICEF. *UNICEF Annual Report 2020 - Responding to COVID-19*.; 2020. Accessed May 1, 2023. www.unicef.org/publications.

93. UNICEF. Mapping de la protection sociale au Maroc. Published online 2018. Accessed May 1, 2023. https://www.unicef.org/morocco/sites/unicef.org.morocco/files/2018-11/Mapping Protection Sociale au Maroc.pdf

94. UNICEF. *Health Budget Brief*.; 2022. Accessed May 1, 2023. https://www.unicef.org/esa/media/8991/file/UNICEF-Malawi-2020-

95. WFP. WFP Malawi - 2022 Annual Country Reports. Published online 2023. Accessed May 1, 2023. https://docs.wfp.org/api/documents/WFP-0000148012/download/#:~:text=WFP%20Malawi%20had%20less%20resources,however%2C%20most%20activities%20were%20sustained.

96. Economic and Social Commission for Western Asia (ESCWA). *Social Protection in Morocco: The Role of Zakat*.; 2015. Accessed May 1, 2023. https://archive.unescwa.org/sites/www.unescwa.org/files/page_attachments/social-protection-morocco-role-zakat-en.pdf

97. CP-PVVIH. *Indice de Stigmatisation Des ES Personnes Vivant Avec Le VIH 2.0 Indice de Stigmatisation Des PVVIH 2.0 Au Maroc*.; 2022. Accessed May 1, 2023. https://www.sante.gov.ma/Documents/2021/tdr/TDR%20STIGMA%20INDEX%202021.pdf?csf=1&e=pGRzx7#:~:text=ou%20la%20stigmatisation%20interne%20montre,%C3%A0%20se%20suicider%20(21.4%25).

98. Mitha A. *Malawi's Approach to Providing Key Populations C&T Services*.; 2022. Accessed May 1, 2023. https://cquin.icap.columbia.edu/wp-content/uploads/2022/12/Mitha_FINAL.pdf

99. Bagyendera JK, Malunga AJ. *HIV-Sensitive Social Protection Assessment Report in Malawi*.; 2021. Accessed May 1, 2023. https://www.childrenandaids.org/sites/default/files/2022-06/ILO_UNAIDS_WFP%20Joint%20Mapping%20Report%20on%20HIV-s%20SP.pdf

100. P4SP Partnerships for Social Protection. Social protection in the Pacific and Timor-Leste: the state of play. Published online 2023. Accessed May 1, 2023. https://devpolicy.org/social-protection-in-the-pacific-and-timor-leste-20220915/

101. Ministry of Gender C and SPR of G. Livelihood Empowerment Against Poverty (LEAP) . Accessed May 1, 2023. https://leap.mogcsp.gov.gh/

102. Hope for Future Generations. Hope for future generations annual report 2021. Published online 2021. Accessed May 1, 2023. https://hffg.org/publication/our-2021-annual-report/

103. Kouyoumjian SP, Mumtaz GR, Hilmi N, et al. The epidemiology of HIV infection in Morocco: systematic review and data synthesis. *Int J STD AIDS*. 2013;24(7):507-516. doi:10.1177/0956462413477971

104. Ministère de l'Economie des F et de la R de l'Administration. Politique publique integrée de Protection Sociale 2020-2030. In: *Les États Submergés.* Institut français des relations internationales; 2019. doi:10.3917/ifri.demon.2011.01.0122

105. Angel-Urdinola D, El-Kadiri F, Pallares-Miralle M. *Morocco: Social Protection and Labor Diagnostic (Draft)*. World Bank; 2015. doi:10.1596/36669

106. Hasanuzzaman. SM. UNHCR Malawi HIV activities summary. Unpublished [personal notes] . Published online 2023.

107. Ministry of Gender C and SPR of G. About Us - Ministry of Gender, Children and Social Protection.

108. Agence Marocaine de Presse. UN: Generalization of Social Protection, a Royal Project for All Moroccans (Minister) 2022. Accessed May 22, 2023. https://www.mapnews.ma/en/actualites/social/un-generalization-social-protection-royal-project-all-moroccans-minister. Published

109. USAID. USA supports Ghanaian children's social welfare system. 2019. Accessed May 1, 2023. https://gh.usembassy.gov/usa-supports-ghanaian-childrens-social-welfare-system/#:~:text=Accra%2C%20GHANA%E2%80%94%20On%20May%2013,the%20Ghanaian%20social%20welfare%20system.

110. UNAIDS. UBRAF Framework — 2022–2023 workplan and budget. Published online 2021. Accessed May 1, 2023. https://www.unaids.org/sites/default/files/media_asset/PCB_49_UBRAF_2022_2023_Workplan_EN.pdf

111. UNAIDS. Organizational report: UNAIDS 2020 performance monitoring report. Published online 2021. Accessed May 1, 2023. https://open.unaids.org/sites/default/files/documents/PCB48_UBRAF_PMR_ORG_REPORT_EN.pdf

112. van der Wal R, Loutfi D, Nha Hong Q, et al. HIV-sensitive social protection for vulnerable young women in East and Southern Africa: a systematic review. *J Int AIDS Soc*. 2021;24:25787. doi:10.1002/jia2.25787/full

113. UNAIDS. UBRAF 2016-2021 Regional and Country Reports. Published online 2021. Accessed May 1, 2023. https://www.unaids.org/en/resources/documents/2021/PCB48_UBRAF2016-2021_Regional_Country_Report

114. UNAIDS. *UNAIDS Summary Report: 2018-2019*.; 2019. Accessed May 1, 2023. https://www.ilo.org/wcmsp5/groups/public/---dgreports/---gender/documents/project/wcms_756097.pdf

115. UNAIDS, WFP. *Providing Cash Transfers for Vulnerable People Living with HIV and Key Populations*.; 2022. Accessed May 1, 2023. https://www.wfp.org/publications/providing-cash-transfers-vulnerable-people-living-hiv-and-key-populations#:~:text=In%202020%2C%20WFP%20and%20UNAIDS,C%C3%B4te%20d'Ivoire%20and%20Niger.

116. UNAIDS. In Danger: Global Aids Update 2022. Published online 2022. Accessed May 1, 2023. https://www.unaids.org/en/resources/documents/2022/in-danger-global-aids-update

117. The World Bank. Pandemic response effectiveness in Pakistan. Published 2023. Accessed October 5, 2023. https://projects.worldbank.org/en/projects-operations/project-detail/P173796

118. UNAIDS. *SRA: HIV and Health Services Integration*.; 2021. Accessed May 1, 2023. https://open.unaids.org/sites/default/files/documents/SRA8_SRA%20report_2020.pdf

Annexes

Annex I: Matrix

Relevance and coherence: These questions are concerned with the design of the Joint Programme's workplans and activities related to social protection, including: whether the Joint Programme's activities are relevant to the needs of people living with, at risk of or affected by HIV, including key populations; what the unique contributions of the Joint Programme are to social protection; and how does it complement the work of other actors within the UN system and external partners.

EQ1. ***Role.*** **To what extent is the role of the Joint Programme in HIV-sensitive social protection aligned with its overall mandate and strategy?**		
Assumptions	**Indicators and findings**	**Methodology**
1.1 Joint Programme mandate clearly defines its role in HIV-sensitive social protection. 1.2 Joint Programme mandate and programming leverages the comparative advantage of each Cosponsor agency. 1.3 Evidence of the need/priorities of populations living with, at risk of or affected by HIV is available to guide the Joint Programme's design and implementation.	Role of the Joint Programme in HIV-sensitive social protection according to country informants	In-country data collection
	Definition of the Joint Programme's role in HIV-sensitive social protection in UBRAF and in discourse with key partners and stakeholders	Document review Global KIIs

EQ2. ***Country relevance.*** **How relevant are the Joint Programme guidance and efforts to integrating HIV into national social protection systems, and how connected to national systems are they?**		
Assumptions	**Indicators and findings**	**Methodology**
2.1 UNAIDS Secretariat and Cosponsors' guidance and policies adequately cover social protection issues. 2.2 Joint Programme activities are designed with the involvement of national stakeholders. 2.3 Evidence informs design and choice of country activities.	Definition of the Joint Programme's role in social protection in UBRAF and in discourse with key partners and stakeholders	Global KIIs
	Examples of alignment/misalignment of social protection strategies and the Joint Programme's approach to social protection	In-country data collection
	Types and scale of Joint Programme activities in social protection at country level	Document review

EQ3. ***Partnerships.*** **To what extent are partners involved in the advancement of HIV-sensitive social protection, what roles do partners play and how can partnerships with and the capacity of stakeholders (civil society, government, others) be strengthened further?**		
Assumptions	**Indicators and findings**	**Methodology**
3.1 Cosponsor agencies agree on common goals and division of labour in social protection. 3.2 Key partners are involved in the planning, implementation or monitoring of HIV-sensitive social protection programmes.	Examples of partnerships established by the Joint Programme with civil society, government and international partners in countries, and perception by partners	In-country data collection
	List of social protection partnerships involving the Joint Programme and assessment and perceptions of key informants on their effectiveness	Document review Global KIIs

3.3. Concrete collaborations are established at global, regional and national levels.		
EQ4. *Models.* What models or instruments for HIV-sensitive social protection are feasible and available in resource-constrained environments, and what are the gaps relevant to the Joint Programme's work?		
Assumptions	**Indicators and findings**	**Methodology**
4.1 Social protection sensitivity to HIV is properly analysed and followed up by the Joint Programme. 4.2 Patterns and models of HIV and TB integration national social protection programmes are analysed and documented by UNAIDS.	Categories of social protection systems according to HIV-sensitivity based on the Joint Programme's Assessment Tool	Country doc review
	Main enabling/limiting factors of HIV-sensitive social protection according to country studies	In-country data collection
	Success cases in HIV-sensitive social protection among LMICs recorded by the Joint Programme	Document review
	Success cases in HIV-sensitive social protection among LMICs according to key informants	Global KIIs
EQ5. *Progress.* To what extent has the Joint Programme contributed to HIV (and to a certain extent TB) integration into national social protection programmes? What are the contributing and/or hindering factors for this integration?		
Assumptions	**Indicators and findings**	**Methodology**
5.1 Social protection sensitivity to HIV is properly analysed and followed up by the Joint Programme. 5.2 Patterns and models of HIV and TB integration with national social protection programmes are analysed and documented by UNAIDS. 5.3 Countries are receptive to information and knowledge from Joint Programme on HIV-sensitive social protection. 5.4 Communication mechanisms exist between the Joint Programme and key populations to engage them in social protection advocacy. 5.5 Focus on national systems, political buy-in and national ownership favour the effectiveness and sustainability of UNAIDS work in social protection.	Evolution in HIV (and to an extent TB) integration across countries according to the UNAIDS Assessment Tool	Country document review
	Examples of progress in HIV-sensitive social protection found in country studies	In-country data collection
	Increase in number of countries with HIV-sensitive systems, distribution across regions	Country document review
	Number of existing social protection programmes collaborated with from 2018–2022 to create, integrate and scale up HIV-sensitive services	Document review
	Number of individuals engaged from 2018–2022 in the design, implementation and evaluation of HIV-sensitive social protection services to increase capacity of key populations	Document review
	Number of institutions that have been given technical support from 2018–2021 to increase their capacity to link people with HIV to social protection services	Document review
	Number of studies or evaluations conducted from 2018–2021 that provide evidence pertaining to efficiency, effectiveness and sustainability of HIV-sensitive social protection programmes and services	Document review
	Number of tools developed or implemented from 2018–2021 that provide guidance on HIV-sensitive social protection programmes and services	Document review
	Progress on output 8.2 of the 2016–2021 UBRAF reported by the Joint Programme and comments by key informants	Document review Global KIIs

EQ6. *Contribution.* How well equipped is the Joint Programme to contribute to HIV-sensitive social protection?

Assumptions	Indicators and findings	Methodology
6.1 The Joint Programme's allocation of human, financial and technical resources is well balanced across the different activities (evidence generation, knowledge translation, capacity-building, community engagement, programming and advocacy). 6.2 The Joint Programme's overall allocation of resources is appropriate to enable the implementation of the activities.	Concrete results on social protection related to Joint Programme work in country-specific reports	Country document review
	Examples of Joint Programme's effective contribution to HIV-sensitive social protection according to observers and the Joint Programme's own records	Document review
	Examples of the Joint Programme's effective contribution to HIV-sensitive social protection according to observers and the Joint Programme's own records	Global KIIs
	Types and scale of Joint Programme activities in social protection at country level	In-country data collection
	Types of activities undertaken by the Joint Programme's social protection area and distribution across countries	Country document review

EQ7. *Tool*. How effectively is the UNAIDS HIV and Social Protection Assessment Tool (and related tools by other agencies) used to link people living with, at risk of or affected by HIV to social protection services?

Assumptions	Indicators and findings	Methodology
7.1 The UNAIDS HIV and Social Protection Assessment Tool has been applied to a significant number of countries. 7.2 The assessments produced with the Tool have been shared with/are available to key stakeholders.	Number of countries in which the tool has been applied, and distribution across relevant clusters of countries	Country document review
	Reports produced with the UNAIDS Assessment Tool and feedback by users of tool and reports	Document review
		In-country data collection
		Global KIIs

EQ8. *Regional activities.* How effective is the Joint Programme supporting the regional initiatives on HIV-sensitive social protection?

Assumptions	Indicators and findings	Methodology
8.1 Concrete collaborations are established at regional national level. 8.2 Regional collaborations and activities inform and support activities at country level.	Countries benefitting from Joint Programme support in social protection through regional initiatives, and correlation with progress towards HIV-sensitive social protection	Country document review
	List of regional activities on social protection involving the Joint Programme and perceptions of informants on their effectiveness	Document review
		In-country data collection
		Global KIIs

EQ9. *Inclusion.* What are the main contributions of the Joint Programme in increasing access and coverage of social protection for populations living with, at risk of or affected by HIV, including key populations?

Assumptions	Indicators and findings	Methodology
9.1 The focus and data of the Joint Programme allows for differentiated	Examples of Joint Programme advocacy on inclusion of key populations	In-country data collection

analysis of access and coverage across population groups and epidemic profile.	Key populations identified at country level, current coverage by social protection system and recent evaluation	In-country data collection
	Key populations supported by Joint Programme work on social protection according to observers and Joint Programme's own records	Document review Global KIIs
EQ10. *COVID-19.* What key lessons have emerged from government and community-led COVID-19 related social protection services supported by the Joint Programme?		
Assumptions	**Indicators and findings**	**Techniques**
10.1 Joint Programme adapts its support to COVID-19. 10.2 The Joint Programme analyses emerging challenges of social protection and draws lessons to support resilient systems for health for COVID-19 and future pandemic responses.	Most important impacts of COVID-19 on HIV-sensitive social protection, types and scale	Document review
		Global KIIs

Annex II: Tools

Tool 1. Field mission questionnaire: UNAIDS and Cosponsors

I. Social protection and HIV

1	How has the national social protection strategy or policy evolved in recent years in terms of coverage of people living with or affected by HIV (and TB)?	EQ5
2	How have the national health insurance (and social health insurance, if it is distinct), life insurance or critical illness insurance evolved in terms of coverage of people living with HIV or TB?	EQ5
3	What are the social safety nets to people living with or affected by HIV (and TB) *(refer to list of social protection programmes different than health insurance, such as cash transfers, scholarships, food aid, livelihood programmes, etc.)*? How have these social safety nets evolved in recent years?	EQ5
4	What is the coverage and access to the country's social protection across population groups and epidemic profiles? Who is left behind by current practices? *Probe* re coverage of gay men and other men who have sex with men, transgender populations, sex workers, people who use drugs, migrant populations, orphans and vulnerable children, and any other key or vulnerable populations	EQ9

II. The Joint Programmes's contribution to HIV-sensitive social protection

5	Which activities were undertaken by the Joint Programme and how did each type of activity contribute to the country's progress in HIV-sensitive social protection?	EQ5
6	How has the Joint Programme advocated inclusive access and coverage in the country?	EQ9
7	Has the Joint Programme's HIV and Social Protection Assessment Tool been used in the country? (If yes, please describe the results of the assessment and its influence on policy-making and assess its adequacy and robustness. If not, explain why it has not.	EQ7
8	How has the country benefitted from Joint Programme support via regional activities (if relevant)?	EQ8

III. Factors enabling/limiting HIV-sensitive social protection

9	What factors have contributed to the integration of HIV in the national social protection system?	EQ5
10	What factors have hindered the integration of HIV in the national social protection system?	EQ5
11	How has the COVID-19 crisis affected achievements in the country's social protection and how has UNAIDS adapted its work in social protection to the pandemic?	EQ10

IV. Reflecting on the relevance and coherence of UNAIDS’ role in social protection

12	How do national stakeholders perceive the role of UNAIDS in social protection vis-à-vis other international actors?	EQ1
13	How do UNAIDS and Cosponsors work in the country align to national priorities and development strategies?	EQ2
14	What successful partnerships have been established by the Joint Programme and civil society, government and international partners in the country?	EQ3
15	How well equipped is the Joint Programme to effectively contribute to HIV-sensitive social protection in the country and what should be its role be going forward?	EQ6

Tool 2. Field mission questionnaire: National counterparts

I. Social protection and HIV

1	Please describe the national social protection strategy or policy and evolution in terms of coverage of vulnerable people.	EQ5
3	How have the national health insurance (and social health insurance, if it is distinct), life insurance or critical illness insurance evolved in terms of coverage of people living with HIV?	EQ5
2	What progress has been made in social safety nets *(refer to list of social protection programmes different than health insurance, such as cash transfers, scholarships, food aid, livelihood programmes, etc.)* and how has it benefitted key populations and people living with HIV?	EQ5
4	What is the coverage and access to the country's social protection across population groups and epidemic profiles? Who is left behind by current practices? *Probe* re coverage of gay men and other men who have sex with men, transgender populations, sex workers, people who use drugs, migrant populations, orphans and vulnerable children, and any other key population	EQ9

II. The Joint Programme's contribution to HIV-sensitive social protection

5	Which UN actors have been active in social protection and how have they contributed to the country's progress in HIV-sensitive social protection?	EQ5
6	How do UN agencies advocate inclusive access to social protection by vulnerable groups in the country? (Refer to groups identified under question 4)	EQ9
7	Has the Joint Programme's HIV and Social Protection Assessment Tool been used in the country? (If yes, please describe the results of the assessment and its influence on policy-making, and assess its adequacy and robustness)	EQ7
8	How has the country benefitted from Joint Programme support via regional activities (if relevant)?	EQ8

III. Factors enabling/limiting HIV-sensitive social protection

9	What factors have contributed to the integration of HIV in the national social protection system?	EQ5
10	What factors have hindered the integration of HIV in the national social protection system?	EQ5
11	How has the COVID-19 crisis affected achievements in the country's social protection and how has UNAIDS adapted its work in social protection to the pandemic?	EQ10

IV. Reflecting on the relevance and coherence of UNAIDS role in social protection

12	What is the added value of the UNAIDS office to the social protection system vis-à-vis other international actors?	EQ1
13	How do UN agencies work in the country align to national priorities related to social protection?	EQ2
14	What successful partnerships have been established by the UN and your government regarding HIV and social protection?	EQ3

Tool 3. Field mission questionnaire: CSOs, key population representatives and other partners

I. Social protection and HIV

Question I. Please describe the current situation and recent evolution of the national social protection system in terms of coverage of people living with or affected by HIV and TB, including key populations. Refer to the populations you represent or work with, and indicate which barriers affect their access to social protection, and how they have been/can be removed.

Possible issues to be raised in follow-up questions:

1	Changes in national social protection strategy or policy	EQ5
2	Health insurance	EQ5
3	Social safety nets (refer to list of social protection programmes different than health insurance, such as cash transfers, scholarships, food aid, livelihood programmes, etc.)	EQ5
4	Coverage of gay men and other men who have sex with men, transgender populations, sex workers, people who use drugs, migrant populations, orphans and vulnerable children, and any other key population	EQ9

II. The Joint Programmes's contribution to HIV-sensitive social protection

Question II. Please describe your involvement in/observation of activities of UNAIDS and Cosponsors related to social protection and their effects on national policies and programmes.

Possible issues to be raised in follow-up questions:

5	Concrete contributions to HIV-sensitive social protection	EQ5
6	Advocacy activities	EQ9
7	The Assessment Tool	EQ7
8	Regional activities	EQ8

III. Factors enabling/limiting HIV-sensitive social protection

Question III. (To be adapted depending on the informants' assessment on the progress made in HIV-sensitive social protection) What are in your opinion the most relevant factors limiting/enabling progress towards HIV-sensitive social protection. How has the pandemic influenced such progress or the lack of it?

Possible issues to be raised in follow-up questions:

9	Possible positive factors (political buy-in, UN guidance, civil society engagement, etc.)	EQ5
10	Possible negative factors (stigmatization, funding, fragmentation, etc.)	EQ5
11	The COVID-19 factor (impact on social protection and HIV, adaptation by the Joint Programme, lessons learnt, etc.)	EQ10

IV. Reflecting on the relevance and coherence of UNAIDS role in social protection

Question IV. What would you recommend to the Joint Programme to effectively support a more inclusive social protection system and increase coverage of people living with or affected by HIV and TB?

Possible issues to be raised in follow-up questions:

12	The niche of UNAIDS in social protection vis-à-vis other international actors	EQ1
13	National alignment	EQ2
14	Successful partnerships	EQ3
15	The way forward	EQ6

Tool 4. Global and regional document review: Operationalization of evaluation questions

This questionnaire is intended to guide the evaluators' review of Joint Programme documents related to social protection at programme level (e.g., UBRAF). There is another list of questions that apply to country-specific documents, such as reports resulting from the application of the UNAIDS Assessment Tool.

Evaluation question / key word	Operationalization
EQ1. Role	How is HIV-sensitive social protection positioned in the Global AIDS strategy and UBRAF (in 2016–2021 and 2022–2026)?
EQ2. Country relevance	What activities related to HIV-sensitive social protection have been conducted at country level in the period under evaluation, and how are they connected to national systems?
EQ3. Partnerships	What partnerships (including government, civil society [including organizations representing people living with, at risk of and affected by HIV, including key populations] and funding partners) have been established to promote HIV-sensitive social protection, and how do the partnership documents and publications assess the added value of each partner?
EQ4. Models	What models of integration of HIV in social protection emerge from the Joint Programme's internal reporting and publications, and how consistent are these models with the state of knowledge in this domain?
EQ5. Progress	What progress has been made towards output 8.2 of the UNAIDS 2016–2021 UBRAF according to internal reporting and how has such progress been achieved? How has such progress been measured? How consistent is the measurement and related analysis by the Joint Programme with information provided by other UN and academic sources?
EQ6. Contribution	What contributions to HIV-sensitive social protection programmes by the Joint Programme have been reported in monitoring and evaluation?
EQ7. Tool	How is the UNAIDS HIV and Social Protection Assessment Tool and its implementation inserted and assessed in the Joint Programme's internal planning and reporting?
EQ8. Regional activities	How has the Joint Programme tapped into regional cooperation initiatives according to its own records, and what information has been published by regional entities on the work of Joint Programme in social protection?
EQ9. Inclusion	What is the information available at the Joint Programme on coverage and access to social protection for populations living with, at risk of or affected by HIV, including key populations, and how has inclusion evolved between 2016 and 2021 according to that information?
EQ9. Inclusion	What equity issues have been addressed by UNAIDS in the period under evaluation according to its internal reporting and publications?
EQ10. COVID-19	How has the COVID-19 crisis affected achievements in HIV-sensitive social protection and how has the Joint Programme adapted its work in social protection to the pandemic?

Tool 5. Country document review: Operationalization of evaluation questions

This questionnaire is intended to guide the evaluators' review of UNAIDS country-specific documents, such as reports resulting from the application of the UNAIDS Assessment Tool.

Evaluation question / key word	Operationalization
EQ4. Models	Categories of social protection systems according to HIV-sensitivity based on the UNAIDS assessment tool
EQ5. Progress	Increase in number of countries with HIV-sensitive systems, distribution across regions
EQ5. Progress	Evolution in HIV integration across countries according to the UNAIDS Assessment Tool
EQ6. Contribution	Types of activities undertaken by the Joint Programme in HIV-sensitive social protection and distribution across countries
EQ6. Contribution	Results on HIV-sensitive social protection related to the work of the Joint Programme in country-specific reports
EQ7. Tool	Number of countries in which the UNAIDS HIV and Social Protection Assessment Tool has been implemented, and distribution across regions
EQ8. Regional activities	Countries benefitting from Joint Programme support in social protection through regional initiatives, and correlation with progress towards HIV-sensitive social protection

Tool 6. Global and regional key informant interviews: Operationalization of evaluation questions

Evaluation question / key word	Question
EQ1. Role	What has been the specific role of the Joint Programme in HIV-sensitive social protection and how has it complemented the role and contribution of other UN and global actors?
EQ2. Country relevance	How is the work of the Joint Programme on national social protection systems perceived at country level and how well does it embed in national systems?
EQ3. Partnerships	What successful partnerships have been established and what has been the role and comparative advantage of other partners (civil society, government, others)?
EQ4. Models	Which would you consider exemplary model(s) in HIV-sensitive social protection?
EQ5. Progress	From your perspective, what progress has been made in recent years regarding HIV-sensitive social protection systems and what are the main challenges ahead?
EQ6. Contribution	How has the Joint Programme contributed to countries' progress in HIV-sensitive social protection programmes at global and country levels (please mention specific countries)?
EQ7. Tool	What is your experience with the UNAIDS Assessment Tool for social protection systems and how do you assess its adequacy and robustness?
EQ8. Regional activities	How effective has been the work of the Joint Programme in regional initiatives to advance HIV-sensitive social protection?
EQ9. Inclusion	What is the coverage and access to social protection for populations living with, at risk of or affected by HIV, including key populations, and who is left behind by current practices?
EQ9. Inclusion	What are the main contributions of the Joint Programme in increasing access and coverage across population groups and epidemic profiles?
EQ10. COVID-19	How has the COVID-19 crisis affected achievements in HIV-sensitive social protection and how do you assess adaptation to the pandemic and the related crisis by the Joint Programme?

ANNEX III: List of interviews

#	Name	Institution	Gender
BENIN			
1	Achille Adoko	UNAIDS	M
2	Adbel Kader Condé Karimou	Ministry of Social Affairs and Microfinance (MASM)	M
3	Alicia Labombonne	Synergie Trans Benin	F
4	Axel Akpaka	BENIN Synergies PLUS (BESYP)	M
5	Bertille Agueh Onambele	USA Embassy	F
6	Bruno Doussoh	Independent consultant to UNAIDS	M
7	Christelle Assogba	APESSA (Association pour l'éducation, la sexualité et la santé en Afrique)	F
8	Donna Sagvohae	UNFPA/Université Nationale du Bénin	F
9	Bertin Affedjou	National Council for the Fight against HIV/AIDS, Tuberculosis, Malaria, STIs and Epidemics (SE/CNLS-TP)	M
10	Carin Ahouada	PLAN international Benin	M
11	Josseline Dorcas Tohon épouse Ayawou	FHI 360 / PEPFAR	F
12	Moussa Bachabi	Ministry of Health	M
13	Simone Kounnouho	National Council for the Fight against HIV/AIDS, Tuberculosis, Malaria, STIs and Epidemics (SE/CNLS-TP)	F
14	Télesphore Houansou	WHO	M
15	Yasmine Gounod	Kowégbo Hospital Sur Léré	F
16	Yasmine Ibrahim	UNAIDS	F
17	Eliot Chagas	Réseau sida Bénin	M
18	Elisette Djossou Ichola	USA Embassy	F
19	Ermence Wouetola	National Council for the Fight against HIV/AIDS, Tuberculosis, Malaria, STIs and Epidemics (SE/CNLS-TP)	F
20	Euphrem Ganmou	Réseau sida Bénin, CP	M
21	Flore Gangbo	Ministry of Health	F
22	Francine Arlette Akouekou	UNFPA	F
23	Justina Houessou	Solidarité	F
24	Justine Houzanmè	Réseau des ONG et Associations de Femmes contre la Féminisation du VIH/SIDA au Benin (ROAFEM)	F
25	Komolio Bankole	BENIN Synergies PLUS (BESYP), National Coordinating Body of Global Fund (INC)	M

#	Name	Institution	Gender
26	KV Loko	National Council for the Fight against HIV/AIDS, Tuberculosis, Malaria, STIs and Epidemics (SE/CNLS-TP)	M
27	Mabel Agbosu Afi	Solidarité	F
28	Marie Veillon	French Embassy	F
29	Marius Gnintoungbe	USA Embassy	M
30	Maures Doukpo	Réseau SIDA Bénin, DF	M
31	Michaël Ayihou	APESSA (Association pour l'éducation, la sexualité et la santé en Afrique)	M
32	Nicole Paqui	UNICEF	F
33	Odile Sodoloufo	PLAN international Benin	F
34	Oscar Daanon	BORNES	M
35	Passita Gonzalez	Synergie Trans Benin	F
36	Rodrigue Agossou	BORNES	M
37	Sylvain Ogoudele	PLAN international Benin	M
38	Yolande Agueh	World Food Programme (WFP)	F
CHINA			
39	Bai Hua	BaiHuaLin	M
40	Chen Zhongdan	WHO	M
41	Chen Zihuang	BlueD	M
42	Duan Yi	Youan Aixinjiayuan	M
43	Guo Wei	UNAIDS	M
44	Jing Jun	Tsinghua University	M
45	Kong Lingkun	U=U	M
46	Li Meiying	Guizhou people living with HIV	F
47	Liu Jie	UNAIDS	F
48	Liu Ming	UNICEF	M
49	Liu Wenli	Beijing Normal University	F
50	Ma Tiecheng	Shenyang Aideyuanzhu	M
51	MuMu	Family of Red Ribbon, Ditan Hospital	M
52	Weng Huiling	UNAIDS	F
53	Wu Rulian	International Labour Organization (ILO)	F
54	Yang Yuning	UNICEF	F
55	Yuan Wenli	Women's Network Against AIDS in China	F

#	Name	Institution	Gender
56	Zhang Liyuan	UNAIDS	F
57	Zhou Jie	International Labour Organization (ILO)	F
DOMINICAN REPUBLIC			
58	Bethania Betances	UNAIDS	F
59	Mayra Minaya	SENASA	M
60	Dulce Chahin	UNFPA	F
61	Eneyda Almonte	UNICEF	F
62	Felix Reyes	REDNACER	M
63	Gavino Severino	UNICEF	M
64	Humberto López	CONAVIHSIDA	M
65	Ingrid Bretón	Grupo Paloma	F
66	Joseph Cherubin	Movimiento Sociocultural para los Trabajadores Migrantes (Mosctha)	M
67	Leticia Martínez	SISALRIL	F
68	Lucila Ramón	World Food Programme (PMA)	F
69	Mina Harperm	Clínica de la Familia	F
70	Mónica Thormann	MSP/DIGECITSS	F
71	Nilo Mercedes	Mesón de Dios	M
72	Olivia Brathwaite	Pan American Health Organization (PAHO)	F
73	Pedro Reyes	United Nations Development Programme (PNUD)	M
74	Rosa Sánchez	CONAVIHSIDA	F
75	Susana Doñé Corporán	SIUBEN	F
FIJI			
76	Ashna Shaleen	Medical Services Pacific	F
77	Brian Kironde	UNFPA	M
78	Christopher Lutukivuya	Believers Support Group	M
79	Avelina Rokoduru	Medical Services Pacific	F
80	Nuha Mahmoud	WHO	F
81	Salome Daunivalu	Medical Services Pacific	F
82	Subhash Yadav	WHO	M
83	Titilola Duro-Aina	UNFPA	F
84	Jun Fan	UNICEF	M

#	Name	Institution	Gender
85	Renata Ram	UNAIDS	F
86	Sister Taraivosa Nakolinivalu	Reproductive Family Health Association of Fiji (RFHAF)	F
87	Sophie Radrodro	Strumphet Alliance Network	F
88	Surkafa Katafon	International Labour Organization (ILO)	F
89	Tamani Rarama	Fiji Youth on SRHR Alliance (FYSA)	M
GHANA			
90	Abena Amoah	Planned Parenthood of Ghana	F
91	Belynda Amankwa	United Nations Development Programme (PNUD)	F
92	Ben Cheabu	Christian Health Association of Ghana	M
93	Cecilia Senoo	Hope for Future Generations	F
94	Comfort Asamoah-Adu	WAPCAS	F
95	Dinah Akukumah	Ghana AIDS Commission	F
96	Paul Dsane-Aidoo	UNICEF	M
97	Rita Owusu-Amankwah	Ghana AIDS Commission	F
98	Stephen Ayisi-Addo	National AIDS/STI Control Programme	M
99	Elsie Ayeh	Ghana Network of Persons Living with HIV (NAP+)	F
100	Emma Anaman	World Food Programme (WFP)	F
101	Felix Osei-Sarpong	UNICEF	M
102	Frank Adetor	International Labour Organization (ILO)	M
103	Isaiah Doe Kwao	Ghana AIDS Commission	M
104	James Duah	Christian Health Association of Ghana	M
105	Kofi Diaba	WAPCAS	M
106	Kofi Owusu-Anane	WAPCAS	M
107	Mawutor Ablo	Ministry of Gender, Children and Social Protection	M
108	Myra Togobo	Resident Coordinator's Office	F
109	Naa Ashiley Vanderpuye - Donton	West Africa AIDS Foundation	F
110	Nancy Ansah	Hope for Future Generations	F
111	Phinehas Kissiedu Ayeh	West Africa AIDS Foundation	M
112	Rita Afriyie	Ghana AIDS Commission	F
MALAWI			
113	Abiba Longwe	UNICEF	F

#	Name	Institution	Gender
114	Aniz Mitha	Community Health Rights Advocacy (CHeRA)	M
115	Beatrice Targa	UNICEF	F
116	Charles Kalemba	Department of Disaster Management Affairs	M
117	Chikondi Makawa	UNICEF	M
118	David Kamkwamba	Network of Journalists Living with HIV	M
119	Gerald Manthalu	Ministry of Health	M
120	Edna Tembo	Coalition of Women Living with HIV (COWLHA)	F
121	Elina Mwasinga	Network of young people living with HIV (Y+)	F
122	Ellious Chasukwa	National Aids Commission	M
123	Emily Kayimba	MANASO-CLM Team	F
124	Fatsani Nyambi	United Nations Development Programme (PNUD)	F
125	Faustin Matchere	US President's Emergency Plan for AIDS Relief (PEPFAR)	M
126	George Juwawo	UNICEF	M
127	Harry Satumba	Ministry of Gender	M
128	Justin Hamela	Ministry of Gender	M
129	Lawrence Khonyongwa	Malawi Network of people living with HIV (MANET+)	M
130	Lawrence Phiri Chipili	Lesbian, Intersex, Transgender and other Extensions (LITE)	M
131	Linda Malilo	USAID	F
132	Madalitso Mwale	Department of Disaster Management Affairs	M
133	Moses Chimphepo	Department of Disaster Management Affairs	M
134	Mr Bonongwe	Ministry of Gender	M
135	Mr Kamstinjiro	Ministry of Gender	M
136	Nellie Masamba	Ministry of Gender	F
137	Nuha Cessay	UNAIDS	M
138	Precious Soko	Female Sex Workers Association	M
139	Reagan Kaluluma	International Labour Organization (ILO)	M
140	Robert Phiri	SRHR Africa Trust (SAT)	M
141	S M Hasanuzzaman	UNHCR	M
142	Sibia Mjumira	International Labour Organization (ILO)	F
143	Victor Singano	Centers for Disease Control (CDC) – Malawi	M
144	Victoria Thonyiwa	US President's Emergency Plan for AIDS Relief (PEPFAR)	F

#	Name	Institution	Gender
MOROCCO			
145	Agnes Fiamma Papone	Consultante indépendante	F
146	Amar Maria	Conseil Nationale de Droits Humains	F
147	Ayoub Afnakar	Association Sud contre le Sida (ASCS)	M
148	Boutaina El Omari	Unité de Gestion du Fonds Mondial	F
149	Cheikhi Hajar	Association Marocaine de Développement et de Solidarité (AMSED)	F
150	Cheikhi Hajar	Association Marocaine de Développement et de Solidarité (AMSED)	M
151	D'Guennouni Abdelamajid	MSPS	M
152	Fatima Abid	Association Soleil	F
153	Ghita Zaoui	Association de lutte contre le SIDA (ALCS)	F
154	Ghizlane Asendour	Association de lutte contre le SIDA (ALCS)	F
155	Ghizlane Mghaimimi	Association Sud contre le SIDA (ASCS)	F
156	Hind El Hajji	UCO	F
157	Houssine El Rhilani	UCO	M
158	Jaouad Hamou	MSPS	M
159	Jihane El Habti El Idrissi	Ministère de l'économie et des Finances	F
160	Lahoucine Ouarsas	Association de lutte contre le SIDA (ALCS)	M
161	Mohamed Dadsi	CCM	M
162	Mohamed El Khamas	Association de lutte contre le SIDA (ALCS)	M
163	Not available	UNICEF	F
164	Naoual Laaziz	Association de lutte contre le SIDA (ALCS)	F
165	Naoufel El Malhouf	Agence Nationale de l'Assurance Maladie (ANAM)	M
166	Naseem Awl	UNICEF	F
167	Redha Ameur	International Labour Organization (ILO)	M
168	Ricardo Irra Fernández	International Labour Organization (ILO)	M
169	Sakri Noure Ddine	MSPS	M
170	Yassine Soudi	UNFPA	M
PERU			
171	Andrea Boccardi	UNAIDS	M
172	Azucena Rodríguez	Latin American and Caribbean Network of Women Sex Workers: Redtrasex	F

#	Name	Institution	Gender
173	Carlos Benites	Ministry of Health of Peru	M
174	Cinthia Vidal de la Torre	UNICEF	F
175	Dulce Toval Chuquipiondo	Programme beneficiaries	F
176	Equipo UNJT	UNJT	
177	Jerome Mangelinck	Latin American and Caribbean Network of People who use Drugs: LANPUD	M
178	Ivan Bottger	World Food Programme (WFP)	M
179	Johana Gamboa	Programme beneficiaries	F
180	Josué Varela	Programme beneficiaries	M
181	Julia Rios Vidal	Ministry of Health of Peru	F
182	Karla Lino	Programme beneficiaries	F
183	Leida Portal	Latin American Platform of People who Exercise Sex Work: Plaperts	F
184	Lídice López	Key correspondents	F
185	Miguel Barrientos	Health organization: Socios En Salud	M
186	Nuba Crisostomo	UNHCR	F
187	Sandra Mangiante	UNAIDS	F
188	Taki Robles	Amigas por siempre	F
189	Teresa Ayala	AID FOR AIDS	F
190	Yoann Tuzzolino	World Food Programme (WFP)	M
191	Yoshi Yamanija	Health organization: Socios En Salud	F
192	Zoe	Programme beneficiaries	F
GLOBAL			
193	Afsar Syed Mohammed	International Labour Organization	M
194	Anurita Bains	UNICEF	F
195	Bettina Schunter	UNICEF	F
196	Charlotte Feitscher	UNAIDS	F
197	David Chipanta	UNAIDS	M
198	Diddie Schaaf	International Labour Organization	F
199	Gretchen Bachman	USAID & Office of the Global AIDS Coordinator and Health Diplomacy	F
200	Helene Badini Yendifimba	UNAIDS	F
201	Ian Orton	International Labour Organization	M

#	Name	Institution	Gender
202	Juan Gonzalo Jaramillo Mejia	World Food Programme	M
203	Katherine Ward	World Bank	F
204	Kofi Amekudzi	International Labour Organization	M
205	Michael Smith	World Food Programme	M
206	Rikke Le Kirkegaard	UNICEF	F
207	Redha Ameur	International Labour Organization	M
208	Aditia Taslim	International Network of People who Use Drugs (INPUD)	M

ANNEX IV: Social protection indicators and legal barriers

IV.1 Social protection indicators

HIV and AIDS estimates							
Region	Country	Prevalence % (ages 15+)	Incidence	Incidence variation (since 2010)	Fast-Track Target 1	Fast-Track Target 2	Fast-Track Target 3
West and Central Africa	Benin	0.8	0.14	-62%	85	84	66
Asia and Pacific	China	NA	NA	-50%	NA	NA	NA
Latin America and the Caribbean	Dominican Republic	0.9	0.39	-16%	85	55	47
Asia and Pacific	Fiji	0.2	0.19	-129%	57	45	NA
West and Central Africa	Ghana	1.7	0.57	-27%	71	71	NA
Eastern and Southern Africa	Malawi	7.7	1.13	-66%	90	90	90
Middle East and North Africa	Morocco	0.1	0.02	-48%	83	80	76
Latin America and the Caribbean	Peru	0.4	0.17	31%	NA	80	NA
Eastern Europe and Central Asia	Uzbekistan	0.2	0.11	-4%	77	51	NA
	World average	0.7	0.02	-32%	NA	NA	NA

Target 1: % of people living with HIV who know their status
Target 2: % of people living with HIV who know their HIV-positive status and are accessing treatment
Target 3: % of people living with HIV on treatment who have suppressed viral loads

Source: UNAIDS Data 2022.[61]

IV.2 Development indicators and legal barriers to HIV-sensitive social protection

		Development indicators			Social protection			Legal			
Region	Country	Income group*	LDC	HIPC	SDG 1.3.1** (%)	SDG 3.8.1*** (%)	Public Spending on SP (% of GDP)	Sex Work Criminalized	Criminalization of same sex sexual acts	Parental consent to access HIV testing	Mandatory HIV testing for marriage, work or residence permits, or for certain groups
West and Central Africa	Benin	LMI	Yes	Yes	7.8	40	0.4	Yes	No	Yes	No
Asia and Pacific	China	UMI	No	Yes	70.8	79	1.2	Yes	No	Yes	No
Latin America and the Caribbean	Dominican Republic	UMI	No	No	53.6	41	1.6	Yes	Yes	N/A	N/A
Asia and Pacific	Fiji	UMI	No	No	58.9	64	0.7	Yes	No	Yes	No
West and Central Africa	Ghana	LMI	Yes	Yes	25.3	47	0.4	Yes	Yes	Yes	No
Eastern and Southern Africa	Malawi	LI	Yes	Yes	21.3	46	1.5	Yes	Yes	Yes	No
Middle East and North Africa	Morocco	LMI	No	Yes	20.5	70	2.5	Yes	Yes	Yes	No
Latin America and the Caribbean	Peru	UMI	No	No	29.30	77	NA	Yes	No	Yes	Yes
Eastern Europe and Central Asia	Uzbekistan	LMI	No	No	42.70	73	0.8	Yes	Yes	Yes	Yes

* LMI – lower middle income; UMI – upper middle income; LI – low income
** Population covered by at least one social protection benefit (excluding health)
*** Universal health coverage

Sources: World Bank Open Data[60]
UNAIDS Data 2022[61]
ILO Data Dashboards 2020[123]

Annex V: Revisiting UNAIDS ToC on HIV-sensitive social protection

Topic	Assumptions	Validated?	Comments and link to assessment against evaluation criteria
Role	1.1 Joint Programme mandate clearly defines its role in social protection.	No	As per conclusion VI, HIV-sensitive social protection is not a well-established area of work for UNAIDS at country level, nor are its conceptual definition and scope clear to all key stakeholders, nor is data on progress on HIV-sensitive social protection produced by the Secretariat used by Country Offices.
	1.2 Joint Programme mandate and programming leverages the comparative advantage of each Cosponsor agency.	Yes	UNAIDS is in a unique position to work towards this goal based on Cosponsors' mandates, experiences and counterparts (conclusion II), and at country level it was found that the UNAIDS Secretariat and its Cosponsors, researchers and civil society are uniquely organized to produce new evidence, and to bridge analysis with policy and practice (conclusion V).
	1.3 Evidence of the need/priorities of populations living with, at risk of or affected by HIV is available to guide the Joint Programme's design and implementation.	No	Progress towards HIV-sensitive social protection worldwide reported by in JPMS monitoring system was not validated by the evaluation (conclusion VI); the UNAIDS Assessment Tool is largely unknown (conclusion IX).
Country relevance	2.1 UNAIDS guidance and policies adequately cover social protection issues.	No	As per conclusion VI, HIV-sensitive social protection is not a well-established area of work for UNAIDS at country level, nor are its conceptual definition and scope clear to all key stakeholders, nor is data on progress HIV-sensitive social protection produced by the Secretariat used by country Offices. Regional activities: conclusion X indicates that regional activities were not used to raise awareness on HIV-sensitive social protection and related UNAIDS guidance.
	2.2 Joint Programme activities are designed with the involvement of national stakeholders.	Yes	UNAIDS Secretariat and its Cosponsors have important relationships with governments and experience in providing technical assistance to strengthen national capacity to deliver health and social services for people living with, at risk of or affected by HIV (conclusion V).
	2.3 Evidence informs design and choice of country activities.	No	Conclusions VI and IX on JPMS monitoring of HIV-sensitive social protection and the tool for assessment of national systems indicate that such a link is not well established in this area of work.
Partnerships	3.1 Cosponsor agencies agree on common goals and division of labour in social protection.	Yes	Joint Programme members have been effective in addressing concrete discriminatory practices as well as barriers that exclude people living with, at risk of or affected by HIV (conclusion VII). ILO, UNICEF and WFP are recognized as lead agencies in social protection activities at the global and country level, and demand UNAIDS Secretariat involvement to link generalized social protection to access barriers people living with, at risk of and affected by HIV (conclusion III).

Topic	Assumptions	Validated?	Comments and link to assessment against evaluation criteria
	3.2 Key partners are involved in the planning, implementation or monitoring of HIV-sensitive social protection programmes.	Yes	The work of the UN Joint Programme on HIV and AIDS aligns well with national priorities, plans and strategies related to HIV prevention, care and treatment. This alignment is facilitated by close collaboration among UN agencies, national governments and donors (conclusion IV). Moreover, UNAIDS Secretariat and its Cosponsors have important relationships with governments and UNAIDS, in particular, is found to be uniquely placed to engage with civil society organizations representing key populations and people living with HIV (conclusion V).
	3.3. Concrete collaborations are established at global, regional and national levels.	Yes	Joint Programme members have been effective in addressing concrete discriminatory practices as well as barriers that exclude people living with, at risk of or affected by HIV, often by means of joint initiatives and collaboration across agencies (conclusion VII).
Models	4.1 Social protection sensitivity to HIV is properly analysed and followed up by the Joint Programme.	No	Conclusions VI and IX on JPMS monitoring of HIV-sensitive social protection and the tool for assessment of national systems indicate that social protection sensitivity to HIV is not properly analysed and followed up by the Joint Programme.
	4.2 Patterns and models of HIV and TB integration national social protection programmes are analysed and documented by UNAIDS.	No	The tool is completely unknown in most countries included in field missions, and alternative tools and methods are used to assess HIV-sensitivity of social protection. Moreover, in countries where the tool was used, most respondents representing national stakeholders were unaware of the assessment tool (conclusion IX).
Contribution	5.1 Social protection sensitivity to HIV is properly analysed and followed up by the Joint Programme.	No	Conclusions VI and IX on JPMS monitoring of HIV-sensitive social protection and the tool for assessment of national systems indicate that social protection sensitivity to HIV is not properly analysed and followed up by the Joint Programme.
	5.2 Patterns and models of HIV and TB integration national social protection programmes are analysed and documented by UNAIDS.	No	Conclusions VI and IX on JPMS monitoring of HIV-sensitive social protection and the tool for assessment of national systems indicate that social protection sensitivity to HIV is not properly analysed and followed up by the Joint Programme, which hinders the sharing of models of integration.
	5.3 Countries are receptive to information and knowledge from Joint Programme on HIV-sensitive social protection.	No	Conclusion IV highlights difficulties as national social protection systems do not explicitly indicate people living with, at risk of or affected by HIV as priority populations for social protection benefits, despite evidence of and confirmation by country informants of the existence of stigma-related barriers for people living with HIV and key populations to access social protection.
	5.4 Communication mechanisms exist between the Joint Programme and key populations to engage them in social protection advocacy.	Yes	UNAIDS Secretariat and its Cosponsors have important relationships with governments and UNAIDS, in particular, is found to be uniquely placed to engage with CSOs (conclusion V).

Topic	Assumptions	Validated?	Comments and link to assessment against evaluation criteria
	5.5 Focus on national systems, political buy-in and national ownership favour the effectiveness and sustainability of UNAIDS work in social protection.	No	In most countries, national social protection systems do not explicitly indicate people living with, at risk of or affected by HIV as priority populations for social protection benefits, despite evidence of and confirmation by country informants of the existence of stigma-related barriers for people living with HIV and key populations to access social protection (conclusion IV).
Efficiency	6.1 The Joint Programme's allocation of human, financial and technical resources is well balanced across the different activities (evidence generation, knowledge translation, capacity-building, community engagement, programming and advocacy).	No	UNAIDS Country Offices lack the resources to effectively engage in national social protection systems (conclusion XI). Eliminating the position of HIV-sensitive social protection officer has compromised the potential influence of the Joint Programme in this area (conclusion XII).
	6.2 The Joint Programme's overall allocation of resources is appropriate to enable the implementation of the activities.	No	UNAIDS Country Offices lack the resources to effectively engage in national social protection systems (conclusion XI). Eliminating the position of HIV-sensitive social protection officer has compromised the potential influence of the Joint Programme in this area (conclusion XII).
Assessment tool	7.1 The UNAIDS HIV and Social Protection Assessment Tool has been applied to a significant number of countries.	No	The tool is completely unknown in most countries included in field missions, and alternative tools and methods are used to assess HIV-sensitivity of social protection. Moreover, in countries where the tool was used, most respondents representing national stakeholders were unaware of the assessment tool (conclusion IX).
	7.2 The assessments produced with the Tool have been shared with and are available to key stakeholders.	No	The tool is completely unknown in most countries included in field missions, and alternative tools and methods are used to assess HIV-sensitivity of social protection. Moreover, in countries where the tool was used, most respondents representing national stakeholders were unaware of the assessment tool (conclusion IX).
Regional cooperation	8.1 Concrete collaborations are established at regional level.	No	There was little to no awareness of regional activities related to HIV-sensitive social protection (conclusion X).
	8.2 Regional collaborations and activities inform and support activities at country level.	No	There was little to no awareness of regional activities related to HIV-sensitive social protection (conclusion X).
Equity	9.1 The focus and data of the Joint Programme allows for differentiated analysis of access and coverage across population groups and epidemic profiles.	No	HIV-sensitive measures found in this evaluation referred to people living with HIV in general terms and did not put a concrete focus on population groups (conclusion XIII).
COVID-19	10.1 The Joint Programme adapts its support to	Yes	The COVID-19 crisis added pressure to Joint Programme resources, public finances and livelihood strategies, but it has also put social protection on

Topic	Assumptions	Validated?	Comments and link to assessment against evaluation criteria
	challenges presented by the COVID-19 pandemic.		many governments' agendas and has improved knowledge and partnerships on service delivery (conclusion XIV).
	10.2 The Joint Programme analyses emerging challenges of social protection and draws lessons to support resilient health systems for COVID-19 and future pandemic responses.	Yes	The COVID-19 crisis added pressure to Joint Programme resources, public finances and livelihood strategies, but it has also put social protection on many governments' agendas and has improved knowledge and partnerships on service delivery (conclusion XIV).

UNAIDS
20 Avenue Appia
CH-1211 Geneva 27
Switzerland

+41 22 791 3666

unaids.org