

HIV Sensitive Social Protection

In East And Southern Africa Fast Track Countries



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Contents

Acronyms	v
Executive summary.....	vi
1. Introduction	1
1.1. Background	1
1.2. The concept of HIV-sensitive social protection	2
1.3. Objectives of this report	4
1.4. Methodology.....	4
1.5. Structure of the report.....	6
2. Country overview: ANGOLA	7
2.1. Brief HIV situational analysis.....	7
2.2. Social protection mechanisms.....	7
2.2.1. Legislative and policy context.....	7
2.2.2. Social assistance programmes.....	8
2.2.3. Social security programmes.....	10
2.3. Summary	12
3. Country overview: BOTSWANA.....	14
3.1. Brief HIV situational analysis.....	14
3.2. Social protection mechanisms	14
3.2.1. Legislative and policy context	14
3.2.2. Social assistance programmes	15
3.2.3. Social security programmes	17
3.3. Summary	19
4. Country overview: ESWATINI	21
4.1. Brief HIV situational analysis.....	21
4.2. Social protection mechanisms.....	21
4.2.1. Legislative and policy context.....	21
4.2.2. Social assistance programmes.....	23
4.2.3. Social security programmes	25
4.3. Summary	27
5. Country overview: ETHIOPIA	28
5.1. Brief HIV and AIDS situation analysis.....	28
5.2. Social protection mechanisms	28
5.2.1. Legislative and policy context	28
5.2.2. Social assistance programmes	30
5.2.3. Social security programmes	31
5.3. Summary	34

6. Country overview: KENYA	35
6.1. Brief HIV and AIDS situation analysis.....	35
6.2. Social protection mechanisms	35
6.2.1. Legislative and policy context	35
6.2.2. Social assistance programmes	36
6.2.3. Social Security.....	38
6.3. Summary	40
7. Country overview: LESOTHO	42
7.1. Brief HIV situational analysis.....	42
7.2. Social protection mechanisms	42
7.2.1. National social protection legislative and policy context	42
7.2.2. Social assistance programmes	43
7.2.3. Social security programmes	44
7.3. Summary	46
8. Country overview: MALAWI	47
8.1. Brief HIV situational analysis.....	47
8.2. Social protection mechanisms	47
8.2.1. National social protection legislative and policy context	47
8.2.2. Social assistance programmes.....	48
8.2.3. Social security programmes.....	49
8.3. Summary	51
9. Country overview: MOZAMBIQUE	53
9.1. Brief HIV situational analysis.....	53
9.2. Social protection mechanisms	53
9.2.1. National social protection legislative and policy context	53
9.2.2. Social assistance programmes.....	54
9.2.3. Social Security programmes	55
9.3. Summary	57
10. Country overview: NAMIBIA.....	58
10.1. Brief HIV situational analysis.....	58
10.2. Social protection mechanisms	58
10.2.1. National social protection legislative and policy context	58
10.2.2. Social assistance programmes.....	59
10.2.3. Social Security programmes	60
10.3. Summary	63

11. Country overview: SOUTH AFRICA	64
11.1. Brief HIV situational analysis.....	64
11.2. Social protection mechanisms	64
11.2.1. National social protection legislative and policy context	64
11.2.2. Social assistance programmes	65
11.2.3. Social security programmes	67
11.3. Summary	70
12. Country overview: SOUTH SUDAN	72
12.1. Brief HIV situation analysis.....	72
12.2. Social protection mechanisms	72
12.2.1. National social protection legislative and policy context	72
12.2.2. Social assistance programmes	73
12.2.3. Social security	75
12.3. Summary	75
13. Country overview: TANZANIA	78
13.1. Brief HIV situational analysis.....	78
13.2. Social protection mechanisms	78
13.2.1. National social protection legislative and policy context	78
13.2.2. Social assistance programmes	79
13.2.3. Social security programmes.....	81
13.3. Summary	84
14. Country overview: UGANDA.....	85
14.1. Brief HIV situational analysis.....	85
14.2. Social protection mechanisms	85
14.2.1. National social protection legislative and policy context	85
14.2.2. Social assistance programmes.....	86
14.2.3. Social security programmes.....	87
14.3. Summary	89
15. Country overview: ZAMBIA.....	90
15.1. Brief HIV and AIDS situation analysis.....	90
15.2. Social protection mechanisms	90
15.2.1. National social protection legislative and policy context	90
15.2.2. Social assistance programmes	91
15.2.3. Social security programmes.....	92
15.3. Summary	95

16. Country overview: ZIMBABWE	96
16.1. Brief HIV and AIDS situation analysis.....	96
16.2. Social protection mechanisms	96
16.2.1. National social protection legislative and policy context	96
16.2.2. Social assistance programmes	97
16.2.3. Social security programmes.....	98
16.3. Summary	100
17. Summary, conclusion, and recommendations	101
17.1. Introduction	101
17.2. Key findings	101
17.2.1. Policy and legislative overview	101
17.2.2. Conceptualisation of social protection in the region	103
17.3. Overview of existing social protection programmes	105
17.3.1. HIV-sensitive social assistance programmes	105
17.3.2. Contributory social security programmes	109
17.4. Stakeholders involved in social protection programming.....	110
17.5. Views on the impact of COVID-19	115
17.6. Recommendations	115
References.....	117
APPENDIX A: List of country organisations consulted	121
APPENDIX B: 90–90–90 country scorecard, selected fast track countries, Eastern and Southern Africa, 2020	122

Acronyms

AGYW	Adolescent girls and young women
AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral therapy
CSO	Civil society organisation
DANIDA	Danish International Development Agency
DFAT	Australian department of Foreign Affairs and Trade
EC	European Commission
EU	European Unions
FCDO	UK Foreign, Commonwealth & Development Office (Formerly DFID - Department for International Development)
GBV	Gender based violence
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit (German Government aid agency)
HIV	human immunodeficiency virus
ILO	International Labour Organisation
IPV	Intimate partner violence
JICA	Japan International Cooperation Agency
LGBTI	lesbian, gay, bisexual, transgender and intersex
MOLSA	Ministry of Labour and Social Affairs
MSM	Men who have sex with men
NHIF	National Hospital Insurance Fund, Kenya
OVC	Orphans and Vulnerable children
PEPFAR	President's Emergency Plan For AIDS Relief
PLHIV	People Living with HIV
PLWHA	People living with HIV and AIDS
PWID	People who inject drugs
SIDA	Swedish International Development Cooperation Agency
UN	United Nations
UNDP	United Nations Development Fund
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WB	World Bank
WFP	World Food Programme
WHO	World Health Organisation
AGYW	Adolescent Girls and Young Women

Executive summary

Background

There is increased recognition and acknowledgment that HIV infections are driven by multiple factors operating at individual, community and societal levels. This has led to calls for greater attention and political support for the development of HIV-sensitive social protection, which entails programmes designed for people living with, at risk of, or affected by HIV. These calls are largely based on a wide body of evidence showing that social protection can be a critical enabler of efforts to reduce HIV risks, mitigate their impacts, and increase the capacity of households to cope and response to the risks. Social protection can also be used as an entry point to address deeply rooted social vulnerabilities and structural factors faced by those who are vulnerable to HIV infection.

This report presents the results of an exercise aimed at mapping HIV-sensitive social protection programmes in East and Southern Africa (ESA), the region most affected by HIV in the world. Particular focus was on 15 countries in the region (Angola, Botswana, Eswatini, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Namibia, South Africa, South Sudan, Tanzania, Uganda, Zambia, Zimbabwe) identified, on the basis of their HIV epidemic profiles, as 'Fast Track' countries in line with the UNAIDS Fast Track Commitment to end AIDS by 2030. The mapping exercise – commissioned by the World Food Programme (WFP) and the International Labour Organisation (ILO), the co-conveners of the UNAIDS Division of Labour area on scaling up HIV-sensitive social protection – was aimed at understanding how existing social assistance and social security programmes in ESA are integrating the vulnerabilities exacerbated by HIV.



The exercise was executed in two phases between 2019 and 2020. The first phase entailed a desktop review of each country's legislative and policy framework in relation to social protection. The purpose was to obtain a deeper understanding of the broad conceptualisation of social protection in each country as well as to understand the Constitutional, legislative, and policy commitments to social protection. The second phase entailed consultations with stakeholders from government, development partners and civil society organisations that support social protection programming in each country (see Appendix A). The aim was to validate the information obtained in the first phase, solicit stakeholders' perspectives on the key strengths and challenges of the social protection programming in their countries, as well as to obtain recommendations for future action for enhanced provision of HIV-sensitive social protection in the countries and the region.

Summary of key findings

Policy and legislative overview

Virtually all countries in the region have created enabling policy environments for social protection programming through the development and implementation of national social protection policies, supported by Constitutional provisions to social protection and long-term national visions. Although mitigating the effects of HIV and AIDS is rarely the main impetus for their development, the legislative and policy instruments in these countries can be described as HIV-sensitive as they typically aim to address many of the factors that increase the risk of HIV infection and vulnerability in the region.

Conceptualisation of social protection

Concepts such as capability, agency, improved access to economic and other livelihood resources, and overall improved quality of life are implicit in all the countries' definition of social protection. Conspicuously absent in these definitions is any reference to informal or indigenous social protection systems. Based on an emerging body of literature highlighting the limitations of the conceptualisation of formal social protection systems in the African context, this neglect of informal systems suggests that contemporary social protection programmes in the region may be missing out on the benefits offered by frameworks rooted in the socio-cultural milieu of Africans societies. For example, a wide body of evidence has shown how informal social protection systems such as community-based organisations and the extended family played a major role in providing much needed social care and support to those infected and affected by HIV and AIDS during the peak of that epidemic in many East and Southern countries during much of the 2000s decade.

Overview of existing social assistance programmes

- **Types and focus of programmes.** The most prominent social protection programmes in the region are protective and preventive in nature with each country having at least one cash (mostly unconditional) and one in-kind (mainly food) transfer programme. Livelihood promotion activities, in the form of public works programmes targeting young people and able-bodied working age populations, are also widely implemented in the region. To the extent that out-of-pocket health fees are some of the key factors that increase vulnerability and exposure to the risk of HIV infection in ESA, the absence of social health protection systems in most of the countries is a notable gap. Another is the general absence of 'cash plus' programmes which provide cash payments in combination with complementary services and have been shown to lead to relatively longer term positive impacts on several health and development outcomes. There is also a general absence of a transformative aspect in the region's social protection programming, where transformative relates to adopting policies that address societal power imbalances that support and sustain the existence of vulnerabilities. This is reflected in, for example, widespread criminalisation of sex work and same sex-acts as well as in the existence of punitive legislation or regulations in many countries.
- **HIV-sensitivity of programmes.** Although the majority of social protection programmes in the countries do not specifically target HIV-related issues or people living with HIV (PLHIV) the focus on vulnerability in the legislative and policy frameworks as well as in the programmes is sufficient to encompass HIV and AIDS.
- **Coverage of programmes.** Data constraints hampered the comprehensive analysis of the specific duration, locations, and overall coverage of social protection programmes across the countries. This brings to the fore the widespread issue of poor data collection systems in sub-Saharan Africa's social protection programming.

Overview of contributory social security programmes

As in many parts of sub-Saharan Africa, contributory social security schemes across ESA benefit formal sector employees, the majority of whom are public servants. Informal sector workers, who account for more than two thirds of the labour force in the many countries of the region, do not have access to social security benefits. With men dominating formal sector employment in Africa, this social security pattern also has a gender bias and the potential to leave families, headed by women, vulnerable to poverty and to the impact of HIV.

Stakeholders involved in social protection programming

In each country there are various stakeholders from government, civil society, bilateral and multilateral development agencies, and in some instances, the private sector involved in social protection programming. A number of gaps and barriers in relation to stakeholder harmonisation and alignment of efforts were identified. Key among these were overall weak stakeholder coordination at national and local levels as well as limited human resources constraints and limited administrative capacity requisite for effective social protection programming particularly in 'hard to reach' areas.

Recommendations

From the key findings of the mapping exercise, the following are recommended actions for governments, donors and civil society as well as WFP, ILO, and UNAIDS to consider in reforming and/or improving the availability and accessibility to HIV-sensitive social protection programmes in the region as well as in specific countries. The recommendations are not presented in any order of priority.

1. Support regional and national processes to ensure that social protection policies and programming are HIV-sensitive.

Although ESA enjoys general political commitment to social protection through enabling legislative and policy frameworks, there is no specific targeting for PLHIV in social protection programmes in many countries of the region. Partners should therefore consider offering technical support to the region and/or individual countries in making sure that major social protection programmes are explicitly HIV-sensitive. This could be done as a specific targeted process or as part of future processes meant to evaluate and/or amend existing programmes.

2. Support civil society organisations in improving transformative social protection programming.

Against the wide body of evidence showing the comparative advantage of civil society organisations in reaching out to vulnerable and/or hard to reach populations, stakeholders and partners should consider supporting and/or working with these organisations to ensure the attainment of widespread transformative social protection across the countries in the region.

3. Support the expansion of social health promotion.

Drawing on the wide evidence from the region on the modalities of operation and success of social health promotion schemes, all governments in the region need to consider the development and/or expansion of social health promotion schemes, also considering the specific HIV landscape and epidemic.

4. Improve the quality and quantity of data available to drive national and regional decision making and resource allocation.

There is need for investments in data collection and dissemination systems that will provide robust data to support HIV-sensitive programming and decision-making in all countries and in the region as a whole.

5. Support the coordination and harmonisation of stakeholder efforts.

The apparent lack of coordination among the different stakeholders, especially at local levels, as well as the duplication of efforts call for better clarification and strengthening of the mode of operation of all partners in each country's HIV-sensitive social protection programming.

6. Strengthen social protection programmes to cater for covariate shocks.

By design, many of the current social protection programmes in the region are aimed at managing idiosyncratic risks. The Covid-19 epidemic has however highlighted the need for social protection programmes to build communities' resilience to covariate shocks (those that affects everybody and/or every households in a community or region) and for future programming to take this into consideration.

7. Establish mechanisms and strategies to integrate informal social protection systems into current programming.

Given the evidence of the important role that informal social protection systems play in supporting vulnerable populations in many of the countries in the region, it is recommended that these systems be incorporated into existing formal systems.

1. Introduction

1.1. Background

Many countries in East and Southern Africa (ESA) have shown notable political and financial commitment to fight the HIV epidemic through, among other things, the scaling up of prevention, treatment and care services. Despite this, the region remains the most affected in the world. According to UNAIDS (2020a), while ESA is home to around 6.2% of the world's population, over half (54%) of the total number of people living with HIV in the world (an estimated 20.6 million people in 2020) live in the region. In the same year, there were an estimated 670 000 new HIV infections and 310 000 AIDS-related deaths in the region (UNAIDS, 2020a). Furthermore 15 countries in the region were among the 30 that were identified by UNAIDS as accounting for 89% of all new HIV global infections in 2015 (UNAIDS, 2015).

Available evidence (see for example, UNAIDS 2021) shows that HIV prevalence in ESA is particularly high among the following key populations: women, young people, children, sex workers, men who have sex with men (MSM) and people who inject drugs (PWID). Structural factors that increase these key populations' vulnerability to HIV include poverty, gender inequality, gender-based violence, HIV-related stigma and discrimination, HIV-specific criminal legislation, and social barriers to treatment such as out-of-pocket health fees (Mbonu et al, 2009; Ellsberg & Betron, 2010). Limited access to education and employment opportunities for young people, especially adolescent girls and young women (AGYW) is another structural factor which also explains why the region is reportedly home to nearly 60% of the world's adolescents (those aged 10-19 years) living with HIV (UNICEF, 2018:3). While AIDS-related deaths in the region have declined among adolescent girls and young women aged 15-24 years between 2010 and 2020, they remain stable and possibly increasing among young men aged 15-24 years (UNAIDS, 2021). Another structural factor relates to deficit of human resources for the provision of general healthcare as well as treatment and care for those infected and affected by HIV and AIDS (Vermund, et al, 2015; Haseeb, 2018). Food and nutrition insecurity is another major underlying factor, with the World Food Programme (2019:1) highlighting that:

[Food and nutrition insecurity] compound HIV risks and vulnerabilities by undermining adherence to HIV and TB treatment and retention in care while exacerbating the socio-economic impact of the virus, reducing work capacity and productivity, and endangering household livelihoods. ... At the individual level, adequate dietary intake and macro and micro nutrient absorption are crucial for effective treatment outcomes because HIV/AIDS weakens the immune system, impairing nutrient intake and absorption, augmenting vulnerability to undernutrition and increasing morbidity and mortality.

It is largely against the foregoing that ESA was among the focus regions for the UNAIDS's Fast Track Approach. Set up in 2015, the approach is a locally-led, global implementation agenda with a particularly strong focus on the 30 countries that account for most of the world's new HIV infections. Using combined targets for service coverage, impact, and zero-discrimination, the identified Fast Track countries were urged to adopt rights-based approaches to reach the following milestones by 2020:

- Fewer than 500 000 people newly infected with HIV per year globally¹. Emphasis would be on MSM, transgender people, sex workers, PWID, prisoners, and AGYW in certain high-burden settings;
- Achievement of all the three 90-90-90 (three 90s) targets. These entail ensuring that 90% of people living with HIV know their HIV status; 90% of those who know their HIV status are receiving antiretroviral therapy; and 90% of those on treatment have a suppressed viral load;
- Ensuring that everyone, everywhere, is living a life free from HIV-related discrimination; and
- Achieving and sustaining the elimination of new HIV infections among children.

To the extent that the drivers of HIV in their region are multidimensional, the implementation of HIV-sensitive social protection programmes was deemed an important and plausible pathway to achieving the above targets.

¹ This translates to a 75% reduction across all populations compared with 2010

1.2. The concept of HIV-sensitive social protection

Despite having no standard definition, social protection is widely conceptualised as having the overall aim of responding to and providing protection from issues of risk, vulnerability and extreme poverty (Holmes & Lwanga-Ntale, 2012:4). In essence, it entails

... a set of all initiatives, both formal and informal, that provide social assistance to extremely poor individuals and households; social services to groups who need special care or would otherwise be denied access to basic services; social insurance to protect people against the risks and consequences of livelihood shocks; and social equity to protect people against social risks such as discrimination and abuse (Devereux & Sabates-Wheeler, 2008 cited in Tirivayi & Rodriguez, 2017:3).

To be considered HIV-sensitive, the design and implementation of social protection measures needs to target and include people living with, at risk of or affected by HIV by deliberately considering and addressing the multi-dimensionality of HIV risk and vulnerability without discrimination (Roelen et al, 2011). Box 1.1 below illustrates how, by reaching and supporting the most vulnerable, social protection programmes can be HIV-sensitive.

Box 1.1 Examples of how social protection interventions can mitigate the impact of HIV and AIDS

Combined social protection transfers sustain HIV prevention by decreasing the probability of unprotected sex among girls living with HIV.

Consistent access to social protection supportive provisions (i.e. school feeding, violence prevention, parenting support, HIV prevention education) reduce the probability of early sexual risk exposure among adolescents.

Cash transfers can reduce adolescent girls' exposure to HIV risk. Child-focused cash transfers has been shown to reduce the percentage of incidence of transactional and age disparate sex.

Combined social protection interventions targeting adolescents living with HIV have additive benefits for HIV prevention, treatment and adherence and bear direct positive outcomes across multiple Sustainable Development Goals

Hunger and food insecurity are positively correlated with increased age-disparate sex and risky sexual behaviours particularly among adolescents - consistent access to school feeding reduces exposure to sexual risk, specifically among adolescent boys while school attendance can reduce HIV-infection risk among girls.

Cash plus care (specific combinations of cash transfers, school feeding, free schools, parental supervision and teacher support) shows cumulative risk-reduction effects among adolescents. Cash plus care reduces the probability of incidence of casual sex, sex under the effect of substances and sex with multiple partners

Cash plus care plus classroom: specific social protection interventions in the three domains (cash, psychosocial support and education) independently reduce specific HIV-risk behaviours amongst adolescent boys and girls

Food assistance interventions can help mobile and displaced populations including refugees with adherence to antiretroviral treatment, reduce the risk of HIV transmission by reducing negative coping mechanisms, such as transactional sex, and support treatment outcomes

Social protection transfer programmes can increase the uptake of critical prevention health services, such as prevention of mother-to-child treatment and counselling, thereby contributing to HIV prevention.

Social protection can help mitigate the effects of climatic shocks on HIV affected households during humanitarian emergencies.

Social transfers including food support and nutrition assistance may be useful to support viral suppression in pregnant women

Combined social protection transfers improve adherence to antiretroviral therapy by decreasing the probability of past week non-adherence to treatment

Source: Adapted from World Food Programme (2019:4)

According to UNAIDS (2018b:4), to achieve the Fast Track targets, country stakeholders – working collaboratively with partners and dictated by each country's HIV epidemic profile and social protection programmes – were expected to intensify actions on the following four pillars:

Pillar 1: scale up and progressively broaden sustainable social protection programmes. These programmes should enhance care, support and treatment outcomes for people living with HIV, key populations, adolescent girls and young women, vulnerable families and caregivers. Combination social protection approaches, including financial incentives, social assistance and social economic approaches should be delivered in relevant geographical areas for appropriate populations, as required.

Pillar 2: invest in expanding access to primary, secondary and tertiary schooling and pathways to employment as an effective HIV prevention strategy in countries with high HIV incidence. Predisposing factors that keep adolescents out of school or prevent them from remaining in school should be identified and addressed.

Pillar 3: increase access to essential health services for people living with, at risk of or affected by HIV by addressing barriers that prevent them from accessing health services. Linkages to financial incentives and social economic approaches, social assistance and social services should be forged and strengthened. Stronger linkages would help address the multiple needs of people living with, at risk of or affected by HIV. This may encompass advocating for access to free health care at the point of use; birth registrations for children; providing identity cards for populations likely to be excluded from accessing health services, such as migrants and transgender people; providing transport support for health-care appointments; food security and nutrition programmes; housing and related subsidies; and reducing stigma and discrimination.

Pillar 4: strengthen the active and meaningful engagement of civil society, in particular representatives of people living with, at risk of or affected by HIV, in the design and implementation of social protection to enable social protection programmes to meet the needs of such populations. Individuals and communities need to be empowered to address and respond to stigma and discrimination and advocate for strengthening the legal and policy environment to address stigma and discrimination. Civil society organizations may need to be supported in strengthening administrative and financial management capacities to manage their affairs effectively and have the necessary resources and social protection literacy to engage in national social protection coalitions and processes.

1.3. Objectives of this report

This report presents the findings of a project that aimed to map the social protection programmes in all the 15 Fast Track countries² in ESA and to explore the extent to which the programmes are HIV-sensitive. The project was commissioned by the regional offices of the World Food Programme (WFP) and the International Labour Organisation (ILO) – with the support of their UNAIDS counterparts. Within the context of the revised 2018 UNAIDS Division of Labour (DoL), WFP and ILO are responsible for coordinating the work of the inter-agency task team (IATT) on HIV-sensitive Social Protection at the global level, as well as to co-chair the Social Justice Technical Working Group (SJTWG) under the Regional AIDS Team for East and Southern Africa (RATESA).

It is envisaged that the findings of this project will be used to inform the SJTWG's regional support plan on HIV-Sensitive Social Protection for the 2020-2021 biennium and beyond. To achieve this objective the following activities and tasks were specified as core to the project:

- i. Providing an overview of the existing social safety net interventions, target groups, duration and location, and their alignment with the policy and strategic frameworks.
- ii. Providing an overview of the work done by government, United Nations agencies, NGOs and other relevant stakeholders vis-à-vis UNAIDS' targets.
- iii. Assessing partnership arrangements for integrating PLHIV into social safety net programmes including workplace programmes.
- iv. Exploring the level of sensitivity of current social protection programmes to HIV and barriers to access to HIV sensitive social protection programmes.
- v. Identifying entry points, opportunities and instruments to integrate PLHIV into social protection programmes and interventions, considering the relevant institutional arrangements, capacity gaps and coordination mechanisms.
- vi. Providing recommended actions to reform and/or improve HIV sensitive social protection programmes.
- vii. Identifying concrete recommended actions for ILO, WFP and UNAIDS secretariat as well as for government, donors and civil society.

- viii. Documenting, where possible, lessons learned and good practice for integrating PLHIV (in all their diversity) into social safety net programmes.

This work will also complement a similar study that was commissioned by the Regional Interagency Task team on Children Affected by AIDS in ESA (RIATT-ESA) focusing on the extent to which social protection programmes in the region are sensitive to the needs of adolescents and young people.

1.4. Methodology

The project was executed in two phases as described below.

Phase 1

This entailed a desktop review of each country's legislative and policy framework in relation to social protection. For each country, three specific documents were reviewed: the Constitution, the national long-term vision, the social protection policy, and all social protection-specific legislative Acts. Where any of these documents are non-existent, this is reported as a key findings. The purpose of the review was to obtain a deeper understanding of the broad conceptualisation of social protection in each country as well as to understand the frameworks for commitment to social protection and policy implementation. For each country, this review began with an assessment of the legislative framework (the extent to which a country's Constitution and, where available, other legal instruments) and national long-term national visions provided for social protection programme. Constitutional entitlements to social protection are important as they can provide important guidelines for the development and implementation of social protection systems. Along with a supportive legal framework, Constitutional provisions not only ensure the permanence, predictability and transparency of social protection programmes, but also enables rights-holders to enforce their entitlements to social protection benefits (Kaltenborn et al, 2017:3). National long-term visions, on the other hand, describe "what a country wishes to become, the national priorities and the objectives to be reached" (Pino & Confalonieri (2014:132). Pino and Confalonieri assert that, taken together with Constitutional and legislative provisions to social protection, national long-term visions form coherent packages that constitute the first essential steps to avoid a haphazard approach and last-minute decisions with regard to social protection law.

Given the important role of policy and strategy documents in harmonising and catalysing bottom-up and top-down interests in the building social protection systems

² Angola, Botswana, Eswatini, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Namibia, South Africa, South Sudan, Tanzania, Uganda, Zambia, Zimbabwe

(Kaltenborn et al, 2017:17), the existence of explicit social protection policies was also assessed, as was the definition of social protection as outlined in these policies. Definitions adopted are important as they reflect cultures, values, traditions, as well as institutional and political structures that can affect how and to whom social protection is provided in a country (García & Gruat, 2003).

Overall, this desktop review was important as legislation and policies can be transformative social protection measures. These are those that reduce vulnerability by transforming the socio-legal context within which livelihoods are constructed. They do this by addressing issues of social equity and exclusion through interventions that include legal, judicial, and policy reforms (Temin, 2010).

The reviews of the legislative and policy frameworks were followed by explorations of each country's main, publicly funded social assistance programmes. Particular focus was placed on exploring the extent to which the programmes take the form of social transfers; livelihood building activities; and social health protection as described below (see Temin, 2010):

- **Social transfers.** These include cash transfers, in-kind transfers (mostly food), as well as vouchers for specific goods or services delivered to institutions, households or individuals on a periodic or regular basis. The transfers are protective as they offer relief from economic and social deprivation by protecting households' income and consumption. They can also be preventive as they avert deprivation or mitigate the impact of adverse shocks for the ultra-poor and those who are unable to meet their basic household needs. Examples include health insurance, pensions, and maternity benefits.
- **Livelihood building** activities include public works, income-generating activities and microfinance that seek to promote livelihoods. They enhance assets, human capital, and income-earning capacity and, hence fulfil the promotional aspect of social protection.
- **Social health protection** programmes are aimed at reducing financial barriers to access health care including HIV-related services. Examples include social health insurance and homebased care.

In addition to the foregoing, a brief overview of each country's social security landscape was deemed important and relevant for the project. Also known as social insurance, social security refers to statutory contributory schemes that protect income earners and their dependants against temporary or permanent involuntary loss of income as a result of exposure to contingencies that impair earning capacity (Kaseke, 2005). By definition, therefore, social security provides individuals with a degree of income security

when faced with the contingencies of old age, survivorship, incapacity, disability, unemployment and children rearing. It may also offer access to curative or preventive medical care. All these are critical aspects to consider in efforts to ensure that social protection interventions are HIV-sensitive. In this project, social security systems were explored using the International Social Security Association's typology below:

- **Old-age, disability, and survivor benefits** (meant to compensate the loss of income resulting from old-age or permanent retirement);
- **Sickness and maternity benefits** (to deal with the risk of temporary incapacity);
- **Work injury benefits** (compensation for work-related injuries and occupational illnesses);
- **Unemployment benefits** (compensation for the loss of income resulting from involuntary unemployment); and
- Family benefits (meant to provide additional income for families with young children to meet at least part of the added cost of their support. In some countries, they include school grants, birth grants, maternal and child health services, and allowances for adult dependents).

Phase 2

The second phase entailed consultations with stakeholders from government, development partners, United Nations agencies, and civil society organisations (CSOs) that support social protection programming in the focus countries. The stakeholders consulted were purposively selected (with the assistance of UNAIDS and WFP country offices) based on their positions and/or involvement in socio protection programming in their organisations. In addition to complementing and validating the information collected in first phase, the specific objectives of the second phase included:

- i. The mapping of key stakeholders in each country and establishing a 4W matrix (showing Who is Where, doing What, When) as a basis for development of an integrated HIV social protection platform.
- ii. Soliciting stakeholders' perspectives on key strengths and challenges of their countries' social protection programming, particularly in relation to HIV sensitivity; and
- iii. Providing recommendations for future action including identification of opportunities to address critical gaps in the social protection programming for effective stakeholder coordination for enhanced provision of HIV-sensitive social protection; as well as for the post COVID-19 environment.

Relevant stakeholders were identified and selected with the assistance of in-country focal persons identified by WFP and UNAIDS. The initial plan to undertake country missions to conduct face-to-face stakeholder consultations was cancelled due to the various travel restrictions that came with the COVID-19 pandemic. Consultations were therefore conducted using virtual platforms, mainly Zoom and Microsoft Teams. Appendix A shows the list of organisations and countries from which stakeholders came from.

Assessing HIV-sensitivity of programmes

The UNAIDS HIV and Social Protection Assessment Tool (UNAIDS, 2017) was used as the broad framework for assessing HIV-sensitive of social protection programmes in all the countries. To this end, the description of each social protection programme includes their purpose, target beneficiaries, eligibility criteria, coverage and HIV sensitivity. In terms of the latter, a social assistance or social security programme was deemed HIV-sensitive if, according to its description, it does not exclude or discriminate against people living with HIV or if it deliberately targets people living with, at risk of or affected by HIV (World Food Programme, 2019). Also explored was whether PLHIV, at high risk of HIV infection (such as adolescent girls and young women), key populations and others eligible to benefit from social protection benefits are accessing existing programmes or schemes. If not, the key barriers people face in accessing social protection benefits were explored.

Limitations

While all attempts were made to provide a comprehensive mapping of the social protection programmes in the 15 countries during the first phase, the desktop nature of the phase meant that some of the information could be incomplete, missing and/or outdated. As stated above, plans to validate findings from Phase 1 were hampered by the Covid-19 travel restrictions. While the virtual consultations that were then adopted were largely efficient, various factors such as poor internet connectivity in some countries and non-responses to request for appointments led to the consultations being held with relatively few stakeholders in only 11 of the 15 Fast Track countries in the region. The countries consulted (see Appendix A) were Eswatini, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Namibia, South Sudan, Tanzania, Uganda, and Zimbabwe. Therefore, gaps may still exist in some of the information collected and presented herein. Overall, however, the report does provide a sufficient and relatively up-to-date portrait of the social protection landscape in the region and an assessment of its HIV sensitivity. The report also provides adequate stakeholder perceptions to contextualise the emergent patterns and to provide strategic recommendations for future programming.

1.5. Structure of the report

In the next 15 sections, the findings are presented in relation to each Fast Track country (arranged alphabetically). Each section begins with a brief HIV and AIDS situation analysis of the country. This is followed by an overview of the social protection programmes in the country with a focus on the legislative and policy framework; social assistance programmes; and social security programmes. Each country section concludes with a summary that includes a presentation of the main social protection stakeholders in the country. Drawing from the country sections and the stakeholder consultations, the last chapter concludes the report by summarising the key findings and providing strategic recommendations for future action.

2. Country overview:

ANGOLA

2.1. Brief HIV situational analysis

At 1.8%, the HIV prevalence among adults (those aged 15–49 years) in Angola is one of the lowest in sub-Saharan Africa. However, the absolute number of people living with HIV, estimated to be 340 000 in 2020 is notable, as is the 22 000 people who were newly infected with HIV, and the 16 000 (up from 10 000 in 2010) who died from AIDS-related illnesses (UNAIDS, 2021). This situation partly explains the country's poor progress towards the 90-90-90 targets where in 2020 only 54% of people living with HIV knew their HIV status and 33% of those were on treatment (Appendix B). Major factors that hamper the national HIV response in Angola include deprivation-based poverty reflected in limited access to basic services such as health and education (UNICEF, 2012) as well as HIV-related stigma and discrimination. In 2016, for example, 34.6% of women and men aged 15–49 years reported discriminatory attitudes towards people living with HIV (UNAIDS, 2019). UNAIDS further reports of existing legislation that subjects transgender people in the country to possible prosecution (UNAIDS, 2019). Largely because of the foregoing factors, key populations in Angola include MSM, transgender people, women, and female sex workers.

2.2. Social protection mechanisms

2.2.1. Legislative and policy context

Constitutional and legal provisions

Constitutional provisions for social protection in Angola are found in Article 77 and are largely related to health care. The Article reads, *"The state shall promote and guarantee the measures needed to ensure the universal right to medical and health care, as well as the right to child care and maternity care, care in illness, disability, old age and in situations in which they are unable to work, in accordance with the law"*. Broader commitment to the provision to social protection is found

in the 2004 Basic Law on Social Protection (Law No.7/04) which organises the country's social protection system into the following three pillars (World Bank, 2018):

- i. **Basic social protection** - non-contributory transfers and other welfare services targeted either at the poor and vulnerable, or specifically to war veterans, surviving relatives of fallen soldiers and civilian victims of the civil war;
- ii. **Compulsory social protection** - contributory pensions (and other social insurance) schemes for formal workers, public servants and the military; and
- iii. **Complementary social protection** – an additional voluntary (and private) pillar for those enrolled in public social insurance schemes, that is funded out-of-pocket, and not from the government's budget.

In Article 5, the law describes those that will be covered by the above social protection measures as:

...the resident population that is in a situation of lack or diminution of livelihood and cannot take in all your own protection, namely:

- a) persons or families in serious poverty situations;
- b) disadvantaged women;
- c) children and teenagers with special needs or in situation of risk;
- d) elderly in situations of economic or physical dependence and isolation;
- e) people with disabilities, at situation of risk or social exclusion;
- f) unemployed at risk of marginalization.

National long-term vision

Angola's long-term strategy, *Angola 2025*, was approved in 2008 with the major strategic objective of "transforming Angola into a prosperous, modern country without poverty ... and with a growing insertion in the world and regional economy". The strategy however has a heavy focus on the energy sector, and does not consider social protection in any way. For example, "providing access to electricity to the majority of the population" is stated as the main route to achieve the only social protection-related specific objective in the Strategy: 'promoting the human development and the wellbeing of Angolans'.

National social protection policy

Angola does not currently have an explicit social protection policy. However, a World Bank Public Expenditure Review was undertaken in 2018 to inform the development of such a policy. In the interim, the country obtains guidance from

the National Development Plan (2018-2022) which has 'social assistance and protection' among the eight key priorities of its first Axis of "Human Development and Well-being". In relation to social protection, the Plan has a number of aims that include (World Bank, 2018):

- Promoting the social and productive reintegration of the most vulnerable and excluded groups;
- Contributing to equitable and sustainable development;
- Promoting the reduction of social, economic, cultural and territorial asymmetries;
- Re-adapting institutional architecture of support of the social action of the state, in accordance with the Sustainable Development Goals; and
- Supporting initiatives that provide support services for people with disabilities and their families.

2.2.2. Social assistance programmes

Programme	Description and focus	HIV sensitivity
Cash transfers		
Cartão Kikuia Card Programme	<p>Unconditional in-kind transfer introduced in 2013 with the aim of fighting poverty, improving beneficiaries' nutritional status, reinforcing the role of women in fighting against food insecurity. Beneficiaries are households that have at least one of the following:</p> <ul style="list-style-type: none"> • a female head; • a high dependency ratio; • a member who has a disability or is a war veteran, elderly or chronically ill; • a malnourished child; and/or at least one orphan <p>Their benefits include food stamps and vouchers that allows beneficiaries to receive a variety of products including food, agricultural inputs, construction material, clothing, hygiene and cleaning materials, and school materials. The amount of the benefits is approximately USD100 per month. The programme has 101 246 beneficiaries nationwide (2016) and it is administered by the Ministry of Social Action, Family, and Promotion of Women.</p>	Supports food and nutrition for women, children and the chronically ill (including PLHIV)

<i>Merenda Escolar</i> School Feeding Programme	<p>Conditional in-kind (food) transfer introduced in 1999 to stimulate children's school enrolment and attendance, as well as to prevent school attrition by promoting a healthy diet in schools. Beneficiaries are children enrolled in public and private primary schools countrywide. They are provided with daily snacks distributed in school cafeterias or community kitchens of primary public schools and in private schools through co-participation. The amount of benefits are dependent on students' age and time of feeding, and the predominant eating habits of the region. The programme covers 48% of eligible children in the country and it is administered by the Ministry of Education.</p>	Supports food and nutrition for children
<i>Valor a Crianca'</i>	<p>This is a universal child benefit programme consisting of a quarterly social cash transfer of approximately US\$4.55 per month per child under five years of age, for up to three children per family. It is thus expected to cover around 20,000 children, which is equivalent to 14 000 families from six municipalities. The main objective of <i>Valor a Crianca'</i> is to reduce poverty and social vulnerability of needy Angolan families. It is envisaged that by focusing on young children (in a country with 13 million children out of a total population of 24 million), the scheme will address key risks that can have irreversible impacts (World Bank, 2020). The programme is administered by Ministry of Social Action, Family, and Promotion of Women with technical support from the World Bank, UNICEF and the European Union.</p>	Supports food and nutrition for children
<i>Kwenda</i> Monetary Social Transfer Programme	<p>Implemented in 2020 with a three-year implementation period, this programme aims to mitigate the social risk of vulnerable families. Each beneficiary family will, over the three years, benefit for three years from a monthly income set at Kz: 8,500 (about US\$15). The pilot phase covered five provinces and the programme, which is expected to benefit roughly 1.6 million families all over the country. It is implemented with financial support from the World Bank and the National Treasury.</p>	Reduction in household income poverty
Livelihoods promotion		
<i>Not available</i>		
Social health protection		
<i>Not available</i>		

Source: World Bank (2018; 2020); socialprotection.org

2.2.3. Social security programmes

Programme	Beneficiaries and benefits
Old age, Disability and Survivor benefits: <i>To compensate the loss of income resulting from old disability or survivorship</i> Administrative organisations: <ul style="list-style-type: none"> Ministry of Public Administration, Labour Social Security; National Social Security Institute 	
Old-age pension	<ul style="list-style-type: none"> Age 60 with at least 180 months of contributions; at any age with at least 420 months of contributions. Retirement is possible up to 10 years before the normal retirement age with at least 180 months of contributions in hazardous or arduous working conditions. The pension is payable abroad under bilateral agreement.
Old-age allowance	Age 60 and unemployed with at least 120 months but less than 180 months of contributions.
Permanent survivor pension	<ul style="list-style-type: none"> The deceased had at least 36 months of contributions in the five years before death. Eligible survivors include a widow(er) and parents aged 50 or older at the time of the deceased's death who are unable to work, and orphans assessed with a significant loss of earning capacity. The widow(er)'s pension ceases upon remarriage. The pension is payable abroad under bilateral agreement.
Temporary survivor pension	<ul style="list-style-type: none"> The deceased had at least 36 months of contributions in the five years before death and the survivor does not qualify for a permanent survivor pension. Eligible survivors include an unemployed widow(er) at any age; a divorced spouse who was receiving alimony and has not remarried, and orphans up to age 18 (age 25 if a student; no limit if disabled). The widow(er)'s pension ceases upon remarriage. The pension is payable abroad under bilateral agreement.
Death grant	<ul style="list-style-type: none"> The deceased had at least six months of coverage and at least three months (36 months for members of the clergy) of contributions. Eligible survivors include a widow(er) and orphans; if there is no widow(er) or orphans, the grant may be paid to the deceased's parents, a divorced spouse who was receiving alimony and has not remarried, or the legal heir. The death grant is payable abroad under bilateral agreement.
Funeral grant	<ul style="list-style-type: none"> The deceased was employed and had at least three months (12 months for members of the clergy) of contributions in the 12 months immediately before death. The benefit is paid to a widow(er) or orphans. The funeral grant is payable abroad under bilateral agreement.
Sickness and maternity benefits*: <i>To deal with the risk of temporary incapacity</i> Administrative organisations: <ul style="list-style-type: none"> Ministry of Health ; National Social Security Institute 	
Universal (medical benefits)	All citizens of Angola

Social insurance (cash maternity benefits)	<ul style="list-style-type: none"> • Employed persons, including public-sector employees not covered by a special system and foreign nationals covered under bilateral agreements; and self-employed persons. • Voluntary coverage for household workers. • Special systems for firefighters, military, intelligence, police, and correctional personnel <p>Breastfeeding benefit Monthly earnings paid to insured person for each child younger than age 3 years. Amount based on insured person's earnings relative to the legal monthly minimum wage for agricultural workers.</p> <p>Maternity benefit 100% of the insured's average monthly earnings in the six months before the maternity leave began is paid for three months; four months in case of multiple births; 45 days in case of a stillbirth. The maternity leave can start from up to four weeks before the expected date of delivery.</p> <ul style="list-style-type: none"> • At-risk pregnancy benefit 60% of the insured's average monthly earnings in the six months before the prenatal leave began is paid from the assessment of a risky pregnancy until childbirth, up to 180 days
Employer-liability (cash sickness benefit) system	<p>Private-sector employees. Exclusions: Self-employed persons.</p> <p>Sickness benefit. For employees in large and medium-sized enterprises, 100% of the employee's monthly earnings is paid for the first two months plus 50% from the third to the 12th month. For employees in small and microenterprises, 50% of the employee's earnings is paid for up to 90 days.</p>
<p>Work injury benefits: <i>Compensation for work-related injuries and occupational illness</i></p> <p>Administrative organisations:</p> <ul style="list-style-type: none"> • Ministry of Public Administration, Labour, and Social Security; • National Social Security Institute 	
Employer-liability system through private carriers <u>Note:</u> A separate system for public-sector employees has not yet been implemented.	<ul style="list-style-type: none"> • Private-sector employees; Voluntary coverage for self-employed persons. • Must be assessed with a work injury or occupational disease. Accidents that occur while commuting to and from work are covered. Occupational diseases are specified by law. • Consists of temporary and permanent disability cash benefits, workers' medical benefits survivor pensions, death grant, and funeral grant
<p>Unemployment benefits: <i>Compensation for the loss of income resulting from involuntary unemployment</i></p> <p>Administrative organisations: N/A</p>	
<p>Under the 2015 labour law, employers must provide employees with severance pay for dismissal due to unfair disciplinary dismissal, wrongful collective dismissal, the employer's insolvency, restructuring, economic conditions, and for technological reasons. For dismissal due to economic conditions, the benefit is the number of years of service multiplied by a percentage of the employee's basic salary at the time of dismissal. An additional benefit may be paid to employees dismissed due to wrongful termination or economic conditions.</p>	
<p>Family benefits: <i>To provide additional income for families with young children to meet at least part of the added cost of their support</i></p> <p>Administrative organisations:</p> <ul style="list-style-type: none"> • Ministry of Public Administration, Labour, • Social Security: National Social Security Institute 	

Family allowance	<ul style="list-style-type: none"> • Monthly benefit paid for up to five children aged 3 to 14 years whose parents are employed or receive an old-age pension. • Children must be vaccinated in accordance with Ministry of Health regulations, and regularly attend school. • Benefits. For an insured person monthly income (either from earnings or a pension) that are relative to the legal monthly minimum wage for agricultural workers.
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Source: Social Security Programs Throughout the World: Africa, 2019. <https://www.ssa.gov/policy/docs/progdesc/ssptw/2018-2019/africa/ssptw19africa.pdf>

* A 2008 law extending the social insurance program's coverage to self-employed persons has been partially implemented.

2.3. Summary

Pattern of social protection programmes

Angola has an enabling legislative and policy framework for the provision of social protection albeit narrowly focused on health services, the poor and vulnerable as well as veterans of the civil war. Of the country's key populations, those specifically identified as deserving of social protection by the Basic Law on Social protection are 'disadvantaged women'. Others such as MSM, transgender people, and female sex workers are not explicitly targeted, and this may be attributed to the country's punitive legislation in this regard. It may be argued, however, that together with PLHIV and those affected by the epidemic, key populations make up the "people at situation of risk and social exclusion" that are mentioned in the policy as a target group.

In terms of social protection programmes, Angola implements 28 social safety net programmes (World Bank, 2020). However, the World Bank describes these as "small, scattered and highly fragmented" with low coverage where only 5% of those in the poorest quintiles receive benefits. In essence, therefore, there are only two social assistance programmes in the country: the *Merenda Escolar* school feeding programme and the *Cartão Kikuia* card programme. The following are noteworthy about these programmes:

- *The programmes have limited coverage.* Although the school feeding programme has the largest coverage, it only reaches 48% of its intended beneficiaries. The *Cartao Kikuia*, on the other hand, has just over 100,000 beneficiaries in a country where 41% of the population (32.8 million in 2020) lives below the national poverty line (World Bank, 2020).
- The programmes' intended beneficiaries are largely ex-militants, ex-veterans, children, and the elderly. Thus while HIV-sensitive, the programmes exclude all of the country's key populations: women, MSM, transgender people, and female sex workers.

- Both programmes provide in-kind food transfers. To this end, as the World Bank (2020) has highlighted, duplication of benefits is a major issue in the country's social protection and safety net programmes. For example, while the *Cartão Kikuia* programme gives a credit card to buy a food basket, the Protection Program and Strengthening of Family Competencies gives food baskets to vulnerable families. Similarly, "both the Support to Rural Women and the Economic and Productive Structuring of Rural Communities provide professional kits" World Bank (2020:114).
- The two programmes' focus on food transfers also means that other types social protection (cash transfers, livelihood promotion and social health promotion) are not widely available in the country's social protection system. The absence of a social health promotion programme is a particularly noteworthy gap given that the constitutional provision to social protection are largely related to the provision of health care and services.

Key stakeholders

The Ministry of Social Action, Family, and Promotion of Women (MASFAMU) is the main institution responsible for coordinating the implementation of social policies in Angola and it is also the lead administrator for the *Cartao Kikuia* card programme. The Ministry of Education, on the other hand, administers the *Merenda Escolar* school feeding programme. The Ministry of Public Administration, Employment and Social Security is the leading authority for labour issues and administers social security benefits for civil servants and private sector workers through the National Social Security Institute. Social security benefits for military personnel are administered by the Social Security Fund of the Angolan Armed Forces (World Bank, 2020: 110).

Development partners that offer technical and financial support to the country's social protection system include the WFP, UNDP and the WHO. Donors such as Jack Ma, the Ali Baba Foundation, various oil companies, and other private sector companies have also actively provided financial support for the provision of health care services including equipment and materials for infection prevention and control (World Bank, 2020). In terms of civil society participation, it emerged that there are a number of CSOs working on HIV and human rights in Angola (Southern African Litigation Centre, 2020: 2) and that these organisations continue to "help improve the basic services available to Angolan communities in areas such as education, water and sanitation, agriculture, health ..." (ADPP Angola, 2019:6). It was however, not possible in this project to document a list or part thereof of CSOs in this regard.

Advancement of the AIDS response

Given Angola's social protection landscape, and notwithstanding the country's relatively low HIV prevalence, it is imperative for partners and stakeholders to ensure the effective implementation of all the four Fast Track pillars. That is, there is need to scale up and progressively broaden sustainable social protection programmes as well as to adopt pathways to employment (such as livelihoods promotion) as an effective HIV prevention strategy. There is also need to increase access to essential health services for PLHIV, at risk of or affected by HIV through the development of social health protection programmes and to strengthen the active and meaningful engagement of civil society in the area of HIV-sensitive social protection.

3. Country overview:

BOTSWANA

3.1. Brief HIV situational analysis

Botswana became the first sub-Saharan African country to provide free and universal antiretroviral treatment (ART) to people living with HIV. This partly explains the country's progress towards achieving the 90-90-90 targets. As shown in Appendix B, 91% of people living with HIV know their HIV status; 81% of those living with HIV and know their status are on treatment; and more than 95% of those on treatment have suppressed viral loads (UNAIDS, 2021). Despite this progress, Botswana – with an adult HIV prevalence of 19.9 % – is still one of the countries most affected by HIV in the world after South Africa, Lesotho, and Eswatini (UNAIDS, 2021). UNAIDS data further shows that in 2020 there were 370 000 people living with HIV, 8 900 new HIV infections, and 5 100 AIDS-related deaths in the country.

Barriers to the country's HIV response include high levels of gender inequality and widespread HIV-related stigma and discrimination. There still exists, for example, punitive regulation for sex work among consenting adults (UNAIDS, 2019). Before a recent (June 2019) ruling, same sex relationships in Botswana were criminalised. To this end, female sex workers and MSM are among the groups most affected by HIV in Botswana, others being adult women, young people, and prisoners.

3.2. Social protection mechanisms

3.2.1. Legislative and policy context

Constitutional and legal provisions

While the Constitution of Botswana, developed in 1966, provides for the protection of the fundamental rights and freedoms of individuals, it does not provide for socio-economic rights to cater for the needs of vulnerable people

or member of society who need social protection (RHVP, 2011; Botlhale, 2015; UNICEF, 2017). Notwithstanding this, social protection is a top priority in key strategic development documents (UNICEF, 2019:2). For example, the current National Development Plan³ (NDP 11), which covers the period 2017-2023 under the theme *Inclusive Growth for the Realisation of Sustainable Employment Creation and Poverty Eradication*, has four (out of six) national priorities that are directly relevant for social protection. These are diversification of economic growth; human capital development; social development; and strengthening of national security.

National long-term vision

Botswana *Vision 2036*, which came into place at the end of the first Vision 2016 (1997-2016), has a transformational agenda that aims to see Botswana move from an upper middle-income country to a high-income country by 2036. Of its four pillars, 'Human and Social Development' is directly relevant to social protection as its objectives include improving health and wellness; social inclusion (ending poverty and empowering the poor and marginalised people); education and skills development; gender equality; youth; and children's well-being.

National social protection policy

Botswana does not currently have a national social protection policy. However, with support from the World Bank the country is presently developing a National Social Protection Framework that aims to "guide the transition from a fragmented approach to a systems approach to social protection" (UNICEF, 2017:3). According to UNICEF,

³ National Development Plans (NDPs) guide the overall development of the country. They outline government strategies planned to be undertaken over the Plan period.

this framework defines social protection as “programmes that employ public and private initiatives, guided by state policies, to prevent, address, and reduce the risks of poverty and vulnerability for Batswana, be they individuals, family or communities throughout their lives.” The framework will ensure the provision of a variety of non-contributory social assistance programmes that include cash and in-kind transfers, fee waivers, community-based programmes and social care services. While the framework is being formulated, the following national policies, geared towards reducing poverty and addressing various types of vulnerabilities, guide social protection provision in the country:

- National Strategy for Poverty Reduction
- Revised National Policy on Rural Development
- Community-Based Strategy for Rural Development Strategic
- National Policy on Gender and Development
- National Policy on Orphans and Vulnerable Children
- National Youth Policy
- National Policy on Needy and Vulnerable Families
- National Policy on Disaster Management
- Revised Remote Area Development Programme
- National Policy on the Rights of Persons with Disabilities
- Revised National Policy on Education
- National Health Policy
- National Policy on HIV/AIDS and Employment
- National Strategic Framework for HIV/AIDS

3.2.2. Social assistance programmes

Programme	Description and focus	HIV sensitivity
Cash transfers		
Old Age pension	An unconditional cash transfer introduced in 1996 to provide income security for older citizens (aged at least 65 years old). The coverage is nationwide and reaches 95% of the elderly in the country. It is administered by the Department of Social Services, Ministry of Local Government and Rural Development	Reduction in household income poverty and supports families' child care roles
In-kind-transfers		
School Feeding Programme	Conditional in-kind (food) transfer started in 2012 to prevent child malnutrition, improve school attendance; and promote of nutrition education in schools nationwide. All children enrolled in government primary and secondary schools are provided with one meal per day. Children in Remote Area Districts receive a second meal, and boarders at secondary schools are provided three meals a day. The programme is administered by the Department of Food Relief Services in the Ministry of Local Government and Rural Development. In 2012/13 it had 430,690 beneficiaries.	Supports food and nutrition for children
National orphan care program	Unconditional in-kind (food basket) transfer started in 1999 to alleviate hardships for orphans and vulnerable children from low- and middle-income families. The amount of the benefit ranges between US\$50 to US\$75 per month depending on the area; price of school uniform; fees for transportation and extra curricula activities. Beneficiaries can also receive limited cash grants according to necessity. The programme is implemented nationwide by the Department of Social and Community Development in the Ministry of Local Government and Rural Development. There were 35,076 beneficiaries in 2015.	Supports food and nutrition for children

Vulnerable Group Feeding Programme	<p>Unconditional in-kind (food) transfer started in 1988 to assist the most vulnerable and food-insecure populations during droughts. Children; pregnant women; and chronically ill individuals are provided with monthly, take-home food rations of maize meal, beans and vegetable oil, sorghum/soya with vitamin enrichment, and dry skimmed milk. The programme is implemented nationwide by the Food Relief Services Division in the Ministry of Local Government and Rural Development. In 2012/2013 it had 383,392 beneficiaries.</p>	Supports food and nutrition for children, women and chronically ill individuals, including PLHIV
Destitute Persons' Allowance	<p>Unconditional transfers that include cash, in-kind (food basket), and social support services. The programme started in 2003 with the aim of providing minimum assistance to destitute citizens. For the purpose of this allowance, the latter are defined as poor people and people with disabilities who are unable to work due to disability, health issues and insufficient assets and income sources. Also included are able-bodied people who are temporarily destitute or incapacitated due to natural disasters and accidents or health-related issues. The amount of the monthly benefits are:</p> <ul style="list-style-type: none"> • a food basket with a cash equivalent of between US\$60 and US\$70 depending on area; • burial services; • cash allowance of (US\$23 per person. <p>Additionally, destitute students receive school uniforms, toiletries, private clothing and other grants for educational needs. All destitute persons are exempt from paying for public services (such as medical, water, service levy and electricity charges). The programme is delivered nationwide by the Department of Social Services; Ministry of Local Government and Rural Development.</p>	Reduction in household income poverty and improves general population nutrition
Livelihoods promotion		
Ipelegeng (Self-Help)	<p>A public works programme that includes Cash-for-work and Food-for-work components. The target group is working-age people in both urban and rural areas who earn US\$ 48 for each six-hour work period for 20 or 22 working days; supervisors receive US\$56 per month. A daily meal is also supplied at a cost of that adds another US\$10 to the monthly pay. The programme is implemented nationwide by the Ministry of Local Government and Rural Development. There were 55,000 beneficiaries in 2012/2013.</p>	Increasing households' access to income or employment; general population nutrition
Graduate Volunteer Scheme	<p>The aim of this scheme is to facilitate skills development and transfer to young graduates; contribute to community development; promote the spirit of volunteerism; improve resilience of the graduate youth, and reduce idle time. It is targeted at unemployed young people with graduate qualifications; graduate youth who are not enrolled in other schemes; and those who have gone through 2 years of internship but are willing to continue as volunteers under the scheme. These young people are given a monthly allowance of P600 (US\$60). The scheme is administered nationwide by the Ministry of Youth Empowerment, Sport and Culture Development.</p>	Prepares adolescents and young people for future livelihood

Created in 2009 to:

- to promote the active participation of youth in the country's socioeconomic development;
- encourage growth-oriented citizen-owned youth enterprises in rural areas;
- encourage out-of-school, marginalized, and unemployed youths to venture into viable income-generating projects; and
- create sustainable employment opportunities for young people through the development of sustainable projects.

Youth Development Fund

To receive the benefits youth prepare simplified business plans that are appraised by multi-sectoral committees. If successful, the programme provides 50% of the funding as a grant and 50% as an interest free loans with the objective of establishing a revolving fund. The maximum amount of the loan/grant for individuals is about US\$13 000 and about US\$59 000 for groups. There is a grace period of between 6 and 20 months and a repayment period of five years. The target is youth between the ages of 18 and 35 who are not in school or employed and who have no particular academic background; and unemployed graduates (with Bachelor's degree). As of November 2012, there were 3 243 active interns in the programme. Absorption for permanent employment by the public sector stands at 45% and other sectors (combined) is 55%. The Fund is administered nationwide by the Ministry of Youth Empowerment, Sport and Culture Development.

Prepares adolescents and young people for future livelihood

Social health protection

Community Home-based Care programme

Established in 1995 in response to the HIV/AIDS pandemic to provide quality care at home for terminal patients as health facilities were becoming overwhelmed. The programme now also covers people with other chronic illnesses. Benefits are clinical medical assistance as well as a food basket that is aimed at meeting their nutritional needs, including feeding tubes if necessary. The programme targets poor people and people with disabilities who are unable to work due to disability, health issues and insufficient assets and income sources. It is implemented nationwide by the Ministry of Health as well as the Ministry of Local Government and Rural Development.

Support to access basic health services

3.2.3. Social security programmes

Programme	Beneficiaries and benefits
Old age, Disability and Survivor benefits: <i>To compensate the loss of income resulting from old disability or survivorship</i> Administrative organisations: <ul style="list-style-type: none"> • Department of Social Protection of the Ministry of Local Government and Rural Development 	
Old-age pension (universal)	<ul style="list-style-type: none"> • All citizens aged 65 years and over • US\$53 per month, adjusted periodically for inflation.

Disability benefit (social assistance, means tested)	<ul style="list-style-type: none"> • All citizens registered with a severe disability • Means test: Individual and family income and assets must not exceed certain limits. • US\$45 month plus a food voucher worth US\$60-US\$80, depending on the local authority, under the Destitute Persons Allowance (See section 3.2.2).
Orphan care benefit (universal)	<ul style="list-style-type: none"> • Paid for children younger than age 18 who lost one parent (if parent was single) or both parents (if parents were married). • <i>Benefits:</i> The cost of school uniforms, subsidies for transportation, clothing and rent (where applicable), support for special dispensation for tertiary education students, and support for educational needs such as reading glasses. Also Monthly food voucher of US\$65 • Benefits paid to the orphan's guardian
Sickness and maternity benefits: <i>To deal with the risk of temporary incapacity</i> Administrative organisations: <ul style="list-style-type: none"> • Department of Labour and Social Security of the Ministry of Employment, Labour Productivity, and Skills; • Ministry of Health; • Employers pay cash benefits directly to employees; Public clinics, primary and district hospitals, and referral hospitals 	
Sickness benefit (employer liability)	<ul style="list-style-type: none"> • 100% of the employee's basic earnings is paid. Employers must provide at least 20 days of certified paid sick leave a year; there is no limit on the amount of sick leave that can be provided.
Maternity benefit (employer liability)	<ul style="list-style-type: none"> • At least 50% of the employee's basic earnings is paid for six weeks before and six weeks after the expected date of childbirth; may be extended up to two weeks if there are complications arising from pregnancy or childbirth.
Medical benefits (universal)	<ul style="list-style-type: none"> • Public hospitals and clinics provide medical services. Benefits include generalist and specialist care, hospitalization, laboratory services, dental care, emergency care, X-rays, maternity care, and mental health care. • Cost sharing: Patients pay a 5 pula consultation fee. (Children younger than age 5 and persons older than age 65 are exempt).
Work injury benefits: <i>Compensation for work-related injuries and occupational illness</i> Administrative organisations: <ul style="list-style-type: none"> • Ministry of Employment, Labour Productivity, and Skills Development through (i) Department of Occupational Health and Safety and (ii) Department of Labour and Social Security: <p>Employers may insure work injury liability with private insurance companies.</p>	
Employer-liability system, normally through private carriers	<ul style="list-style-type: none"> • Must be assessed with a work injury or occupational disease. There is no minimum qualifying period. Accidents that occur while commuting to and from work are not covered (except if the employer provides the transportation) • Benefits include temporary disability benefits, permanent disability, workers medical benefits, survivor benefits, and funeral grant • Voluntary coverage for self-employed persons. • Exclusions: Casual workers and family labour

Unemployment benefits: *Compensation for the loss of income resulting from involuntary unemployment*

Administrative organisations: *Not specified*

The amended 2010 Employment Act requires employers to provide severance pay in case of termination of the employment contract before an employee has served a continuous period of 60 months. The payment amount varies depending on the length of service.

Family benefits: *To provide additional income for families with young children to meet at least part of the added cost of their support*

Administrative organisations: *Not specified*

No statutory benefits are provided.

Source: Social Security Programs Throughout the World: Africa, 2019. <https://www.ssa.gov/policy/docs/progdesc/ssptw/2018-2019/africa/ssptw19africa.pdf>

3.3. Summary

Pattern of social protection programmes

Botswana does not have specific constitutional provisions for social protection or an explicit social protection policy. However, the country does have a comprehensive and multi-sectoral policy framework that enables provision of a mix of universal and targeted social protection programmes. Although the programmes provide support across the four types of social protection, there is a notable focus on livelihood promotion targeted at young people as well as in-kind transfers mainly for children and, to a lesser extent, other poor and vulnerable groups in the population. To this end, therefore, of the country's key populations, young people are adequately catered for in the social protection system. The reverse is true for others key populations such as adult women, female sex workers, MSM, and prisoners. Overall, the focus of the country's social protection programmes are more focused on interventions meant to address risks and vulnerabilities related to poverty. HIV risk factors such as gender inequality, HIV-related stigma and discrimination as well as the country's restrictive legal environment for some key populations play a major role in this regard.

Key stakeholders

The Ministry of Local Government and Rural Development is the lead government department providing policy support and overseeing the implementation of social protection programmes in Botswana. The Ministry of Youth Empowerment, Sport and Culture Development oversees most of the livelihood promotion programmes targeted at young people while the Ministry of Health works closely with Ministry of Local Government and Rural Development in the administration of the home-based care programme. The government, through the Ministry of Employment, Labour Productivity, and Skills Development, is also the main actor in the administration of social security programmes in the country, with the Ministry of Local Government and Rural Development and the Ministry of Health also involved to some degree.

As a middle-income country, Botswana does not have many development partners working in the social protection arena. Among the few are the World Bank, which is providing support in the development of the country national social protection framework. United Nations agencies such as UNAIDS and UNICEF are also notable actors in the space of HIV-sensitive social protection. Involvement of local civil society is mainly in the area of psychosocial support services including in the home-based care programme. Organisations such as the Botswana Christian AIDS Intervention Program (BOCAIP) and the Botswana Network of People living with HIV and AIDS (BONEPWA+) have been

notable actors in this regard. Civil society organisations in Botswana play a particularly major role in ensuring transformative social protection for PLHIV and key populations. The Botswana Network on Ethics, Law and HIV and AIDS (BONELA), for example, implements programmes to address human rights-related barriers to HIV-prevention and treatment services at scale. The organisation was the only one uncovered by a national 'Best Practices Study' of organisations in either civil society or the public sector that had a clear mandate and were actively working towards the provision of a strengthened legal and ethical environment on matters relating to HIV and AIDS. Another organisation, the Lesbians, Gays & Bisexuals of Botswana (LeGaBiBo) was admitted as "a friend of the court" case that led to a June 2019 High Court ruling that decriminalized homosexuality in the country. The ruling made Botswana one of the few African countries that have legalised same-sex relationships.

There are also a number of informal social protection systems that operate within communities. Examples are Burial societies made up of friends, relatives, workmates or community residents who come together to insure themselves and their extended families against death and funeral-related expenses. Members typically pay a regular and agreed subscription fee that is used to build a collective investment fund with a set return to be used towards a burial of a member or their nominated beneficiaries' death (Ngwenya, 2003; Wheeler, 2011). In addition to financial assistance, burial societies also provide members and their relatives with various forms of psychosocial and practical support during the time of bereavement period (Ngwenya, 2003; Dafuleya, 2018).

Another prevalent informal system relates to the broad concept of Rotating Savings and Credit Associations (ROSCAs). Known in Botswana as '*metshelo*'. There are different models of operating these community associations. However, at the core is the group (made up of selected community members) contributing an agreed periodic amount to a central 'collective savings vehicle' or 'central pot' (Mulaudzi, 2017). Regardless of model, savings from these associations are to build up reserves that can be used to mitigate the effects of unforeseen contingencies by providing easy access to credit and mini-loans for members; enhancing the ability to meet basic needs; promoting saving and investment; providing moral support and mutual assistance; and creating social capital (Radipotsane 2007; Matuku & Kaseke 2014).

Advancement of the AIDS response

With Botswana's relatively high HIV prevalence, Fast Track pillars 1, 2 and 4 are particularly important in advancing the country's AIDS response. There is need, for example, to improve gender inequality through intensifying social protection approaches targeted at key populations such as women as well as young people. There is also need to address the widespread HIV-related stigma and discrimination which is a key structural factor underlying the country's HIV prevalence.

4. Country overview:

ESWATINI

4.1. Brief HIV situational analysis

Previously known as Swaziland, the Kingdom of Eswatini, has very high HIV prevalence, reported to be 26.8% among those aged 15-49 years in 2020 (UNAIDS, 2021). This figure suggests that prevalence has stabilized between 27- 28% during the 2009-2019 decade. UNAIDS data further shows that there were 200 000 people living with HIV, 4 800 new HIV infections, and 2 400 AIDS-related deaths in the country in 2020 (UNAIDS, 2021). It is largely against this background that the Government of Eswatini has, over the last decade, made great efforts and shown a strong commitment to fighting the disease through a variety of HIV prevention and treatment interventions. These include mainstreaming HIV and AIDS into national planning and budgeting processes, increasing awareness programmes, home-based care, and mainstreaming sex education in school curriculum. There has also been improved access to HIV testing services and the provision of free antiretroviral treatment to those who need it. It is largely because of this that the country is one of only three countries in Eastern and Southern Africa (others being Botswana and Namibia) that have achieved all the three 90s of the HIV treatment cascade. As Appendix B shows, 100% of people living with HIV know their HIV status; more than 100% of those living with HIV and know their status are on treatment; and 91% of those on treatment have suppressed viral loads.

Despite this progress and the efforts of the government and partners in ensuring access to HIV health services, HIV stigma and discrimination in Eswatini continues to be a major barrier to accessing HIV prevention and treatment services. Additionally, same sex unions remain criminalised and couples can face imprisonment for up to 14 years. There is also punitive regulations for sex work. For these reasons, MSM and female sex workers are the country's key populations along with women, young people, as well as orphans and vulnerable children (OVCs).

4.2. Social protection mechanisms

4.2.1. Legislative and policy context

Constitutional and legal provisions

The Constitution of the Kingdom of Swaziland (2005) does not specifically make mention of social protection. However, there are a number of Constitutional provisions safeguarding the rights to several social-protection-related areas. These include the following:

Article 27 (Rights and protection of the family)

- 27/4: "Motherhood and childhood are entitled to special care and assistance by society and the State".
- 27/6 "Subject to the availability of resources, the Government shall provide facilities and opportunities necessary to enhance the welfare of the needy and the elderly".

Article 28 (Rights and freedoms of women)

- 28/1 "Women have the right to equal treatment with men and that right shall include equal opportunities in political, economic and social activities".

- 28/2 "Subject to the availability of resources, the Government shall provide facilities and opportunities necessary to enhance the welfare of women to enable them to realise their full potential and advancement".

Article 29 (Rights of the child)

- 29/1 "A child has the right to be protected from engaging in work that constitutes a threat to the health, education or development of that child".
- 29/6 "Every Swazi child shall within three years of the commencement of this Constitution have the right to free education in public schools at least up to the end of primary school, beginning with the first grade.

Article 30 (Rights of persons with disabilities)

- 30/1 "Persons with disabilities have a right to respect and human dignity and the Government and society shall take appropriate measures to ensure that those persons realise their full mental and physical potential".
- 30/2 "Parliament shall enact laws for the protection of persons with disabilities so as to enable those persons to enjoy productive and fulfilling lives.

National long-term vision

At the time of its formulation in 1997, the country's long-term vision, *Vision 2022 and National Development Strategy* (NDS) envisaged that "By the Year 2022, the Kingdom of Swaziland will be in the top 10% of the medium human development group of countries founded on sustainable economic development, social justice and political stability". Among the stated strategies to achieve this vision is a focus on improved standard of living in the country through a number of social protection-related pathways such as poverty eradication, employment creation, gender equality, and environmental protection. The NDS is currently under review and is expected to be replaced by the Strategy for Sustainable Development and Inclusive Growth (SSDIG), which articulates the vision for Eswatini for the year 2022 and beyond. Among the latter Strategy's development priorities will be social protection (particularly for children, the elderly and people with special needs) as well as a focus on education, health, gender and youth issues.

National social protection policy

At the policy level, the country adopted the *National Social Development Policy* in 2010 with a mission to provide "integrated, comprehensive and equitable social-development services, in partnership with key stakeholders, to improve the quality of life of the Swazi nation, particularly its poorest and most vulnerable members" (pg. 9). The policy recognises social protection and social investment as the twin pillars of its core social development approach. It defines social protection as "public or private arrangements to protect individuals and families against life-cycle crises. These include the provision of social security, basic social services and developmental social welfare. It also includes developing appropriate labour market policies and strengthening livelihoods" (pg. 3).

The policy targets all Swazi nationals, particularly those who have been marginalised and/or made vulnerable by poverty and social exclusion. These include older persons, children, persons with physical and mental disabilities, ex-servicemen, substance abusers, ex-convicts, victims of disasters, widows and widowers, persons infected and affected by HIV and AIDS and terminal illnesses, and any other vulnerable individuals and groups (pg. 13). The National Social Development Policy is implemented alongside a number of vulnerability-focused laws and policies that aim to protect the rights of the disadvantaged. These include:

- The National Poverty Reduction Strategy and Action Plan (2006);
- The National Health Policy (2007);
- The National Food Security Policy (2006);
- The Children's Policy (June 2009);
- The Girls and the Women's Protection Act No. 39 of 1920;
- The Child Care Service Order of 1977;
- The Children's Protection and Welfare Bill of 2009;
- The Sexual Offences and Domestic Violence Bill of 2009; and
- The National Multisectoral HIV and AIDS Strategic Framework 2018-2023.

4.2.2. Social assistance programmes

Programme	Description and focus	HIV sensitivity
Cash transfers		
Old age grant	Unconditional cash transfer introduced in 2005 to reduce extreme vulnerability experienced by elderly people as one of the outcomes of the HIV/AIDS pandemic. Beneficiaries receive a cash benefit of US\$20 (SZL 600/month) quarterly. Coverage is nationwide with 65,000 beneficiaries in 2010. Administrated by the Department of Social Welfare	Reduction in household income poverty and supports families' childcare roles. Elderly headed households care for AIDS orphans and vulnerable children.
Public Assistance Grant	Unconditional cash transfer introduced in 1985 to reduce vulnerability among the elderly, disables, poor and terminally ill. Beneficiaries receive a monthly cash benefit of US\$ 5. Coverage is nationwide, reaching approximately 5,000 individuals annually. Administrated by the Department of Social Welfare	Cash transfers for the terminally ill including PLHIV
In-kind-transfers		
Food for Assets	Food transfers introduced in 2006 to improve food security for beneficiary households and participation of those households in community activities. Beneficiaries are vulnerable households in drought-prone regions of Eswatini and they receive either maize meal, corn, soya blend or oil monthly. The programme is financed by various NGOs. However, the major donor is the WFP. The government also provides personnel and technical assistance	Supports food security and nutrition
Free Primary Education and OVC schools grants	The OVC grant was conceptualised in 2002 to mitigate as a majority of AIDS orphans and vulnerable children dropped out of school due to deceased or ill patients. In 2010, the FPE was rolled out to all public primary schools.	Supports AIDS orphans and vulnerable children
MCH and under 5 Support	Food transfer introduced in 2005 to improve nutrition among children under 5 years of age as well as pregnant and lactating mothers in 51 clinics across the country. Benefits are monthly food transfers that include corn and soya blend. Administered by the Ministry of Health with the WFP as the major donor.	Supports nutrition for children
School feeding	Conditional food transfer programme started in 1982 to provide an incentive to attend school. The benefit is one daily meal given to school-age children, provided they attend school. The programme is implemented nationally by the Ministry of Education with partnerships from various NGOs as well as financial donations from the WFP and UNICEF	Supports nutrition for children
HIV Treatment	Since its roll out in 2003, Government provides 'free' antiretroviral therapy to all patients accessing public health centres. Government purchases nearly all HIV drugs since 2010.	Support PLHIV

Support for families of ART patients	Food transfer programme started in 2005 to increase the accessibility of food for families of anti-retroviral treatment (ART) patients. Beneficiaries are families with no more than five members on ART as well as families referred into the programme by a healthcare worker. They receive monthly food transfers including maize meal, pulses and vegetable oil. The programme is implemented by the Ministries of Health and Social Welfare with financial support from the WFP	Supports food security and nutrition for PLHIV and those affected by it
Neighbourhood Care Points (NCP)	The programme entails the provision of at least one meal a day to orphans and other vulnerable children who attend the 252 neighbourhood care points across the country. The aim is to improve their nutrition and food security. At the community level coordination is provided by the Deputy Prime Minister's office, with financial support from UNICEF and WFP	Supports food security nutrition for children
Indlunkhulu/Chief's Fields	Annual transfers of inputs such as seeds and tools that are required to cultivate crops in each region. Aim is to increase accessibility of food for OVCs and other vulnerable community members (the ill, the elderly and the disabled) who must be referred into the programme. The programme was initiated in 2004 and it is implemented by FAO, Ministry of Agriculture and Co-operatives, Microprojects and the National Emergency Response Council on HIV and AIDS (NERCHA)	Supports food security for the ill including PLHIV
Livelihoods promotion		
Livelihood Activity Support for PLHIV/TB	This activity aims to provide resilience against future shocks, provide nutritious food, and sustainable income-generating activities for PLHIV/TB. Activities often do not disrupt the provision of other HIV/TB services (including scheduled clinic appointments). The livelihood activities include nutrition gardens, poultry production, piggery, peanut butter manufacturing, sewing, household detergents manufacturing. Beneficiaries are given inputs to start-up their activities. Issues of adherence that affect retention to care, among all groups often leads to (or suspected to) recipient of care being exposed to new infection while trying to put food on the table; hence beneficiaries are also capacitated on HIV/TB/SRHR/ Nutrition Integrated Treatment Literacy. This programme is implemented by the Ministries of Health, Agriculture, Tinkhundla Administration and Development, in partnership with Joint UN Team on AIDS (JUNTA), and civil society organizations i.e. networks of PLHIV/TB.	Supports capacity strengthening and resilience building among PLHIV/TB households
Social health protection		
Phalala Fund (Referral Medical Fund),	The objective of the fund is to assist deserving citizens, who would otherwise not have access to specialist medical care, to secure such care either, within the Eswatini or, in special circumstances, outside the Kingdom. It is implemented nationally by the Ministry of Health	Provides access to health care services for all including PLHIV. The majority of patients are co-infected with HIV and another life threatening illness (co-morbidities) that require specialised care.

4.2.3. Social security programmes

Programme	Beneficiaries and benefits
Old age, Disability and Survivor benefits: <i>To compensate the loss of income resulting from old disability or survivorship</i> Administrative organisations: <ul style="list-style-type: none"> • Social Welfare Department. • Ministry of Labour and Social Security. • Eswatini National Provident Fund. 	
Provident fund	<ul style="list-style-type: none"> • Citizens of Eswatini employed in the private sector. • Voluntary coverage for employees without mandatory coverage, including civil servants and members of religious organizations. • Exclusions: Self-employed persons, household workers, casual employees, and foreign workers. • Special system for civil servants
Old-age grant (universal)	<ul style="list-style-type: none"> • Age 60 • 1,200 lilangeni a quarter is paid.
Old-age benefit (provident fund)	<ul style="list-style-type: none"> • Age 50 (age 45 if covered employment ceases, at any age if emigrating permanently). • Employment may continue. • The total employee and employer contributions plus accrued interest is paid as a lump sum or an annuity. • If emigrating permanently, the benefit is paid as a lump sum. • The interest rate is at least 3% a year.
Disability benefit (provident fund)	<ul style="list-style-type: none"> • A lump sum of total employee and employer contributions plus accrued interest is paid. • The interest rate is at least 3% a year.
Survivor benefit (provident fund)	<ul style="list-style-type: none"> • A lump sum of total employee and employer contributions plus accrued interest is split among eligible survivors. • The interest rate is at least 3% a year.
Funeral grant (Siphephelo free funeral plan, provident fund)	A lump sum of 5,000 lilangeni is paid (10,000 lilangeni if death resulted from an accident).
Sickness and maternity benefits: <i>To deal with the risk of temporary incapacity</i> Administrative organisations: <ul style="list-style-type: none"> • Ministry of Labour and Social Security Employers pay benefits directly to employees	
Cash sickness benefit	<ul style="list-style-type: none"> • Must have at least three months of continuous employment with the same employer and provide a medical certificate • 100% of the employee's basic earnings is paid for the first 14 days of incapacity plus 50% of basic earnings for an additional 14 days. • The sickness benefit is paid for a maximum of 28 days in each 12-month period of employment with the same employer.

Cash maternity benefit	<ul style="list-style-type: none"> • Must have at least 12 months of continuous employment with the same employer, and at least 24 months of continuous employment since the last maternity leave. Must provide a medical certificate with the expected date of childbirth. • Additional benefit: The maternity leave may be extended in case of an illness arising from childbirth. Must provide a medical certificate. • 100% of the employee's earnings is paid for at least 12 weeks, including up to six weeks before the expected date of childbirth. • Additional benefit: 100% of the employee's earnings is paid for up to six weeks
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Work injury benefits: *Compensation for work-related injuries and occupational illness*

Administrative organisations:

- Ministry of Labour and Social Security

Employers must insure the assessed liability with a private insurance company..

Employer-liability system through a private carrier	<ul style="list-style-type: none"> • Must be assessed with a work injury or occupational disease. Accidents that occur while commuting to and from work are covered. • Consist of temporary and permanent disability cash benefits, workers' medical benefits, survivor benefits, and funeral grant • Coverage: Public- and private-sector employees, trainees, and apprentices. • Exclusions: Self-employed persons, household workers, certain types of contract workers, family labour, and casual workers
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Unemployment benefits: *Compensation for the loss of income resulting from involuntary unemployment*

Not specified

The labour code requires employers to provide severance pay to employees with at least 12 months of continuous employment. The benefit is 10 times the employee's daily earnings at the time of employment termination for each year of employment exceeding one year.

Family benefits: *To provide additional income for families with young children to meet at least part of the added cost of their support*

Not specified

Source: Social Security Programs Throughout the World: Africa, 2019. <https://www.ssa.gov/policy/docs/progdesc/ssptw/2018-2019/africa/ssptw19africa.pdf>

4.3. Summary

Pattern of social protection programmes

Even though the Constitution of Eswatini does not make any explicit reference to social protection, a number of its articles provide rights to several social protection benefits including for children and women, who are among the country's key populations. The country's long-term vision also underscores the need to address HIV risk factors such as poverty, unemployment creation and gender inequality. In the national social protection policy, "persons infected and affected by HIV and AIDS and terminal illness" are specifically identified among the policy's groups of particular focus. The country also has a comprehensive legislative and policy framework that supports the provision of services to those in social protection.

Against the background of this supportive legislative and policy framework, Eswatini's social protection programmes can be described as generally HIV-sensitive. Government provides free ART to all PLHIV using public health centres. The two main cash transfers were specifically designed to, among other things, reduce vulnerability as an outcome of HIV and AIDS (Old Age Grant). In-kind food transfers, – which make up the majority of social protection programmes in the country – are designed to provide food security and improve nutrition among vulnerable children, who are among the country's key populations, as well as among women, the sick, and families who have members on antiretroviral treatment. Furthermore, all citizens have access to a referral medical fund that insures access to specialist medical care. Within the framework of the National Health Policy of 2007 which has the "prevention and control of communicable and non-communicable diseases and other major health concerns such as HIV and AIDS ..." (pg. 19) among its key areas of focus, "there have been major advances in health and health technology, including life-saving medicines for diseases such as HIV/AIDS..." (WHO, 2018:1). This may largely explain the country's achievement of all the 90-90-90 targets. It is noteworthy, however, that none of the social protection programmes in Eswatini target barriers in the country's HIV response such as HIV-related stigma and discrimination, punitive laws against same-sex relationships, as well as the needs of MSM and female sex workers. Stakeholder consultations however revealed that in November 2019, the government through the *National Emergency Response Council on HIV and AIDS* launched a livelihood programme for PLHIV. This initiative allows PLHIV to form groups, come up with ideas of plausible livelihood activities of their choice, and submit applications for financial support of about US\$2000 per group.

Key stakeholders

In terms of stakeholders, the government through the Department of Social Welfare is the main administrator of social assistance programmes in the country. United Nations agencies, particularly the WFP, UNICEF, UNDP, UNFPA, UNAIDS, WHO and the FAO, play a major role in supporting government with technical and financial support in the implementation of social assistance programmes. Government ministries in this space are the Ministry of Education, Ministry of Health, Ministry of Agriculture, the Prime Minister's Office, and the National Emergency Response Council on HIV and AIDS (NERCHA). Major government entities in the area of social security are the Social Welfare Department, Ministry of Labour and Social Security, and the Eswatini National Provident Fund.

There are a number of active local non-governmental organisations (NGOs) that work primarily in the areas of health, education, and social services. Through the Coordinating Assembly of Non-Governmental Organizations (CANGO), for example, the Eswatini HIV/AIDS Consortium (ESHACO) advocates for the provision of quality HIV services that are delivered by communities to those most affected by HIV. Other relevant NGOs include the Swaziland Network Young Positives (SNYP+) which advocates for the general rights of young people living with HIV and AIDS and the Membatsise Home-based Care Organisation. The latter is a community-based organisation with a mission to provide holistic care and support to families and children infected and affected by HIV and AIDS as well as to address factors such as poverty and unemployment⁵ that accelerate new HIV infections among young people in rural communities. Overall, it emerged during stakeholder consultations that many of these NGOs focus on issues that are not addressed by the country's main social protection programmes. A representative of the Swaziland Network Young Positives, for example, shared details of their back-yard gardening and poultry projects that were being implemented in a number of districts with assistance from the WFP. In addition to contributing to young people's food security and nutrition, these projects were also important avenues for income-generation and livelihood promotion. The activities of local NGOs are coordinated by the Ministry of Home Affairs.

Advancement of the AIDS response

Against the foregoing, and given the social protection landscape in Eswatini, strengthening the active and meaningful engagement of civil society is an important avenue of advancing the country's AIDS response. Through this Fast Track pillar, the high levels of HIV stigma and discrimination at both community and policy levels can also be addressed.

4 https://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/legaldocument/wcms_174726.pdf

5 https://sahee.org/pages/projekte_detail.php?lg=en&ii=339&ld=1&archiv=0

5. Country overview:

ETHIOPIA

5.1. Brief HIV and AIDS situation analysis

Ethiopia's adult HIV prevalence of 0.9% (UNAIDS, 2021) is certainly among the lowest in the region. This however translates to 620 000 people living with HIV. There were also 15,000 new infection and 12,000 AIDS-related deaths in 2019 (UNAIDS, 2021). Given this background, there have been ongoing government and NGO efforts to raise awareness and increase HIV testing rates. Despite these, as of 2020 the country was still to achieve any of the three 90s: 83% of people living with HIV knew their HIV status and 78% of those living with HIV and knew their status are on treatment; and 67% of those on treatment have suppressed viral loads (Appendix B). The high level of HIV-related stigma may be playing a major role in this pattern. For example, the percentage of women and men aged 15–49 years who report discriminatory attitudes towards people living with HIV was 59.9% in 2011 and 58.5% in 2016. Sex work and same-sex acts are also criminalised in the country. To this end, female sex workers are the main key population in Ethiopia, with prisoners being the other. Other priority populations for HIV interventions are widowed, separated or divorced women; long distance truck drivers; PLHIV and their partners; and people working in hotspot areas, both mobile and resident (Federal HIV/AIDS Prevention and Control Office, 2018).

5.2. Social protection mechanisms

5.2.1. Legislative and policy context

Constitutional and legal provisions

Through its Article 90 which states “to the extent the country's resources permit, policies shall aim to provide all Ethiopians access to public health and education, clean water, housing, food and social security” the Constitution of the Federal Democratic Republic of Ethiopia (1994), exhibits an implicit commitment to providing the country's citizens with social protection programmes. This is reaffirmed by other constitutional provisions, specifically the following:

Article 41/3: Every Ethiopian national has the right to equal access to publicly funded social services.

Article 41/4: The State has the obligation to allocate an ever increasing resources to provide to the public health, education and other social services.

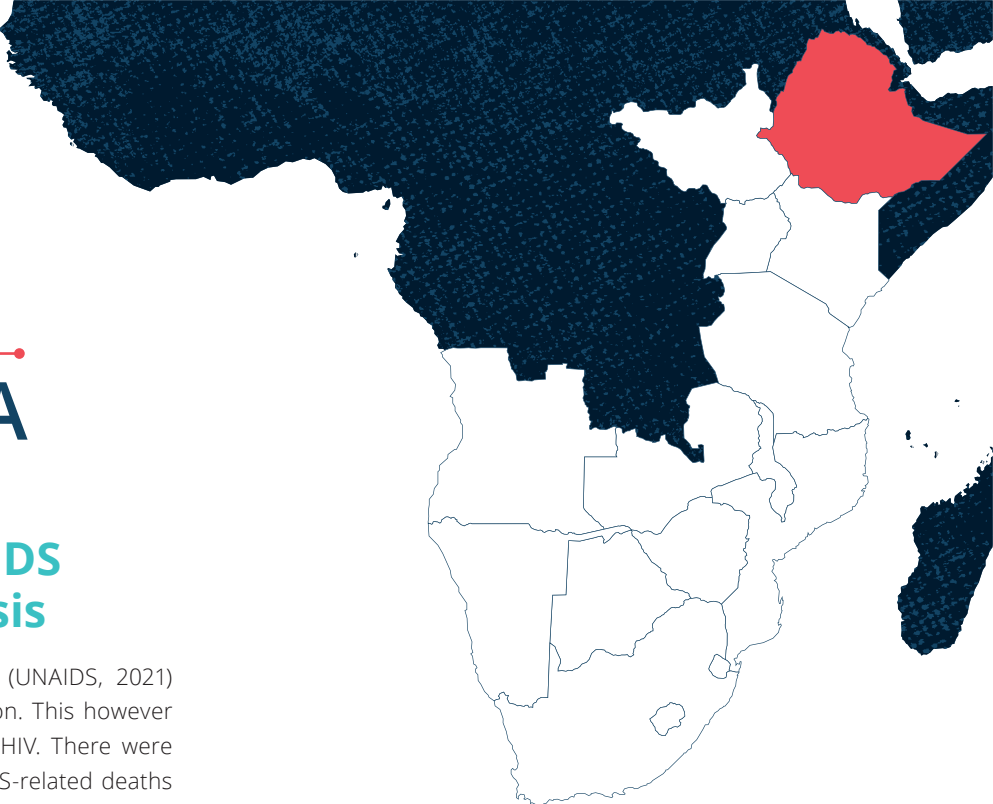
Article 41/5: ‘The State shall, within available means, allocate resources to provide rehabilitation and assistance to the physically and mentally disabled, the aged, and to children who are left without parents or guardian.

Article 41/6: ‘The state shall pursue policies which aim to expand job opportunities for the unemployed and the poor and shall accordingly undertake programmes and public work projects’.

Article 41(7): ‘The state shall undertake all measures necessary to increase opportunities for citizens to the find gainful employment.

Article 43/1: The Peoples of Ethiopia as a whole, and each Nation, Nationality and People in Ethiopia in particular have the right to improved living standards and to sustainable development.

Article 43/4: The basic aim of development activities shall be to enhance the capacity of citizens for development and to meet their basic needs.



A number of legal reforms aimed at removing discriminatory laws to protect the rights of vulnerable groups have also been enacted. Those related to social protection include:

- The Revised Family Code of 2000 which addresses gaps and inconsistencies inherent in the 1960 Civil Code. The Code proscribed several harmful traditional practices inimical and prejudicial to the rights and welfare of children and women.
- The Labour Proclamation No. 377/2003 which sets and enforces minimum workplace standards to address workplace vulnerabilities. It focuses on issues related to occupational safety and health and work environment, industrial relations, employment. It also prohibits employment of children below the age of 14 years of age and the engagement of young workers (i.e. between ages 14 and 18 years) in types of employment which are considered 'hazardous'.
- Proclamation to Provide for Social Health Insurance (Proclamation No. 690/2010).
- Public Servants Pension Proclamation and (Proclamation No. 714/2011).
- Private Organization Employees' Pension Proclamation (Proclamation No. 715/2011).
- Productive safety nets: where poor and vulnerable households will receive conditional and/or unconditional transfers in the form of cash or food, to improve their food security, to access essential services, and to make productive investments.
- Livelihoods and employment support: where poor households will be supported with demand-led technical and financial support and/or information on employment opportunities, to enable them improve their on and off-farm livelihood activities.
- Social insurance: which will entail the expansion of mandatory insurance for formal sector workers and innovative insurance products for the rural poor and urban informal workers will enable people to better manage the risks they face.
- Access to health, education and other social services. This aims to improve access to services for the most vulnerable through, among other things, health fee waivers, subsidised health insurance, specialised services for people with disabilities, pregnant and lactating women, school feeding, and support from an expanded social work system.
- Addressing violence, abuse and exploitation: through a range of interventions both to prevent and respond to violence, abuse and exploitation. The aim is to protect and empower some of the most disempowered and marginalised members of society.

National social protection policy

In line with the country's Constitutional provisions, the *National Social Protection Strategy of Ethiopia*, adopted in 2016 has a stated vision "to see all Ethiopians enjoy social and economic wellbeing, security and social justice" (page 4). It defines social protection as "as part of social policy framework that focuses at reducing poverty, social and economic risk of citizens, vulnerability, and exclusion by taking measures through formal and informal mechanisms to ascertain accessible and equitable growth to all". The Strategy aims realise its vision by adopting the following five integrated focus areas as strategic directions to achieve its mission:

5.2.2. Social assistance programmes

Programme	Description and focus	HIV sensitivity
Cash transfers		
Productive Safety Net Programme (PSNP)	Social assistance programme with public works; direct support; livelihood components. It started in 2005 with the aim to (i) enhance livelihoods and resilience to shocks and (ii) to improve food security and nutrition for rural households vulnerable to food insecurity. Benefits are monthly food, cash (equivalent to 15kg of cereals) or a combination of both. Beneficiaries are chronically food-insecure households. Able-bodied households conducting public works receive conditional transfers whereas non-abled households receive unconditional transfers. Coverage is over 300 districts and the aim is to reach 8 million beneficiaries per year. The administrator is the Ministry of Agriculture and food security for public works beneficiaries and the Ministry Labour and Social Affairs for direct support beneficiaries	Increases households' access to income; supports food security and nutrition
Tigray Social Cash Transfer Pilot Programme (SCTPP)	Unconditional cash transfer started in 2011 to reduce poverty, hunger and starvation in extremely poor and labour-constrained households. Beneficiaries (extremely poor and labour-constrained households) receive a monthly fixed amount of USD7.88 in addition to: • USD1.27 for each child plus USD0.50 if the child is enrolled in school (up to a maximum of four children) • USD2 for households with a child with disabilities, additional • USD2.54 for households with an adult with disabilities, and • USD3.05 if one of the household members is an elderly dependent. The programme covers 3,767 households (2014) and is administered by the Tigray Bureau of Labour and Social Affairs with support from UNICEF	Increases households' access to income; supports food security and nutrition
In-kind-transfers		
School Meals Programme	Conditional in-kind transfer started in 1984 to improve school enrolment, attendance and retention in the country's most food-insecure areas. Benefits are food (a daily hot meal as well as take-home rations in the form of vegetable oil are also distributed to girls). There are complementary measures that include deworming campaigns (supported by WHO) and school gardening activities (supported by FAO). The programme targets country's most food-insecure areas and is administered by the Government of Ethiopia and the WFP. In 2012 it reached 681,195 children; of those, 127,136 girls benefited from the take-home rations	Increases food security and nutrition for children
Livelihoods promotion		
See public works components of PSNP		

Social health protection

Community Based Health Insurance (CBHI)	<p>Started in 2011 to enhance access to health care, help defray costs, and prevent the use of harmful coping strategies. It provides outpatient and inpatient health care services in public health facilities and does not cover treatment with largely cosmetic value. Monthly contributions for core household members (parents and minor children) vary between Birr 10.50 (US\$ 0.56) and Birr 15 (US\$0.80) per month with an additional monthly premium of 2.10 to 3 Birr per non-core household members. There are no co-payments or deductibles. The scheme was launched in 13 districts, of which nine were classified as food insecure and were covered by the PSNP. While the scheme is government driven, the community is engaged in scheme management and supervision. In 2013 it was estimated that almost 51 per cent of individuals in the pilot districts had enrolled in the scheme</p>	<p>Provides access to health services for all including PLHIV</p>
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5.2.3. Social security programmes

Programme	Beneficiaries and benefits
<p>Old age, Disability and Survivor benefits: <i>To compensate the loss of income resulting from old disability or survivorship</i></p> <p>Administrative organisations:</p> <ul style="list-style-type: none"> Public Servants' Social Security Agency administers the public-sector program and collects contributions jointly with the Ministry of Finance <p>Private Organization Employees' Social Security Agency administers the private-sector program and collects contributions.</p>	
Old-age pension (Retirement Pension)	<ul style="list-style-type: none"> Age 60 with at least 10 years of contributions. The qualifying conditions may be reduced for persons working under certain hazardous or arduous conditions Employment must cease The maximum monthly old-age pension is 70% of the insured's average monthly basic salary in the three years before retirement
Old-age settlement (Retirement Gratuity)	<ul style="list-style-type: none"> Age 60 with less than 10 years of contributions Employment must cease A lump sum of the insured's basic salary in the month before retirement multiplied by 1.25 (civilian) or 1.65 (military and police) and by the number of years of contributions is paid
Disability pension (Invalidity Pension)	<ul style="list-style-type: none"> Must be assessed with an incapacity for any gainful employment and have at least 10 years of contributions The maximum monthly disability pension is 70% of the insured's average monthly basic salary in the three years before retirement
Disability settlement (Invalidity Gratuity)	<ul style="list-style-type: none"> Must be assessed with an incapacity for any gainful employment and have less than 10 years of contributions. A lump sum of the insured's basic salary in the month before the disability began multiplied by 1.25 (civilian) or 1.65 (military and police) and by the number of years of contributions is paid

Survivor pension	<ul style="list-style-type: none"> The deceased received or was entitled to receive an old-age or disability pension at the time of death. Eligible survivors include a widow(er), orphans younger than age 18 (age 21 if disabled), and dependent parents. The widow(er)'s pension ceases upon remarriage if the widow is younger than age 45 (age 50 for a widower, no limit if disabled).
Survivor settlement (Survivors' Gratuity)	<ul style="list-style-type: none"> The deceased had less than 10 years of contributions and did not qualify for an old-age or disability pension. Eligible survivors include a widow(er) and orphans younger than age 18 (age 21 if disabled).
Sickness and maternity benefits: <i>To deal with the risk of temporary incapacity</i> Administrative organisations: <ul style="list-style-type: none"> Ministry of Labour and Social Affairs provides general supervision. Employers pay cash benefits directly to employees.	
Universal (medical benefits)	<ul style="list-style-type: none"> Citizens of Ethiopia.
Sickness benefit (employer liability)	<ul style="list-style-type: none"> 100% of the employee's earnings is paid for the first month; 50% of earnings for the next two months; the next three months of leave are unpaid. The maximum sick leave period is six months in a year
Maternity benefit (employer liability)	<ul style="list-style-type: none"> 100% of the employee's earnings is paid for 30 days before and 60 days after the expected date of childbirth; may be extended if there are complications arising from childbirth. Workers' Medical Benefits Public hospitals and community health facilities provide limited free health services. Dependents' Medical Benefits <ul style="list-style-type: none"> Public hospitals and community health facilities provide limited free health services.
Work injury benefits: <i>Compensation for work-related injuries and occupational illness</i> Administrative organisations: <ul style="list-style-type: none"> Public Servants' Social Security Agency administers the public-sector program and collects contributions jointly with the Ministry of Finance Private Organization Employees' Social Security Agency administers the private-sector program and collects contributions. Individual employers insure work injury liability through private carriers or pay compensation directly to employees or dependent survivors	
Employer liability	<ul style="list-style-type: none"> Employed persons in the formal sector, including private-sector employees and civil servants. Exclusions: Self-employed persons, employees of non-profit organizations; workers with training-related contracts and contracts for treatment, care or rehabilitation activities; and household workers. Special systems for military and police personnel Must be assessed with a work injury or occupational disease. Accidents that occur while commuting to and from work are covered if the employer provides the transportation. Consists of temporary and permanent disability cash benefits, survivor benefits and funeral grant

Unemployment benefits: *Compensation for the loss of income resulting from involuntary unemployment**Not specified*

Under the 2003 labour proclamation, employers must provide severance pay in case of unfair dismissal; workforce restructuring; the employer's death, insolvency, or bankruptcy; the employee's death at work; physical incapacity; or HIV/AIDS diagnosis. Severance pay is 30 times the employee's average daily wage in the last week of employment for the first year of service plus 10 times for each additional year of service, up to the employee's annual salary. An additional amount is paid for bankruptcy and workforce restructuring

Family benefits: *To provide additional income for families with young children to meet at least part of the added cost of their support**Not specified*

Source: Social Security Programs Throughout the World: Africa, 2019. <https://www.ssa.gov/policy/docs/progdesc/ssptw/2018/2019/africa/ssptw19africa.pdf>

5.3. Summary

Pattern of social protection programmes

Ethiopia has an enabling constitutional, legislative, and policy framework for social protection. Supported by a number of proclamations, this framework aims to improve all citizens' wellbeing and welfare by ensuring access to basic social services. Although there is no specific focus on those living with HIV, they are essentially covered by the reference to all citizens in the Constitution, as well as to "vulnerable individuals" in the National Social Protection Policy, which provides for most of the country's key populations. The same applies to the two main social assistance programmes (the PSNP and the SCTPP), the main school meals programme, as well as the key social health protection programme (the Community Based Health Insurance).

Key stakeholders

The Ministry of Labour and Social Affairs (MOLSA) is the lead government entity responsible for the administration of social protection programmes in Ethiopia. MOLSA also provides supervision of the sickness and maternity benefits provided by the country's social security system. The Ministry of Agriculture has the mandate to coordinate social protection as per Ethiopia's National Social Protection Policy and is also the lead ministry for the administration of the PSNP which is by far the largest programme in Ethiopia. The Ministries of Education and Health are also active players in the country's social protection system responsible for the school meals programme and the Community Based Health Insurance Scheme respectively. The Public Servants' Social Security Agency and the Ministry of Finance administer all social security benefits for civil servants while the Private Organization Employees' Social Security Agency administers private sector schemes.

Non-governmental actors that support social protection programming in Ethiopia include United Nations agencies such as WHO, UNICEF, FAO, and WFP and who provide various technical and financial support mainly for the school meals programme and the SCTPP. According to USAID (2010), CSOs in the country "have a history of successfully helping communities achieve health and economic improvements centred on HIV and AIDS. These organisations provide services tailored to their communities to extend care beyond the health facility". This also emerged during consultations with stakeholders in the country where it was revealed that

in addition to international donors such as PEPFAR and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), there are a number of local and international NGOs that support HIV-sensitive social protection in the country. Examples include NEP+, a local network of PLHIV in Ethiopia, FHI 360, USAID's AIDS Support and Technical Resources (AIDSTAR) program, PATH, and the International HIV/AIDS Alliance. Support is also provided by various bilateral and multilateral agencies that include the Embassy of the Kingdom of the Netherlands; DANIDA, DFAT, SIDA, Irish Aid; DFID, the European Commission, and the World Bank.

Community-based organisations also play a major role in the administration and implementation of the Community Based Health Insurance (CBHI) as well as other treatment and care services. A representative of NEP+, for example, stated that due to the disruptions and travel restrictions that came with COVID-19, the network successfully advocated for patients on ART to be provided with at least three months' worth of prescription instead of the usual one month. Additionally, the network's 5400+ volunteers made home deliveries to willing ART patients who are resident in remote areas to ensure that they adhered to treatment during the travel restrictions.

Advancement of the AIDS response

To advance the AIDS response in Ethiopia consideration should be given to the implementation of combination social protection programmes aimed at particular geographical areas as well as the country's priority populations for HIV interventions. These include, as stated earlier, widowed, separated or divorced women, long distance truck drivers, and people working and residing in hotspot areas. The engagement of CSOs in addressing the high levels of HIV-related stigma and discrimination is another avenue of advancing the AIDS response in the country.

6. Country overview:

KENYA

6.1. Brief HIV and AIDS situation analysis

In 2020, Kenya's HIV prevalence was estimated to be 4.2% which was a decrease from the 5.7% and 5.1% reported in 2010 and 2015 respectively (UNAIDS, 2021). While these proportions may seem low, they translate to 1.4 million people living with HIV in the country. This means that the country has the third-largest HIV epidemic in the world, alongside Mozambique and Uganda. According to UNAIDS (2021) there were 33,000 new HIV infections and 19 000 AIDS-related deaths in the country in 2020. With regard to the 90-90-90 targets, 96% of people living with HIV know their HIV status, 86% of those know their status on treatment, and 75% of those on treatment have suppressed viral loads (Appendix B). Thus, the country is still to achieve the targets. The high level of HIV-related stigma plays a major role in this regard. In 2008, for example 27.9% women and men aged 15-49 years reported discriminatory attitudes towards people living with HIV. The proportion, while on the decline, was still relatively high at 11.9% in 2014 (UNAIDS, 2019). UNAIDS also reports that same sex-unions and sex work are still criminalised in Kenya. To this end, key populations in the country are sex workers, MSM as well as PWID, women, and young people.

6.2. Social protection mechanisms

6.2.1. Legislative and policy context

Constitutional and legal provisions

After years of Constitutional provisions that were virtually silent on social protection, Kenya adopted a new Constitution in 2010 "that is cognisant of the right to social security and social protection broadly conceived" (Barya, 2011:64). In addition to general provisions in relation to social protection, the constitution provides for socioeconomic rights for selected categories of vulnerable population with children and youth provided for in Articles 53 and 55 respectively as follows:

Article 53: Every child has the right:

- to a name and nationality from birth;
- to free and compulsory basic education;
- to basic nutrition, shelter and health care;
- to be protected from abuse, neglect, harmful cultural practices, all forms of violence, inhuman treatment and punishment, and hazardous or exploitative labour;
- to parental care and protection, which includes equal responsibility of the mother and father to provide for the child, whether they are married to each other or not; and

Article 55: The State shall take measures, including affirmative action programmes, to ensure that the youth:

- access relevant education and training;
- have opportunities to associate, be represented and participate in political, social, economic and other spheres of life;
- access employment; and
- are protected from harmful cultural practices and exploitation

Article 43 (3) The State shall provide appropriate social security to persons who are unable to support themselves and their dependants.

Article (21), (2) "All State organs and all public officers have the duty to address the needs of vulnerable groups within society, including women, older members of society, persons with disabilities, children, youth, members of minority or marginalised communities, and members of particular ethnic, religious or cultural communities."

Other relevant sections include Article 54 on People living with Disabilities, Article 56 on minorities and marginalized groups, and Article 57 on older persons. Supporting legislation includes the National Social Security Fund (NSSF) Act and the National Hospital Insurance Fund Act.

National long-term vision

Given the foregoing Constitutional and legislative framework, the country's long-term national planning strategy, *Vision 2030*, seeks to build "a just and cohesive society with social equity in a clean and secure environment". The Vision's goal is "to increase opportunities all-round among women, youth, and all disadvantaged groups" through, among other things, the establishment of a consolidated Social Protection Fund.

National social protection policy

In terms of policies, the Kenya Social Protection Policy⁶ was adopted in 2012 "to ensure that all Kenyans live in dignity and exploit their human capabilities to further their own social and economic development" (Government of Kenya, 2011:5). The policy defines social protection as:

Policies and actions, including legislative measures, that enhance the capacity of and opportunities for the poor and vulnerable to improve and sustain their lives, livelihoods, and welfare, that enable income-earners and their dependants to maintain a reasonable level of income through decent work, and that ensure access to affordable healthcare, social security, and social assistance (pg. 2)

Another relevant policy is the National Food Security and Nutrition Policy which "addresses associated issues of chronic, poverty-based food insecurity and malnutrition, as well as the perpetuity of acute food insecurity and malnutrition associated with frequent and recurring emergencies, and the critical linkages thereof" (pg vii).

6.2.2. Social assistance programmes

Programme	Description and focus	HIV sensitivity
Cash transfers		
Cash Transfers for Orphans and Vulnerable Children (CT-OVC).	Unconditional, cash transfers started in 2004 to (i) strengthen the capacity of poor people to care for and protect OVCs, (ii) encourage the fostering and retention of OVCs within their families and communities; and (iii) promote the development of human capital of OVCs. Beneficiaries are poor households with at least one OVC aged 0–17 years who has at least one deceased parent, or whose parent or main caregiver is chronically ill or has a severe disease. They receive a bi-monthly cash benefit of around USD21. As of 2019, the Coverage for the CT-OVC programme was 353,000. Administration is overseen by Constituency Social Assistance Committees and Location OVC Committees monitor programme performance at the local level to ascertain receipt of benefits and household compliance with conditionalities	Supports families' child care roles
Inua Jamii 70+	Universal non-contributory social pension introduced in 2018 and targeting older persons who are 70 years and above with transfer values of USD 20 monthly. Total coverage is 800,000 older people.	Supports families' child care roles

⁶ The policy is currently under review

Hunger Safety Net Programme	<p>Unconditional cash transfer started in 2008 to reduce extreme hunger and vulnerability. The target is households with chronic food insecurity and in extreme poverty (unable to afford basic expenses or to invest in the development of human capital); and/or have a high dependency ratio (without adult members or whose members are not fit for work or have long-term illnesses or severe disabilities). They receive a cash benefit of about US\$26 every two months. The programme is implemented in four counties (Turkana, Mandera, Marsabit and Wajir) by the Ministry of Devolution and Planning with support from the UK Foreign, Commonwealth & Development Office (FCDO, formerly DFID) and the Australian Department for Foreign Affairs and Trade (DFAT). Between 2018 and 2019, the programme was reached 100,868 households that are most vulnerable to drought. It also disbursed drought shock-responsive cash transfers targeting up to 274,000 households as dictated by drought severity</p>	Improves food security and nutrition for those PLHIV, among others
Persons with Severe Disability Cash Transfer	<p>Unconditional cash transfer started in 2010 to improve the welfare of beneficiaries (poor people with disabilities) and increase their access to services. They receive a cash benefit of KES2,000 (USD22) per month. The programme is implemented nationwide and is administered by the <i>Ministry of Labour and Social Protection</i>. According to the social protection sector annual report 2018/19, the coverage for CT-PWSD was 47,000</p>	Increases households' access to income
In-kind-transfers		
Home Grown School Meals	<p>Conditional in-kind (food) transfer started in 2009 to improve the health and nutrition of food-insecure children who attend pre-primary and primary schools. The children are provided with daily hot meals and in 2016 the programme reached 900 000 children. The Ministry of Education is the administrator, with support from the WFP.</p>	Improves food security and nutrition for children
Livelihoods promotion		
Kenya Youth Empowerment Project	<p>Public works programme with Cash for work and training components. It started in 2010 with the aim to provide temporary employment opportunities and improve the employability of beneficiaries. The target is youth aged 15–29 years who have at least 8 years of schooling, have been out of school for at least 1 year and are not currently employed. Benefits are labour-intensive works and social support services: cash, and private-sector internships and training. Beneficiaries receive between US\$1.35 and US\$2.25 per task depending on the type of work performed as well as private-sector internships and training. The programme provides 190,000 job opportunities and is administered by the Ministry of Devolution and Planning in partnership with the World Bank and the Kenya Private Sector Alliance.</p>	Prepares adolescents and youth for future livelihoods

Social health protection		
National Hospital Insurance Fund	Has different components:	
	<ul style="list-style-type: none"> Contributory – National Hospital Insurance Fund, enhanced benefits package mandatory statutory contributions for formal sector and voluntary to the informal economy (coverage remains a challenge) Non-contributory – HISP now extended to all recipients of social assistance programmes, inua jamii 70+ and all secondary school pupils in public schools UHC – tax funded mechanisms HIV – mainly funded by external donors Private Health Insurance – Employer and Individual liability inclusive of HIV cover as the HIV Prevention and Control Act of 2006 outlaws insurance based discrimination based on HIV status 	Provides access to health care for different components of the population including PLHIV
Health Insurance Subsidy Programme (HISP)	Non-contributory health insurance started in 2014 to cover the costs of health insurance for the country's poorest households. The benefit, a health insurance package which includes outpatient and inpatient care, is targeted at the poorest households. The programme is administered by the National Health Insurance Fund with support from the World Bank	Provides access to health care for all including PLHIV
Expanded Free Maternity (Linda Mama)	Offers free maternity health services covering outpatient and inpatient services including antenatal, delivery and neonatal, and postnatal care and one year of paediatric services. The aim of the programme is to "achieve universal access to maternal and child health ... and improving access to healthcare and giving social protection to <i>all Kenyans</i> " ⁷ . Services are available from all public health facilities; 2000 private sector facilities and 700 faith-based facilities. The programme is administered by the Ministry of Health and the National Hospital Insurance Fund.	Provides access to health care for all including PLHIV

6.2.3. Social Security

Programme	Beneficiaries and benefits
Old age, Disability and Survivor benefits: <i>To compensate the loss of income resulting from old disability or survivorship</i> Administrative organisations: <ul style="list-style-type: none"> National Social Security Fund. Ministry of Labour and Social Protection administers the universal program. National Social Security Fund administers the mandatory individual account and provident fund program 	
Old-age pension (Inua Jamii 70+ programme, universal)	<ul style="list-style-type: none"> Age 70 and not receiving any other government pension Employment must cease 2,000 shillings (US\$20) a month is paid.

⁷ <http://www.socialprotection.go.ke/>

Old-age benefit (Age Benefit, provident fund)	<ul style="list-style-type: none"> • Age 50. • Employment must cease
Emigration benefit (mandatory individual account and provident fund)	<ul style="list-style-type: none"> • Paid if a member emigrates to a country that does not have a reciprocal agreement with Kenya
Disability pension (Invalidity Pension, mandatory individual account)	<ul style="list-style-type: none"> • Must be assessed with a total permanent physical or mental incapacity and have at least 36 months of contributions before the disability began
Disability settlement (mandatory individual account)	<ul style="list-style-type: none"> • Must be assessed with a total permanent physical or mental incapacity and not meet the contribution requirements for the disability pension
Disability benefit (Invalidity Benefit, provident fund)	<ul style="list-style-type: none"> • Must be assessed with a total permanent physical or mental incapacity, or be unable to work as the result of a partial disability
Survivor pension (Survivor's Pension, mandatory individual account)	<ul style="list-style-type: none"> • Paid if the deceased had at least 36 months of contributions and was contributing at the time of death. • Eligible survivors include persons named by the deceased. If there are no named survivors, survivors include (in order of priority) a dependent widow(er), orphans, parents, and siblings.
Survivor settlement (mandatory individual account)	<ul style="list-style-type: none"> • The deceased had less than 36 months of contributions. • Eligible survivors include persons named by the deceased. If there are no named survivors, survivors include (in order of priority) a dependent widow(er), orphans, parents, and siblings
Survivor benefit (provident fund)	<ul style="list-style-type: none"> • Paid to named beneficiaries or dependent family members if a fund member dies before withdrawing his or her full account balance
Funeral grant (mandatory individual account)	<ul style="list-style-type: none"> • Must have at least six months of contributions. • Eligible survivors include a widow(er) or, in the absence of a widow(er), the father, mother, brother, sister, or the person who paid for the funeral

Sickness and maternity benefits: *To deal with the risk of temporary incapacity*

Administrative organisations:

- Ministry of Labour and Social Protection provides general supervision of the employer-liability program.
- Ministry of Health through a board of directors, provides general supervision of medical benefits.
- National Hospital Insurance Fund administers medical benefits.

Social insurance	<ul style="list-style-type: none"> • Employed and self-employed persons, including public-sector employees, with monthly earnings of at least 1,000 shillings. • Voluntary coverage for employed persons in the formal sector with monthly earnings of less than 1,000 shillings, pensioners, unemployed persons, and informal-sector workers.
Cash sickness benefit (employer liability)	<ul style="list-style-type: none"> • Must have at least two months of continuous employment with the same employer and provide a medical certificate issued by a registered medical practitioner.
Cash maternity and paternity benefits (employer liability)	<ul style="list-style-type: none"> • There is no minimum qualifying period. Must give at least seven days written notice of intention to take leave on a specific date and to return to work thereafter. A medical certificate may be required

Work injury benefits: *Compensation for work-related injuries and occupational illness***Administrative organisations:**

- Ministry of Labour and Social Protection enforces the law and approves the benefit amounts.

Employers insure work injury liability through private carriers or provide benefits directly to employees or dependent survivors.

Employer-liability system through private carriers

- Private-sector employees and public-sector employees not covered by a special system.
- Exclusions: Self-employed persons, casual workers, and family labor.
- Special system for civil servants, military, police, and correctional personnel.
- Must be assessed with a work injury or occupational disease. Occupational diseases are specified by law.
- Consists of temporary and permanent disability cash benefits, survivor benefits and funeral grant

Unemployment benefits: *Compensation for the loss of income resulting from involuntary unemployment*

N/A

The 2007 Employment Act requires employers to provide severance pay in case of redundancy to dismissed employees with at least one year of service. The payment amount is at least 15 days of the employee's earnings for each year of service.

Family benefits: *To provide additional income for families with young children to meet at least part of the added cost of their support*

Not specified

Source: Social Security Programs Throughout the World: Africa, 2019. <https://www.ssa.gov/policy/docs/progdesc/ssptw/2018-2019/africa/ssptw19africa.pdf>

6.3. Summary

Pattern of social protection programmes

Kenya's Constitution explicitly underscores citizens' right to both social assistance and social security. This imperative is also clearly outlined in the country's long-term vision as well as the National Social Protection Policy. To this end, it is clear that Kenya has a solid legislative and policy framework for the provision of social protection to some of the country's key population and those vulnerable to HIV such as OVCs, young people and women. It also emerged during stakeholder consultations that Social Assistance Fund Regulations are currently being developed. This overall framework also makes provision for addressing some of the well-documented risk factors for HIV such as poor access to food and nutrition, employment and education. However, some of the key barriers to the country's HIV response are not covered. These include HIV-related stigma and discrimination as well as the legal and structural barriers faced mainly by people in same-sex relationships as well as transgender people. In May 2019, for example,

the High Court of Kenya refused an order to declare as unconstitutional those sections of the Constitution that do not recognise any relationships between persons of the same sex⁸. To this end, MSM – a key population in the country – has no explicit protection against discrimination, and this can hamper their access to social protection services. Other key populations not adequately covered in the legislative and policy framework as well as in the focus of the social protection programmes are sex workers and PWID.

Key stakeholders

The Ministry of Labour and Social Protection is the government entity responsible for coordinating and overseeing the implementation of social protection programmes in the country as well as the Ministry of Education, Ministry of Health, Ministry of Devolution and Planning and agricultural sector ministries. Other government entities that are involved, mainly in social security provisions are the National Hospital Insurance Fund and the National Social Security Fund. The private sector has limited participation through the Kenya Private

⁸ <https://theconversation.com/homosexuality-remains-illegal-in-kenya-as-court-rejects-lgbt-petition-112149>

Sector Alliance. At the local level, Constituency Social Assistance Committees and Location OVC Committees are among community-based organisations that support the implementation of the cash transfer for OVC programme.

In terms of contributory social security, the private sector has an important role with the Federation of Kenya Employers and the Central Organization of Trade Unions in Kenya being part of the governance structures of NSSF and NHIF.

With much of the social protection programmes in Kenya being cash transfers, many of the development partners in the country work in this social protection area. The key actors include the WFP, UNICEF, the World Bank, FCDO, OXFAM, JICA, and Concern International.

Although Kenya has a large and diverse civil society, with over 14,000 civil society entities estimated to be engaged in HIV and AIDS activities in the country⁹, the institutional framework as outlined in the National Social Protection Policy does not seem to make provision for the involvement of CSOs in the country's social protection programming. Nonetheless, it emerged that there are about 700 faith-based organisations that provide facilities for the expanded free maternity programmes, Linda Mama. A 2006 UNAIDS report also showed that there were, among others, seven CSOs in Kenya that aim to enact social protection measures to support women in their domestic and caring responsibilities; 18 that aim to prevent HIV infection among women; 14 that aim to ensure access by women and girls to care and treatment; six that supporting ongoing efforts towards universal education for girls; and 17 that aim to fight violence against women (UNAIDS, 2006). The existence of relevant CSOs such as Women Living with HIV in Kenya, Network of People Living with HIV, and the Kenya Network of Young People living with HIV also emerged in this project.

Additionally, the African Platform for Social Protection (APSP) has its head office in Nairobi. The APSP has been described as a “pan-African network of organizations operating at grassroots, national and regional levels, with a commitment to promote active engagement of National Platforms in the shaping of Social Protection policies, programs, and practices in Africa”¹⁰. It works in collaboration with governments, the private sector, development agencies, research institutions and grassroots communities in Africa. It also emerged during stakeholder consultations that Government has put in place a Single Registry to enhance coordination in identification of cash transfer beneficiaries which should be used by all partners to include NGOs. Identification of beneficiaries is done using a harmonized targeting tool which includes chronic illness such as HIV in its criteria. There is also a Cash Plus Working Group is mainly constituted by NGOs.

Advancement of the AIDS response

Given the overall profile of Kenya's social protection programmes, Fast Track pillar 4 is an important pathway to advancing the country's AIDS response. Essentially, to the extent that key populations such as MSM, sex workers and PWID have no explicit protection against discrimination in Kenya, it is imperative for the country's CSO's to address the issue of HIV-related stigma and discrimination and to advocate for more inclusive legislation and policies. Otherwise, the ability of these populations to access social protection services will continue to be hampered.

9 <http://nacc.or.ke/civil-society/>

10 <https://africapsp.org/>

7. Country overview:

LESOTHO

7.1. Brief HIV situational analysis

Lesotho's adult HIV prevalence of 21.1% (UNAIDS, 2021) is the second highest in the world after South Africa. According to UNAIDS, in 2020 there were 280 000 people living with HIV, 7 700 new HIV infections, and 4 700 AIDS-related deaths in the country (UNAIDS, 2021). Although the HIV prevalence affects the general population, people aged 50 years and above, sex workers, factory workers in the textile and apparel industry, MSM, herd boys, prison inmates, orphans and vulnerable children, and AGYW are disproportionately affected. The country's progress towards the 90-90-90 targets, presented in Appendix B, shows that only one target (percentage of people living with HIV who know their status) has been achieved as it was 94% in 2020. The other targets are still to be achieved: 82% of those living with HIV who know their status are on treatment and 72% of those on treatment have suppressed viral loads. Contributory factors to the country's HIV profile include high levels of poverty, gender inequality and HIV-related stigma and discrimination. In 2014, for example, 13.9% of women and men aged 15–49 years reported discriminatory attitudes towards people living with HIV.

7.2. Social protection mechanisms

7.2.1. National social protection legislative and policy context

Constitutional and legal provisions

Although the Constitution of Lesotho does not explicitly make provisions for social protection, its Section 26 (2) implicitly does so by stipulating that “the State shall take appropriate measures in order to promote equality of opportunity for the disadvantaged groups in the society and enable them to participate fully in all spheres of public life”.

National long-term vision

Lesotho's National *Vision 2020* was launched in 2003 with the vision that the country will, by 2020, “be a stable democracy and a united, prosperous nation at peace with itself and its neighbours; that it should have healthy and well-developed human resources; [and] its economy would be strong, its environment well-managed and its technology well-established”¹¹. Among the Vision's overarching objectives are poverty reduction through employment generation and reduction of social vulnerability; promoting HIV/AIDS prevention, care and treatment; and radically transforming technical, vocational and higher education to produce world-class skills.

National social protection policy

The *National Social Protection Strategy (2011/12-2018/19)* was developed with a vision of “a decent and dignified quality of life for all Basotho, free from poverty and hunger, that allows them to share in the benefits of national economic growth”. The strategy adopted a life-course approach to design an integrated suite of core programmes to address vulnerabilities of citizens during pregnancy and early childhood; school age and youth; working age; old age as well as in terms of disability and shocks. Although the strategy did not state an explicit definition of social protection it implicitly recognises it as systems established to tackle poverty and to provide families with protection against the challenges, shocks and crises that make them susceptible to falling into, or deeper into, poverty (Kingdom of Lesotho, 2013:3). With the strategy having elapsed in 2019, it emerged during the stakeholder interviews that a revision was currently underway.

¹¹ <http://www.commonwealthgovernance.org/countries/africa/lesotho/national-development-plan/>

7.2.2. Social assistance programmes

Programme	Description and focus	HIV sensitivity
Cash transfers		
Child Grants Programme	Unconditional cash transfer started in 2009 to improve the living standards and health status of orphans and vulnerable children, reduce malnutrition, and increase school enrolment. Beneficiaries are poor households with OVC (aged 0–17) or child-headed households. They receive cash benefits of US\$25-US\$50 on a quarterly basis. The programme reaches about 24,500 households and is administered by the Ministry of Social Development with financial support from the European Commission	Improves food security and nutrition for children; supports families' care roles
Old-Age Pension	Unconditional cash transfer introduced in 2005 to provide elderly citizens (those aged 70 years and older) with a source of income (US\$45 per month). The programme reaches just over 85,087 beneficiaries and is administered by the Department of Pensions in the Ministry of Finance and Development Planning	Supports families' care roles
Public Assistance (PA) grant	An unconditional cash transfer of US\$20 per person per month and various unconditional in-kind transfer grants (including medical exemptions, food packages, hygiene kits and devices for people with disabilities). The aim is to improve the living conditions of extremely destitute people, OVC; people with disabilities; and the elderly. In 2018, it had 12,684 beneficiaries countrywide. The Ministry of Social Development is the administrator.	Improves overall household wellbeing for OVCs and PLHIV
In-kind-transfers		
School feeding programme	Conditional in-kind transfer started in 2005 to combat malnutrition among children, increase school enrolment rates, stabilise attendance, and reduce drop-out rates. The benefit is a daily mid-morning snack of maize meal and a one midday meal of maize meal, pulses and vegetable oi provided to learners in pre-primary and primary schools across the country. The programme reaches 389,000 learners nationwide and is administered by the Ministry of Education and Training with support from the WFP.	Improves food security and nutrition for children
OVC Bursary	Educational fee waiver introduced in 2000 to promote the education of children younger than 18 years old who are enrolled in secondary school and who have lost one or both parents; have an incapacitated or incarcerated parent; or are considered 'needy'. The benefit is an annual bursary that covers secondary schooling fees (registration, books etc.) and tuition. Amounts vary by school and grade, but should cover tuition and other fees. There are about 13, 172 beneficiaries and the programme is administered by the Ministry of Social development	Enhances educational outcomes for OVCs

Livelihoods promotion		
Public works programmes (known locally as <i>Fato Fato</i>)	The programme employs community members to create soil and water conservation assets. Another component (the Integrated Watershed Management Programme) employs people for one month to plant trees and carry out environmental conservation work at village level. The programme works on a first-come, first served basis and only one household member can participate at a time. It is administered by the Lesotho Ministry of Forestry and Land Reclamation	Increases households' access to income
Social health protection		
Not available		

7.2.3. Social security programmes

Programme	Beneficiaries and benefits
Old age, Disability and Survivor benefits: <i>To compensate the loss of income resulting from old disability or survivorship</i> Administrative organisations: <ul style="list-style-type: none"> Ministry of Finance administers the program. 	
Old-age pension	<ul style="list-style-type: none"> Age 70 and not receiving any other public pension. 700 maluti (US\$45) a month is paid.
Survivor pension	<ul style="list-style-type: none"> The deceased received or was entitled to receive an old-age pension. Eligible survivors include a widow, a dependent widower, and orphans younger than age 18. 100% of the old-age pension the deceased received or was entitled to receive is split equally among eligible survivors.
Sickness and maternity benefits: <i>To deal with the risk of temporary incapacity</i> Administrative organisations: <ul style="list-style-type: none"> Ministry of Labour and Employment provides general supervision of cash benefits. Employers pay benefits directly to employees. Ministry of Health provides general supervision and coordination of medical benefits. 	
Universal (medical benefits)	<ul style="list-style-type: none"> Citizens of Lesotho. Special systems for public-sector employees and military and police personnel
Employer liability (cash benefits)	<ul style="list-style-type: none"> Private-sector employees; Exclusions: Self-employed persons and apprentices.
Cash sickness benefit (employer liability)	<ul style="list-style-type: none"> Must have at least six months of continuous employment with the same employer and provide a medical certificate.
Cash maternity benefit (employer liability)	<ul style="list-style-type: none"> Must have at least one year of continuous employment with the same employer and provide medical certificates indicating the expected and actual dates of childbirth

Work injury benefits: *Compensation for work-related injuries and occupational illness***Administrative organisations:**

- Ministry of Labour and Employment provides general supervision

Employer-liability system through a private carrier

- Employed persons and apprentices.
- Exclusions: Self-employed persons, household workers, family labour, home-based workers, and farmers and foresters.
- Special system for judges; members of parliament; certain civil servants; and military, police, and correctional personnel.
- Must have an incapacity for work lasting at least three days. Accidents that occur while commuting to and from work are covered. Occupational diseases are covered for certain occupations, according to a schedule in law.
- Consists of temporary and permanent disability cash benefits, workers' and dependent medical benefits, survivor benefits and funeral grant

Unemployment benefits: *Compensation for the loss of income resulting from involuntary unemployment**Not specified*

The 1992 labour code requires employers to provide severance pay in cases of dismissal to employees with at least one year of continuous service with the same employer. The employer pays two weeks of the employee's wages (at the rate payable at the time the contract is terminated) for each completed year of continuous service with the employer. The employer can make the severance payment immediately or delay it for up to 12 months.

Family benefits: *To provide additional income for families with young children to meet at least part of the added cost of their support**Not specified*

Source: Social Security Programs Throughout the World: Africa, 2019. <https://www.ssa.gov/policy/docs/progdesc/ssptw/2018-2019/africa/ssptw19africa.pdf>

7.3. Summary

Pattern of social protection programmes

Lesotho's commitment to the provision of social protection is implicitly outlined in Section 26(2) of the Constitution as well as in the country's long-term vision. It is more explicit in the National Social Protection Strategy, which came to an end in 2019, and is currently under revision. Of the three instruments, only the long-term vision identifies HIV and AIDS treatment, care and support as a focus area. It can be argued that in the Constitution, the PLHIV and those affected by it are covered by the reference to "disadvantaged groups in the society" while the Social Protection Strategy's life-course approach ensures that some of the country's key populations, especially OVCs as well as adolescents and young women are particularly targeted. While Lesotho does not have a specific social health protection programme, citizens have access to free healthcare services at over 300 primary healthcare facilities and centres. This includes free HIV testing, counselling and ART services. The Ministry of Health and Social Welfare is the administrator.

Key stakeholders

The Ministry of Social Development is the lead government administrative department in the area of social protection. Other key government actors are the Ministry of Finance and Development Planning, the Ministry of Education and Training, the Ministry of Health, and the Ministry of Forestry and Land Distribution. The Ministries of Finance and Health are also involved in some aspects of the social security system. However, the Ministry of Labour and Employment is the main actor in this regard.

In terms of development partners, it emerged that United Nations agencies such as UNICEF, WFP, FAO, UNDP, and UNAIDS are active actors along with international NGOs and donors such as USAID, PEPFAR, Elizabeth Glaser, M2M, and World Vision. In terms of CSOs, the project did not identify any that work directly with social protection. Rather, like development partners, the majority of CSOs in the country work in the various areas of HIV and AIDS programming. These include advocating for the right of PLHIV to access various services including social protection as well as to address some of the key risk factors for HIV in the country. For example, the mandate of the Lesotho Network of People Living with HIV (LENPWHA) is to ensure that every citizen gets tested and know their status. According to a representative of the network, "this mandate was bought about because in the past there was a lot of stigma and discrimination which was directed to PLHIV". It also emerged during stakeholder consultations that a five-year USAID-funded activity (*Karabo ea Bophelo*) had just been launched

in the country with the aim of preventing new HIV infections and reducing vulnerability among OVCs and AGYW. Working in collaboration with the Ministry of Gender, Youth, Sports & Recreation, the National AIDS Commission, the activity aims to achieve its objective through by strengthening support for gender equality and GBV prevention interventions. Other CSOs addressing key HIV risk factors in Lesotho include the *People's Matrix Association*, which has the eradication of "stigma and discrimination on the basis of sex, sexual orientation, gender identity and expression in Lesotho" among its key objectives. The other is *Phelisanang Bophelong* which implements interventions improve access to HIV prevention, care and support and treatment services for all at risk MSM including those in prison. It can be concluded that CSOs largely complement government's efforts by focusing on otherwise overlooked issues in the national social protection system.

Advancement of the AIDS response

As stated earlier, contributory factors to the country's HIV profile include high levels of poverty, gender inequality and HIV-related stigma and discrimination. To this end, Fast Track pillars 1 and 4 are important avenues of advancing the country's AIDS response. There is particularly need to broaden sustainable social protection programmes for AGYW as well as for engaging CSOs in strengthening the legal and policy environment to address stigma and discrimination. The development of a social health protection programme is also needed to increase access to essential health services for PLHIV, as well as those at risk of or affected by HIV (Pillar 3).

8. Country overview:

MALAWI

8.1. Brief HIV situational analysis

Malawi's HIV prevalence of 8.1% among the adult population (aged 15-49) is one of the highest in the world. In 2020 an estimated 990 000 Malawians were living with HIV, 12,000 died from AIDS-related illnesses in the same year, and there were 21 000 new HIV infections (UNAIDS, 2021). The Malawian HIV epidemic plays a critical role in the country's low life expectancy of just 57 years for men and 60 years for women. Although the epidemic has limited the country's economic and social development, the last decade has seen notable efforts to reduce the HIV prevalence and impact. For example, the 21 000 new HIV infections reported in 2020 are a notable decline from the 55 000 reported in 2010. However, as shown in Appendix B, there is somehow limited progress towards achieving the 90-90-90 targets: in 2020, 91% of people living with HIV in Malawi were aware of their status, of which 86% were on treatment, of which 77% were virally suppressed.

Despite this progress, HIV-related stigma and discrimination remains a key barrier to progress, particularly among MSM and sex workers. In 2016, for example 17.6% of women and men aged 15-49 years reported discriminatory attitudes towards people living with HIV. This was actually an increase from the 16.5% reported in 2010. In addition, same-sex acts are criminalised and those involved in them can face imprisonment of 14 years to life. For this reason, MSM and sex workers are among the country's key populations along with OVCs, young people, and women.

8.2. Social protection mechanisms

8.2.1. National social protection legislative and policy context

Constitutional and legal provisions

The Constitution of the Republic of Malawi (1996) implicitly provides for the provision of social protection services to its citizens in the 'Right to Development' article as follows:

Article 30/1: All persons and peoples have a right to development and therefore to the enjoyment of economic, social, cultural and political development and women, children and the disabled in particular shall be given special consideration in the application of this right.

Article 30/2: The State shall take all necessary measures for the realization of the right to development. Such measures shall include, amongst other things, equality of opportunity for all in their access to basic resources, education, health services, food, shelter, employment and infrastructure.

National long-term vision

When Malawi's long-term development blueprint, *Vision 2020*, was launched in 1998 it envisaged that by the year 2020 the country "will be secure, democratically mature, environmentally sustainable, self-reliant with equal opportunities for and active participation by all, having social services, vibrant cultural and religious values and being a technologically driven middle-income country". The development of the social sector and a focus of food security and nutrition were among the key targets seen as important in realising this vision. The development of the social sector was to entail, among other things, a reduction in illiteracy and improvement in the quality of education as well as the availability, accessibility and quality of health services. With food security and nutrition, the broad notion was to increase food production and improve the overall nutritional status of Malawians through the promotion of non-farm income generating activities; implementation of effective disaster management systems, and economically empowering poor in Malawians¹².

12 <https://www.social-protection.org/gimi/ShowCountryProfile.action?sessionId=IQq2vcg0HUWhBwzyJFzjEbQwtz9B0Ao45WSHIVHKZiaM7AsT-ws63!917277963?iso=MW>

National social protection policy

At the policy level, the second *Malawi National Social Support Policy* (MNSSP II) meant to cover the 2018-2023 period builds on the lessons learned during the implementation of the first MNSSP (2013-2016). The current policy's mission is to "provide and promote productivity-enhancing interventions and welfare support for the poor and vulnerable thereby facilitating the movement of people out of poverty and reducing the vulnerability of those in danger of falling into poverty" (pg. 4). This is to be achieved through the implementation of interventions organised around thematic priority social-protection-related areas:

1. **Consumption support** – provision of consumption support through timely, predictable and adequate cash and/or in-kind transfers to poor and vulnerable households throughout the lifecycle.
2. **Resilient livelihoods** – promoting resilient livelihoods through tailored packages based on individual, household, and community needs via graduation pathways, inter-programme linkages, and by facilitating access to and utilisation of services beyond the MNSSP II.

3. **Shock-sensitive social protection** – developing a shock-sensitive social protection system that meets seasonal needs, prepares for - and respond to - unpredictable shocks in cooperation with the humanitarian sector, and supports recovery and the return to regular programming.

While the policy does not have an explicit definition of social protection, it somehow conceptualises it as social support that helps the poor and vulnerable to meet their basic needs and overcome their exposure to risks (pg.1).

In addition to the Constitution of the Republic of Malawi, the MNSSP II is aligned to the National Resilience Strategy (2018–2023) and the National Agriculture Policy (2016). These two policy documents emphasise the importance of breaking the cycle of recurring shocks and disasters and recognise the crucial contribution that social support makes to building the resilience of individuals, households and communities (Republic of Malawi, 2018: 2)¹³.

8.2.2. Social assistance programmes

Programme	Description and focus	HIV sensitivity
Cash transfers		
The Malawi Social Cash Transfer (Mtukula Pakhomo)	<p>Unconditional cash transfer introduced in 2006 to address poverty and food insecurity while improving school enrolment and attendance, and the health and nutrition status of beneficiaries (ultra-poor, labour-constrained households with members who are elderly, chronically ill, orphaned and/or have disabilities). The benefit is a monthly cash transfer equivalent to 2US\$, 3US\$ and 4US\$ for households of size 1 to 4 or more, respectively. A bonus to incentivize school enrolment is provided to each primary-school age child (0.5US\$) and secondary-school age child (1US\$). As of September 2017, the programme was reaching over 777,000 beneficiaries in over 174,500 households across 18 districts of the country, including approximately 430,000 child members.</p> <p>The programme was expected to be operational in all 28 districts by 2018. It is administered by Ministry of Gender, Children, Disability and Social Welfare, GFATM; German government Irish Aid; the European Union; World Bank; UNICEF</p>	Increases households' access to income; improves food security and nutrition;
In-kind-transfers		
Not available		

¹³ [file:///C:/Users/u04837127/Downloads/MNSSP%20II_Final%20Draft%202018%20\(3\).pdf](file:///C:/Users/u04837127/Downloads/MNSSP%20II_Final%20Draft%202018%20(3).pdf)

Livelihoods promotion		
Improved Livelihoods Through Public Works	Public works; Cash for work programme started in 1996 to create temporary jobs as a means of income transfer and to build economic infrastructure. Beneficiaries are members of ultra-poor households and they receive a cash benefit of about US\$1.00 per day, paid as lump sum wage for 12 days paid within two weeks after completion of works. About 2.2 million households were reached over nine public works cycles averaging 434,000 beneficiary households per cycle or 15 per cent of all households nationwide in 2015. The programme is administered by the Government of Malawi and the World Bank.	Increases households' access to income
Social health protection		
Not available		

8.2.3. Social security programmes

Programme	Beneficiaries and benefits
Old age, Disability and Survivor benefits: <i>To compensate the loss of income resulting from old disability or survivorship</i> Administrative organisations: <ul style="list-style-type: none"> Reserve Bank of Malawi licenses pension management companies and provides financial supervision. Licensed pension management companies manage the mandatory individual accounts.	
Old-age pension	<ul style="list-style-type: none"> Age 50; at any age if permanently emigrating or with at least 20 years of contributions. Employment must cease. Early withdrawal: At any age if unemployed with no contributions in the last six months.
Disability benefit	<ul style="list-style-type: none"> Must be assessed with a total permanent incapacity for work. A medical doctor must certify the incapacity.
Survivor benefit	<ul style="list-style-type: none"> Paid to named survivors when the insured dies
Sickness and maternity benefits: <i>To deal with the risk of temporary incapacity</i> Administrative organisations: <ul style="list-style-type: none"> Ministry of Labour, Youth, Sports, and Manpower Development enforces the law. Employers provide benefits through private insurance companies. Ministry of Health oversees the public health system. 	
Employer-liability (cash sickness and maternity benefits) system. Cash benefits only	<ul style="list-style-type: none"> Employed persons. Exclusion: Military, police, and prison personnel
Cash sickness benefit	<ul style="list-style-type: none"> Must have 12 months of continuous employment with the same employer and provide a medical certificate from a registered medical practitioner.
Cash maternity benefit	<ul style="list-style-type: none"> There is no minimum qualifying period. The employee can claim the benefit once every three years.

Workers' Medical Benefits	<ul style="list-style-type: none"> No statutory benefits are provided. The public health system provides some free medical services in government health centers and hospitals, including immunizations and treatments for tuberculosis, malaria, HIV/AIDS, and sexually transmitted diseases
Work injury benefits: <i>Compensation for work-related injuries and occupational illness</i> Administrative organisations: <ul style="list-style-type: none"> Ministry of Labour, Youth, Sports, and Manpower Development enforces the law. Employers provide benefits through private insurance companies.	
Employer-liability system through a private carrier	<ul style="list-style-type: none"> Employed persons, including apprentices. Exclusions: Self-employed persons, casual workers, family labour, military personnel, and certain miners. Must be assessed with a work injury or occupational disease and be certified by a medical doctor to be unfit for work for at least seven days. Accidents that occur while commuting to and from work are covered if the employer provides the transportation. Consists of temporary and permanent disability cash benefits, worker's medical benefits, survivor benefits and funeral grant
Unemployment benefits: <i>Compensation for the loss of income resulting from involuntary unemployment</i> <i>Not specified</i>	
<p>The 2000 Employment Act and Employment Amendment Act 27 (2010) requires employers to provide severance pay for contract terminations because of redundancy, retrenchment, or economic conditions, and for unfair dismissals. The severance pay is two weeks of the employee's wages for each of the first five years of continuous service, plus three weeks of wages for each year of continuous service from the sixth year to the 10th year, plus four weeks of wages for each year of continuous service exceeding 10 years.</p>	
Family benefits: <i>To provide additional income for families with young children to meet at least part of the added cost of their support</i> <i>Not specified</i>	

Source: Social Security Programs Throughout the World: Africa, 2019. <https://www.ssa.gov/policy/docs/progdesc/ssptw/2018-2019/africa/ssptw19africa.pdf>

8.3. Summary

Pattern of social protection programmes

Malawi's commitment to the provision of social protection is implicitly outlined in Sections 30(1) and 30 (2) of the Constitution as well as in the country's long-term vision. It is clearly explicit in the National Social Protection Policy where the priority is on consumption support, resilient livelihoods, and shock-sensitive social protection. While none of these three legislative and policy instruments make mention of HIV and AIDS, the constitution and the policy pay particular attention to key populations such as 'women and children' and 'vulnerable households' respectively. All three instruments also aim to address some of the key HIV risk factors by improving, among others, food security and nutrition, access to education, health services, and employment opportunities, as well as reducing vulnerability to poverty. In line with this, the main cash transfer programme in Malawi are focused on addressing poverty and food insecurity while improving educational outcomes as well as health and nutritional status of beneficiaries, who include the chronically ill and OVCs (Mtukula Phakomo). The public works programme, on the other hand, aims to improve the financial capital of beneficiaries (members of ultra-poor households) through temporary employment opportunities. The above was also reflected in the country's HIV Sensitive Social Protection Assessment Report (Bagyendera & Malunga, 2021:vi) which stated that of the 17 functional social protection schemes and programmes in the country, two were "perfectly HIV-sensitive", three were partially HIV-sensitive while 12 were not explicitly HIV-sensitive. Bagyendera & Malunga concluded that overall, beyond existent health schemes, the majority of the existing social protection policies, programmes and schemes in the country are not HIV-sensitive.

Although there is no specific social health protection programme in Malawi, available evidence shows that Malawi has 750 health-care facilities, in both the private and public sector that provide HIV-testing and treatment throughout the country. However, Palk et al (2020) found that distance to health care facilities and poor access to transportation are among the major barriers to HIV services and the achievement of the three 90s targets. They argue:

We have found that ... because of the spatial pattern of the epidemic, and the geographical dispersal of health-care facilities in rural areas, many individuals in Malawi are travelling long distances to access HIV treatment. By analysing the distances in the context of the difficulty of traversing the landscape, we have found that many individuals with HIV are spending a long time travelling to receive treatment. ... Importantly, we have found that the need to travel long distances to health-care facilities, and the limited availability of motorised transportation in rural areas, are major barriers to Malawi reaching UNAIDS' 2030 target of 90% coverage (Palk et al, 2020: e1561)

Key stakeholders

The Ministry Gender, Children, Disability and Social Welfare is the lead government department responsible for social protection in Malawi and it has the mission to "promote social economic empowerment and protection of women and children using community and welfare approaches". The Ministry administers the *Mtukula Pakhomo* cash transfer programme. The Ministry of Transport and Public Works, on the other hand, oversees the implementation of the Improved Livelihoods through Public Works programme. The Ministry of Finance, Economic Planning and Development has a division dealing specifically the poverty reduction and social protection in Malawi.

The two government ministries that administer social protection programmes receive technical and financial support from various United Nations agencies such as UNICEF and WFP as well as bilateral multilateral partners and donors that include the German government, and Irish Aid, European Union, GFATM, the World Bank, Save the Children, OXFAM, World Vision, and HelpAge International. Along with the Reserve Bank of Malawi, the Ministries of Health and of Labour, Youth Sports and Manpower Development are the key actors in the country's social security system.

A 2015 desk study by the Council for NGOs in Malawi (CONGOMA, 2015) found among other things that (i) there is inadequate understanding among civil society officials of how social policies can be an investment tool for economic growth alongside furthering human rights (pg. 12) and (ii) most civil society stakeholders in Malawi are of the view that the social protection agenda is being pushed and supported by international development agencies. To this end, the stakeholders were of the view that social protection might end up being supply-driven which may not be sustainable beyond the support period (pg. 5). This may largely explain why this project found little evidence of CSOs actively engaged in the social protection arena in the country. Among the few identified were the Chinansi Foundation which works in the areas of HIV/AIDS, sustainable environmental management, food security, education and health; the Outreach Scout Foundation¹⁴, and Christian Aid.

It emerged, however that there were a number of CSOs that work in the area of HIV and AIDS and, through their work, advocate for the rights of some key populations and/or for interventions to address some of the key HIV risk factors. The Coalition of Women Living with HIV and AIDS (COWLHA), for example, aims to create a united voice of women and girls living with HIV and AIDS in addressing the challenges affecting them¹⁵. The mandate of the National Association for People Living with HIV and AIDS in Malawi (NAPHAM), on the other hand, is to fight against HIV-related stigma and discrimination, advocate for supportive environments for PLHIV, and facilitate localised support groups for those who are infected and directly affected by HIV and AIDS¹⁶. By the same token, the Umunthu Foundation is a human rights and HIV NGO operating in the Blantyre region of Malawi where it empowers communities to educate and protect themselves against HIV infection, know their HIV status, and access the counselling and testing support they may need¹⁷.

It also emerged that in the absence of a specific social health protection programme in Malawi, a national NGO, the Christian Health Association of Malawi (CHAM), has been an active actor in this regard. Comprising of a network of church-owned health facilities, hospitals and training colleges facilities primarily in rural and hard-to-reach areas, CHAM is the largest non-governmental healthcare provider in the country and provides 37% of the country's healthcare services and trains up to 80% of Malawi's healthcare providers. Due to its strength as a network and status as a non-governmental entity, CHAM is able to provide lower-cost health services, promote diverse and specialty healthcare services, and quickly disseminate best practices and innovations.¹⁸

Advancement of the AIDS response

To advance the AIDS response in Malawi, the effective implementation of Fast Track pillars 1 and 3 is imperative. In essence, there is need to consider combination social protection programmes targeted specifically at young people and women – who are among the country's key populations. The development of a social health protection programme in the country will also ensure that PLHIV, as well as those at risk of or affected by HIV have access to essential health services by complementing the services provided by CHAM.

14 <https://outreachscoutfoundation.webs.com/>

15 <http://cowlha.org/>

16 <https://www.justassociates.org/en/ally/national-association-people-living-hiv-and-aids-malawi-napham#:~:text=A%20membership%20organisa-tion%20active%20in,affected%20by%20HIV%20and%20AIDS.>

17 <https://tackleafafrica.org/about-us/african-partners/umunthu-foundation/>

18 <https://www.devex.com/organizations/christian-health-association-of-malawi-cham-42898>

9. Country overview:

MOZAMBIQUE

9.1. Brief HIV situational analysis

With an HIV prevalence of 11.5% among those aged 15-49 years in 2019 (UNAIDS, 2021), Mozambique is one of the countries hard-hit by the HIV and AIDS epidemic. UNAIDS data further shows that 2.1 million people were living with HIV in 2020 and there were 198 000 new HIV infections and 18 000 AIDS-related deaths in the country in the same year. As Appendix B shows, the country still has a long way to go in reaching the 90-90-90 targets: only 81% of people living with HIV know their HIV status and 68% of those living with HIV who know their status and are on treatment and 50% of those on treatment have suppressed viral loads. This is all despite legislative strides that the country has made in the fight against HIV. Like in many countries of the region, HIV-related stigma is also major barrier to the national response. In 2011, for example, 28.0% of women and men aged 15-49 years reported discriminatory attitudes towards people living with HIV. In 2015 this was still high at 20.7% (UNAIDS, 2019). Key populations in the country include female sex workers, MSM, incarcerated individuals, and PWID (Pathfinder International, 2019).

9.2. Social protection mechanisms

9.2.1. National social protection legislative and policy context

Constitutional and legal provisions

Chapter III (Social Organisation) of the Constitution of the Republic of Mozambique outlines several provisions safeguarding the rights to a number of social-protection-related areas. These include the right to work (Article 84), education (Article 88) and health (Article 89). The chapter further affirms these rights particularly for often-vulnerable population groups such as children, youth, the elderly, the disabled, and women.

National long-term vision

Mozambique' *Agenda 2025* is defined as "the spotlight for illuminating Mozambique in its path towards an effective national reconciliation, strengthening the country's unity and cohesion, to ensure prosperity for all Mozambicans"¹⁹ It aims to achieve this ideal through the implementation of four strategic options, all of which have relevance to social protection (pg. 121):

- i. **Human capital** - entailing comprehensive education of all Mozambicans;
- ii. **Health** - with a focus on improving the basic living standards, an efficient and effective National Health service, expansion of the health infrastructure network, fighting against major endemic diseases (HIV/AIDS, tuberculosis and malaria);
- iii. **Education** - with a focus on the expansion of basic education, on strengthening secondary education, and on community participation in educational processes; and
- iv. **Social capital** - strategic actions include promotion of access and ownership of land by communities and households, and promotion of pro-active policies for the effective participation of women and youth in efforts to make the country grow.

¹⁹ <https://www.cartercenter.org/documents/nondatabase/Agenda%202025%20Final%20Integral%20English.pdf>, pg. 117

National social protection policy

The *National Strategy for Basic Social Security (2016-2024)* has a mission to “build a basic social security system, harmonising the efforts of governmental and non-governmental actors in planning and implementing actions in support of poor and vulnerable individuals or groups of individuals and to contribute to the human and social development of the country” (pg. 15). It has four core objectives:

- i. To boost the level of consumption and the resilience of the poor and vulnerable strata of the population;
- ii. To contribute to the development of human capital through improving nutrition and access to basic health and education services for the poor and vulnerable strata of the population;
- iii. To prevent and respond to risks of violence, abuse exploitation, discrimination and social exclusion through social welfare services; and
- iv. To develop the institutional capacity to implement and coordinate the basic social security sub-systems.

9.2.2. Social assistance programmes

Programme	Description and focus	HIV sensitivity
Cash transfers		
Programa Subsídio Social Básico—Basic Social Subsidy Programme	Unconditional cash transfer introduced in 1990 to (i) provide basic assistance to extremely poor people who are incapable of working; (ii) promote the development of human capital, and (iii) improve access to basic social services for beneficiary households. Beneficiaries are labour-constrained and extremely poor households and they receive a monthly cash benefit of USD6.90, up to a maximum of USD13.50 per month for a household with four dependents. The programme currently covers about 17% of the potential beneficiaries and is administered by the National Social Action Institute under the Ministry of Gender, Children and Social Action	Increases households' access to income
In-kind-transfers		
Food allowance (Apoio Social Directo)	A means-tested in-kind (food) transfer meant to cover the cost of the basic food basket for households with members receiving antiretroviral treatment for HIV/AIDS, with children recovering from acute malnutrition, and with no members with work capacity, including households headed by elderly persons, children aged 12 to 18, or disabled or chronically ill persons. It is paid in kind over a fixed period of time. The average monthly cost of the basic food basket is US\$20. The programme is administered by the Ministry of Gender, Child, and Social Action and the National Social Action Institute.	Improve food security and nutrition for PLHIV including those on antiretroviral treatment
Livelihoods promotion		
Programa De Acção Social Produtiva (PASP). (Labour-Intensive Public Work)	Public works - cash for work programme started in 2012 to enhance individuals' access to income-generating activities for vulnerable households. The beneficiaries are vulnerable households with at least one able-bodied member of working age and the benefit is a monthly cash allowance of USD25. The programme is administered by the Government of Mozambique and the World Bank.	Increases households' access to income
Social health protection		
<i>Not available</i>		

9.2.3. Social Security programmes

Programme	Beneficiaries and benefits
Old age, Disability and Survivor benefits: <i>To compensate the loss of income resulting from old disability or survivorship</i>	
Administrative organisations: <ul style="list-style-type: none"> Ministry of Labour, Employment, and Social Security provides general supervision of the social insurance program. National Social Security Institute administers the social insurance program and collects contributions. Ministry of Gender, Child, and Social Action provides general supervision of the social assistance program. National Social Action Institute administers the social assistance program 	
Old-age social pension (Subsídio Social Básico, social assistance, means tested)	Age 60 (men) or age 55 (women) and living in a household having no members with work capacity.
Disability pension (Pensão por Invalidez, social insurance)	<ul style="list-style-type: none"> Must be younger than the normal retirement age, be assessed as mentally or physically unable to work, and have at least 30 months of paid or credited contributions in the five years before the disability began. Contributions may be credited for periods the insured received sickness, maternity, work injury, or unemployment benefits, and for military service. The disability pension ceases at the normal retirement age and may be replaced by an old-age pension.
Disability social pension (Subsídio Social Básico, social assistance, means tested)	<ul style="list-style-type: none"> Must be younger than the normal retirement age, assessed with a permanent disability or a chronic disease, and living in a household having no members with work capacity. The beneficiary and his or her family members must not be receiving any other pension and must meet certain residency requirements.
Survivor pension (Pensão de Sobrevivência, social insurance)	<ul style="list-style-type: none"> The deceased received or was entitled to receive a full or partial social insurance old-age pension or a disability pension at the time of death, or had at least five years of contributions. Eligible survivors include a dependent widow(er), and orphans younger than age 18 (age 22 if a student in a technical school; age 26 if a university student; no limit if disabled).
Death grant (Subsídio por Morte, social insurance)	<ul style="list-style-type: none"> The deceased received a social insurance old-age or disability pension, or had at least three years of coverage and at least six months of contributions in the 12 months immediately before death. Eligible survivors include a widow(er), an orphan, or other descendant of the deceased.
Funeral allowance (Subsídio de Funeral, social insurance)	<ul style="list-style-type: none"> Paid to a widow(er), a parent, an orphan, or other descendant of a deceased person with at least three months of contributions before death.
Sickness and maternity benefits: <i>To deal with the risk of temporary incapacity</i>	
Administrative organisations: <ul style="list-style-type: none"> Ministry of Labour, Employment, and Social Security provides general supervision of the social insurance program. National Social Security Institute administers the social insurance program and collects contributions. Ministry of Gender, Child, and Social Action and Ministry of Health provide general supervision of the universal and social assistance programs. National Social Action Institute administers the universal and social assistance programs. 	

Social insurance	<ul style="list-style-type: none"> • Employed persons, including apprentices, part-time workers, and seasonal workers; self-employed persons; and public-sector employees not covered by a special system. • Voluntary coverage for unemployed persons with at least 12 months of previous contributions. • Special systems for certain public-sector employees and military personnel
Cash sickness benefit (Subsídio por Doença, social insurance)	<ul style="list-style-type: none"> • Must have at least three months of contributions in the 12 months before the incapacity began. • The cash sickness benefit is also paid to an insured parent caring for a hospitalized child or a child in need of special care.
Cash maternity benefit (Subsídio por Maternidade, social insurance)	<ul style="list-style-type: none"> • Must have at least 12 months of contributions in the 18 months immediately before the expected date of childbirth.
Medical benefits (universal)	<ul style="list-style-type: none"> • Provided for children aged 5 or younger, pregnant women, persons aged 60 or older, and persons with disabilities

Work injury benefits: *Compensation for work-related injuries and occupational illness*

Administrative organisations:

- Ministry of Public Function provides general supervision.

Employers insure work injury liability through private carriers.

Employer-liability system through private carriers	<ul style="list-style-type: none"> • Resident salaried employees in the private and public sector. • Voluntary coverage for certain self-employed persons. • Special systems for certain civil servants and military personnel. • Consists of temporary and permanent disability cash benefits, survivor benefits and funeral grant
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Unemployment benefits: *Compensation for the loss of income resulting from involuntary unemployment*

Not specified

Family benefits: <i>To provide additional income for families with young children to meet at least part of the added cost of their support</i>
<i>Not specified</i>

Source: Social Security Programs Throughout the World: Africa, 2019. <https://www.ssa.gov/policy/docs/progdesc/ssptw/2018-2019/africa/ssptw19africa.pdf>

9.3. Summary

Pattern of social protection programmes

The rights to social protection services, specifically education, health and employment opportunities are implicitly provided for in the Constitution of Mozambique as well as in the country's national long-term vision. While the Constitution does not make any reference to HIV and AIDS, it does identify women – one of the country's key populations – among the vulnerable population groups that it targets. The national long-term vision, on the other hand, mentions HIV and AIDS among the major diseases it needs to address to achieve its objective of improving basic living standards. The national social protection policy aims to address risks of discrimination, which remain a major barrier to the country's HIV response as well as other HIV risk factors such as violence and malnutrition. The country's legislative and policy framework can therefore be described as HIV-sensitive.

The country's main social protection system comprises of one cash transfer programme, an in-kind food transfer programme, and a livelihood promotion programme. Under the Basic Social Subsidy Programme, for example, HIV is not specifically mentioned as a pre-condition to receive social benefits. However, there is a criterion that states “households with people living with chronic diseases” (presumably including those with HIV and AIDS) are included. Moreover, under the new, yet-to-be published HIV National Strategic plan, it is mentioned that PLHIV should benefit from social protection programmes in the country. The absence of a social health protection programme is however a major gap in the country's social protection system given wide evidence affirming that the “public healthcare system in Mozambique is basic and limited” with a persistently low coverage due to, among other things, frequent staff and supply shortages.²⁰ For example, in 2014 the workforce/population ratio was reportedly among the five worst in the world and the health facility/per capita ratio being only 1 per 16,795 (Pfeiffer & Chapman, 2019). The gap is of particular concern given that the commitment to provide holistic health care services to all Mozambicans is highlighted in all instruments relevant to the country's social protection legislative and policy framework.

Key stakeholders

Existing social transfer programmes in the country are administered by the Ministry of Gender, Children and Social Action; the food allowance programme is also partly overseen by the National Social Action Institute. The country's public works programme is administered by the *Ministry of Public Works*, Housing and Water Resources. Government administrative organisations for the social security system include the Ministry of Labour, Employment and Social security, the Ministry of Gender, Children and Social Action, the Ministry of Public Function, the National Social Security Institute, and the National Social Action Institute. The latter is particularly responsible for implementing the Basic Social Subsidy Programme and the Direct Social Support Programme, among others. In the non-governmental arena United Nations agencies such as the WFP, UNAIDS, UNICEF and ILO are key actors, while local and international NGOs include Pathfinder; CUAMM (which implements a programme to strengthen the healthcare system, in order to improve mother and child health)²¹; North Star Alliance (which provides HIV testing, and ART referrals for some of the country's key population such as sex workers, young people and truck drivers); and Comusanas which provides community support in the areas of community health and sustainable development.²² There are also a number of CSOs providing care and support for PLHIV in Mozambique.

Advancement of the AIDS response

The development of a social health protection programme in Mozambique will ensure that PLHIV, as well as those at risk of or affected by HIV have access to essential health services. Fast Track Pillar 4 (strengthening the active and meaningful engagement of civil society in representing PLHIV as well as those at risk of or affected by HIV) is another pathway that will make a notable advance the country's HIV response. Among other things, the latter can help address the high levels of HIV-related stigma and discrimination in the country.

20 <https://www.allianzcare.com/en/support/health-and-wellness/national-healthcare-systems/healthcare-in-mozambique.html#:~:text=The%20public%20healthcare%20system%20in,South%20Africa%20for%20elective%20procedures>

21 <https://www.mediciconlafrica.org/en/what-we-do/in-africa/our-work-in-mozambique/>

22 <http://comusanas.org/en/our-services/>

10. Country overview:

NAMIBIA

10.1. Brief HIV situational analysis

In 2020, Namibia's adult HIV prevalence was reported to be 11.6% (UNAIDS, 2021). UNAIDS data also shows that there were 210 000 people living with HIV, 5 500 new HIV infections, and 3 000 AIDS-related deaths in the country in that year (UNAIDS, 2021). Appendix B shows that 90% of people living with HIV knew their status and 88% of those with HIV who know their status were on treatment while 79% of those on treatment had suppressed viral loads in 2020. HIV-related stigma remains a major factor underlying this limited progress. In 2013, for example, 13% of women and men aged 15–49 years reported discriminatory attitudes towards people living with HIV (UNAIDS, 2019). Key populations in Namibia include MSM, sex workers and their clients who are often mobile and migrant populations of various types; prisoners, and PWID (Republic of Namibia, 2015).

10.2. Social protection mechanisms

10.2.1. National social protection legislative and policy context

Constitutional and legal provisions

The Constitution of the Republic of Namibia (1990) does not make any specific reference to social protection. However certain articles make provisions for a number of social protection rights. These include Article 15 (children's rights) and Article 20 (education).

National long-term vision

Adopted in 2004, Namibia's *Vision 2030* spells out development programmes and strategies that will lead to a "prosperous and industrialised Namibia, developed by her human resources, enjoying peace, harmony and political stability" by the year 2030. Among the broad strategies to achieve this vision are: achieving full and gainful employment; providing excellent, affordable health care for all; mainstreaming HIV/AIDS into develop policies, plans, and programmes; creating access to abundant, hygienic and healthy food; and providing full and appropriate education at all levels²³

National social protection policy

As of September 2019, Namibia was still in the process of drafting of a national social protection policy which is expected to provide a background to social protection in the country. Among other things, the new policy envisages to widen social grants in the country by including a maternity grant (a once-off payment for every woman giving birth), a universal child grant for every child from birth until the age of 17, as well as a Basic Income Grant for the unemployed aged between 30 and 59 years.²⁴

²³ file:///C:/Users/u04837127/Desktop/Vision_2030_Chapter_3.pdf

²⁴ <https://neweralive.na/posts/namibias-new-social-protection-policy-a-chance-to-close-the-gaps>

10.2.2. Social assistance programmes

Programme	Description and focus	HIV sensitivity
Cash transfers		
Child Maintenance Grant	Conditional cash transfer aimed at children enrolled in pre-primary and primary schools in selected regions. The recipient must earn less than NAD1,000 (US\$65) per month, be the biological parent of a child younger than 18, and have a spouse who is: receiving a disability or old-age grant; has passed away; is serving a jail sentence of at least three months; or is certified as unfit for labour-market activity. School attendance is required of children over 7 years. The benefit is a monthly cash benefit of US\$15 for the first child plus US\$5 for each additional child, up to six children per household. The programme covers 117,663 people and is administered by the Ministry of Gender Equality and Child Welfare	Supports families' child care roles
Foster care grant	Conditional cash transfer targeting citizens and permanent residents who are caregivers of children placed in their custody. School attendance is required of children over 7 years of age. The monthly amount of the benefit is US\$15 for the first child plus US\$5 (without limits to the number of children). The grant lasts for the duration of the foster care period. The programme is implemented nationally and is administered by the Ministry of Gender Equality and Child Welfare	Supports families' child care roles
Vulnerable child grant	Means-tested cash transfer targeting low-income households with children younger than age 16 but with one or both living parents. Monthly household income must not exceed US\$70.00. A monthly cash benefit of US\$30 is paid for each eligible child. The programme is meant to have a national coverage but still disproportionately accessed by caregivers in urban and peri-urban areas. It is administered by the Ministry of Gender Equality and Child Welfare.	Supports families' child care roles
Disability Grant	Unconditional cash transfer introduced in 1995 to prevent poverty among people with disabilities. Beneficiaries are citizens and permanent residents aged 16–59 years who are declared disabled by a State Medical Officer; and people who are blind or who are living with AIDS. They receive a monthly cash benefit of US\$40. Coverage is nationwide and the administrator is the Ministry of Labour and Social Welfare.	Provides PLHIV with cash transfers
Old Age Pension	Unconditional cash transfer started in 1949 (and extended to all in 1992) to prevent poverty among people with disabilities. Beneficiaries are citizens of Namibia; 60 years old or older; and not resident outside Namibia for more than six months. They receive a monthly cash benefit of US\$40. The programme is implemented nationwide and it had 150 000 beneficiaries in 2010. It is administered by the Ministry of Health and Social Services.	Supports families' child care roles

In-kind-transfers		
School Feeding Programme	Conditional in-kind transfer introduced in 1995 to increase school attendance and retention rates as well as provide assistance to food-insecure students. The target is children enrolled in pre-primary and primary schools in the selected regions. They are given a daily mid-morning meal consisting of fortified maize meal. The programme has 320 000 beneficiaries and is administered by the Ministry of Education.	Improves food security and nutrition for children
Livelihoods promotion		
Not available		
Social health protection		
Not available		

10.2.3. Social Security programmes

Programme	Beneficiaries and benefits
Old age, Disability and Survivor benefits: <i>To compensate the loss of income resulting from old disability or survivorship</i> Administrative organisations: <ul style="list-style-type: none"> Ministry of Labour, Industrial Relations, and Employment Creation provides general supervision. Social Security Commission administers the social insurance program and collects contributions. Ministry of Poverty Eradication and Social Welfare administers the universal and social assistance programs. 	
Old-age pension (Old-age Grant, universal)	<ul style="list-style-type: none"> Age 60. N\$1,250 a month is paid.
Old-age benefit (social insurance)	<ul style="list-style-type: none"> Age 60 with at least six months of contributions. Employment must cease. A lump sum of N\$8,475 is paid.
Veterans' pension (Veterans' Subvention, social assistance, income tested)	<ul style="list-style-type: none"> Age 55 and a veteran of the Namibian War of Independence. Income test: Income from work and other sources must not exceed a certain limit. N\$2,200 a month is paid.
Disability pension (Disability Grant, universal)	<ul style="list-style-type: none"> Must be aged 16 or older and assessed with a temporary or permanent disability or diagnosed with AIDS by a doctor in the public healthcare system. A medical practitioner assesses the disability. The disability pension cannot be combined with the old-age pension. N\$1,250 a month is paid.
Disability benefit (social insurance)	<ul style="list-style-type: none"> Must be assessed with a permanent disability and have at least six months of contributions. A medical practitioner assesses the disability.

Survivor benefit (social insurance)	<ul style="list-style-type: none"> • The deceased had at least six months of contributions. • Eligible survivors include a widow(er), the deceased's children, and persons who were financially dependent on the deceased. • A lump sum of N\$8,475 is paid. • A lump sum of N\$8,475 is paid to the widow(er). If there is no widow(er), the benefit is split equally among other eligible survivors.
Funeral benefit (universal)	<ul style="list-style-type: none"> • The deceased received or was entitled to receive a universal old-age or disability pension at the time of death • The cost of the funeral, up to N\$3,200, is paid.
Sickness and maternity benefits: <i>To deal with the risk of temporary incapacity</i>	
Administrative organisations: <ul style="list-style-type: none"> • Ministry of Labour, Industrial Relations, and Employment Creation provides general supervision. • Social Security Commission administers social insurance cash sickness and maternity benefits, and pays benefits through the Maternity, Sickness, and Disability Fund 	
Social insurance	<ul style="list-style-type: none"> • Employed persons working at least one day a week on a regular basis, including public-sector employees who are not civil servants, household workers, or casual workers. • Voluntary coverage for self-employed persons. • Special system for civil servants
Employer liability	<ul style="list-style-type: none"> • Employed persons. • Exclusions: Self-employed persons. • Special systems for military, police, and correctional personnel.
Cash sickness and maternity benefits (social insurance)	<ul style="list-style-type: none"> • Must have at least six months of contributions.
Cash sickness benefit (employer liability)	<ul style="list-style-type: none"> • Must be currently employed and provide a medical certificate
Cash maternity benefit (employer liability)	<ul style="list-style-type: none"> • Must have at least six months of continuous employment and provide a medical certificate.
Compassionate benefit (employer liability)	<ul style="list-style-type: none"> • Must have at least 12 months of continuous employment. Paid for the death or serious illness of a child, spouse, parent, grandparent, brother, sister, father-in-law, or mother-in-law
Work injury benefits: <i>Compensation for work-related injuries and occupational illness</i>	
Administrative organisations: <ul style="list-style-type: none"> • Ministry of Labour, Industrial Relations, and Employment Creation provides general supervision. • Social Security Commission administers the Employees' Compensation Fund and collects contributions. 	
Social insurance system	<ul style="list-style-type: none"> • Employed persons, including apprentices, with earnings up to N\$81,300 a year. • Exclusions: Self-employed persons, casual workers, and persons employed temporarily outside of Namibia for more than 12 consecutive months. • Must be assessed with a work injury or occupational disease that lasts for at least three days; Special systems for civil servants. • Consists of temporary and permanent disability cash benefits, worker's medical benefits, survivor pension and funeral grant and death benefit

Unemployment benefits: *Compensation for the loss of income resulting from involuntary unemployment**Not specified*

The Labour Act 2007 requires employers to provide severance pay to employees with at least 12 months of continuous employment. Severance pay is provided in the case of unfair dismissal, if the contract is terminated because the employer dies or becomes insolvent, if the employee dies while working, or if the employee terminates the contract because of a physical incapacity. A lump sum of at least one week of the employee's last earnings for every year of continuous employment is paid.

Family benefits: *To provide additional income for families with young children to meet at least part of the added cost of their support**Not specified***Child disability grant (universal)**

- Paid for a child younger than age 16 with a disability. Must provide a social background report from a social worker and a medical certificate issued by a state medical doctor.
- The child disability grant ceases when the child reaches age 16 and is replaced by the disability grant (see Old Age, Disability, and Survivors).
- N\$250 a month is paid for each eligible child.

Source: Social Security Programs Throughout the World: Africa, 2019. <https://www.ssa.gov/policy/docs/progdesc/ssptw/2018-2019/africa/ssptw19africa.pdf>

Note: N\$1.00 = US\$ 0,069

10.3. Summary

Pattern of social protection programmes

Namibia has an enabling legislative and policy framework for the provision of social protection as reflected in the country's Constitution, national long-term vision and planned national social protection policy. However, only the national long-term vision has a specific aim to mainstream HIV and AIDS into development policies, plans and programmes. It is perhaps largely as a result of this that none of the country's main social protection programmes – which comprises of only two types: cash transfers and in-kind food transfers – are targeted at PHLIV. The only exception in this regard is the Disability Grant as its beneficiaries include citizens and permanent residents aged 16-59 years, including those living with HIV. Apart from the Old Age Pension, all the other social transfer programmes are aimed at children. The programmes therefore do not directly cover the country's key populations or the main HIV risk factors.

Healthcare in Namibia is provided through a four-tiered health system, consisting of primary health care sites, district hospitals, intermediate hospitals and a referral hospital. To this end, access is relatively good with 76% of the population living within a 10 kilometres radius of a healthcare facility and the country's total health expenditure as a percentage of GDP is reportedly the highest in Africa, along with South Africa (Christians, 2020). Despite this, as Christians posits, disparities in health access and outcomes are evident across income groups, races and geographic locations with only 18% of the population is covered by medical aid funds. "The remaining 82% of the population are covered by the public health system or out-of-pocket ... expenditure in the private sector" where there is often shortage of requisite workforce and specialised services to address the current health care challenges and priorities (Christians, 2020:2). The absence of a specific health protection programme in the country's social protection system is thus a notable gap. To this end, it is encouraging to note that as of 2019, discussions were continuing around the planned Universal Health Coverage which intends, among other things, to integrate the country's HIV/AIDS response into the broader health response and into the standard package of primary healthcare services as opposed to being treated as a standalone response.²⁵

Key stakeholders

In terms of key stakeholders, the Ministry of Gender Equality, Poverty Eradication and Social Welfare is the lead government department responsible for the provision of social protection in Namibia and it administers all programmes except the Old Age Pension and the School Feeding Programme. The latter are administered by the Ministry of Health and Social Services and the Ministry of Education respectively. In the social security arena, the main actors are also government entities: Ministry of Gender Equality, Poverty Eradication and Social Welfare; the Ministry of Labour, Industrial Relations and Employment Creations, and the Social Security Commission.

As an upper-middle income country, Namibia has limited and decreasing donor support to national programmes (Christians, 2020). To this end, this project did not identify any development partners actively involved in the area of HIV-sensitive social protection programming except for support provided by sector specific United Nations agencies such as the WFP, UNICEF and UNAIDS²⁶. All in all, rather than social protection, most CSOs play various roles in the HIV response. Even then, these organisations, "often have few staff, limited resources, and are not formally recognized by the Namibian government, which makes it harder for them to advocate for resources" (Walsh, 2011:1).

Advancement of the AIDS response

The overall social protection landscape in Namibia suggests that there is need to the effective implementation of all the four Fast Track pillars. For example, there is need for combination social protection programmes to be developed and targeted mobile and migrant populations (pillar 1). There is also need for livelihood promotion programmes that can ensure that can create employment as an effective HIV prevention strategy (pillar 2). The development of a social health protection programme, on the other hand, will ensure that PLHIV, as well as those at risk of or affected by HIV have access to essential health services (Pillar 3) while the active and meaningful engagement of civil society in HIV-sensitive social protection (pillar 4) is important in addressing issues of HIV-related stigma and discrimination.

25 https://acs.r4d.org/wp-content/uploads/2020/04/Where-We-Work_Namibia_Resource-2.pdf

26 https://assessment-action.net/wp-content/uploads/2014/03/Example-Presenting-landscape-of-stakeholders_Namibia.pdf

11. Country overview:

SOUTH AFRICA

11.1. Brief HIV situational analysis

With an adult HIV prevalence of 19.1% and 7.8 million people living with the virus in 2020, South Africa has the largest and most high-profile HIV epidemic on the world (UNAIDS, 2021). Data from 2020 further shows that there were 230 000 new HIV infections, and 83 000 AIDS-related deaths in the country (UNAIDS, 2021). Sex workers, transgender women, PWID, children and orphans, adult women and adolescent girls have been identified as been particularly at high risk of HIV infections. Factors that increase HIV risk in the country include high levels of violence, poverty, low educational levels, criminalisation of sex workers, injecting drug use, substance and alcohol abuse.²⁷ Of the 90-90-90 targets, South Africa has only achieved one: 92% of people living with HIV know their HIV status. With the other two, only 72% of people living with HIV and know their status and are on treatment, while 61% of those with HIV on treatment have suppressed viral loads.

11.2. Social protection mechanisms

11.2.1. National social protection legislative and policy context

Constitutional and legal provisions

The Constitution of The Republic of South Africa (1994) through Article 27(1c) of the Bill of Rights (Chapter 2) provides for the country's citizens' rights to "social security, including, if they are unable to support themselves and their dependants, appropriate social assistance". It also provides for access to healthcare, food, water. Other social protection-related provisions in the Constitution relate

to freedom and security (Article 12), housing (Article 26), children (Article 28) and education (Article 29). To this end, South Africans can be said to have constitutional rights to social protection. On the legal front, the Social Assistance Act of 2004 provides the legislative framework for providing social assistance through the social grants system.

National long-term vision

The country's commitment to social protection provision is explicitly outlined in its long-term vision, the *National Development Plan 2030* which highlights plans to significantly eliminate income poverty and reduce inequality in the country by 2030. Among the stated pathways to achieve this is to 'Entrench a social security system covering all working people, with social protection for the poor and other groups in need, such as children and people with disabilities'. Other stated pathways are to "Provide affordable access to quality health care while promoting health and wellbeing" as well as to increase the quality of education and to ensure household food and nutrition security (National Planning Commission, 2012:24).

²⁷ <https://www.avert.org/professionals/hiv-around-world/sub-saharan-africa/south-africa>

National social protection policy

South Africa does not have an explicit social protection policy. Instead, social protection policy-making and coordination is the mandate of the social development sector of the government's Outcomes Framework. Outcome 13 of this framework calls for an "inclusive and responsive social protection system" (RSA Government, MTSF, 2014–2019). To execute its mandate, the country's social development sectors draws on a number of laws and policies including:

- The 1997 White Paper for Social Welfare, which sets out the broad principles for a developmental social welfare system in South Africa;
- The Children's Act (2005), which sets out the principles relating to the care and protection of children;
- The Prevention of and Treatment for Substance Abuse Act (2008) (Act No. 70 of 2008), which provides for a comprehensive response for the combating of substance abuse and for mechanisms aimed at demand and harm reduction in relation to substance abuse through prevention, early intervention, treatment and reintegration programmes.

11.2.2. Social assistance programmes

Programme	Description and focus	HIV sensitivity
Cash transfers		
Old age grant	A conditional, means tested monthly cash paid to citizens, permanent residents, and refugees aged 60 years or older with no other means of financial income. This grant is meant to help older residents cope financially during their old age.	Supports families' child care roles
Child Support Grant	Unconditional cash transfer introduced in 1998 to reduce poverty and promote investments in the physical, social and human capital of poor children. Beneficiaries are poor children under 18 years of age. Their caregivers receive a monthly cash benefit. The programme is administered by the South Africa Social Security Agency nationally.	Supports families' child care roles
Care Dependency grant	A conditional monthly cash transfer paid to the parent, guardian, foster parent or custodian of a child younger than 18 years, who needs full-time care because of mental or physical disability. The child must need and have permanent home care.	Supports families' child care roles
Foster Care Grant	Unconditional monthly cash transfer paid per court order to an appointed foster parent. The grant is payable until the child reaches the age of 18.	Supports families' child care roles
Disability Grant	Unconditional cash transfer introduced in 2004 to assist South African citizens with disabilities who cannot support themselves. The beneficiaries -- South African citizens, permanent residents or refugees aged 18–59, who are considered disabled – receive a monthly cash transfer. The programme is administered by the South Africa Social Security Agency nationally	Provides people with disabilities including PLHIV with a cash transfer

Social relief of distress	A means-tested social assistance programmes that offers temporary assistance to certain vulnerable individuals or households. Consists of cash or in-kind benefits paid monthly for up to three months; may be extended for three months. The target is people in desperate need. The grant helps those who are unable to provide for their families', most basic needs. The programme is administered by the South African Social Security Agency and the National Department of Social Development. Coverage in nationwide.	Increase households' access to income in emergency situations
In-kind-transfers		
National School Nutrition Programme	Aim is to enhance the learning capacities of students by providing them a healthy meal. The food is provided as a daily cooked meal (of around 15 per cent of the Recommended Dietary Allowance) consisting of a protein, starch and vegetable with a fruit one day per week. Menus vary from province to province according to cultural variation, and serving portions are larger for older students. Schools with access to a food garden may supplement the meals with their own produce. The programme targets the country's most poorly resourced public schools in poor communities are selected jointly with schools for students with disabilities. It covers about 8 million students in primary and secondary schools and is administered by the Department of Health and the Department of Basic Education.	Improves food security and nutrition for children
Livelihoods promotion		
Expanded Public Works Programme	Started in 2004 to provide labour and income to poor households in the short to medium-term, using public expenditure on goods and services to create temporary work opportunities for the unemployed. The programme targets working-age group who are unemployed or underemployed and live close to the area where the public works project is taking place. They earn the minimum EPWP wage rate (which is adjusted annually) which was about US\$5.00 per day or per task in 2014. The programme is administered by the Department of Public Works and is implemented nationally. Its Phase III aims to create 6 million work opportunities across the country.	Increase households' access to income
Social health protection		
<i>Currently being piloted</i>		

11.2.3. Social security programmes

Programme	Beneficiaries and benefits
Old age, Disability and Survivor benefits: <i>To compensate the loss of income resulting from old disability or survivorship</i>	
Administrative organisations: <ul style="list-style-type: none"> • Department of Labour provides general supervision of the social insurance program. • Unemployment Insurance Fund administers the social insurance program and collects contributions jointly with the Commissioner of the South African Revenue Services. • The Department of Social Development provides general supervision of the social assistance program. • South African Social Security Agency administers the social assistance program. 	
Old-age pension (Older Person's Grant, social assistance, means tested)	<ul style="list-style-type: none"> • Age 60 and not receiving any other social assistance benefit. • Means test: Annual income must be below 78,600 rand (for a single person) or 157,200 rand (for a couple), and assets must not exceed 1,122,000 rand (for a single person) or 2,244,000 rand (for a couple). • Constant-attendance allowance (Grant-in-Aid): Paid if the old-age pensioner requires the constant attendance of others to perform daily functions
Disability benefit (Disability Grant, social assistance, means tested)	<ul style="list-style-type: none"> • Must be aged 18 to 59, assessed with a disability lasting at least six consecutive months, and not receiving any other social assistance benefit. • The disability must be confirmed by a medical assessment, which may be reviewed every six months (temporary disability lasting at least six but less than 12 consecutive months) or 12 months (permanent disability lasting at least 12 consecutive months). • Means test: Annual income must be below 78,600 rand (for a single person) or 157,200 rand (for a couple), and assets must not exceed 1,122,000 rand (for a single person) or 2,244,000 rand (for a couple). • Constant-attendance allowance (Grant-in-Aid): Paid if the disability grant beneficiary requires the constant attendance of others to perform daily functions.
Survivor benefit (Dependant's Benefit, social insurance)	<ul style="list-style-type: none"> • The deceased must have been contributing to the Unemployment Insurance Fund and have at least one credit at the time of death. • One credit is earned for every five completed days of employment. Accumulated credits can be used for survivor, sickness, adoption, and unemployment benefits. • Eligible survivors include a surviving spouse or partner who applies for the benefit within six months of the insured's death. If there is no eligible surviving spouse or partner, or if the spouse or partner does not apply for the benefit within the required timeframe, the benefit is paid to a dependent child younger than age 21 (age 25 if a student). • Survivors may only receive one benefit (survivor, unemployment, or work injury) at a time. Benefits are not paid if the deceased was suspended from claiming because of fraud
Sickness and maternity benefits: <i>To deal with the risk of temporary incapacity</i>	
Administrative organisations: <ul style="list-style-type: none"> • Department of Labour provides general supervision for cash benefits. • Unemployment Insurance Fund administers the social insurance program and collects contributions jointly with the Commissioner of the South African Revenue Services • Department of Health administers provincial hospitals. 	

Cash sickness benefit (social insurance)	<ul style="list-style-type: none"> • Must be unable to work for at least seven days and be receiving less than normal wages. • Must be contributing to the Unemployment Insurance Fund and have at least one accumulated credit at the time the incapacity begins. • Absences from work must be the result of the illness for which the worker is receiving medical treatment
Cash sickness benefit (employer liability)	<ul style="list-style-type: none"> • Must have worked for the same employer for at least 26 days. A medical certificate may be required
Cash maternity benefit (social insurance)	<ul style="list-style-type: none"> • Must be contributing to the Unemployment Insurance Fund, have at least one accumulated credit before the expected date of childbirth, and have at least 13 weeks of employment before the claim is made. The insured earns one credit (one day of paid leave) for every five completed days of employment. • The maternity benefit must be claimed within 12 months of the birth
Medical benefits (hospitalization, social assistance, income tested)	<ul style="list-style-type: none"> • There is no minimum qualifying period. Eligible persons include unemployment and social assistance beneficiaries (including of the old-age pension, child support grant, war veteran's grant, care dependency grant, disability benefit, foster child grant, and social relief of distress) and persons with mental disorders discharged from hospitals for the mentally ill and still in need of care. • Income test: Annual income must not exceed 72,000 rand (for a single person) or 100,000 rand (for a household).
<p>Work injury benefits: Compensation for work-related injuries and occupational illness</p> <p>Administrative organisations:</p> <ul style="list-style-type: none"> • Department of Labour provides general supervision. • Compensation Commissioner administers the program, including claims decisions and the management of funds from which benefits are paid. • Employers must normally insure against liability with a public compensation fund but in certain instances may insure with an employer's mutual association licensed by the Minister of Labour. 	
Employer-liability system through a public carrier (compensation fund)	<ul style="list-style-type: none"> • Employed persons, including contract workers, casual workers, agricultural workers, and certain military personnel. • Exclusions: Self-employed persons, household workers, unpaid volunteers, and certain military personnel. • Special systems for mine • Consists of temporary and permanent disability cash benefits, workers' medical benefits and survivor benefits

Unemployment benefits: *Compensation for the loss of income resulting from involuntary unemployment***Administrative organisations:**

- Department of Labour provides general supervision.
- Unemployment Insurance Fund administers the program and collects contributions jointly with the Commissioner of the South African Revenue Services

Social insurance system

- Employed persons working more than 24 hours a month, including certain civil servants, household workers, and seasonal workers; and certain categories of self-employed persons.
- Exclusions: Most categories of self-employed persons and certain civil servants.
- Must be contributing to the Unemployment Insurance Fund and have at least one accumulated credit at the time employment ceases.
- One credit is earned for every five completed days of employment. Accumulated credits can be used for sickness, adoption, unemployment, and survivor benefits.
- Must be capable of and available for work and register with and report to the public employment exchange, unless unemployment is the result of illness or pregnancy. Unemployment must be the result of termination of the insured's contract, the ending of a fixed term contract, the dismissal of the insured (except for disciplinary reasons), insolvency of the employer, or the death of the employer for a household worker. Must be unable to find work within 14 days of becoming unemployed. Must apply for benefits within 12 months of first becoming unemployed; may be extended under certain conditions.

Family benefits: *To provide additional income for families with young children to meet at least part of the added cost of their support***Administrative organisations:**

- South African Social Security Agency administers the universal and social assistance programs.

Cash family responsibility leave (employer liability)

- Paid for the death of a spouse, partner, parent, adoptive parent, grandparent, child, adopted child, grandchild, or sibling. The employee must have worked for the same employer for at least four months with at least four working days a week.

Adoption benefit (social insurance)

- Paid for the adoption of a child younger than age 2. The insured must leave work to look after that child and must be receiving less than his or her daily earnings before the leave began. The insured must be contributing to the Unemployment Insurance Fund and have at least one accumulated credit at the time of the expected date of adoption.
- One credit is earned for every five completed days of employment. Accumulated credits can be used for sickness, adoption, unemployment, and survivor benefits.
- The adoption benefit must be claimed within six months after the date of the order for adoption.
- 960 rand a month is paid for each eligible child.

Foster child grant (universal)

- Paid to a person caring for a foster child up to age 18 (age 21 if a student). There must be a court order indicating the foster care status of the child.
- Foster parents may receive more than one social grant at a time.
- 960 rand a month is paid for each eligible child

Child support grant (social assistance, means tested)	<ul style="list-style-type: none"> • Paid to the primary caregiver of a child up to age 18 for up to six biologically non-related children (no limit for biologically related children). The primary caregiver must be aged 16 or older. • Means test: Annual income must not exceed 49,200 rand (for a single person) or 98,400 rand (for a couple). • Beneficiaries may only receive one social grant at a time. • 410 rand a month is paid for each eligible child.
Care dependency grant (social assistance, means tested)	<ul style="list-style-type: none"> • Paid to a parent, foster parent, or primary caregiver of a child up to age 18 who requires permanent care or support services as the result of a severe mental or physical disability. The child must be cared for at home and the disability confirmed by a medical assessment. • Means test: Annual income must not exceed 204,000 rand (for a single person) or 408,000 rand (for a couple). The foster child grant is not considered income in the means test. • Beneficiaries may only receive one social grant at a time; a foster parent may receive more than one social grant at a time. • 1,700 rand a month is paid for each eligible child.

Source: Social Security Programs Throughout the World: Africa, 2019. <https://www.ssa.gov/policy/docs/progdesc/ssptw/2018-2019/africa/ssptw19africa.pdf>

11.3. Summary

Pattern of social protection programmes

The right of South Africans' to social protection is explicitly outlined in the country's Constitution, national long term vision as well as in the government's Outcome Framework which is a policy document aimed at ensuring social development in the country. Against this background, the country has a social grants system that has been widely described as the most comprehensive in Africa. While it has not necessarily reduced inequality, there is wide evidence that the grant system has significantly reduced poverty, and continues to do so in areas with high poverty rates as well as among the most poverty-prone sections of society. These include the Black African population, female-headed households, and those resident in rural areas (Satumba et al, 2017; Cooper et al, 2020). However, with the programmes mainly targeted as providing various forms of cash transfers to the elderly, the disabled, and those caring for poor and vulnerable children, many of the country's key populations for HIV are not precisely covered by these programmes. Additionally, some of the key HIV risk factors, such as violence, substance and alcohol abuse, and the criminalisation of sex work, are not focus areas of the grant system.

The high levels of poverty and inequality in South Africa has seen many poor people in the country facing predisposing factors that are recognised as social determinants of ill-health and has also led to bi-modal health system where

the majority of poor people cannot afford to seek care when ill (Ataguba et al, 2011). It is for this reason that the country is currently piloting a National Health Insurance (NHI) programme premised on the Constitution's recognition of healthcare as a fundamental human right. According to the National Health Insurance Bill²⁸:

The NHI fund will cover South Africans of all races, rich or poor and legal long-term residents.

- There will be one pool of healthcare funding for private and public healthcare providers alike.
- The cost of our healthcare system, which is currently the most expensive in the world, will be reduced.
- When people visit healthcare facilities, there will be no fees charged because the NHI fund will cover the costs of people's medical care in the same way that medical aids do for their members.
- NHI will narrow the gap between the rich and poor in terms of standards of healthcare.
- South Africans will no longer be required to contribute directly to a medical health scheme to get quality health care. The NHI Fund will be funded from:

The NHI will be funded from three sources: general taxes; contributions of persons earning above a set amount, and monthly contributions made by the employees to the fund.

²⁸ <https://www.parliament.gov.za/project-event-details/54>

Key stakeholders

All cash transfers offered by the social grant system is administered by the South African Social Security Agency, a government entity under the Department of Social Development. The Department of Health and the Department of Education administers the National School Nutrition Programme while the Department of Public works administers and implements the Expanded Public Works Programme. In terms of social security, the Department of Labour is the lead governmental entity with other government entities being the Unemployment Insurance Fund, the South African Review Services, the Compensation Commission, and the Department of Health.

As an upper-middle income country, South Africa, like Botswana and Namibia, has limited and decreasing donor support to national programmes (Christians, 2020). There are however a number of international NGOs and donor agencies that typically provide technical and financial support to local civil society organisations in ensuring better access to basic social services as well as in the area of transformative social protection for PLHIV and those are risk of it. In South Africa, Treatment Action Campaign – a volunteer-based organisation operating at community, provincial and national levels – has been widely recognised and credited with using a combination of human rights education, HIV treatment literacy, demonstration, and litigation to force the government of former South African President Thabo Mbeki to avail antiretroviral therapy to all South Africans living with HIV and in need of treatment (Heywood, 2009; Sabi & Rieker, 2017).

Informal social security systems are also prevalent in South Africa. It is reported, for example, that 19% of the South African population belongs to a burial society (Semenya, 2013). As in Botswana, rotating savings and credit association, known in South Africa as *Stokvels* and their popularity has been attributed to many obstacles that make it difficult for low income and poor households to access formal financial services. The majority of community members also join these associations because they are not covered by any social protection scheme, or are covered but the level of protection is not adequate (Matuku and Kaseke 2014).

Advancement of the AIDS response

Despite having a comprehensive social protection system, South Africa faces high levels of youth unemployment and school dropout rates. To this end, Fast track pillar 2 is an important avenue in advancing the country's AIDS response. Through this pillar, investments need to be made to expand and retain access to all levels of schooling as well as to create pathways to employment as an effective HIV prevention strategy. The effective rollout of the planned National Health Insurance programme will also ensure that increase access to essential health services for PLHIV as well as those at risk of or affected by HIV by addressing barriers that prevent them from accessing health services.

12. Country overview:

SOUTH SUDAN

12.1. Brief HIV situation analysis

According to UNAIDS (2021), the HIV prevalence among South Sudanese aged 15-49 years was 2.3% in 2020. In total, 180 000 people were living with HIV and 8 900 people died from an AIDS-related illness in the same year. UNAIDS further asserts that while there has been no change in HIV prevalence and the number of AIDS-related deaths since 2010, the number of new HIV infections has increased from 14 000 to 17 000 in 2020 (UNAIDS, 2021). The country has also exhibited poor progress towards achieving the 90-90-90 targets. As Appendix B shows, only 29% of people living with HIV know their HIV status and 23% of those living with HIV who know their status and are on treatment, and 16% of those on treatment have suppressed viral loads.

Key populations in the country include female sex workers, MSM, internally displaced populations, refugees, long distance truck drivers and “Boda Boda” (motorbikes) riders and military personnel (Jervase et al, 2018:1). Risk factors for HIV include a low level of HIV knowledge, high prevalence of multiple concurrent partnerships, low usage of condoms, high rates of probable alcohol dependence, and high levels of HIV-related stigma. As a post-civil-war country, high rates of probable depression and post-traumatic stress syndrome have also been found as risk factors (Courtney et al, 2017: 7).

12.2. Social protection mechanisms

12.2.1. National social protection legislative and policy context

Constitution and legal provisions

No specific provisions related to social protection are evident in South Sudan’s Transitional Constitution of 2011. However, there are provisions safeguarding the rights to a number of social-protection-related areas. These include Article 16 (rights of women), Article 17 (rights of children), Article 29 (education), Article 31 (public health) and Article 40, which speaks to the rights of children, youth and sports.

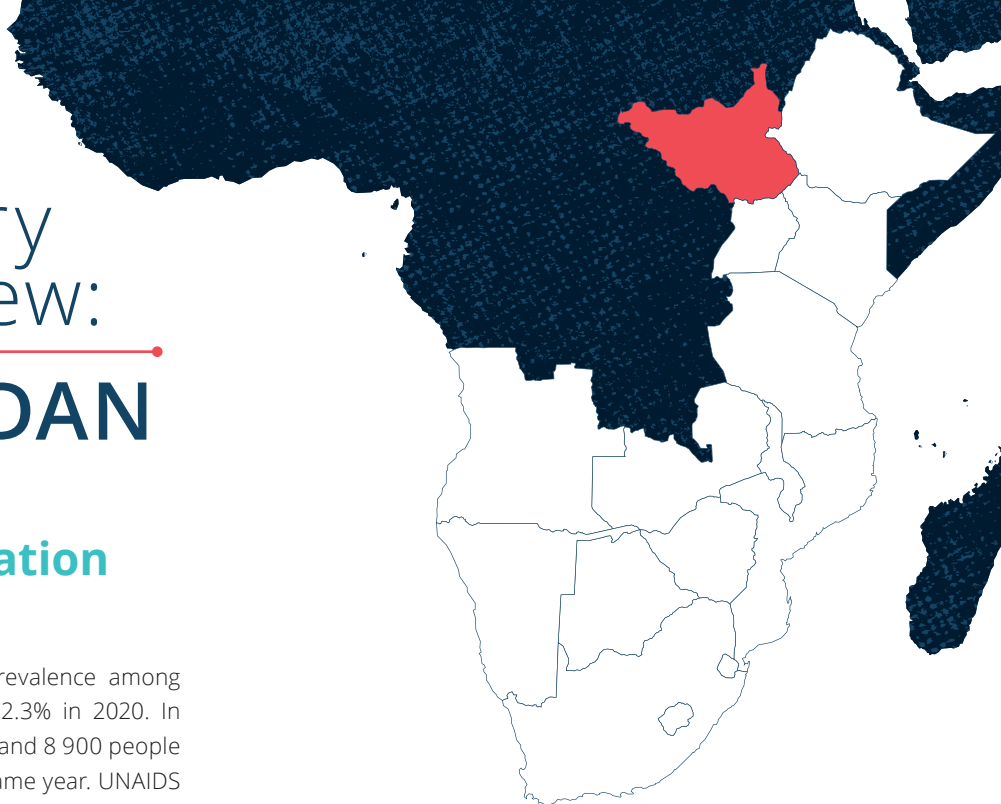
National long-term vision

In the country’s long-term vision, *South Sudan Vision 2040*, two social protection-related ideals are “an educated and informed nation” and “a safe, secure, and healthy nation” are two of the seven strategic areas identified as critical to achieving the vision of “freedom, equality, justice, peace and prosperity for all”.

National social protection policy

At the policy level, a *National Social Protection Policy Framework* was launched in 2016, with the overall goal “to respond to and address the multiple vulnerabilities faced by South Sudan’s citizens, with a particular focus on the poorest and most excluded sectors” (World Bank 2018). The policy framework identifies the achievement of the following six as its main objectives:

- i. inclusive social protection: ensuring access to basic social services for all;
- ii. protective environments for children;
- iii. strengthened linkages among social protection, economic development and sustainable livelihoods;
- iv. improved livelihoods for women;
- v. a systems approach to social protection; and
- vi. progressive realization of coverage



To translate its objectives into interventions, the Framework has identified the following three clusters:

- a. social assistance to poor and vulnerable persons, which includes Child Support Grant, School Feeding Programme, War Veterans Grant, Foster Family Grant, and Girls' Scholarship Programme;
- b. promoting the participation of poor and vulnerable persons in national economic growth, which includes the provision of temporary jobs and support for income-generating opportunities; and
- c. legal reforms to equitably realise constitutional and human rights for all, which include legislative reforms to protect the right of vulnerable groups, including women and children.

12.2.2. Social assistance programmes

The majority of social protection programmes in South Sudan have been found to be implemented by various NGOs and community-based organisations, funded by development partners and outside the national government system (World Bank 2018:11). Given the involvement of multiple actors, from different sectors, who use different policies and implementation arrangements, studies have revealed differing lists of the main social protection programmes in the country. According to the World Bank (2018:vi), for example, the most common social protection programmes in South Sudan can be categorised into two: (i) Social safety nets to the poor and most vulnerable and (ii) Productive inclusion programs. The former constitutes the most common type of social protection support, and include food assistance, unconditional cash grants, and public works programs that target poor and vulnerable households. Productive inclusion programmes, on the other hand, include activities supporting the promotion of skills and livelihoods, and these are highly limited in scope. A 2019 Mapping and Analysis of Social Protection in South Sudan project (MGCSW & UNICEF, 2019), on the other hand, reported that the seven most significant and important social protection programmes in the country are those summarised in Table 12.1 below.

Table 12.1 *Seven most significant and important social protection programme in South Sudan, 2019*

Programme and funder	Duration	Programme type	Benefit level	# beneficiaries
SSSNP – World Bank	2019–2021 (anticipated)	Public works and unconditional cash transfer	US\$3 per day (urban); US\$2.40 per day (rural) for 90 days per year	390,000 individuals (anticipated)
SNSDP – World Bank 2	2017–2019 (closed)	Public works	US\$3 per day (urban); US\$2.40 per day (rural) for 90 days per year	48,507 households (approx. 291,000 individuals)
GESS – DFID	2014–2019 (second phase 2019–2024)	Cash transfer to schoolgirls	20£ per year per girl	355,457 girls
BRACE II – DFID	2016–2020	Cash-based transfer for asset creation (public works)	US\$40.50 per month per household for 6 months	268,304 individuals
Food for Assets – WFP	Ongoing	Cash/food-based transfer for asset creation (public works)	US\$40.50 per month per household for 6 months, or 34 kg per month per household	520,150 individuals
Urban Safety Nets – WFP	Ongoing	Cash-based transfer for training	US\$10–60 per month per household for 6 months (according to household size)	80,112 individuals
School Feeding Programme – WFP	Ongoing	School meals	One third of nutritional requirements	412,118 children

Source: MGCSW & UNICEF, 2019

In a report entitled *National social protection programmes and safety nets in Sudan* by Turkawi (2015), the following key social protection programmes in South Sudan were identified as those in Table 12.2:

Table 12.2 Key special protection programmes in South Sudan, 2015*

Programme	Description
Cash transfers	
Social Support Project	This is the country's largest transfers programme that deals with the provision of an unconditional cash transfers of SDG150 (about US\$3.30) per month per family to poor pre-identified and targeted beneficiaries from a common list in all states. In addition, each selected family is automatically eligible and included in the National Health Insurance Fund for which the government, through the Ministry of Finance and National Economy, pays a monthly quota.
Student Support Grant	This is a grant for students from poor households to pursue university education. Each student receives SDG100/month (about US\$2.20) in cash and an additional SDG100/month is paid to the educational institution on behalf of the student, for food and rental expenses.
Food transfers	
"Building Resilience through Asset Creation and Enhancement" (BRACE)	programme which provides food and cash transfers to households while building skills, physical assets, and knowledge with the aim of strengthening household and community resilience. The programme is implemented with a range of Food for Asset (FFA) activities across three states – Northern and Western Bahr el Ghazal and Warrap.
School feeding programme	introduced in the then Southern Sudan in 2003 with the aim of enhancing access to food. The school feeding programme is a safety net aimed at incentivising education and school attendance. In 2018 it supported 939 schools in which 412,118 children (51 percent boys and 49 percent girls) received a daily school meal and 310,065 were de-wormed.
Safety net household food support	This programme provides food support for households hosting PLHIV on treatment to improve household food security and support treatment uptake and adherence. The programme is implemented in all the 10 states of South Sudan supported by the WFP.
Livelihood promotion	
Rural Women's Empowerment and Revolving Fund	Provides microfinance and training on business development fund for rural women
Microfinance and Microenterprise Development/ Asset Transfer Programme	Provides small loans for livelihood promotion
Social health protection	
National Health Insurance Fund	Supports the access to health services. Although the Fund is conditional and contributory, there is a provision to include poor households that are unable to contribute the premium. The programme covers all the recipients of the unconditional cash transfer. This programme was expected to cover over 1.1 million households by 2018.

*While 2015 is somehow dated, this was the 'most recent' data available at the time of the project.

12.2.3. Social security

There was no evidence from the document review of the existence of a social security system in South Sudan. This section is therefore not populated and further research on the South Sudanese social security landscape is recommended.

12.3. Summary

Pattern of social protection programmes

The concept of social protection is not explicitly referred to in the transitional Constitution of the Republic of South Sudan. However, the Constitution guarantees protection for the vulnerable, including orphans, the elderly, the disabled, pregnant and lactating women; and access to education and health. Support for a social protection system that support some of these groups also exists in the Child Act (2009) and the War Disabled, Widows and Orphans Commission Act (2011). By the same token, while the country's long-term vision does not make reference to social protection it has the improvement of education and health services – some of the pillars of any social protection system – among its strategic areas. The national social protection policy aims to address the multiple vulnerabilities faced by all poor and excluded groups of people, not necessarily those infected or affected by HIV. The policy however aims to address some of the factors that enhance HIV responses such as provision of employment and income-generating opportunities as well as legal reforms to protect the rights of vulnerable groups, specifically women and children. To this end, it could be argued that South Sudan's legislative and policy framework is not precisely geared towards the country's key populations or the main HIV risk factors.

Despite an enabling legislative and policy framework, the South Sudanese government's capacity to deliver on social protection objectives has been noted as limited. According to Pape & Pontara (2015), there are currently no state-sponsored social assistance programmes in South Sudan. Rather, "Zakat is the most important source of social protection in Sudan. It takes many forms, ranging from unconditional cash transfers to pre-selected households to arbitrary assistance for sick people in hospitals and requests from acute cases that face unaffordable medical expenses, to seasonal assistance to families during Ramadan and assistance to poor communities during crises" (Turkawi, 2015:67). Indeed, the overall pattern emerging from Section 12.2.22 is in line with the assertion by O'Brien et al (2018) that social safety nets in fragile and conflict-affected states often include cash and in-kind transfers, school feeding programmes and public works programmes.

Similarly and consistent with an observation by Holmes et al (2012) that long-term government-led safety nets are rarely in place in fragile and conflict-affected countries, it emerged that all existing social protection programmes in South Sudan are exclusively funded by development partners, a finding also noted by O'Brien et al (2018). The latter also found that four of the seven programmes they assessed were of a specific short-term duration while three were ongoing at the time of the mapping exercise. The following are other notable points about South Sudan's social protection programmes:

- The focus is mainly on poor and vulnerable households (e.g. where children are acutely malnourished);
- Food insecurity is a common criterion for the geographic prioritization of most programmes and according to the World Bank (2018), food transfer programmes accounted for approximately 98% of total social safety nets expenditures and covered 70% of social safety nets beneficiaries in 2015. School feeding represented an additional 14% of beneficiaries.

All in all, therefore, the main HIV risk factors and key population are not precisely the focus of the country's social protection system.

Key stakeholders

In terms of key actors, the Ministry of Gender, Child and Social Welfare is responsible for the coordination and implementation of social protection programmes in South Sudan with other involved government departments being:

- **The Ministry of General Education and Instruction:** responsible for the school feeding programmes as well as the promotion of girls' education;
- **The Ministry of Agriculture and Food Security:** prioritises food security and nutrition among its key objectives;
- **Ministry of Finance and National Economy** oversees multi-donor and bi-lateral funding for social services;
- **Ministry of Health** is responsible for nutrition programmes as well as overseeing the free health insurance to pregnant and lactating mothers and children under five years of age and other vulnerable groups. All this is within the framework of the South Sudan National Health Sector Strategic Plan 2015-2019. Among the Plan's strategic priorities is to ensure "financial and social risk protection of the poor and the vulnerable when accessing health care";
- **Ministry of Labour** is responsible for labour market activities and programming, including for youth.

According to UNICEF (2019) at the local level, selected authorities and committees also have a number of important roles including the sensitization of communities on social protection programmes, identification of beneficiaries and delivery of local services (UNICEF, 2018). United Nations agencies active in this space include UNICEF, UNDP, UNHCR, FAO, WFP and the International Organisation for Migration (IOM). Support is also received from international donor agencies and NGOs such as World Vision, Oxfam, Danish Church Aid, the World Bank, the African Development Bank, the International Fund for Agricultural development (IFAD), OXFAM, USAID and GIZ.

Stakeholder consultations revealed that there are a number of local CSOs in South Sudan who work mainly in the areas of food security, peace building, emergency responses,

and support of internally displaced persons, vulnerable populations that include women head households, widows, people living with disabilities, as well as those with chronic diseases. While the latter may be understood to include PLHIV, statements by some civil society stakeholders suggested that social protection programmes are not specifically aimed those living with or affected by HIV. For example, one stakeholder said, *“The current programming in South Sudan is tailored mostly towards humanitarian aid. So the concept of social protection is normally in the background”*. Similarly, one stated, *“As NGOs we are driven by the donors as well as government policy. So most of the programmes in South Sudan are emergency driven. There is a lack of focus on areas such as social protection and HIV”*. Table 12.3 below summarises the key roles of the different social protection actors in South Sudan.

Table 12.3 Main roles of key social protection stakeholders in South Sudan

Partner	Role(s)
Government partners	Facilitates increased access to locations and population through government structures and systems in place, coordinates efforts, and at times, implements programs that supports the poor and marginalized to build resilience and improve livelihood and welfare
United Nations Agencies and other partners	Provides technical and financial support for social protection interventions and system building. Also supported policy dialogue implements social protection programs. At times, directly implements programs.
Bilateral and Multi-lateral Donors	Provides technical and financial support for social protection interventions and system building, which are usually implemented through NGO or UN partners. Also supports policy dialogue.
NGOs	Implements social protection programs. Also has a key role in serving as a liaison between the people and local authorities and in building local management systems for transparency and social accountability.
Faith-based organisations and CBOs	Provide psychosocial support linked to facility and community-based medical care services including home base care, information sharing, counselling, referral
United Nations Mission in South Sudan	Provided support for Return, Reintegration and Protection (RRP) to enabling county level development through County Support Bases (CSBs)

Source: World Bank (2018)

All in all, the following statement by the World Bank (2018:70 summarises the situation in South Sudan, "... much of the funding provided in related social protection activities continues to be dominated by the humanitarian sector, particularly in the most conflict-affected and difficult to access locations given the acute need. As a result, much of the support provided continue to be outside the Government system...".

Advancement of the AIDS response

To advance South Sudan's HIV response and given that the South Sudanese government's capacity to deliver on social protection objectives has been noted as limited, there is a need to scale up and progressively broaden sustainable social protection programmes. Combination social protection programmes that go beyond food transfers and public works programmes that are implemented by development partners need to be developed and delivered in relevant geographical areas for appropriate key populations (Fast Track pillar 1). Invest in expanding pathways to employment as an effective HIV prevention strategy (pillar 2) as well as strengthening the active and meaningful engagement of civil society, in HIV-sensitive social protection (pillar 4) are also important avenues for advancing the country's AIDS response.

13. Country overview:

TANZANIA

13.1. Brief HIV situational analysis

In 2020 the adult HIV prevalence in Tanzania was 4.7% and 1.7 million people were living with HIV (UNAIDS, 2021). UNAIDS data further shows that there were 68 000 new HIV infections, and 32 000 AIDS-related deaths in the country (UNAIDS, 2021). In terms of the 90-90-90 targets, Appendix B shows that 84% of people living with HIV in the country know their HIV status; 82% of those with HIV who know their status are on treatment while 68% of those living with HIV and on treatment have suppressed viral loads. Thus, the country has only achieved one target. Structural barriers to the country's HIV response include poor physician-to-patient ratios, gender inequality, and gender-based violence. As in many countries of the region, sex work and same sex acts are criminalised in the country. In 2013, 8.7% of people living with HIV reported having being denied health services because of their HIV status in the last 12 months (UNAIDS, 2019). Key populations in the country include adolescent girls and women, pregnant and lactating women living with HIV, PWID, cross-border truck drivers, people living with disabilities, MSM, men living with limited health-seeking behaviour, older people aged 60 years and above (Both & Magotir, 2019).

13.2. Social protection mechanisms

13.2.1. National social protection legislative and policy context

Constitutional and legal provisions

Tanzania²⁹ has no explicit Constitutional provisions related to social protection. While this has often been attributed to the country's long subscription to the socialist philosophy and ideology of *Ujamaa* (Barya, 2011), there are two Articles in the Constitution that are relevant to social protection. Article 11 (2) states, in part, that "Every person has the right to access education, and every citizen shall be free to pursue education in a field or his choice up to pursue

education of his choice to his merit and ability, the highest level according to his merits and ability". Article 22(1), on the other hand, states that "Every person has the right to work".

National long-term vision

The *Tanzania Development Vision 2025* aims to achieve "high quality livelihood for its people, attain good governance through the rule of law, and develop a strong and competitive economy" (pg. 12). Outlined strategies relevant for social protection include the realisation of food self-sufficiency and food security; universal primary education, the eradication of illiteracy and the attainment of a level of tertiary education and training; gender equality and the empowerment of women in all spheres of society; access to quality primary health care for all; access to quality reproductive health services for all individuals of appropriate ages; and absence of abject poverty.

National social protection policy

The *draft* Tanzania's National Social Protection Framework (NSPF) adopts a lifecycle approach to protect the poor and vulnerable with cash transfers, both conditional and unconditional as well as through feeding and nutrition schemes. The framework also underscores the importance of providing emergency assistance to victims of abuse and violence, particularly pregnant women, children in early childhood, and school-aged children. Public works, agricultural schemes and other livelihood programmes such as entrepreneurial training are targeted at working age adults which include young people in the 15-24 years age bracket (Ajwad et al, 2018). The framework defines social protection in a comprehensive manner that also explicitly recognises indigenous social protection systems: According to the framework, social protection includes:

29 Tanzania is a union between the Mainland and the Zanzibar islands both of which have different jurisdictions in relation to social protection (Ulriksen, 2016). In line with Ulriksen's approach, the focus herein is only on social protection mechanisms in Mainland Tanzania

... traditional family and community support structures, and interventions by state and non-state actors that support individuals, households and communities to prevent, manage, and overcome the risks threatening their present and future security and wellbeing, and to embrace opportunities for their development and for social and economic progress in Tanzania' (URT, 2008 cited in Ulrikse, 2016:11).

While the NSPF is still to be finalised, National Social Security Policy was enacted in 2003 with the aim of expanding social security coverage to the informal sector, and harmonise the existing funds so as to reduce fragmentation and rationalize contribution rates and benefit structures. The document's definition of social security is in line with the ILO conceptualisation of social security being a three-tier system consisting of: (i) social assistance, which are non-contributory assistance to poor and vulnerable groups;

(ii) mandatory schemes, which are contributory insurance payments through employment; and (iii) private savings, as in voluntary savings schemes for retirement and insurance against events such as ill health and loss of income. A number of relevant policies are also currently in place and these include:

- *The National Employment Policy* which aims to provide equal access to decent employment opportunities with a focus on vulnerable groups.
- *The National Food Security Policy* which aims, among other things, to improve the nutritional situation of the Tanzanian community, especially the nutritionally (most) vulnerable groups that include children, pregnant and lactating women, the sick, people in institutions, and people in disaster situations.
- *The National Education and Training Policy* which guarantees access to education and literacy for all citizens as a right,

13.2.2. Social assistance programmes

Programme	Description and focus	HIV sensitivity
Cash transfers		
Productive Social Safety Net (PSSN)	<p>This is a programme funded and implemented by the Tanzania Social Assistance Fund (TASAF). Consists of three components: (i) conditional cash transfers to the very poor; (ii) public works and (iii) Livelihood Enhancement activities (proposals from Community Saving Groups. This programme started in 2000 (as PSSN1) to increase income and consumption, improve the ability to cope with shocks, and enhance and protect the human capital of children among extremely poor populations. . PSSN2 was launched in February 2020; Beneficiaries (children; elderly people; able-bodied citizens who are unemployed) receive unconditional fixed cash transfer US\$6 per household per month; Public works: USD1.35 per day; Livelihood enhancement: livelihood enhancing grants disbursed in response to proposals by existing Community Savings Groups. The benefit is delivered bi-monthly (cash transfers) and fortnightly (public works). Coverage is nationwide and plans are to targets about 30% of the Tanzanian population. The administrator is the Government of Tanzania with support from the International Development Association (IDA); UK Foreign, Commonwealth & Development Office (FCDO, formerly DFID); Department for International Development (DFID); Swedish International Development Cooperation Agency (SIDA); United States Agency for International Development (USAID); UNICEF; United Nations Development Programme (UNDP); International Labour Organization (ILO); United Nations Population Fund (UNFPA) and World Food Programme (WFP)</p>	Increase households' access to income

Tanzanian Mainland Social Fund Community based conditional cash transfer	Conditional cash transfer introduced in 2009 to ensure that children are properly educated and that children and elderly people are healthy. Beneficiaries are children and vulnerable elderly people. The amount of benefits varies according to the number of elderly people and vulnerable children in each household, from a minimum transfer of USD12 to a maximum transfer of USD36 paid bi-monthly. The programme is administered by the Government of Tanzania; International Development Association (IDA); UK Department for International Development (DFID); United States Agency for International Development (USAID); UNICEF; World Food Programme (WFP)	Increases households' access to income and supports families' child care roles
In-kind-transfers		
The Most Vulnerable Children (MVC) program	The MVC programme aims to assist children who are abandoned, neglected, abused, orphaned, affected by the AIDS crisis, as well as all children who are at risk of not receiving basic social services including education. The programme provides vulnerable children with basic services including health care, food, shelter, psychological and legal services, and education. Coverage was 2.3 million children in 2016.	Improves food security and nutrition as well as access to healthcare and education for children
Livelihoods promotion		
See public works and livelihoods enhancement components of the PSSN		
Social health protection		
Mother and Child Health and Nutrition (MCHN)	Aimed at reducing the rate of stunting, and the acute malnutrition rate. MCHN provides a monthly take-home ration (Super Cereals, Super Cereals Plus, and fortified vegetable oil) to pregnant and lactating women and children aged 2 years and below. This programme is implemented by WFP under the EU funded Boresha Lishe Programme. Coverage is 30,000 pregnant and lactating women and children under 2 years of age in 4 districts of Singida and Dodoma regions. It also provides a nutrition sensitive component that covers nutrition social behavior change communication and assets transfer to enhance production of nutritious food	Improves nutrition for children and to pregnant and lactating women
Moderate Acute Malnutrition (MAM)	Provides targeted supplementary feeding programs, which includes nutrition education and other health related services to pregnant mothers and children under 5. Through 40 local government health facilities	Improves nutrition for children

13.2.3. Social security programmes

Programme	Beneficiaries and benefits
Old age, Disability and Survivor benefits: <i>To compensate the loss of income resulting from old disability or survivorship</i>	
Administrative organisations: <ul style="list-style-type: none"> • Prime Minister's Office, Labour, Youth, Employment and Persons with Disability provides general supervision. • Social Security Regulatory Authority regulates and supervises the performance of the public- and private- sector programs. • Public Service Social Security Fund administers the public-sector program and collects contributions. • National Social Security Fund administers the private-sector program and collects contributions 	
Old-age pension (public- and private- sector programs)	<ul style="list-style-type: none"> • Age 60 with at least 180 months of contributions. The contribution requirement is reduced for workers who become covered at older ages, ranging from 165 months (if age 45) to 45 months (if aged 55 to 59) of contributions. • Employment must cease. • The minimum monthly old-age pension is 40% of the legal monthly minimum wage.
Old-age settlement (public- and private- sector programs)	<ul style="list-style-type: none"> • Age 60 and does not qualify for an old-age pension. • Employment must cease.
Disability pension (public- and private- sector programs)	<ul style="list-style-type: none"> • Must have at least a 66.7% assessed loss of earning capacity and at least 180 months of contributions or at least 36 months of contributions, including 12 months immediately before the disability began. • The disability pension may be replaced by an old-age pension at the normal retirement age if the value of the old-age pension is at least equal to the disability pension. • A medical board of doctors appointed by the Ministry of Health assesses the loss of earning capacity. A medical examination may be required.
Disability settlement (public- and private- sector programs)	<ul style="list-style-type: none"> • Must have at least a 66.7% assessed loss of earning capacity and not qualify for a disability pension.
Survivor pension (public- and private- sector programs)	<ul style="list-style-type: none"> • The deceased was not receiving an old-age or disability pension at the time of death but had at least 180 months of contributions. • Eligible survivors include a widow(er) aged 45 or older (no age limit if caring for a child younger than age 15) and orphans younger than age 18 (age 21 if a full-time student, no limit if disabled). If there is no widow(er) or eligible orphan, the pension is paid to the deceased's parents. • The widow(er)'s pension ceases upon remarriage.
Survivor settlement (public- and private- sector programs)	<ul style="list-style-type: none"> • The deceased received an old-age or disability pension at the time of death. • Eligible survivors include a widow(er) aged 45 or older (no age limit if caring for a child younger than age 15) and orphans younger than age 18 (age 21 if a full-time student, no limit if disabled). If there is no widow(er) or eligible orphan, the benefit is paid to the deceased's parents.
Funeral grant (private- sector program only)	<ul style="list-style-type: none"> • Paid to the person who paid for the funeral if the deceased had at least one month of contributions and was in covered employed at the time of death. The benefit must be claimed within 60 days of the date of death.

Sickness and maternity benefits: *To deal with the risk of temporary incapacity***Administrative organisations:**

- Prime Minister's Office, Labour, Youth, Employment and Persons with Disability provides general supervision.
- Social Security Regulatory Authority regulates and supervises the performance of all social security programs.
- Public Service Social Security Fund collects contributions and administers the social insurance program for public-sector employees.
- National Social Security Fund managed by a director general, collects contributions and administers the social insurance programs for private-sector employees.

Social insurance	<p>Cash maternity benefit:</p> <ul style="list-style-type: none"> • Public-sector employees, including civil servants, employees of local governments, police and correctional personnel, and judiciary officers; and private-sector employees, including foreign nationals and employees of international organizations working in Mainland Tanzania. • Voluntary coverage for self-employed persons. • Special system for military personnel and certain high-ranking civil servants. <p>Medical benefits and maternity medical benefits:</p> <ul style="list-style-type: none"> • Private-sector employees and self-employed persons working in Mainland Tanzania. • Voluntary coverage for pensioners (private-sector program only). <p>Special systems for public-sector employees</p>
Employer liability (cash sickness and paternity benefit)	<ul style="list-style-type: none"> • Private-sector employees working in Mainland Tanzania. • Exclusions: Self-employed persons. • Special systems for public-sector employees. • Consists of temporary and permanent disability cash benefits, workers' benefits, survivor benefits and funeral grant

Work injury benefits: *Compensation for work-related injuries and occupational illness***Administrative organisations:**

- Prime Minister's Office, Labour, Youth, Employment and Persons with Disability provides general supervision.
- Social Security Regulatory Authority regulates and supervises the program.
- Workers Compensation Fund collects contributions and administers the program.

Social insurance system	<ul style="list-style-type: none"> • Employed persons in Mainland Tanzania. • Must be assessed with a work injury or an occupational disease by a recognized medical practitioner. Accidents that occur while commuting to and from work are covered • Exclusions: Self-employed persons
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Unemployment benefits: *Compensation for the loss of income resulting from involuntary unemployment*

Administrative organisations:

- Prime Minister's Office, Labour, Youth, Employment and Persons with Disability provides general supervision.
- Social Security Regulatory Authority regulates and supervises the performance of the public- and private-sector programs.
- Public Service Social Security Fund administers the public-sector program and collects contributions.
- National Social Security Fund administers the private-sector program and collects contributions

Social insurance system

- Employed citizens of Tanzania, including civil servants, employees of local governments, police and correctional personnel, judiciary officers, and private-sector employees.
- Special system for military personnel and certain high-ranking civil servant
- Unemployment benefit: Must be younger than age 55, have at least 18 months of contributions before unemployment began, and be involuntarily unemployed. Must not be entitled to receive any other social insurance pension or benefit.
- Unemployment grant: Must be younger than age 55, have less than 18 months of contributions, be involuntarily unemployed, and not be entitled to receive any other social insurance pension or benefit.

Family benefits: *To provide additional income for families with young children to meet at least part of the added cost of their support*

Not specified

Source: Social Security Programs Throughout the World: Africa, 2019. <https://www.ssa.gov/policy/docs/progdesc/ssptw/2018-2019/africa/ssptw19africa.pdf>

13.3. Summary

Pattern of social protection programmes

Although Tanzania does not have explicit constitutional provisions to social protection, it contains two relevant articles related to education and health. The country's long-term vision also outlines a comprehensive strategy to address many HIV risk factors such as food security and gender inequality – all in addition to improving access to quality health and educational services. The draft national social protection policy is among the most comprehensive in the region, recognising the potential role of both formal and informal social protection systems, and adopting a lifecycle approach to address the multiple factors of vulnerability that can place citizens at risk for HIV. This enabling policy and legislative framework is also reflected in the comprehensive pattern of the country's social protection programmes, where at least one type of promotive, protective and transformational social protection programme exists. There are also two social health protection programmes. It is, noteworthy, however, that the programmes tend to overlook key structural factors such as gender inequality, and gender-based violence. These is despite them being identified in the national long-term vision, and implied in the planned social protection framework. The existence of some form of Gender Strategy under the PSSN2 was also suggested by some stakeholders.

Key stakeholders

Prime Minister's Office has overall responsibility for TASAF. With a mission to "promote community development, gender equality, equity and children rights through formulation of policies, strategies and guidelines in collaboration with stakeholders active in the country", the Ministry of Health, Community Development, Gender, Elderly and Children is the lead government department responsible for the administration of the social protection system in Tanzania. The Education, Science, Technology and Vocational Training is also involved specifically in the while the Ministry of Health is involved with the social health protection programmes and the Ministry of Finance and Planning is responsible with the financing of the Productive Safety Net Programme. In the social security systems, the main government actors are the Prime Minister's office, Ministry of Labour, Youth, Employment and Persons with Disabilities, the Social Security Regulatory Authority, the Public Service Social Security Fund as well Workers' Compensation Fund. The government ministries work with technical and financial support from United Nations agencies such as the ILO, UNFPA, UNICEF, UNWomen, WFP, WHO and the

International Organisation for Migration play a particular role in supporting public social protection mechanisms and providing technical assistance in various areas.³⁰

Various CSOs throughout the country are also reportedly involved in the running in the clinical and home-based care programmes for HIV/AIDS patients as well advocacy and awareness raising and advocacy work (Haaonan, 2007). A number of CSO are also engaged in the provision of additional sexual and reproductive health and HIV education, in and out of school settings. Civicus, the global alliance of CSOs, however asserts that as recent as in 2017, Tanzania was placed on a watch list due to growing threats to civil society after, among other things, the government closed 40 healthcare facilities providing HIV services on suspicions that they were promoting homosexuality. Concerns have been raised that such repercussions can affect key populations' access to HIV and sexual health services, and increase stigma and discrimination.³¹

Advancement of the AIDS response

To advance Tanzania's AIDS response, Fast Track pillar 4 (strengthening the active and meaningful engagement of civil society in HIV-sensitive social protection) is an important pathway. Among other things, this pillar can assist in addressing the high levels of HIV-related stigma and discrimination in the country a well as to advocate for the strengthening the legislative and policy environment through, for example, the finalisation of the draft national social protection policy and the drawing of attention to the high levels of gender-based violence. The latter is one of the major structural factor underlying the country's HIV prevalence.

30 https://tz.one.un.org/images/PDF/un_social_protection.pdf

31 https://www.avert.org/professionals/hiv-around-world/sub-saharan-africa/tanzania#footnote85_5sp3nke

14. Country overview:

UGANDA

14.1. Brief HIV situational analysis

In 2020, approximately 1.4 million people were living with HIV in Uganda and the adult HIV prevalence in the country was 5.4% (UNAIDS, 2021). There were 38 000 new HIV infections, and 22 000 AIDS-related deaths in the country (UNAIDS, 2021). While there have been increased efforts to scale up treatment initiatives in Uganda there are still many people living with HIV who do not have access to the treatment they need. As Appendix B shows, of the 91% of people living with HIV who know their HIV status, 90% are on treatment while 78% of those on treatment have suppressed viral loads. Punitive laws and stigmatising attitudes towards a number of key populations play a major role in this. In 2011, for example, 26.2% of women and men aged 15-49 years reported discriminatory attitudes towards people living with HIV. Five years later, in 2016, this proportion had reportedly increased to 33.2% (UNAIDS, 2019). Similarly, 4.2% of people living with HIV reported that they had been denied health services because of their HIV status in the last 12 months. Along with a number of political and cultural barriers, these attitudes have hindered effective HIV prevention programming in Uganda and may largely explain why the country has not achieved any of the 90-90-90 targets. Uganda's key population include women, sex workers, AGYW, MSM, PWID, truck drivers, and transient fishing communities (UNAIDS Uganda, 2019).

14.2. Social protection mechanisms

14.2.1. National social protection legislative and policy context

Constitutional and legal provisions

The 1995 Constitution of the Republic of Uganda (as amended in 2005), provides for the protection and promotion of fundamental human rights and freedoms. Although it makes no specific mention of social protection, its Section XIV on general social and economic objectives

states that "The State shall endeavour to fulfil the fundamental rights of all Ugandans to social justice and economic development and shall, in particular, ensure that ... all Ugandans enjoy rights and opportunities and access to education, health services, clean and safe water, work, decent shelter, adequate clothing, food security and pension and retirement benefits". Mention is also made of nutrition and the recognition of the role of women in society.

National long-term vision

The country's *Vision 2040* which was launched in 2013 identifies the Government of Uganda's development plans and strategies to operationalize the country's vision statement of a "transformed Ugandan society from a peasant to a modern and prosperous country within 30 years".³² The Vision clearly articulates the importance of social protection in addressing risks and vulnerabilities by age, social class, gender, climate disaster exposure and cultural norms. It underscores the need to achieve this through national programmes targeting persons in both formal and informal employment, through social assistance to children (among other groups), and by offering national health insurance as a strategy to provide affordable health services for all.

Using Vision 2040 as the basis, the government plans to develop five-year National Development Plans (NDPs) over the course of the Vision's time frame. In the current and third NDP 2020-2025 social protection is a key component of the human capital development programme where the focus is on supporting a healthy workforce. In this plan, therefore, social protection is primarily seen through productive lenses.

³² <https://www.ldpg.or.ug/vision-2040-and-national-development-plans/>

National social protection policy

In terms of policies, the Uganda *National Social Protection Policy* is an overarching policy document that came into being in 2015, following the launch of the Vision 2040. The policy envisions a society in which all individuals are secure and resilient to socio-economic risks and shocks. It thus aims to provide comprehensive social protection services to address risks and vulnerabilities. To this end, the three major objectives of the policy are to (i) increase access to social security; (ii) enhance care, protection and support for vulnerable people; and (iii) strengthen the institutional framework for social protection service delivery. The policy defines social protection as “public and private interventions to address risks and vulnerabilities that expose individuals to income insecurity and social deprivation, leading to undignified lives”. Other policies supporting the country's commitment to social protection include:

- *The National Food and Nutrition Policy* (2003) which aims to promote the nutritional status of all the people of Uganda through multi-sectoral and co-coordinated interventions that focus on food security, improved nutrition and increased incomes;
- *The National Orphans and Other Vulnerable Children Policy* (2004) which provides for survival, development, participation and protection of vulnerable children and obliges Government to design appropriate instruments to achieve this;
- *The National Child Labour Policy* (2006) which provides a framework for addressing child labour and actions that need to be taken to deal with child labour;
- *The Uganda Gender Policy* (2007) which promotes gender equality and women's empowerment in all spheres and provides guidance for engendering social protection interventions;
- *Universal Secondary Education Policy* (2007) which aims to increase access to quality secondary education for economically vulnerable families by soliciting the participation of private schools to offer fee-free education by receiving public assistance;
- *The National Health Policy* (2010) which aims to provide a good standard of health for all people in Uganda in order to promote healthy and productive lives;
- *The National HIV/AIDS Policy* (2011) which provides a broad framework for delivering HIV/AIDS related services in Uganda;
- *The Special Needs and Inclusive Education Policy* (2012) which provides guidelines to all stakeholders to ensure that learners with special needs have equal education opportunities in this country;
- *The Gender in-Education Sector Policy* (2016) which seeks to address existing gender gaps in the education sector.

14.2.2. Social assistance programmes

Programme	Description and focus	HIV sensitivity
Cash transfers		
Senior Citizens Grant within the Social Assistance Grants for Empowerment (SAGE)	Commonly known among donors as the Expanding Social Protection Programme (ESP), this unconditional cash transfer started in 2010 to reduce chronic poverty and improve life conditions of Uganda's poorest population. Beneficiaries are elderly people; people with disabilities; children; and households with a high dependency ratio. They receive a cash benefit of US\$8.00 per month paid out bi-monthly. The programme is administered by a Fund Manager (DAI) while the Ministry of Gender, Labour and Social Development; UK Foreign, Commonwealth & Development Office (FCDO); Irish AID; and WFP are active actors in the implementation of the programme.	Increases households' access to income
In-kind-transfers		
<i>Not available</i>		

Livelihoods promotion		
Northern Uganda Social Action Fund (NUSAF)	Public works programme with cash for work and microfinance components started in 2009 to generate income-earning opportunities and improve beneficiaries' access to services. Beneficiaries are households with able-bodied persons who can work, but 10% of the grant goes to vulnerable people including PLHIV. They receive a cash benefit of US\$1.00 for a maximum duration of 1 month, or 22 work days. The scheme relies on community-based targeting, as potential beneficiaries must form groups and submit projects to apply to the scheme. The programme has 77 000 beneficiaries and is administered by the Office of the Prime Minister; and the World Bank.	Increases households' access to income
Development Response to Displacement Impacts Project (DRDIP)	Implemented in 2017, the programme covers 11 districts that host the largest number of refugees and therefore bearing a disproportionate amount of strain on existing community social services and infrastructure. The aim of the programme is therefore to support investments in basic social service infrastructure, integrated natural resources management and income generating activities including alternative livelihoods like value-addition to agriculture products, and fish farming. The programme is implemented by the Office of the Prime Minister with financial assistance from the World Bank	Increases household access to income and basic social services in refugee communities
Social health protection		
Not available		

14.2.3. Social security programmes

Programme	Beneficiaries and benefits
Old age, Disability and Survivor benefits: <i>To compensate the loss of income resulting from old disability or survivorship</i> Administrative organisations: <ul style="list-style-type: none"> Ministry of Finance, Planning, and Economic Development provides general supervision. Uganda Retirement Benefits Regulatory Authority supervises and regulates the provident fund and private pension plans. National Social Security Fund administers the program and collects contributions 	
Old-age benefit	<ul style="list-style-type: none"> Age 55; age 50 if employment ceased at least a year before the claim is made; before age 55 if switching to an approved private pension plan or if permanently emigrating, usual employment must cease.
Disability benefit (Invalidity Benefit)	<ul style="list-style-type: none"> Must be assessed with a permanent total disability for any work that the fund member was able to perform before the disability began or a permanent partial disability that prevents the fund member from earning a reasonable living. Employment must cease. A medical practitioner assesses the degree of disability. Fund members may be referred to an NSSF medical doctor to confirm the disability assessed by the medical practitioner.
Survivor benefit (Survivor's Benefit)	<ul style="list-style-type: none"> Paid when a fund member dies before withdrawing the full account balance. Eligible survivors (in order of priority) include a widow(er); dependent orphans younger than age 18 (no limit if fully dependent on the deceased); dependent parents and brothers; grandparents, grandchildren, or next-of-kin; and the person who paid for the funeral

Sickness and maternity benefits: *To deal with the risk of temporary incapacity*
Administrative organisations:

- Ministry of Gender, Labour, and Social Development provides general supervision.

Employers pay benefits directly to employees.

Employer-liability system

- Public-sector employees, including civil servants, employees of local authorities, and state-owned enterprises; and private-sector employees.
- Exclusions: Family labour.
- Special system for military personnel

Work injury benefits: *Compensation for work-related injuries and occupational illness*
Administrative organisations:

- Ministry of Gender, Labour, and Social Development approves settlements and pays benefits from money deposited by employers.

Employers must insure against liability with private insurance companies.

Employer-liability system through private carriers

- Public- and private-sector employees, including apprentices.
- Exclusions: Self-employed persons and active military personnel
- Consists of temporary and permanent disability cash benefits, workers' medical benefits and survivor benefits.

Unemployment benefits: *Compensation for the loss of income resulting from involuntary unemployment*

Not specified

The 2006 Employment Act (Act No. 6) regulates severance pay for employed persons who have completed at least six months of continuous service. It requires employers to provide severance pay for unfair dismissal; if an employment contract is terminated because the employer becomes insolvent or dies; if the employee dies in the service of his or her employer; or if the employee terminates the contract because of a physical incapacity. The amount of severance pay is negotiated between the employer and employee or the employee's labour union.

Family benefits: *To provide additional income for families with young children to meet at least part of the added cost of their support*

Not specified

Source: Social Security Programs Throughout the World: Africa, 2019. <https://www.ssa.gov/policy/docs/progdesc/ssptw/2018-2019/africa/ssptw19africa.pdf>

14.3. Summary

Pattern of social protection programmes

Uganda has a comprehensive and enabling legislative and policy framework and that there basically two main social assistance programmes in the country: Expanding Social Protection Programme, a cash transfer programme and the Northern Uganda Social Action Fund, a public works programme. It also emerged from the stakeholder consultations that the WFP implements school feeding programme in the food insecure Karamoja sub-region as well as a general food assistance programme to refugees.

The assessment report further revealed the existence of two nutrition programmes that provide specialised nutritious foods to prevent and manage acute malnutrition that are implemented with the support from the WFP in selected districts. In terms of a social health protection programme, it emerged that within the framework of the National Public Health Insurance Bill of 2014, a national insurance scheme is currently being developed. In the meantime:

The public health sector in Uganda includes national and regional hospitals and a tiered system of health centres which handle a range of services. At the community level, community health workers, known as village health teams, refer sick patients to Health Centre II's or III's, which are supposed to treat simple illnesses and provide a package of maternal and child health services. User fees in public hospitals were abolished in 2001 and free services include Antiretroviral therapy (ART) for PLHIV. However, fees are charged in the private wings of the public health facilities. In turn, private not-for-profit health providers are subsidized by government (pg. 17)

Key stakeholders

The Office of the Prime Minister monitors performance of social protection interventions; integrates social protection indicators in the National Monitoring and Evaluation framework; and provides information and national guidance on social protection. The Ministry of Gender, Labour and Social development is the main administrator of the country's main social protection programmes. The Ministry along with the Ministry of Finance, Planning and Economic Development also administers some of the social security schemes. Other government entities in this regard are the Uganda Retirement Benefits Regulatory Authority and the National Social Security Fund. At the local level, the country's Social Protection Policy makes provision for local government, traditional and cultural institutions as well as households and communities to provide social protection.

Key development partners in Uganda's social protection programming include the following United Nations agencies; WFP, ILO, UNICEF, UNWOMEN, UNHCR, and UNAIDS. Other development partners include FCDO Irish AID, the World Bank, the European Union Commission, SIDA, Save the Children, and USAID. These partners generally align financial support to the priorities of the National Social Protection Policy and provide technical assistance for various social protection programmes.

National and international NGOs are also active in Uganda's social protection programming where they play various roles including advocating for social protection policies and legislations; participating in planning, implementation and monitoring of social protection programmes; monitoring the operationalisation of international instruments on social protection; and mobilising and sensitising the population on social protection. These include umbrella bodies such as the Uganda Parliamentary Forum for Social Protection; and the Uganda Social Protection Platform. Membership of the latter includes Uganda NGO Forum, HelpAge International, Platform for Labour Action, the Uganda Women's Network, and the Uganda Network of Young people Living with HIV.

Other stakeholders include the private sector such as the Federation of Uganda Employers-Policy engagement. As a business association, it facilitates, among others, the incorporation of social protection in corporate policies and programmes; and also supports social protection programmes as part of corporate social responsibility.

Advancement of the AIDS response

One of the main pathways of advancing Uganda's AIDS response will be the development and active implementation of a social health protection programme as this will increase access to essential health services for PLHIV as well as those at risk of or affected by HIV by addressing barriers that prevent them from accessing health services (Fast Track pillar 3). Pillar 4 which relates to strengthening the active and meaningful engagement of civil society, particularly in advocating for stronger legal and policy environment to address stigma and discrimination is also an important pathway.

15. Country overview:

ZAMBIA

15.1. Brief HIV and AIDS situation analysis

In 2020 the adult HIV prevalence in Zambia was 11.1% and 1.5 million people were living with HIV (UNAIDS, 2021). UNAIDS data further shows that there were 69 000 new HIV infections, and 24 000 AIDS-related deaths in the country (UNAIDS, 2021). The most affected populations are women, children and young people, sex workers, MSM, migrants, prisoners, transgender people and people who inject drugs. The patriarchal nature of the Zambian society and its resultant gender inequality, resources constraints in the health sector, and HIV-related stigma and discrimination are the main barriers to the country's HIV response. For example, the proportion of women and men aged 15–49 years who reported discriminatory attitudes towards people living with HIV was 30% and 18% in 2007 and 2014 respectively (UNAIDS, 2019). There is also punitive regulation of sex work while those engaging in same-sex sexual acts face imprisonment of up to 14 years. Gender-based violence is also a major factor with 26.7% of ever-married or partnered women aged 15–49 years in 2014 reporting that they had experienced physical or sexual violence from a male intimate partner in the past 12 months. Due to a combination of these factors, HIV prevalence among adults in Zambia has changed little over the last decade despite decreasing infection rates. To this end UNAIDS data shows that 86% of Zambians living with HIV know their HIV status; 81% of those who know their status are on treatment and 68% of those with HIV and on treatment who have suppressed viral loads.

15.2. Social protection mechanisms

15.2.1. National social protection legislative and policy context

Constitutional and legal provisions

The Constitution of the Republic of Zambia does not have explicit provisions for social protection. However, access to social protection is implicitly guaranteed through provisions that provide for various economic and economic rights. Social protection is also underscored in relevant provisions of laws such as the Persons with Disabilities Act No. 6 of 2012; the Day Nurseries Act CAP313; the Employment of Children and Young Persons Act CAP274; and the Anti-Gender Based Violence Act of 2009.

National long-term vision

Published in 2006, Zambia's *National Long Term Vision 2030* expresses aspirations for Zambians to “live in a strong and dynamic middle-income industrial nation that provides opportunities for improving the wellbeing of all, embodying values of socio-economic justice...” (Republic of Zambia, 2006:2)³³ Envisaged pathways to this are through three pillars: (i) economic growth and wealth creation; (ii) social investment and human development; and (iii) creating an enabling environment for sustainable social economic development. One of the stated strategies of the second pillar is to promote and provide sustainable security against deprivation and extreme vulnerability by 2030. Other strategies relate to education and skills development, health, food and nutrition. The reduction of HIV and AIDS prevalence as the promotion of gender equality are some of the strategies outlined under the third pillar.

33 https://oneplanetnetwork.org/sites/default/files/vision_2030.pdf

National social protection policy

As part of its commitment to reducing poverty and vulnerability among its population in general, and for the poor and vulnerable segments of society in particular, the Government of Zambia developed the *National Social Protection Policy* in 2004. The aim of the policy is to provide a well-coordinated, integrated and sustainable system for alleviate hunger and poverty as well as increase incomes, improve education and health outcomes of poor families and other vulnerable groups in society. The policy defines

social protection as “policies and practices that protect and promote the livelihoods and welfare of people suffering from critical levels of poverty and deprivation and/or are vulnerable to risks and shocks”. To this end the policy sets out clear guidelines for ensuring access to social assistance, social security, social health insurance, as well as livelihood and empowerment activities to protect vulnerable populations from all forms of abuse, violence, discrimination, denial and neglect, and mainstreaming disability in national social protection programmes.

15.2.2. Social assistance programmes

Programme	Description and focus	HIV sensitivity
Cash transfers		
Social Cash Transfer Programme	Unconditional cash transfer started in 2010 to reduce extreme poverty and intergenerational transmission of poverty. Beneficiaries are people with disabilities, children, including those with disabilities. women; orphans; elderly people; people with disabilities. They receive a cash benefit of US\$10 on a bi-monthly basis. Beneficiary households with persons with severe disabilities receive double the amount. By the end of 2015 the programme reached 180,261 households or approximately 900,000 individuals (about 6 per cent of the population). It is administered by the Ministry of Community Development and Social Welfare; UNICEF; UK Foreign, Commonwealth and Development Office (FCDO) Irish Aid; Government of Finland; Government of Sweden; WFP; International Labour Organization (ILO).	Increases households' access to income, supports families' child care roles
In-kind-transfers		
Public Welfare Assistance Scheme	Unconditional in-kind transfer started in the 1950s to provide assistance to the most vulnerable population so that individuals can meet their basic needs, and to promote community capacity for overcoming poverty and vulnerability. The programme provides in-kind benefits (food, clothing) and social services (health, education, shelter) to Incapacitated households; elderly people; people with disabilities; children; and survivors of natural disasters. The amount of benefits ranges between US\$2–US\$20 annually. Coverage is nationwide and it had 25,859 beneficiaries in 2015. The administrators are the Ministry of Community Development and Social Services; Ministry of Health; Ministry of Education; World Vision; Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ)	Increases households' access to income; improves food security and overall household wellbeing

Home-Grown School Feeding Programme	Conditional in-kind transfer introduced in 2003 to improve the learning outcomes of students by providing meals at schools, preferably made from produce procured from smallholder farmers. Beneficiaries are primary-school students within the districts targeted by the programme. The districts targeted by the programme have high levels of food insecurity, HIV infection, poverty and malnutrition and low levels of educational achievement. They are provided with a daily meal of 100 grams of fortified maize. The estimated cost of each meal is of US\$0.10), which implies a transfer value of US\$3.12 per month. The programme is implemented in 31 districts in eight provinces and 890,000 children in 2,200 schools were reached in (2015). It is administered by the Ministry of General Education and the WFP in 2011	Improves food security and nutrition for children
Food Security Pack	Sustainable livelihood programme (access to agricultural inputs) started in 2000 to improve productivity and food security of smallholder farmers, leading to a reduction in poverty. Beneficiaries are poor smallholder farmers as well as households headed by a woman, elderly person or child. The households have no other sources of income and have less than one hectare of land. They receive in-kind benefits: maize, beans, soy, groundnut and cassava seeds; fertiliser; seed and fertilisers for rice, sorghum or millet; and, where soils are acidic, lime. In 2015 the programme reached 30,100 households, It is administered by Ministry of Community Development and Social Welfare	Improves household food security
Livelihoods promotion		
<i>Not available</i>		
Social health protection		
<i>Not available</i>		

15.2.3. Social security programmes

Programme	Beneficiaries and benefits
Old age, Disability and Survivor benefits: <i>To compensate the loss of income resulting from old disability or survivorship</i> Administrative organisations: <ul style="list-style-type: none"> Ministry of Labour and Social Security provides general supervision. National Pension Scheme Authority administers the program through two regional offices and 27 district offices 	
Old-age pension (Retirement Pension)	<ul style="list-style-type: none"> Age 55 (age 60 for persons whose insurance period began after August 14, 2015) with at least 180 months of contributions (reduced by 12 months for each year the insured was older than age 38 for those who were aged 39 to 48 on February 1, 2000). Employment must cease. Early pension: Age 50 (age 55 for persons whose insurance period began after August 14, 2015) and meets the contribution requirements for an old-age pension. The early pension must exceed the minimum monthly old-age pension. Deferred pension: The pension may be deferred until age 65. The old-age pension is payable abroad.

Old-age settlement (Retirement Lump Sum)	<ul style="list-style-type: none"> • Age 55 (age 60 for persons whose insurance period began after August 14, 2015) but does not meet the contribution requirement for the old-age pension. • The old-age settlement is payable abroad
Disability pension (Invalidity Pension)	<ul style="list-style-type: none"> • Must be younger than the normal retirement age, be assessed with a permanent incapacity for work, and have at least 60 months of contributions, including at least 12 months in the 36 months before the disability began. • A medical board appointed by the Minister of Labour and Social Security assesses the loss of work capacity. • The disability pension ceases at the normal retirement age and is replaced by the old-age pension. • The disability pension is payable abroad.
Disability settlement (Invalidity Lump Sum)	<ul style="list-style-type: none"> • Must be younger than the normal retirement age, be assessed with a permanent incapacity for work, and not meet the contribution requirement for the disability pension. • A medical board appointed by the Minister of Labour and Social Security assesses the loss of work capacity. • The disability settlement is payable abroad.
Survivor pension	<ul style="list-style-type: none"> • The deceased received or was entitled to receive an old-age or disability pension, or had at least 60 months of contributions at the time of death. • Eligible survivors include a widow(er) and orphans younger than age 18 (age 25 if a student, no limit if disabled). • The widow(er)'s pension ceases upon remarriage unless the widow(er) is caring for one or more of the deceased's children. • The survivor pension is payable abroad.
Survivor settlement (Survivor's Lump Sum)	<ul style="list-style-type: none"> • The deceased was entitled to receive an old-age or disability settlement. • Eligible survivors include a widow(er), a child of the deceased, or a nominated beneficiary
Funeral grant	<ul style="list-style-type: none"> • Paid if the deceased received or was entitled to receive an old-age or disability pension, or had at least 12 months of contributions in the 36 months before death
Sickness and maternity benefits: <i>To deal with the risk of temporary incapacity</i> Administrative organisations: <ul style="list-style-type: none"> • Ministry of Labour and Social Security provides general supervision for cash maternity benefits. • Employers pay cash benefits directly to employees. • Ministry of Health provides general supervision for medical benefits. 	
Universal (medical benefits)	Resident citizens of Zambia.
Employer liability (cash benefits)	<ul style="list-style-type: none"> • Public- and private-sector employees. • Exclusions: Self-employed persons, apprentices, casual workers, and military and police personnel
Cash sickness benefit (employer liability)	<ul style="list-style-type: none"> • Must have at least 12 months of continuous employment with the same employer and provide a medical certificate
Cash maternity benefit (employer liability)	<ul style="list-style-type: none"> • Must have at least two years of continuous employment with the same employer and provide a medical certificate from a registered medical practitioner.

Work injury benefits: *Compensation for work-related injuries and occupational illness***Administrative organisations**

- Ministry of Labour and Social Security provides general supervision.
- Workers' Compensation Fund Control Board collects contributions and administers benefits.

Employer-liability system through a public carrier

- Employed persons, including certain casual workers, household workers, and apprentices; self-employed persons; and public-sector employees not covered by a special system.
- Special system for certain public-sector employees and military and police personnel
- Consists of temporary and permanent disability cash benefits, workers' medical benefits survivor benefits and funeral grant

Unemployment benefits: *Compensation for the loss of income resulting from involuntary unemployment**Not specified*

The Minimum Wages and Conditions of Employment Act 2011 regulates employers to provide severance pay for the unlawful dismissal of employees, and lump-sum payments for termination of employment on medical grounds that are certified by a registered medical doctor. In either case, at least two months of an employee's basic wages is paid for each completed year of service. Severance pay is otherwise provided only when there is an express agreement between the employer and the employee.

Family benefits: *To provide additional income for families with young children to meet at least part of the added cost of their support**Not specified*

Source: Social Security Programs Throughout the World: Africa, 2019. <https://www.ssa.gov/policy/docs/progdesc/ssptw/2018-2019/africa/ssptw19africa.pdf>

15.3. Summary

Pattern of social protection programmes

Constitutional provisions to social protection in Zambia are implicitly embedded in guarantees to the protection of access to health and education. These constitutional imperatives are also supported by a number of sector-specific legislation that addresses some of the structural factors underlying HIV prevalence in the country such as gender-based violence. These factors are also outlined in the country's long-term vision which also has HIV and AIDS reduction among its key strategic priorities. Some of the country's HIV risk factors are also targeted in the National Social Protection Policy, although no particular focus is played on the epidemic.

In terms of social protection programmes, majority are in-kind food transfers aimed at improving food security and nutrition among the poor as well as children. The target beneficiaries of the country's only cash transfer programmes are children. To this end, many of the key populations and the main HIV risk factors such as HIV-related stigma and discrimination and gender inequality, are not target by the social protection system.

Key stakeholders

The lead government organisation in the area of social protection is the Ministry of Community Development and Social Welfare with the Ministry of General Education being a main player in the Home Grown School Feeding programme. The Ministry of Labour and Social Security provides general supervision of the country's social security systems while the National Pension Scheme Authority, which administers programmes in various regional, and district offices. The Ministry of Health is an important actor in the administration of and sickness and maternity benefits, while the Workers' Compensation Fund Control Board administers work injury benefits.

In overseeing the country's social protection system, the Ministry of Community Development and Social Welfare receives technical and financial support from a number of development partners including United Nations agencies such as the ILO, UNICEF, and the WFP. Other active development partners include FCDO, USAID, Irish Aid, Governments of Finland, Sweden, and Germany and international and local NGOs such as World Vision, the Regional Psychosocial Support Initiative (REPSSI), ChildFund and the Serenity Harm Reduction Programme Zambia or SHARPZ (Chabila & Nyemba (2016). It is to this end that

Zambia's civil society response to HIV has been described as "one of the most vibrant" in the ESA region, with approaches relevant to HIV-sensitive social protection including home-based care and peer support for PLHIV (UNAIDS, 2015). UNAIDS however notes that the work of many CSOs involved in the area of for transformative social protection, such as those advocating to the rights of LGBTI people, is often hampered by the country's punitive legal environment.

Advancement of the AIDS response

In Zambia, the AIDS response can be advanced through the effective implementation of Fast Track pillars 2, 3 and 4. In terms of the former, investments in employment opportunities, especially for the youth, can be an effective HIV prevention strategy. In terms of pillar 3 the development and implementation of a social health protection programme as this will increase access to essential health services for PLHIV as well as those at risk of or affected by HIV by addressing barriers that prevent them from accessing health services. Strengthening the active and meaningful engagement of civil society in HIV-sensitive social protection (pillar 4) on the other hand, can help address and respond to high levels of HIV-related stigma and discrimination as well as to advocate for strengthening the legal and policy environment to protect the rights of key populations such as sex workers, MSM, transgender people and PWID.

16. Country overview:

ZIMBABWE

16.1. Brief HIV and AIDS situation analysis

With an adult HIV prevalence of 11.9% (UNAIDS, 2021), Zimbabwe is one of the countries most affected by HIV in sub-Saharan Africa. UNAIDS data further shows that in 2020 there were 1.3 million people were living with HIV, 25 000 new HIV infections, and 22 000 AIDS-related deaths in the country (UNAIDS, 2021). The most affected populations are women, young people, sex workers, prisoners, PWD, and MSM. The main barriers to the country's HIV response include socio-cultural and legal barriers such as polygamous relationships, high levels of gender-based violence, the illegal nature of sex work and same-sex acts, as well as HIV-related stigma and discrimination. In 2011 for example, 20.3% of women and men aged 15–49 years reported discriminatory attitudes towards people living with HIV; this figure barely changed as it was reported to be 20.9% in 2015. In 2014, 6.3% of people living with HIV reported that they had been denied health services because of their HIV status in the last 12 months (UNAIDS, 2019). The working poor, particularly workers in the informal economy have also been identified as facing barriers to accessing HIV services mainly because of poverty resulting from low and erratic income patterns and very difficult working conditions (Zimbabwe National AIDS Council (2020:17). Despite these barriers, UNAIDS data shows that Zimbabwe has achieved two of the three 90s targets: 93% of people living with HIV in the country know their HIV status and a similar proportion of these are on treatment. Only 77% of those on treatment have suppressed viral loads. (Appendix B). Among other things, this progress can be attributed to the availability of a National Policy on HIV/AIDS and National AIDS Strategic Plan (2017-2020), HIV testing and counselling services, antiretroviral treatment (ART) availability as well as prevention programmes such as condom distribution, sex education, Prevention of mother-to-child transmission (PMTCT).

16.2. Social protection mechanisms

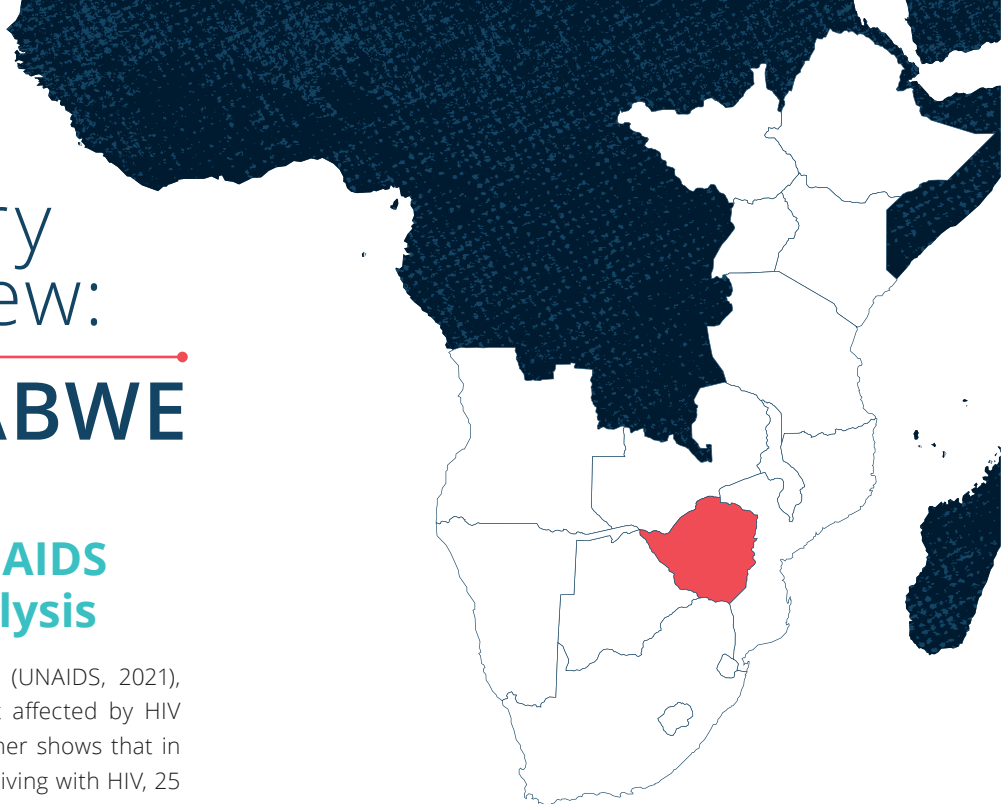
16.2.1. National social protection legislative and policy context

Constitutional and legal provisions

The Constitution of Zimbabwe fully and explicitly recognises and upholds the need to provide social protection to its citizens as articulated by Section 30, which states that ... “the state must take all practical measures, within the limits of the resources available to it, to provide social security and social care to those who are in need.

National social protection policy

The *National Social Protection Policy Framework for Zimbabwe* (2016) aims to “reduce extreme poverty through empowering and building resilience in poor, vulnerable and disadvantaged households” (pg. 32). The policy measures are grouped into five broad categories: social assistance; social insurance; labour market interventions; livelihoods and resilience interventions; social support and care. The Framework defines social protection as a set of interventions whose objectives are to reduce social and economic risk and vulnerability, and alleviate poverty and deprivation.



16.2.2. Social assistance programmes

Programme	Description and focus	HIV sensitivity
Cash transfers		
Harmonised Social Cash Transfer	Unconditional cash transfer introduced in 2011 to increase households' consumption to a level above the food poverty line; and help beneficiaries avoid risky coping strategies (such as child labour and early marriage). Beneficiaries are ultra-poor households that are both labour-constrained and food-poor. They receive cash benefits of between US\$10 and US\$25 per month based on household size. The benefit is paid bi-monthly. Currently there are 19 districts enrolled in the programme and the government plans to scale up the programme to all districts. In 2015 there were 52,049 beneficiary households and 236,013 individual beneficiaries. The programme is administered by the Ministry of Public Service, Labour and Social Welfare and UNICEF	Increases households' access to income
Public Assistance Monthly Maintenance Allowances	Unconditional cash transfer that provides individuals and households in distress with a cash US\$20 per month. Beneficiaries are poor and elderly (60 years of age and older); or people with physical or mental disabilities, or who are severely ill; or a dependent of a destitute or indigent person. The programme reached 6,688 households in 2015. It is administered by the Department of Social Services	Increases access to income for households and individuals that include PLHIV.
In-kind-transfers		
Basic Education Assistance Module	Educational fee waiver introduced in 2001 to enhance access to primary and secondary education for orphans and vulnerable children (aged 6–19), at primary- or secondary-school level. Others are children who have never been to school or who have dropped out due to poverty or children who are currently in school but failing to pay the fees. Ten per cent of beneficiaries should be children with disabilities. The benefits are school fee waivers that cover tuition, levies and examination fees. The amounts are based on the amount charged by each school and are paid every school term (there are three terms per year. There were 194,000 in 2015 and the programme is administered by the Ministry of Public Service Labour and Social Welfare	Educational support for OVCs
Livelihoods promotion		
<i>Not available</i>		
Social health protection		
Assisted Medical Treatment Order	Non-contributory health insurance started in the 1960s to enhance access to health care among vulnerable populations: very poor households; elderly people over the age of 60; people with disabilities; people who are severely ill. Through the programme they have access to health insurance that covers medical bills; Direct government payments to the hospitals upon receipt of claims. There were 25,000 beneficiaries in 2011. The programme is administered by the Government of Zimbabwe, Ministry of Public Service Labour and Social Welfare; and selected mission hospitals	Provides access to health care including HIV and AIDS-related services

16.2.3. Social security programmes

Programme	Beneficiaries and benefits
Old age, Disability and Survivor benefits: <i>To compensate the loss of income resulting from old disability or survivorship</i> Administrative organisations: <ul style="list-style-type: none"> Ministry of Public Service, Labour, and Social Welfare provides general supervision. National Social Security Authority administers the program and collects contributions 	
Old-age pension (Retirement Pension)	<ul style="list-style-type: none"> Age 60 with at least 10 years of contributions; age 55 if in arduous employment for at least seven of the 10 years from age 45 to 55. Employment must cease. Deferred pension: The pension may be deferred up to age 65.
Old-age grant (Retirement Grant)	<ul style="list-style-type: none"> Age 60 (age 55 if in arduous employment) with at least one year but less than 10 years of contributions. Deferred grant: The grant may be deferred up to age 65.
Disability pension (Invalidity Pension)	<ul style="list-style-type: none"> Must be younger than the normal retirement age, be assessed with a permanent incapacity for work, and have at least one year of contributions. A medical doctor assesses the disability.
Disability grant (Invalidity Grant)	<ul style="list-style-type: none"> Must be younger than the normal retirement age, be assessed with a permanent incapacity for work, and have at least six months but less than one year of contributions. A medical doctor assesses the disability.
Survivor benefit	<ul style="list-style-type: none"> The deceased received or was entitled to receive an old-age or disability pension. Eligible survivors (in order of priority) include a widow(er), orphans younger than age 18 (age 25 if a student, no limit if permanently disabled), parents, and other dependents. If there is no widow(er), dependent children are paid through a legal guardian
Survivor grant	<ul style="list-style-type: none"> The deceased received or was entitled to receive an old-age or disability grant. Eligible survivors (in order of priority) include a widow(er), children younger than age 18 (age 25 if a student, no limit if permanently disabled), parents, and other dependents.
Funeral grant	<ul style="list-style-type: none"> Paid to eligible survivors if the deceased had at least one year of contributions. Eligible survivors (in order of priority) include a widow(er), orphans younger than age 18 (age 25 if a student, no limit if permanently disabled), parents, and other dependents.
Funeral allowance (Funeral Benefit Enhancement)	<ul style="list-style-type: none"> Funeral services may be provided when an old-age pensioner dies
Sickness and maternity benefits: <i>To deal with the risk of temporary incapacity</i> Administrative organisations: <ul style="list-style-type: none"> Ministry of Public Service, Labour, and Social Welfare provides general supervision. Employers pay benefits directly to employees.	
Social insurance	<ul style="list-style-type: none"> A government-run health care program provides free primary health care to certain vulnerable persons, including children younger than age 5, pregnant women, and persons older than age 65.

Employer-liability system. Cash sickness and maternity benefits only	<ul style="list-style-type: none"> • Employed persons, including persons employed by local authorities and quasi-governmental organizations. • Exclusions: Self-employed persons. • Special systems for civil servants, military, police, and correctional personnel. • Cash sickness benefit: Must provide a medical certificate from a registered medical practitioner. The benefit is paid for any one-year period of service with the same employer. • Cash maternity benefit: Must have at least one year of continuous service with the same employer and provide a medical certificate from a registered medical practitioner. The employee is eligible for maternity benefits for up to three times with the same employer and only once in a -24month period calculated from the day the previous maternity leave was approved
<p>Work injury benefits: <i>Compensation for work-related injuries and occupational illness</i></p> <p>Administrative organisations:</p> <ul style="list-style-type: none"> • Ministry of Public Service, Labour, and Social Welfare provides general supervision. <p>National Social Security Authority administers the program and collects contributions.</p>	
Social insurance system	<ul style="list-style-type: none"> • Private-sector employees, including casual workers and apprentices; persons employed by local authorities, quasi-governmental, and nongovernmental organizations; and members of cooperatives. • Exclusions: Self-employed persons and household workers. • Special system for civil servants. • Consists of temporary and permanent disability cash benefits, workers' medical benefits, survivor benefits, dependents' allowance and funeral grant
<p>Unemployment benefits: <i>Compensation for the loss of income resulting from involuntary unemployment</i></p> <p><i>Not specified</i></p>	
<ul style="list-style-type: none"> • No statutory unemployment benefits are provided. • The 2015 amendment to the labour law requires employers to provide severance pay to employees who are dismissed due to down-sizing or redundancy. The minimum benefit is 30 days of the employee's wages for every two years of employment 	
<p>Family benefits: <i>To provide additional income for families with young children to meet at least part of the added cost of their support</i></p> <p><i>Not specified</i></p>	

Source: Social Security Programs Throughout the World: Africa, 2019. <https://www.ssa.gov/policy/docs/progdesc/ssptw/2018-2019/africa/ssptw19africa.pdf>

16.3. Summary

Pattern of social protection programmes

In Zimbabwe, citizens' right to social protection and indeed, social security are explicitly recognised in the Constitution and the National Social Protection Policy. Both instruments emphasise the need to provide social care to those in need as well as those at risk of, and vulnerable to, poverty and deprivations. These ideals are supported by the Public Assistance Act of 1998, which provide for the granting of social welfare assistance to persons in need and their dependants; and are also reflected in the pattern of the country's social protection programmes. In essence there is at least one programme falling under each of the four types of social protection, with the chronically ill (including PLHIV) and children being the typical target beneficiaries. It is noteworthy, however, that other key populations such as women, young people, sex workers and MSM are not specifically targeted by these programmes unless they are severely ill or identified as being at risk of, or vulnerable to poverty.

The HIV-sensitive social protection assessment undertaken in early 2020 revealed that there are two specific HIV-sensitive social protection programmes that are currently being implemented, albeit not national. These are:

- i). *Determined Resilient Empowered AIDS-free, Mentored, and Safe women (DREAMS)*. With support from PEP-FAR, this programme is implemented in high HIV prevalence districts and it focuses on HIV and AIDS interventions targeting Adolescent Girls and Young Women (AGYW). The aim is to prevent new infections and the intergenerational impacts of HIV in this age group through interventions such as cash transfers, voluntary Counselling and Testing (VCT), health, education, treatment and psychosocial support.
- ii). *Expansion and Scale-Up of HIV-Sensitive Social Protection*. This is a UNICEF ESARO supported programme implemented in three other ESA countries: Malawi, Mozambique, and Zambia (UNICEF, 2018b). In Zimbabwe, activities under the programme include "strengthening the existing child protection case management system and ensuring effective linkages between the Harmonized Social Cash Transfers and access to additional services" (Zimbabwe National AIDS Council, 2020:17).

Although not acknowledged in any of the national instruments relevant to social protection, informal social protect schemes are also prevalent in Zimbabwe. Perhaps

the most HIV-sensitive is the *Zunde raMambo/Insimu yeNkosi* traditional method of caring for orphans. It essentially refers to a collective field that is worked by the community under the leadership of the traditional authority such as a Chief or village head, for the benefit of indigent persons, specifically orphans (UNAIDS Zimbabwe, 2020:22). Other include burial societies and rotating savings and credit associations as in Botswana and South Africa.

Key stakeholders

In terms of stakeholders, the Ministry of Public Service, Labour and Social Welfare is the lead government ministry responsible for both social protection and social security coordination and implementation in Zimbabwe. Other key actors in this regard are the Ministry of Health and Child Care, Ministry of Primary and secondary Education, the National Social Security Agency and the Workers' Compensation Insurance Fund. The Zimbabwean government receives technical and financial support from United Nations agencies such as the WFP, UNICEF, UNAIDS, UNDP, and ILO. International development partners working mainly in the areas of food security and nutrition include the Catholic Relief Service, Action Aid, Save the Children, Oxfam, among others.³⁴

In terms of civil society participation, there is evidence of the existence of organisations working mainly in the area of HIV and AIDS. For example, a 2019 mapping of CSOs in Zimbabwe (UNDP & UNAIDS, 2019) identified at least 300 CSOs working in one or more aspect of HIV in the country. The extent to which these organisations were also involved in social protection could, however, not be established. What has been established is that CSOs working areas such as human rights and governance issues often face adversarial relationship with the Zimbabwean government (Chikoto-Schultz & Uzochukwu, 2016) These includes CSOs advocating for the promotion of LGBT rights among others.

Advancement of the AIDS response

Zimbabwe's AIDS response can be advanced through the effective implementation of Fast Track pillars 2 and 4. Investments in employment opportunities, especially for the women and youth, who are among the country's key populations, can be an effective HIV prevention strategy. In terms of pillar 4 (strengthening the active and meaningful engagement of civil society in HIV-sensitive social protection), the high levels of HIV-related stigma and discrimination can be addressed as can the rights key populations such as sex workers and MSM.

34 https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/3wop_zimbabwe_november_2016.pdf

17. Summary, conclusion, and recommendations

17.1. Introduction

This report presented the findings of a mapping exercise aimed at assessing the extent to which social protection mechanisms in the 15 UNAIDS Fast Track countries in East and Southern Africa (ESA), are HIV-sensitive or are integrating the vulnerabilities exacerbated by HIV. To achieve this broad objective, a two-phased project aimed at mapping social protection policies and programmes in the 15 countries. The first phase was an in-depth and analytical desktop review of national social protection policies and programmes, and the extent to which they are HIV-sensitive. The second phase entailed key informant consultations conducted in the different countries with stakeholders that represented government, development partners and civil society sectors. In addition to validating the information obtained in the first phase, the aim of the consultations was to solicit stakeholders' perspectives on the key strengths and challenges of the social protection programming in their countries, as well as to obtain recommendations for future action for enhanced provision of HIV-sensitive social protection in the countries and the region as a whole. This final section consolidates the major findings and implications drawn from the two phases. It is composed of two parts. The first part summarises and discusses the main findings from the document review and stakeholder consultations and the second presents the recommendations.

to social protection, the Constitutions of all the countries in the region also invariably guarantee rights-based and non-discriminatory access to social services for all citizens. In Kenya, and South Africa these constitutional provisions are further supported by explicit legislative provisions for social protection through the two countries' Social Assistance Acts of 2013 and 2004 respectively.

Except for Ethiopia and Zimbabwe, all countries also have in place long-term national visions. Similar to what Pino & Confalonieri noted in West Africa, recurring themes in all the national visions in ESA are issues of national solidarity, national unity, and social cohesion. In addition, improved access to education and health services (which form part of promotive and preventive social protection respectively) are widely seen as the key issues through which these visions can be achieved. Others include food security as well as women's empowerment and/or gender equality. All the national long-term vision documents also make specific mention of youth (a key population across in the region) among their target populations.

In terms of the policy frameworks, Table 17.1 shows that countries in the region have varying types of social protection policy instruments: eight are (or planned to be) policies, four are (or are planned to be) policy frameworks, and one is a strategy.

17.2. Key findings

17.2.1. Policy and legislative overview

Following processes such as the 2006 Africa Union-driven Livingstone Process and its Call for Action³⁵ as well as the adoption of the 2008 African Union Social Policy Framework, there has been increased recognition of social protection as a valuable tool to realise Africa's attainment of socio-economic development. As a result, many countries in the continent have created enabling environments for the development and implementation of national social protection policies, supported by Constitutional provisions to social protection as well as national long-term vision documents. Although the Constitutions of Kenya, South Africa, and Zimbabwe are the only three in the ESA that make specific reference

³⁵ Following a three-day intergovernmental conference on social protection held in Livingstone, Zambia in March 2006, the representatives of 13 African governments adopted the 'Livingstone call for action' which calls, among other things, for the development of national social protection frameworks in all the African countries and increased investments in the field of social protection

Table 17.1: Social protection policy documents in selected Fast Track countries

Country	National social protection document	Year
Angola	National Development Plan*	2018-2022
Botswana	National Social Protection Framework	Under development
Eswatini	National Social Development Policy	2010
Ethiopia	National Policy on Social Protection of Ethiopia	2014
Kenya	Kenya Social Protection Policy	2012
Lesotho	National Social Protection Strategy	2011/12-2018/19**
Malawi	Malawi National Social Support Policy	2018-2023
Mozambique	National Strategy for Basic Social Security	2016-2024
Namibia	Social Protection Policy	Under development
South Africa	Social Assistance Act***	2004
South Sudan	National Social Protection Policy Framework	2016
Tanzania	• National Social Protection Framework	Under development
	• Zanzibar Social Protection Policy	2014
Uganda	National Social Protection Policy	2015
Zambia	National Social Protection Policy	2004
Zimbabwe	National Social Protection Policy Framework	2016

Note: *The World Bank has since 2018 been assisting the country to develop a national social protection policy. In the meantime this National Development Plan which has 'social assistance and protection' among its eight key priorities of its first Axis of "Human Development and Well-being" is this guiding document.

** The key stakeholder consultations confirmed that the term of this strategy ended in 2019 and that a second revised strategy was currently under development.

***Drawing on the White Paper on Social Welfare this Act provides the legislative framework for providing social assistance through the social grants system.

The pattern emerging from Table 17.1 may be a reflection of the level of development and/or investments that each country is currently making towards social protection (Pino & Confalonieri, 2014). A policy, for example, can be viewed as a "mini mission statement" for guiding actions and determining what is to be done in particular situations, and it is designed by taking into consideration the opinions and general views of various stakeholders. A strategy, on the other hand, is 'a game plan' to achieve institutional objectives; it is a combination of well-thought intents and actions to lead institutions to their desired outcomes (Bagal, 2016). Finally, a policy framework is a document that defines the principles, scope and lifecycle for all of the entities policies, procedures and schedules. It is designed

to: (i) ensure that a clear and consistent governance and management approach is adopted in the development of all policies, as such enabling improved compliance with relevant legislative and regulatory requirements' and (ii) enable efficient and effective decision making, which incorporates quality assurance and risk management practices, where appropriate; and establish clear accountabilities and delegated authorities for roles.³⁶

In assessing the main objectives of the foregoing national social protection instruments, it emerged that, as in other parts of sub-Saharan Africa (Holmes et al, 2012), the focus tends to be on addressing risks, vulnerability, and chronic poverty through formal supply-side initiatives in education, health, and public works programmes aimed at developing

³⁶ <https://www.monash.edu/policy-bank/policy-framework>

infrastructure and ensuring short-term financial relief for poor families. This may be explained by the fact that for many sub-Saharan African countries, social protection programmes continue to be designed in the context of more comprehensive plans aimed at achieving economic growth, poverty reduction, and sustainable development (Mokomane, 2013). Mitigating the effects of HIV and AIDS is rarely the main impetus for the development of the policies. The policies can however be described as HIV-sensitive as they typically aim to address many of the socio-economic factors that increase the risk of HIV infection and vulnerability in the region.

17.2.2. Conceptualisation of social protection in the region

The types of social protection programmes developed and implemented in any country are largely determined by the definition of the concept. Previous studies have argued that the definition or conceptualisation of social protection adopted by African countries often reflect national priorities and policies (Holmes et al, 2012), the opinions and perspectives of donor agencies that support the formulation and implementation of these social protection policies, or are a mix of donor perspectives and national aspirations (Holmes & Lwanga-Ntale, 2012). This, along with the absence of a standard definition of social protection as a concept, may largely explain variations in the definition used by ESA Partner States (Table 17.2).

Table 17.2: Definition of social protection in selected ESA Fast Track Countries

Country	Definition of social protection
Angola	Definition not stated
Botswana	Programmes that employ public and private initiatives, guided by state policies, to prevent, address, and reduce the risks of poverty and vulnerability for Botswana, be they individuals, family or communities throughout their lives."
Eswatini	Public or private arrangements to protect individuals and families against life-cycle crises. These include the provision of social security, basic social services and developmental social welfare. It also includes developing appropriate labour market policies and strengthening livelihoods
Ethiopia	Formal and informal interventions that aim to reduce social and economic risks, vulnerabilities and deprivations for all people and facilitates equitable growth
Kenya	Policies and actions, including legislative measures, that enhance the capacity of and opportunities for the poor and vulnerable to improve and sustain their lives, livelihoods, and welfare, that enable income-earners and their dependants to maintain a reasonable level of income through decent work, and that ensure access to affordable healthcare, social security, and social assistance.
Lesotho	Definition not stated
Malawi	Implicitly conceptualised as social support that helps the poor and vulnerable to meet their basic needs and overcome their exposure to risks.
Mozambique	Definition not stated
Namibia	Policy still under development
South Africa	Definition not stated
South Sudan	Definition not stated
Tanzania	Traditional family and community support structures, and interventions by state and non-state actors that support individuals, households and communities to prevent, manage, and overcome the risks threatening their present and future security and wellbeing, and to embrace opportunities for their development and for social and economic progress in Tanzania.
Uganda	Public and private interventions to address risks and vulnerabilities that expose individuals to income insecurity and social deprivation, leading to undignified lives

Zambia	Policies and practices that protect and promote the livelihoods and welfare of people suffering from critical levels of poverty and deprivation and/or are vulnerable to risks and shocks
Zimbabwe	A set of interventions whose objectives are to reduce social and economic risk and vulnerability, and alleviate poverty and deprivation.

Source: Social protection policies of the different ESA countries

Consistent with the conceptualisation of social protection discussed in Chapter 1, it is clear that where definitions are available, with concepts such as capability, agency, improved access to economic and other livelihood resources, and overall improved quality of life are implicit in definitions used by all the countries. This is further reflected in the main objectives of the policies, which, for the most part, reflect aims to address risks, vulnerability, and chronic poverty through formal supply-side initiatives in education, health, and public works programmes aimed at developing infrastructure and ensuring short-term financial relief for poor families. This may be explained by the fact that, as for many sub-Saharan African countries (Mokomane, 2013), social protection policies in ESA were designed in the context of more comprehensive plans aimed at achieving economic growth, poverty reduction, and sustainable development. Mitigating the effects of HIV and AIDS is rarely the main impetus for the development of the policies. The policies can however be described as HIV-sensitive as they typically aim to address many of the socio-economic factors that increase the risk of HIV infection and vulnerability in the region.

What is also clear from Table 17.2 is that virtually all the definitions, except that of Tanzania, are silent on informal social protection³⁷. Also known as indigenous social protection systems, these have been described as “bundle of measures taken at household and community level to protect against risks or to combat shocks, in the absence or presence of public or market based arrangements (Balgah & Buchenrieder, 2010:357). They include, but are not limited to family, kinship, age, neighbourhood, professional, nationality, ethnic groups etc. (Mokomane, 2018). The definitions’ silence on these systems is noteworthy given an emerging body of (mainly) pan-African literature, which posits that conventional social protection systems are too narrowly focused on income security, the need to respond to risk and vulnerability, and the need to respond to particular lifecycle needs. Thus, the proponents of this view argue, Africa’s most vulnerable miss out on the benefits offered by more comprehensive frameworks rooted in the socio-cultural milieu of Africans societies (Holmes & Lwanga-Ntale, 2012). This is aggravated by the fact that only 17.8 percent of the African population is covered by at least

one social protection mechanism. This is much lower than the corresponding proportions in other developing regions such as Latin America and the Caribbean (61.4 percent) and Asia and the Pacific at 38.9 percent (ILO, 2017).

A study on the role of indigenous social security systems in the context of HIV and AIDS in Cameroon (Arrey, 2018:207), noted how community-based organisations played a major role in providing services for people living with HIV and AIDS (PLWHA) in the context of limited of public health services, and concluded that:

.... Such responses are particularly valuable in Cameroon where the incidence of HIV/AIDS is high and the frequent high prices have threatened food security for many, including older people caring for PLWHA. Besides directly offering support to PLWHA these organisations have also improved the assistance they give to families caring for PLWHA. Such interventions have reduced the distress of sale of productive and household assets such as livestock and land. This often occurs as families try to cover expenditures incurred due to either illness or death.

Another widely available informal social security system in Africa is the extended family which has, for years, been the base of intergenerational and reciprocal caregiving relations between family members and a source of instrumental, affective and protective support during times of need and crisis such as when family members are unemployed, sick, or aged (Mokomane, 2013). Indeed, a wide body of evidence has highlighted the critical role that the extended family plays in the care of PHLIV as well as children who are often left orphaned by HIV and AIDS (see, for example, USAID, 2008; Nsagha et al, 2012). Studies from Southern African countries such as Botswana, South Africa, and Zimbabwe have shown the role played by popular mutual aid associations such as rotating credit and savings associations (ROSCAs) and burial societies (Mokomane, 2018; Mokomane et al, in press). While models of operation vary, ROSCAs typically comprise of a group of people who regularly contribute

³⁷ Uganda’s National Social Protection Policy does, however, recognise and make mention of these in text.

an amount into to a central 'collective savings vehicle' to build up reserves that can be used to mitigate the effects of unforeseen contingencies including providing for HIV-related care during illness. As with ROSCAs, members of burial societies pool financial resources to build a collective investment fund with a set return to be used towards especially for the burial or funeral costs of the members or nominated dependants (Mokomane et al, 2021). In addition to financial assistance, these mutual aid associations are a major source of psychosocial and practical; support and assistance in times of need and adversity (Ngwenya, 2003; Semanya, 2013; Dafuleya, 2018. This includes when their members or members' family members are sick or have died from HIV and AIDS.

Notwithstanding the foregoing, it is worth noting that the absence of informal social protection mechanisms in official government definitions' of social protection does not necessarily preclude a lack of awareness or value in such mechanisms. It could also be the separation of what is perceived as 'public' and 'private' spheres – or those areas in which governments should or should not play a role. To this end, the greater question remains how to better incorporate, value, and lift up informal mechanisms into current social protection systems.

17.3. Overview of existing social protection programmes

17.3.1. HIV-sensitive social assistance programmes

Types and focus of programmes

The mapping exercise revealed that the most prominent social protection programmes in the region are protective and preventive in nature (Table 17.3). The table shows that of the four types of social protection measures, virtually all the countries have at least one cash transfer (mostly unconditional) and one in-kind (food) transfer programme. In line with the objectives of the countries' social protection policy documents, the main focus of these programmes tend to be on increasing household income, enhancing food security and nutrition and improving access to education. To this end, the target groups of these programmes are for the most part, poor and vulnerable households, children, the elderly and people with disabilities. Livelihood promotion activities, mainly public works programmes targeting young people and able-bodied working age pupations, are also widely implemented in the region.

Table 17.3: *Types of social protection programmes in East and Southern Africa, Fast Track countries*

Country	Cash transfer	Food Transfers	Livelihood promotion	Social health protection
Angola	✓	✓	✗	✗
Botswana	✓	✓	✓	✓
Eswatini	✓	✓	✓	✓
Ethiopia	✓	✓	✓	✓
Kenya	✓	✓	✓	✓
Lesotho	✓	✓	✓	✗
Malawi	✓	✓	✓	✗
Mozambique	✓	✓	✓	✗
Namibia	✓	✓	✗	✗
South Africa	✓	✓	✓	✗
South Sudan	✓	✓	✓	✓
Tanzania	✓	✓	✓	✓
Uganda	✓	✓	✓	✗
Zambia	✓	✓	✗	✗
Zimbabwe	✓	✓	✗	✓

Source: Author's interpretation

Notes: ✓ Available

✗ Not available

Another noteworthy point from Table 3 is that there is a general absence of social health protection systems in the region, with only seven countries (less than half) having such a system. This is further reflected in the significantly high

proportions of the population that is without legal coverage for health services in the majority of the countries and the high out-of-pocket health expenditure in those countries that have some form of social health protection (Table 17.3).

Table 17.3: Deficits in universal health protection, East and Southern Africa

Country	Legal health coverage deficient	Out -of-pocket expenditure
	% of population without legal coverage for health services	% of total health expenditure
Angola	100	--
Botswana	--	4.4
Eswatini	93.8	14.1
Ethiopia	95.0	36.1
Kenya	60.6	45.8
Lesotho	82.4	17.6
Malawi	--	14.0
Mozambique	96.0	5.7
Namibia	72.0	7.7
South Africa	--	7.4
South Sudan	--	65.2
Tanzania	87.0	31.9
Uganda	98.0	49.9
Zambia	91.6	26.3
Zimbabwe	99.0	--

Source: ILO (2017). World Social Protection Report 2017-19. General: International Labour Organisation

Notes: ---data not available

To the extent that out-of-pocket health fees are some of the key factors that increase vulnerability and exposure to the risk of HIV infection in the ESA (Abah, 2020), the absence of social health protection systems in most of the countries in the region is a notable gap in terms of HIV- sensitivity. Although many of the countries provide health care services to their citizens through primary health care systems (Chatora & Tumusime, 2004; Onokerhoraye, 2016), social health protection systems are the most ideal in the context of ESA where high levels of poverty and out-of-pocket health fees often force people to choose between paying for health care and paying for basic socio-economic necessities. This is because such systems provide access to universal, affordable access to relatively better quality health care as well as financial protection in times of illness, injury

and maternity (International Labour Organisation, 2008). Furthermore, as Both & Magotir (2019:30) commented in their HIV and social protection assessment for Tanzania “ensuring access to health insurance schemes ... for people living with HIV is critically important considering that, while HIV treatment is provided free of charge, treatments for opportunistic diseases are not; health insurance schemes can therefore assist people living with HIV in accessing the health services they require”. The following excerpt, from a stakeholder consultation with a representative of the Kenyan National Hospital insurance Fund (NHIF) illustrates how a social health protection system can cater for all categories of people including the poor and vulnerable as well as those working in the informal sector:

The way we operate is that, if you are in formal employment your employer will deduct a certain amount based on your salary and that will come to the NHIF; that is based on the law; we are guided by the NHIF Act of 1998. Then we have the informal sector who are voluntary members. This means they join the NHIF if, and when, they wish, and for them there is a flat rate equivalent to US\$5.00 and for this they receive the same services as everyone. We also have the category of the poor and vulnerable who are supported by government. The government pays premiums of their behalf. In general, we work on the principle of cross-subsidisation where the rich pay for the poor, the healthy pay for the sick, the young pay for the old. We balance it on the basis of diseases burdens and the solidarity principle.

It also emerged from the mapping exercise that countries in ESA generally lack transformative social protection programmes, where 'transformative' refers to the need to address societal power imbalances that encourage, create and sustain vulnerabilities (Devereux & Sabates-Wheeler, 2004). For example, although high levels of HIV-related stigma and discrimination and HIV-specific criminal legislation are additional key factors that increase vulnerability and exposure to the risk of HIV infection in the region. To the extent that most of the existing programmes in ESA are not aimed at addressing these issues, it can be argued that social protection programming in the region is missing some of the most critical entry points for interventions. It also means that many vulnerable and often social excluded populations such as sex workers, men who have sex with men, and transgender people are not being reached by the social protection programmes in the region, thus calling into question the HIV-sensitivity of the programmes. As a stakeholder from Namibia asserted:

Namibia has high teenage pregnancies, high gender-based violence and intimate partner violence that create an environment that is not conducive to women and other marginalised populations such as the LGBTIQ from accessing social protection programmes that are available because these populations are not empowered; they don't have the means to do so. So there is one thing about availability of the programmes but there is also the more difficult issue of how do you allow them to be accessible to the people who need them. This calls for a larger discussion about the social, cultural and somehow legal barriers that hamper access. A simple example is a transgender woman not being able to get the healthcare they need because the healthcare worker is stigmatising them, and the difficulty of a transman accessing these services in an environment that does not openly accept their sexuality and gender identity is difficult.

All in all, the widespread criminalisation of sex work and same sex-acts suggest that social protection programming in the region lacks a transformative aspect of social protection and is, somehow, misaligned with the countries' policy and strategic frameworks as well as constitutional provisions that, almost invariably, state commitments to protecting and promoting citizens' fundamental human rights and freedoms. This gap is particularly notable given the high rates of HIV-related stigma and discrimination in the region.

HIV-sensitivity of programmes

In terms of HIV-sensitivity, the majority of social protection programmes do not specifically target HIV issues or PLHIV. Rather, and in line with the constitutional and policy provisions, the programmes tend to be inclusive of the vulnerabilities of various populations including PLHIV and, hence, are seen sufficient to encompass HIV and AIDS (Wakunuma & Matsika, 2020). For example, while old age grants are meant to meet the needs of the elderly themselves, research evidence has shown that these grants play a major role in assisting many grandmothers who are caring for grandchildren including those orphaned by HIV and AIDS. The following statements by various stakeholders illustrate this point further:

We do not have a package specific for HIV but there is a government policy that all HIV and AIDS patients access free ARVs in all government facilities. In terms of the NHIF we cover opportunistic conditions from HIV such as TB, pneumonia etc. Therefore, in most cases you will not be covered as an HIV/AIDS patient but just as an NHIF member accessing services. So PLHIV access services based on their needs (Representative, NHIF, Kenya).

Government social protection system in terms of HIV sensitivity is not very strong because government considers chronic illness and not necessarily HIV and its programmes, so it's very general (Representative, WFP, Mozambique)

Similarly, commenting on a WFP-supported food transfer programme, a WFP Zimbabwe representative said:

Our selection criterion does not side line HIV as such, but it is not specific to HIV. Of course, of PLHIV meet the criteria they may benefit from the programme but the criteria itself is not specific to HIV...I am not sure why but it may be due to issues to do with confidentiality because service provision is very public. It takes place as general food distribution points where the targeting is done at community level.

Despite the foregoing, civil society stakeholders across the countries highlighted the importance of social protection programmes that are targeted specifically at PLHIV and for governments to work with civil society to ensure access. Notwithstanding notions that greater emphasis on HIV in social protection programmes may be counterproductive by increasing stigma and reducing programme inclusiveness (Wakunuma & Matsika, 2020:10), the basic thesis of civil society stakeholders is that PLHIV are often reluctant to either disclose their status and/or access social protection services and hence need specific targeting. For example

... due to stigma, PLHIV often do not want to disclose their status and access safety net programmes. They would rather try to join PLHIV associations and look for support which is currently limited. ... I therefore recommended that PLHIV should be part of the selection committees because when PLHIV are part of that they know who really is in need and needs access (Representative, civil society organisation, Ethiopia).

We need PLHIV to be prioritised. We can be engaged; we can be called to engage with the social development ministry to ensure that we provide the right people who need assistance from the social development ministry (Representative, civil society organisation, Lesotho).

Duration and location

Many of the existing social protection programmes came into being in the late 1990s and early 2000s are now established and provided nationwide or targeted at specific areas of high need. Unfortunately, data constraints hampered a more detailed analysis of the specific duration, locations and coverage of such programmes in the different countries. This affirmed an observation by UNAIDS (2018) that poor data collection systems are widespread and create many challenges in sub-Saharan Africa's social protection programming. UNAIDS asserts that the resultant lack of, or limited access to strategic data, greatly hampers the targeting of interventions aimed at addressing key population needs, compromises the implementation of many high-impact HIV prevention programmes to the necessary standard or scale, and overall limits the monitoring and evaluation of the effectiveness of programmes. In line with this, a stakeholder from a United Nations agency in Ethiopia described the country's data limitations as follows:

At the moment [beneficiary] information is difficult to get hold of; it's bit fragmented. You have to go to individual donors and ministers to get information on beneficiary numbers. It is difficult to say how many people in a programme are disabled or have a certain type of chronic disease or are PLHIV. We cannot even disaggregate how many children are there versus adults. The information is not easy to get and we have to use estimate. At the moment it is quite rudimentary in terms of the data you can pull out of the system and report on.

The stakeholder however shared that they were currently developing a more sophisticated data-driven systems that can inform policy decisions and improve programmes using a life cycle approach.

Available data however suggest that coverage of social protection programmes in ESA is generally low. For example, a United Nations stakeholder in Malawi said, "The cash transfer is the flagship programme in Malawi. It is a programme that is at scale, it's nationwide, it's in every district. However, the programme only target 10% of households in a district".

Scope

Conspicuously absent from the region are ‘cash plus’ programmes which provide cash payments in combination with complementary services such as educational training or nutrition seminars for new mothers or carers, support services such as psycho-social counselling, and the facilitation of access to services such as health insurance, or strengthening the quality of existing services and linkages (Roelen et al 2017). The current momentum around these programmes relates to the evidence showing that despite their numerous positive impacts in reducing poverty and promoting well-being, cash transfers alone are unable to lead to long-term positive impacts on a number of health and development outcomes (Toska et al, 2016; Roelen et al 2017).

An example of a successful ‘cash plus’ programmes in Africa includes the Livelihood Empowerment Against Poverty (LEAP) programme in Ghana, the Integrated Nutrition Social Cash Transfer (IN-SCT) pilot project in Ethiopia, and the Sihleng’imizi Family Programme in South Africa. The LEAP programme is a social cash transfer programme that provides cash and health insurance to extremely poor households across the country³⁸. The cash transfer is paid every two months to registered vulnerable household members (such as the elderly, orphaned children, and people living with disabilities who are unable to work) in selected communities. The second component entails the LEAP programme and Government paying national health insurance premiums for extremely poor people, pregnant women and children under 18 years (Sulemana et al, 2018). An assessment of this programme by Sulemana and colleagues noted its positive contribution to be, *inter alia*, poverty reduction through the reduction of hunger, improved access to health care, child education, investment in agriculture and other income-generating activities (Sulemana et al, 2018: 10).

The IN-SCT is embedded within Ethiopia’s Productive Safety Net Programme. It is delivered to millions of poor rural households throughout rural Ethiopia in the combination of unconditional cash transfers, public and asset transfer (Roelen et al, 2017). Roelen and colleagues report that while several evaluations have confirmed that, while the programme has had limited impact on nutrition, it has improved household food security and protected productive assets against distress sales.

The Sihleng’imizi Family Programme was designed to strengthen families who receive one or more child support grant³⁹ (CSG) in order to complement and scale up the positive benefits of the CSG as a protective measure for

disadvantaged children. It entailed all members of the selected participant families attending a 14-week group programme designed to improve their knowledge and skills in the five areas. These were: (i) child-caregiver relations: improving communication, family cohesion, behavioural management, and caregiving capabilities; (ii) involvement of caregivers in the child’s education; (iii) social and community connectedness: improving social networks and social supports; (iv) financial capabilities: enhancing basic budgeting and savings knowledge and skills, and (v) nutritional knowledge such as basic nutrition and hygiene in food preparation (Patel et al, 2019: 5). The programme evaluation revealed that it considerably enhanced the first four areas while nutritional and food preparation, hygiene knowledge was increased to a modest degree (Patel et al, 2019: 5).

17.3.2. Contributory social security programmes

As in many parts of sub-Saharan Africa, contributory social security schemes in the ESA benefit formal sector employees, majority of whom are public servants. The contingencies covered typically include old age (pension benefits that sometime also provide benefits in case of disability or death of the main breadwinner) and employment injury. The least covered contingency is unemployment, followed by family, sickness and maternity benefits, which are usually directly provided by employers and not by social insurance schemes. Overall, and similar to the observation made by Mokomane (2013), the following are some salient points about the social security landscape in the region:

- i. Informal sector workers, who account for more than two thirds of the labour force in the many countries of the region do not have access to social security benefits (Bonnet et al, 2019; ILO, 2019)
- ii. With men dominating formal sector employment in sub-Saharan Africa (Bonnet et al, 2019), this social security pattern has the potential to leave families, headed by women vulnerable to poverty and, the impact of HIV. As Mokomane (2013: 6) given the relatively higher employment rates among men in the region, the predominance of contributory social security means that in the event of heterosexual family breakdown, either through divorce, separation or death, the affected women are often not entitled to current or future social security benefits.

38 <http://www.ghana.gov.gh/index.php/media-center/features/1641-leap-as-a-tool-to-alleviate-poverty>

39 A means-tested cash transfer paid to the primary caregivers of poor children aged 18 years and below

On a progressive note, this mapping project revealed that many countries in the region are in the processes of undertaking reforms aimed at increasing social security scheme efficiency and addressing some of the exclusion problems inherent in the schemes. For example, after years of social security in Ethiopia being only for permanent public services employees, a government stakeholder explained that *“now it covers all employees in the public sector; even if you work for a month there is coverage”*. It was also revealed that the ILO and the European Union in Uganda are currently developing a programme for the informal sector to ensure that workers in the sector are included under social security insurance and that they are guaranteed some kind of income security. Such developments are important and worthy of sharing given that in many countries many PLHIV or families affected by HIV and AIDS work mainly in the informal sector. A representative of the National Hospital Insurance Fund in Kenya, for example, asserted that, *“retaining informal sector employees in the scheme⁴⁰ is very difficult because the fluid and seasonal nature of their incomes means they fall in and out of poverty”*. An important point to note in all efforts to include informal sector workers in contributory social security schemes.

17.4. Stakeholders involved in social protection programming

When there are multiple actors in a national initiative or programme, the need for stakeholder mapping becomes critical. According to UNAIDS (2007:27), mapping is a way of displaying “the main systems, links, communication/information and funding flows as well as accountability and coordination mechanisms that comprise the complex web of organizational and institutional relationships in the national AIDS response”. According to UNAIDS, stakeholder mapping is useful in several ways including:

- i. showing who the main actors are and how they are working together;
- ii. making explicit the way in which different partners or actors relate to each other;
- iii. helping clarify the strengths and weaknesses of various communication and coordination mechanisms;
- iv. helping in highlighting the ways in which certain essential stakeholders may be “missing”; and
- v. assisting a coordinating authority in assessing the effectiveness of a national response, policy or programme.

To the extent that fragmentation and a lack of coordination and synergy are symptomatic of social protection systems there is typically a need to establish robust institutional frameworks for policy and programme implementation, with specific and complementary roles and mandates (Holmes et al, 2012; Pino & Confalonieri, 2014). In line with this notion, there seem to be wide regional recognition of the multi-sectoral nature of social protection and the important role of various actors in ensuring the effective implementation of the social protection policies, and programmes. To this end, the social protection policies of all the ESA countries provide, to varying extents and details, the institutional frameworks that will operationalise the documents. Almost invariably, the role of stakeholders from government, civil society, and development partners, and in some instances, the private sector are clearly articulated. In line with this, each country in the region has a lead government ministry that provides policy guidance and administration of the overall social protection system. The lead ministry or department is typically supported by other or sector-specific ministries. The ministries of health and education seem to be the most common and this can be partly explained by the programmes’ typical focus on education and health discussed earlier. Employment and/labour-related ministries as well as social security administration entities mostly administer contributory social security programmes (Table 17.3).

40 This can apply to any contributory scheme

Table 17.4: Key government stakeholders in all countries

Country	Lead government ministry/Department	Other government ministries/Departments
Angola	Ministry of Social Action, Family, and Promotion of Women	Ministry of Education; Ministry of Health; Ministry of Public Administration and Labour; National Social Security Institute
Botswana	The Ministry of Local Government and Rural Development	Ministry of Youth Empowerment, Sport and Culture Development; Ministry of Health; Ministry of Employment, Labour Productivity, and Skills Development
Eswatini	Department of Social Welfare	Ministries of Education, Health, Agriculture and Co-operatives; Prime Minister's Office; National Emergency Response Council on HIV and AIDS; Ministry of Labour and Social Security and the Eswatini National Provident Fund
Ethiopia	Ministry of Labour and Social Affairs, Ministry of Agriculture	Ministry of Finance; Public Servants' Social Security Agency; Private Organization Employees' Social Security Agency
Kenya	Ministry of Labour and Social Protection	Ministry of Education; Ministry of Health, Agricultural sector ministries; National Health Insurance Fund; National Hospital insurance Fund
Lesotho	Ministry of Social Development	Ministry of Finance and Development Planning; Ministry of Education; Ministry of Forestry and Land Reclamation; Ministry of Health
Malawi	Ministry of Gender, Children Disability and Social Welfare	Ministry of Transport and Public Works; Ministry of Health; Ministry of Labour, Youth, Sports and Manpower Development; Reserve Bank of Malawi
Mozambique	Ministry of Gender, Children and Social Action	National Social Action Institute; Ministry of Labour , Employment and Social Security; Ministry of Public Function
Namibia	Ministry of Gender Equality and Child Welfare	Ministry of Health and Social services; Ministry of Education; Ministry of Labour, Industrial Relations and Employment Creation; Ministry of Poverty Eradication and Social Welfare; Social Security Commission
South Africa	South African Social Security Agency	Department of Social Development; Department of Health; Department of Basic Education; Department of Public Works; Department of Labour; South African Revenue Services; Unemployment Insurance Fund
South Sudan	Ministry of Gender, Child and Social Welfare	Ministry of Finance and National Economy
Tanzania	Ministry of Health and Social Welfare	Ministry of Education and Vocational Training; Prime Minister's office; Social Security Regulatory Authority; Public Service Social Security Fund; National social Security Fund
Uganda	Ministry of Gender, Labour and Social Development	Office of the Prime Minister; Ministry of Finance, Planning and Economic Development; Uganda Retirement Benefits Regulatory Authority; National Social Security Fund
Zambia	Ministry of Community Development and Social Welfare	Ministry of Health; Ministry of Education; Ministry of Labour and Social Security; National Pension Scheme Authority
Zimbabwe	Ministry of Public Service, Labour and Social Welfare	Ministry of Education; Ministry of Health; National Social Security Authority

Consistent with previous social protection mappings in the region (for example IPCIG, 2016) it emerged that in most of the countries, social protection programmes are implemented with the financial and/or technical support of external partners including United Nations agencies, bilateral and multilaterals agencies as well as international non-governmental organisations. Indeed, the mapping done by the International Policy Centre for Inclusive Growth (IPCIG, 2016) revealed that around 40% of social protection programmes in sub-Saharan Africa are implemented with financial or technical support of external agencies or NGOs. Interviews with in-country stakeholders suggested that United Nations agencies and bilateral and multilateral agencies typically provided technical and/or financial support for broader, national and long-term programmes. As a WFP representative in Mozambique said “WFP works though the government interventions. We do not initiate programmes, the areas we work with are preselected by government and the vulnerability criteria has also been defined by government”. International non-governmental organisations, on the other hand, typically provide support for specific and often short-term projects. World Vision in Lesotho, for example, is supporting an advocacy campaign to child marriage at community levels as well as broadly. A *non-exhaustive*⁴¹ list of development partners that currently provide the various forms of technical and financial support in the different countries of the region includes:

- **United Nations agencies:** WFP, UNICEF, UNAIDS, FAO ILO, UNAIDS
- **Bilateral and multilateral agencies:** World Bank; Embassy of the Kingdom of the Netherlands; European Commission; DANIDA, AUSAID; Irish Aid; SIDA; USAID, FCDO, GFATM, GIZ, Irish Aid; The European Union
- **International NGOs-** World Vision, FHI 360; Save the Children, Oxfam, Concern International, Catholic Relief Services, HelpAge International.

Working in collaboration with government and/or development partners, civil society also plays a major role in supporting social protection programming, including HIV-sensitive social protection. For example, an official from the national AIDS Council in Lesotho said:

We work with civil society to a very great extent when they do HIV/AIDS work. We even have an internal technical working group for civil society organisations where we work with them. We check what they are doing, check their challenges, we advocate accordingly in relevant offices, Recently we have also just started what is called a Directors' Forum where the directors of CSOs meet with us and donors and development partners to discuss funding and so that we can harmonise the work done by civil society throughout the country

It emerged that most CSOs work at the local level to provide important services and benefits that would otherwise be neglected by the main social protection programmes. The Lesotho Network of People Living with HIV and AIDS (LENEPWHA) for example, works with lay counselors in the communities to improve HIV testing. In Ethiopia, one of the key activities of NEP+ (formerly known as Association of **Ethiopians** Living with HIV/AIDS) is to generate updated information on HIV and/or social protection and disseminate it at grassroots levels. CSO also tend to reach key populations that do not form the target of the national policy and programme frameworks. In Mozambique, North Star Alliance works with sex workers and truck drivers, among other groups, to facilitate their HIV testing and, if necessary, to refer them to the appropriate facilities to initiate ART treatment.

In many countries, however, CSOs play a major role in ensuring transformative social protection for PLHIV and key population. The Botswana Network on Ethics, Law and HIV and AIDS (BONELA), for example, implements programmes to address human rights-related barriers to HIV-prevention and treatment services at scale while the Lesbians, Gays & Bisexuals of Botswana (LeGaBiBo) played a major role, by being admitted as “a friend of the court”, in a June 2019 High Court ruling that decriminalized homosexuality in the country. The ruling made Botswana one the few African countries that have legalised same-sex relationships. In South Africa, Treatment Action Campaign has been widely recognised and credited with using a combination of human rights education, HIV treatment literacy, demonstrations, and litigation to force the government of former South African President Thabo

41 This is meant to illustrate the spread of stakeholders and not, in any way, to provide an exhaustive list.

Mbeki to avail antiretroviral therapy to all South Africans living with HIV and in need of treatment (Heywood, 2009). For the most part, CSOs use advocacy activities to ensure this transformative social protection. As a representative of the Swaziland Network of Young People Living with HIV said:

As a network of young people living with and affected by HIV we advocate of an enabling environment for young people to participate in the design of programmes and activities that target the needs of young people living with HIV. We also look at all national policies and programmes to see if they are conducive to our needs...

In many countries, the disruption brought by the COVID-10 epidemic meant that many PLHIV who are on treatment were at risk of missing out on their regular prescriptions. In Ethiopia, NEP+ advocated for AIDS patients to be given 3-6 months advance prescriptions to ensure that they had treatment. In remote parts of the country NEP+ drew on their over 5400 volunteers to make house-to-house deliveries of the treatment to PLHIV who were comfortable with that.

Partnership arrangements in the HIV-sensitive social protection arena

While the foregoing lists of stakeholders are not exhaustive, the critical point is that in each country they are various stakeholders involved in social protection programming and these typically involve – to various degrees – governments ministries, development partners, and CSOs. Private sector organisations tend to participate, to a very limited extent and mainly in the administration of some of the countries' social security programmes. To this end, the harmonisation and alignment of efforts becomes critical. According to the OECD-DAC (2005), *harmonisation* is a foundation for links between partners that can reduce transaction costs for partner governments. Activities can range from the informal exchange of information to simplified procedures and common arrangements for designing, managing and implementing support. *Alignment*, on the other hand, entails the building of relationships between governments and other partners to align the latter's inputs with national processes. Research on the usefulness of stakeholder harmonisation and alignment has consistently identified benefits such as enabling more systematic incorporation of donor activities into national policy and other decisions that can trigger systemic change; identification and addressing of capacity gaps in programme; and the capacity to address weak regulatory functions and governance mechanisms (Welle et al, 2008). Overall, therefore, harmonisation

and alignment of stakeholders' efforts is regarded as a critical foundation for ensuring effective programme implementation and achievement of required results. It is to this end that this project brief specified the exploration of the capacity of stakeholder coordination mechanisms and structures as well as the identification of barriers for effective coordination of stakeholder efforts and inputs. The following, in no order of priority, are some of the main gaps that were identified as barriers to the harmonisation and alignment of efforts made by the different social protection stakeholders in the region.

Overall weak stakeholder coordination at national and local levels.

Weak stakeholder coordination was a recurring theme in virtually all the consultations held with stakeholders. As a stakeholder from Lesotho said:

The issue with civil society in Lesotho is that we do not have a good coordination mechanism so it becomes really difficult to the extent that we find ourselves fighting for meagre resources that are there. So we may in the end find ourselves duplicating efforts. What causes the problems is the absence of a coordinating body. In the past we used to have the National AIDS Commission. It did a good job coordination and ensuring that there is no duplication of efforts because they would know who is doing what and where. They would even tell you where there is a need. Unfortunately they were dissolved and even though they have been resuscitated they face major resources constraints.

Implicit in the foregoing excerpt is that stakeholder coordination is important. Indeed, stakeholders in South Sudan stated due to their regular coordination meetings there was relatively good harmonisation of efforts:

When it comes to the issue of coordination that is going on with the other agencies because we are here to serve the same communities so we make sure that we really work as a team. As a State, they are really out there to try and identify those who are out there to avoid duplication of services. They make sure that every partner that comes in to implement a programme has to go through the State and the programme need to be approved to avoid the aspect of duplication

It emerged that poor coordination leads to an array of issues as the following excerpts illustrate:

You find that there are many interventions targeting the same people and you find that even the beneficiaries receiving these services have fatigue because everyone wants to give them some sort of support ... So you don't have a wide coverage as you are always targeting and covering the same population (Government official, Kenya).

There are various criteria to assess vulnerability of people in the country. That must not be the case. There needs to be one criteria which can be developed by, say, the Disaster Management Authority. But it seems each organisation that has some funding develops their own criteria. A lot of those criteria are different; they don't speak to each other. Having one criteria will ensure that the most vulnerable qualify and that if they qualify for one project they do not unfairly benefit from another similar project (Government official, Lesotho)

Stakeholder coordination is fragmented. We had CSOs in the working groups of the stakeholder consultations we undertook and some of them were simply not aware of some the services or programmes available to their constituents, especially small CSOs that may not be well-connected or have the right information. It is not that they were left out but simple lack of information or lack of dissemination of information (Representative, UN agency, Namibia)

Resources constraints

Limited human resources and administrative capacity required for effective social protection programming, particularly in 'hard to reach' areas was another challenge highlighted by stakeholders. In a way this is also a reflection of the weak stakeholder coordination at national and local levels. For example:

Resources contains go beyond money. In South Sudan it also concerns human resources; human capital. First of all in the remote refugee hosting areas there is high turnover of qualified staff for various reasons: its remote, its insecure but at the same time host population have social protection needs (Representative, UN agency South Sudan)

Documentation issues for nomadic populations hamper efforts to follow up on their receipt of social protection services. We have migrants and cross-border people and we often grapple with the question of how you can give full social protection even though we do give health services to those who cross borders; we don't deny them (Representative, UN agency, Namibia).

Lack of transparency in beneficiary selection

The apparent lack of transparency and prevalence of corruption in the selection of beneficiaries for social protection benefits was highlighted, mainly by civil society stakeholders, as another challenge in the social protection programming of many countries. For example, one stakeholder in Ethiopia lamented, "Selection of benefits is not transparent. Some are selected because they are relatives or friends and sometimes those that should access do not". Similarly, a stakeholder in another country also said, "In [this country] things are not very transparent and selection of beneficiaries tends to be politically motivated. As a result, some of the people who need to receive benefits do not receive them and those that should not be receiving them receive them.

17.5. Views on the impact of COVID-19

Given that the stakeholder consultations were held during the period of the COVID-19 pandemic, the stakeholders' views on its impact on social protection programming now and in the future were solicited. Below are some of the recurring views that emerged from stakeholders in different countries of the region:

- "Covid highlighted the need to expand coverage of social protection because of the devastating nature that the pandemic brought to the people" (Uganda, UN)
- "Covid affected food security and we know food is a very important component of HIV responses. Without food, the nutrition status of PLHIV will deteriorate and their progression of HIV will be fast. So as partners we need to push government through social protection mapping to identify the most vulnerable among PLHIV and design social protection programmes that are nutrition sensitive or to bring to scale those that are existing currently" (Stakeholder, UN agency Uganda)
- "Covid brought a whole lot of disruptions. So social protection should be Covid sensitive in nature more so that most of our population is in the informal sector" (Stakeholder, UN agency Zimbabwe)
- "Covid exacerbated the vulnerabilities of people and highlighted the need for people to have a network whether formal or informal through insurance schemes or health services or through community networks because many people rely on their communities and families" (Stakeholder, UN agency Namibia)
- "Media report and research evidence suggest that PLHIV are the most vulnerable to Covid infections and deaths. The main challenges include defaulting in treatment adherence as well as impact on livelihoods, employment and income. This shows that social protection programming must be multi-sectoral" (Stakeholder, UN agency Ethiopia)

17.6. Recommendations

From the key findings of this mapping project, the following are recommended actions for government, donors and civil society as well as for WFP, ILO, and UNAIDS to consider in reforming and/or improving the availability and accessibility to HIV-sensitive social protection programmes in the ESA as a region, as well as in specific countries. The recommendations are not presented in any order of priority.

1. Support regional and national processes to ensure that social protection policies and programming are HIV-sensitive

A key finding is that the ESA enjoys general political commitment to social protection through enabling legislative and policy frameworks. However, apart from specific and often small projects funded by international non-government organisation, there is no specific targeting for PLHIV in social protection programmes in many countries of the region. Thus the WFP, ILO, UNAIDS as well as other development partners should consider offering technical support to the region and/or individual countries to make sure that major social protection programmes are explicitly HIV-sensitive in this regard. This could be done as a specific targeted process or as part of future processes meant to evaluate and/or amend these programmes.

2. Support the development of transformative social protection programming.

Transformative social protection programmes aimed at addressing HIV-related stigma and discrimination as well as protecting key populations against punitive legislation is conspicuously missing from the region's social protection landscape. Evidence has shown that due to their comparative advantage in reaching out to vulnerable and/or hard to reach populations, as well as increasing demand for services, CSOs have, for the most part attained positive outcomes in this regard. However, the work of these organisations is often hampered by financial, administrative and human resources constraints. United Nations agencies and other development partners should consider supporting and/or working with these organisations to ensure widespread transformative social protection in the region's countries.

3. Support the expansion of social health promotion

Drawing on the wide evidence, from some of the countries the region, on the modalities of operation and success of social health promotion schemes, all governments in the region need to consider the development and /or expansion of social health promotion schemes for their populations in general as well as given the HIV context in each country.

4. Improve the quality and quantity of data available to drive national and regional decision making and resource allocation

There is need for investments in data collection and dissemination system that will provide robust information to support HIV-sensitive programming and decision-making in all countries and in the region as a whole. The following specific considerations may be useful in this regard:

- i. Identification of the core indicators for which data needs to be collected and/or analysed at all levels is important for both partners and partners implementing programmes.
- ii. Putting in place mechanisms to ensure that data is well disseminated and easily accessible to those who need it in order to make the programming more efficient.
- iii. Strengthening monitoring and evaluation systems to enable the region's HIV-sensitive social protection programming to be evidence-based, and ultimately more effective.

5. Support the coordination and harmonisation of stakeholder efforts

The apparent lack of coordination among the different stakeholders, especially at local levels as well as the duplication of efforts call for better clarification and strengthening of the mode of operation of all partners in each country's HIV-sensitive social protection programming. This can begin with in-depth sector analysis to identify key and active actors as well as those missing from the programming. This should be followed by consultative engagements to develop clear partnership coordination arrangements as well as modalities to strengthen communication flows between and among stakeholders. This agenda should have a particular focus on enhancing the role of CSOs given the wide evidence on this sectors' ability to reach out to grassroots levels as well as its documented success in ensuring accessibility to transformative social protection and social health protection.

6. Strengthen social protection programmes to cater for covariate shocks

By design, many of the current social protection programmes in the region are aimed at managing idiosyncratic risks. The Covid-19 epidemic has however highlighted the need for social protection programmes to building communities' resilience to covariate shocks (Balgah & Buchenrieder, 2010) and for future programming to take this into consideration. In doing this, it is recommended that specific consideration should be given to enhancing the role of indigenous social protection systems. Described as "bundle of measures taken at household and community level to protect against risks or to combat shocks, in the absence or presence of public or market based arrangements" (Balgah & Buchenrieder, 2010:357), these systems (for example extended family and community based organisations have consistently demonstrated critical success in the promotion of a variety of HIV-associated risk reduction strategies.

7. Establish mechanisms and strategies to integrate informal social protection systems into current programming

Calls have been made for countries to capitalise on the synergies between informal and formal social protection systems (Holmes & Lwanga-Ntale, 2012; Noyoo & Boon, 2018). Otherwise questions around the appropriateness of existing social protection policies, strategies and programmes in Africa may persist and aggravate the perceived 'resistance among several African governments to the scaling up of the existing [mostly] donor driven pilot schemes. To this end, and given the evidence of the important role that these informal systems is supporting vulnerable population in some of the countries in the region, it is recommended that they should be incorporated into existing formal systems. Doing this may require the involvement of traditional leaders and cultural experts to provide guidance and to ensure that the resultant models of incorporation are both context specific and culturally sensitive social protection.

References

- Abah R. C. (2020). Achieving HIV targets by 2030: The possibility of using debt relief funds for sustainable HIV treatment in sub-Saharan Africa. *Journal of public health policy*, 41(4), 421–435.
- Ajwad, M.I., Abels, M., Novikova, M. & Mohammed, M.A. (2018). *Financing social protection in Tanzania*. <http://documents.worldbank.org/curated/en/999381538657815182/pdf/PER-P161653-ADD-VC-PER-PUBLIC-TZ-SP-PER-Final.pdf>
- ARASA (AIDS & Rights Alliance for Southern Africa (ARASA) (2016). *HIV, TB and human rights in Southern and East Africa: Report 2016*. https://hivlawcommission.org/wp-content/uploads/2017/07/ARASA_2016_Human_Rights_report.pdf
- Arrey, A.E. (2018). The challenge of HIV/AIDS on the indigenous social security systems: The case of Cameroon. In N. Noyoo and E. Boon (Eds.), *Indigenous Social Security Systems in Southern and West Africa*. (pp 197-2015). Sun Press.
- Ataguba, J.E., Akazili, J. & McIntyre, D. (2011). Socioeconomic-related health inequality in South Africa: evidence from General Household Surveys. *International Journal for Equity in Health*, 10:48 <http://www.equityhealthj.com/content/10/1/48>
- Bagal, S. (2016). *The differences between strategies and policies*. <https://www.linkedin.com/pulse/differences-between-strategies-policies-sanjeev/>
- Bagyendera, J.K. & Malunga, A.J. (2021). *HIV Sensitive Social Protection Assessment Report in Malawi*. (Supplied)
- Balgah, R.A. & Buchenrieder, G. (2010). The dynamics of informal responses to covariate shocks. *Journal of Natural Resources Policy Research*, 2(4):357-370.
- Bonnet, F., Vanek, J. & Chen, M. (2019). *Women and men in the informal economy – A statistical brief*. Manchester, UK: WIEGO. https://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---travail/documents/publication/wcms_711798.pdf
- Both, N. & Magotir, E.L. (2019). *Tanzania: HIV and Social Protection Assessment*. (Supplied)
- Bothale, E. (2015). The political economy of poverty eradication in Botswana. *Poverty & Public Policy*. 7(4), 406-419.
- Chabila, C.C. & Nyemba, E. (2016). *HIV and Social Protection Response in Zambia: A situation Analysis*. (Supplied)
- Chatora, R.R. & Tumusime, P. (2004). Primary health care: A review of its implementation in sub-Saharan Africa. *Primary Health Care Research and Development*, 5: 296-306.
- Christians F. (2020). Country profile - Primary healthcare and family medicine in Namibia. *African Journal of Primary Health Care & Family Medicine*, 12(1): e1–e3.
- CONGOMA. (2015). *Desk study on the Malawi social support: Critical issues for reflection*. <https://gcap.global/wp-content/uploads/2018/07/Congoma-Study-on-Social-Protection.pdf>
- Cooper, A., Mokomane, Z. & Fadiji, A.W. (2020). The relationship between social welfare policy and multidimensional well-being: An analysis using the South African child support grant. *Transformation Critical Perspectives on Southern Africa*, 102(1):73-94.
- Courtney, L. P., Goco, N., Woja, J., Farris, T., Cumiskey, C., Smith, E., Makuach, L., & Chun, H. M. (2017). HIV prevalence and behavioral risk factors in the Sudan People's Liberation Army: Data from South Sudan. *PloS one*, 12(11), e0187689.
- Dafuleya, G. (2018). (Non)state and (in)formal social protection in Africa: Focusing on burial societies. *International Social Work*, 61(1): 156–168.
- Devereux, S. & Sabates-Wheeler, R. (2004). *Transformative social protection for Africa's children*. IDS Working Paper 232. https://www.researchgate.net/publication/284802451_Transformative_social_protection_for_Africa's_children
- Devereux, S. & Sabates-Wheeler, R. (2008). Transformative social protection: The currency of social justice. In A. Barrientos & D. Hulme (Eds.), *Social protection for the poor and poorest – concepts, policies and politics*. New York, USA, Palgrave MacMillan.
- Ellsberg, A. & Betron, M. (2010). *Preventing gender-based violence and HIV: Lessons from the field*. AIDSTAR-One: Spotlight on Gender. https://aidsfree.usaid.gov/sites/default/files/preventing_gbv_hiv.pdf
- Federal HIV/AIDS Prevention and Control Office. (2018). *HIV Prevention in Ethiopia National Road Map 2018–2020*. https://ethiopia.unfpa.org/sites/default/files/pub-pdf/HIV%20Prevention%20in%20Ethiopia%20National%20Road%20Map%202018%20-%202020%20FINAL_FINAL.pdf
- García, A.B. & Gruat, J.V. (2003). *Social protection: A life cycle continuum investment for social justice, poverty reduction and sustainable development*. Geneva: International Labour Organisation
- Haapanen, T. (2007). *Civil Society in Tanzania*. https://sarpn.org/documents/d0002929/CS_Tanzania_Haapanen.pdf

- Haseeb, S. (2018). *The critical shortage of healthcare workers in sub-Saharan Africa: A comprehensive review*. <https://ysjournal.com/the-critical-shortage-of-healthcare-workers-in-sub-saharan-africa-a-comprehensive-review>
- Heywood, M. (2009). South Africa's Treatment Action Campaign: Combining law and social mobilization to realize the right to health. *Journal of Human Rights Practice*, Vol 1(1), 14–36.
- Holmes & Lwanga-Natale (2012). *Social protection in Africa: A review of social protection issues in research*. Nairobi: PASGR.
- Holmes, R., Akinrimisi, B., Morgan, J. & Buk, R. (2012). *Social protection in Nigeria: Mapping programmes and their effectiveness*. London: Overseas Development Institute https://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/legaldocument/wcms_532691.pdf
- ILO (2019). *Extending social security and facilitating transition from the informal to the formal economy: Lessons from international experience*. Issue Brief No. 1/2019. https://www.ilo.org/wcmsp5/groups/public/---ed_protect/---soc_sec/documents/publication/wcms_749480.pdf
- International Labour Organisation (2008). *An ILO strategy towards universal access to health care*. https://www.ilo.org/wcmsp5/groups/public/---ed_protect/---soc_sec/documents/publication/wcms_secsec_5956.pdf
- IPCIG. (International Policy Centre for Inclusive Growth). (2016). *Social protection in Africa: Inventory of non-contributory programmes*. https://ipcig.org/pub/eng/Social_Protection_in_Africa.pdf
- Jervase, A., Tahir, H., Modi, J.K., Almobarak, A.O., Mital, D., & Ahmed, M.H. (2018). HIV/AIDS in South Sudan past, present, and future: A model of resilience in a challenging context. *Journal of Public Health and Emergency*, 2(31): 1-5.
- Kaltenborn, M., Abdulai, A., Roelen, K. & Hague, S. (2017). *The influence of policy and legal frameworks on the development of national social protection systems*. Centre for Social Protection Working Paper Number 016. <https://core.ac.uk/download/pdf/286048319.pdf>
- Kaseke, E. (2005). Social security and older people: An African perspective. *International Social Work*, 48(1):89-98.
- Kingdom of Lesotho. (2013). *National Social Protection Strategy*. <http://extwprlegs1.fao.org/docs/pdf/les166451.pdf>
- Matuku, S. & Kaseke, E. (2014). The role of stokvels in improving people's lives: The case in Orange Farm, Johannesburg, South Africa. *Social Work/Maatskaplike Werk*, 50(4), 504-515.
- Mbonu, N.C., van den Borne, B. & De Vries, N.K. (2009). Stigma of people with HIV/AIDS in sub-Saharan Africa: A literature review. *Journal of Tropical Medicine*, 2009, Art. 145891.
- Mokomane, Z. (2013). Social protection as a mechanism for family protection in sub-Saharan Africa. *International Journal of Social Welfare*, 22(3): 248-259.
- Mokomane, Z. (2018). Indigenous social security systems in Botswana. In N. Noyoo and E. Boon (Eds.), *Indigenous Social Security Systems in Southern and West Africa*. (pp 13-28). Sun Press.
- Mokomane, Z., Enworo, O.C., & Setambule, T. (2021). The Role of Indigenous Social Protection Systems in the Sustainable Development of Contemporary African Communities. In W.L. Filho, R. Pretorius & L.O. de Sousa (Eds.), *Sustainable development in Africa. Fostering sustainability in one of the world's most promising continents*. (pp. 75-89). Springer.
- Mulaudzi, R. (2017). *From consumers to investors: An investigation into the character and nature of stokvels in South Africa's urban, peri-urban and rural centres using a phenomenological approach*. Unpublished MPhil Dissertation, University of Cape Town.
- National Planning Commission. (2012). *National Development Plan 2030*. <https://www.nationalplanningcommission.org.za/assets/Documents/ndp-2030-our-future-make-it-work.pdf>
- Ngwenya, B.N. (2003). Redefining kin and family social relations: Burial societies and emergency relief in Botswana. *Journal of Social Development in Africa*, 18(1):85-110.
- Nsagha, D. S., Bissek, A. C., Nsagha, S. M., Assob, J. C., Kamga, H. L., Njamnshi, D. M., Njunda, A. L., Obama, M. T., & Njamnshi, A. K. (2012). The burden of orphans and vulnerable children due to HIV/AIDS in Cameroon. *The Open AIDS journal*, 6, 245–258.
- O'Brien, C., Scott, Z., Smith, G., Barca V., Kardan, A., Holmes, R., Watson, C. and Congrave, J. (2018). *Shock-responsive social protection systems research: Synthesis report*. Oxford Policy Management, Oxford, UK. <https://www.opml.co.uk/files/Publications/a0408-shock-responsivesocial-protection-systems/srsp-synthesis-report.pdf?noredirect=1>
- OECD-DAC (2005) *Harmonisation, alignment, results: Report on progress, challenges and opportunities*. Prepared by the OECD-DAC Working Party on Aid Effectiveness for the High Level Forum on Joint Progress Toward Enhanced Aid Effectiveness, Paris, 28 February-2 March. https://transfer.cpc.unc.edu/wp-content/uploads/2015/09/Rwanda-Country-Report_FINAL.pdf
- Onokerhoraye, A.G. (2016). Achieving universal access to health care in Africa: The role of primary health care. *African Journal of reproductive Health*, 20(3): 29-31.

- Palk, L., Okano, J.T., Dullie, L. & Blower, S. (2020). Travel time to health-care facilities, mode of transportation, and HIV elimination in Malawi: A geospatial modelling analysis. *The Lancet*, 8: e1555- e1564.
- Pape, U. & Pontara, N. (2015). *Alternative social safety nets in South Sudan: Costing and impact on welfare indicators*. <http://documents.worldbank.org/curated/en/509501467993187581/pdf/98808-WP-P155414-PUBLIC-Box393182B.pdf>
- Patel, L., Hochfeld, T., Ross, E., Chiba, J. & Luck, K. (2019). *Connecting cash with care for better child well-being: An evaluation of a Family and Community Strengthening Programme for beneficiaries of the Child Support Grant*. Johannesburg: Centre for Social Development in Africa University of Johannesburg.
- Pathfinder International. (2019). *Rights-based HIV prevention and treatment for key populations in Mozambique*. <https://www.pathfinder.org/wp-content/uploads/2019/06/Rights-based-HIV-prevention-and-treatment-for-key-populations-in-MZ-May2019.pdf>
- Pino, A. & Confalonieri, A.M.B. (2014). National social protection policies in West Africa: A comparative analysis. *International Social Security Review*, 67(3-4):127-152.
- Radipotsane, M.O. (2007). Determinants of household saving and borrowing in Botswana. *IFC Bulletin*, 25: 284-296.
- Republic of Namibia. (2015). *The Namibia AIDS Response Progress Report 2015*. https://www.unaids.org/sites/default/files/country/documents/NAM_narrative_report_2015.pdf
- Republic of Zambia. (2006). *The National Long Term Vision 2030 (Vision 2030)*. https://www.oneplanetnetwork.org/sites/default/files/vision_2030.pdf
- RHVP, 2011. *Social protection in Botswana - a model for Africa?* http://interactions.eldis.org/sites/interactions.eldis.org/files/database_sp/Botswana/Vulnerable%20Group%20Feeding%20Programme/VGF%201.pdf
- Roelen, K., Devereux, S., Kebede, D. and Ulrichs, M. (2017). *Cash 'plus' - Integrated Nutrition and Social Cash Transfer (IN-SCT) Pilot in Ethiopia: Perceptions and feedback from clients and service provider*. IDS Research Report. https://opendocs.ids.ac.uk/opendocs/bitstream/handle/123456789/13469/IN-SCT_operational_report_REVISED_v2_25_aug_17.pdf;jsessionid=C2B6060489D2A503299BBF2349FE7790?sequence=4
- Roelen, K., Edström, J., Butters, S., Sabates-Wheeler, R., Davies, M. et al. (2011). *Documentation of child and HIV sensitive social protection in the Eastern and Southern African region*. [file:///C:/Users/u04837127/Downloads/IDS_CARI_discussion_paper1%20\(3\).pdf](file:///C:/Users/u04837127/Downloads/IDS_CARI_discussion_paper1%20(3).pdf)
- Sabi, S.C. & Rieker, M. (2017) The role of civil society in health policy making in South Africa: a review of the strategies adopted by the Treatment Action Campaign, *African Journal of AIDS Research*, 16:1, 57-64.
- Satumba, T., Bayat, A. & Mohamed, S. (2017). The impact of social grants on poverty reduction in South Africa. *Journal of Economics*, 8 (1):33-49.
- Schiell, R., Leibbrandt, M. & Lam, D. (2014). *Assessing the impact of social grants on inequality: A South African case study*. WIDER Working Paper 2014/160. Helsinki: UNU-WIDER.
- Semenya, D.K. (2013). Burial society versus the Church in the Black society of South Africa: A pastoral response. *Verbum et Ecclesia* 34(1), Art. #698.
- Southern African Litigation Centre. (2020). *The criminalisation of HIV in Angola* <https://www.southernafricalitigationcentre.org/wp-content/uploads/2020/12/SALC-HIV-Criminalisation-report-English.pdf>
- Sulemana, M., Issahaku Malongza, B.F. & Abdulai, M. (2018): Assessment of the Livelihood Empowerment against Poverty Programme in Karaga district, Ghana. *Development in Practice* <https://doi.org/10.1080/09614524.2018.1551859>
- Temin, M. (2010). *HIV-sensitive social protection: What does the evidence say?* https://socialprotection-humanrights.org/wp-content/uploads/2015/10/JC1992_SocialProtection_en.pdf
- Tirivayi, N. & Rodriguez, O. (2017). *Social protection for forest-dependent communities*. FAO Policy Brief. <http://www.fao.org/3/a-i7008e.pdf>
- Toska, E., Gittings, L., Hodes, R., Cluver, L. D., Govender, K., Chademana, K. E., & Gutiérrez, V. E. (2016). Resourcing resilience: social protection for HIV prevention amongst children and adolescents in Eastern and Southern Africa. *African Journal of AIDS Research*, 15(2), 123-140.
- Turkawi (2015). *National social protection programmes and safety nets in Sudan*. <https://www.ids.ac.uk/files/dmfile/SocialprotectionandsafetynetsinSudan.pdf>
- Ulriksen, M.S. (2016). *The development of social protection policies in Tanzania, 2000-2015*. Centre for Social Science Research (CSSR), University of Cape Town. Working Paper No. 377. https://open.uct.ac.za/bitstream/item/24244/Ulriksen_Working%20Paper%20377_2016.pdf?sequence=1
- UNAIDS (2015). *UNAIDS engagement with civil society Case study 2: Zambia*. <https://open.unaids.org/sites/default/files/>

- [documents/Zambia%20-%20Case%20Study%20on%20UNAIDS%20Engagement%20with%20Civil%20Society.pdf](#)
- UNAIDS. (2019). *UNAIDS Data: 2019*. [file:///C:/Users/u04837127/Documents/UP_PROJECTS/WFP/DECEMBER%202019/2019-UNAIDS-data_en.pdf](#) UNAIDS. (2006). *Organisations working in Kenya to address HIV and AIDS in women*. [https://data.unaids.org/pub/report/2006/20060630_gcwa_re_directory_women_aids_kenya_en.pdf](#)
- UNAIDS. (2015). *Understanding Fast-Track: Accelerating action to end the AIDS epidemic by 2030*. [https://www.unaids.org/sites/default/files/media_asset/201506_JC2743_Understanding_FastTrack_en.pdf](#)
- UNAIDS. (2017). *HIV and social protection assessment tool: Generating evidence for policy and action on HIV and social protection*. [https://www.unaids.org/sites/default/files/media_asset/HIV-social-protection-assessment-tool_en.pdf](#)
- UNAIDS. (2018). *UNAIDS Data 2018*. [https://www.unaids.org/sites/default/files/media_asset/unaids-data-2018_en.pdf](#)
- UNAIDS (2018b). *Social protection: a Fast-Track commitment to end AIDS: Guidance for policy-makers, and people living with, at risk of or affected by HIV*. Geneva: UNAIDS
- UNAIDS. (2020a). *UNAIDS Data 2020*. [https://www.unaids.org/sites/default/files/media_asset/2020_aids-data-book_en.pdf](#)
- UNAIDS. (2020b). *Fact Sheet World Aids Day 2020*. [https://www.unaids.org/sites/default/files/media_asset/UNAIDS_Fact-Sheet_en.pdf](#)
- UNAIDS. (2021). Global data on HIV epidemiology and response: [https://aidsinfo.unaids.org/](#)
- UNAIDS Uganda. (2019). *HIV and social protection assessment report*. (Supplied)
- UNDP & UNAIDS. (2019). *Mapping of civil society organizations (CSOs) in Zimbabwe* [https://zimhealthcsos.ngo/files/Mapping-of-CSOs-in-Zimbabwe_FinalReport.pdf](#)
- UNICEF (2017). *Botswana Social Protection Budget Brief 2017*. [https://www.unicef.org/esa/media/771/file/UNICEF-Botswana-2017-Social-Protection-Budget-Brief.pdf](#)
- UNICEF (2018). *Catalysing the HIV response for adolescents*. [https://www.unicef.org/esa/media/126/file/ALL-IN-in-Eastern-and-Southern-Africa-2018.pdf](#)
- UNICEF. (2012). *Towards the protection and holistic development of children in Angola 2012 Annual Report*. [https://www.unicef.org/infobycountry/files/2012_ANNUAL_REPORT_-_FINAL.pdf](#)
- UNICEF. (2018b). *Evaluation of expansion and Scale-up of HIV-sensitive social protection in Eastern and Southern Africa: 2014-2028*. Report prepared by the Economic Policy Research Institute.
- UNICEF. (2019). *Unleashing the potential of social protection for adolescent girls and women*. [https://blogs.unicef.org/evidence-for-action/unleashing-potential-social-protection-adolescent-girls-women/](#)
- USAID. (2010). *Strengthening communities' responses to HIV/AIDS in Ethiopia*. [https://path.azureedge.net/media/documents/HIV-TB_ethiopia_tri_bro.pdf](#)
- Vermund, S. H., Sheldon, E. K., & Sidat, M. (2015). Southern Africa: The highest priority region for HIV prevention and care interventions. *Current HIV/AIDS Reports*, 12(2), 191–195.
- Wakunuma, M. & Matsika, A. (2020). *HIV and Social Protection Assessment in Zimbabwe*. Unpublished report.
- Walsh, E.A. (2011). *Mapping civil society's response to HIV/AIDS in Namibia*. [https://www.msh.org/blog/2011/12/20/mapping-civil-society%E2%80%99s-response-to-hiv-aids-in-namibia](#)
- Welle, K., Nicol, A., and van Steenberg, F. (2008). *Why is harmonisation and alignment difficult for donors? Lessons from the water sector*. ODI Project Briefing. London: ODI.
- WHO. (2018). *Health Access for All: The Kingdom of Swaziland commemorates World Health Day*. [https://www.afro.who.int/news/health-access-all-kingdom-swaziland-commemorates-world-health-day](#)
- WHO. (undated). *Addressing violence against sex workers*. [http://www.who.int/hiv/pub/sti/sex_worker_implementation/swit_chpt2.pdf](#)
- World Bank. (2018). *The state of social protection programs in South Sudan*. Washington, D.C.: World Bank Group.
- World Bank. (2020). *Angola Poverty Assessment*. [https://openknowledge.worldbank.org/bitstream/handle/10986/34057/Angola-Poverty-Assessment.pdf?sequence=4](#)
- World Food Programme. (2019). *Leaving no-one behind: How WFP's approach to HIV-sensitive social protection will help us achieve zero hunger in Eastern and Southern Africa*. Policy Brief. [https://www.wfp.org/publications/leaving-no-one-behind-how-wfps-approach-hiv-sensitive-social-protection-will-help-us](#)
- Zimbabwe National AIDS Council (2020). *HIV and Social Protection Assessment in Zimbabwe*. (Supplied)

APPENDIX A:

List of country organisations consulted

Stakeholders from the following organisations took part in the virtual stakeholder consultations in October and November 2020

Eswatini

- Eswatini Network of Young people Living with HIV

Ethiopia

- NEP+; civil society network of PLHIV
- Ministry of Labour and Social Affairs
- UNICEF

Kenya

- Kenya Network of Young people Living with HIV
- National hospital Insurance Fund
- UNICEF
- WFP

Lesotho

- National AIDS Council
- Lesotho network of People Living with HIV (LENEPWHA)
- UNICEF
- WFP
- World Vision

Malawi

- UNICEF

Mozambique

- North Star Alliance
- WFP

Namibia

- UNAIDS

Tanzania

- WFP

Uganda

- UNAIDS
- ILO
- WFP

South Sudan

- UNHCR
- Rural Community Development Initiative
- Andre Food South Sudan

Zimbabwe

- WFP
- UNAIDS

APPENDIX B:

90–90–90 country scorecard, selected fast track countries, Eastern and Southern Africa, 2020

	First 90: percentage of people living with HIV who know their HIV status	Second 90: percentage of people living with HIV who know their status and who are on treatment	Third 90: percentage of people living with HIV on treatment who have suppressed viral loads
Angola	54	33	--
Botswana	91	87	81
Eswatini	100	100	93
Ethiopia	83	78	67
Kenya	96	86	75
Lesotho	94	82	72
Malawi	91	86	77
Mozambique	81	64	50
Namibia	90	88	79
South Africa	92	72	61
South Sudan	29	23	16
Uganda	91	90	78
Tanzania	84	82	68
Zambia	86	81	68
Zimbabwe	93	93	77

Source: UNAIDS (2021). <https://aidsinfo.unaids.org/>

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