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► **Making universal social protection a reality for people living with, at the risk of, and affected by HIV or Tuberculosis**



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Making universal social protection a reality for people living with, at the risk of, and affected by HIV or tuberculosis

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► List of abbreviations and acronyms

ART	antiretroviral therapy or treatment
ARV	antiretroviral (drug)
BRICS	Brazil, Russian Federation, India, China and South Africa
CENSIDA	Centro Nacional para la Prevención y Control del VIH y el sida / National Center for Prevention and Control of HIV and AIDS (Mexico)
CHBC	Community and Home-Based Care (Botswana)
CSO	civil society organization
ISSA	International Social Security Association
JKN	Jaminan Kesehatan Nasional / National Social Health Insurance Scheme (Indonesia)
MAC	Malaysian AIDS Council
NAA	National AIDS Authority (Cambodia)
NCCAI	National Coordinating Committee on AIDS Intervention (Malaysia)
NGO	non-governmental organization
NHIF	National Hospital Insurance Fund (Kenya)
NHSO	National Health Security Office (Thailand)
OHS	occupational health services
PEPFAR	President's Emergency Plan for AIDS Relief (United States)
PLHIV	people living with HIV
PMTCT	prevention of mother-to-children transmission
PrEP	pre-exposure prophylaxis
RAMED	System of Medical Assistance / Regime d'assistance médicale (Morocco)
SDG	Sustainable Development Goal
SSA	Social Security Administration (United States)
TB	tuberculosis
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
UNAIDS	Joint United Nations Programme on HIV/AIDS
WHO	World Health Organization
WSPDB	World Social Protection Database

► **Foreword**

Social protection is a human right, but it is not yet a universal reality. Only half of the world's population are effectively covered by at least one social protection cash benefit, leaving 4 billion people unprotected. This global estimate hides stark regional differences – with the highest coverage gaps found in Asia and Africa – but also differences across countries and population groups. Extending social protection coverage is therefore a matter of urgency in order to eliminate poverty, reduce inequality, facilitate access to healthcare and education, promote gender equality, and more broadly, to achieve well-being for all. That is why closing the social protection gap lies at the heart of the 2030 Agenda for Sustainable Development.

HIV and tuberculosis (TB) weigh heavily in the global burden of disease. Global strategies to end AIDS and TB, with a view to reaching Sustainable Development Goal target 3.3, point to social protection coverage as a key pillar of country responses to these epidemics. These strategies further highlight the social protection needs created by long-term diseases for patients as well as their households, and the preventive role that social protection systems can play in addressing the socio-economic determinants of those diseases. As such, social protection coverage gaps can disproportionately affect people living with, at risk of and affected by HIV and TB, including vulnerable populations like young people, women and girls, people living with disabilities, refugees, asylum-seekers, migrants and populations in a state of food insecurity or malnourishment and in humanitarian settings. Also, social protection coverage gaps disproportionately affect key populations such as gay men and other men who have sex with men, sex workers, transgender people, people who inject drugs and prisoners and other incarcerated people.

The COVID-19 crisis has placed these populations at further risk while propelling social protection to a crossroads. The pandemic has compounded pre-existing challenges, such as high levels of economic insecurity, rising inequality and informality, and exposed the vulnerability of those who cannot count on adequate social protection, among whom people living with HIV and TB tend to be disproportionately represented. At this critical juncture, short-term crisis responses should be transformed into elements of rights-based social protection systems, including solid, inclusive and responsive social protection floors. This requires effective mechanisms to ensure that social protection systems respond well to the needs of people living with these diseases and are inclusive of all vulnerable groups.

The present working paper aims at highlighting concrete examples of institutional practices that were changed and adapted by social protection institutions with a view to improving their responsiveness and their inclusiveness with respect to HIV and TB. We hope these practices provide inspiration to encourage social protection institutions and practitioners to systematically integrate this dimension to maximize the impacts of social protection systems on health and well-being.

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▶ Executive summary

Sustainable Development Goal (SDG) target 3.3 has committed the international community to ending the epidemics of AIDS and tuberculosis (TB) by 2030. Ensuring that populations who are living with, at risk of or affected by HIV and/or TB can effectively access prevention, diagnosis and treatment services will be crucial in this mission. Social protection systems have a pivotal role to play in the coverage of both direct medical and non-medical costs, as well as income loss incurred due to the disease.

This paper provides examples of institutional practices that improve the inclusiveness of national social protection schemes for people living with HIV and/or TB and the responsiveness of such schemes to their needs. The main findings can be summarized under four key points:

- ▶ First, practices adopted by social protection institutions to respond to HIV and TB and to make active efforts to include key and vulnerable populations need to be better and more systematically documented with a view to generating good practices. Such practices would help develop guidelines and mainstream the HIV and TB lens within existing social protection tools used at the global, regional and country levels.
- ▶ Second, social protection programmes, schemes and benefits that focus solely on people living with HIV or TB run the risk of accentuating stigma and discrimination; therefore, active efforts to ensure their integration in wider social protection programmes and schemes are needed. Such an approach ensures that social protection systems not only contribute to SDG target 3.3 but also ensure effective universal health and social protection coverage, leaving no one behind.
- ▶ Third, the review highlighted the critical importance of social protection institutions partnering with organizations that provide prevention and referral services in the community and in the workplace as part of an active outreach effort to key and vulnerable populations.
- ▶ Lastly, the COVID-19 pandemic has revealed opportunities in terms of enhancing the shock responsiveness of social protection systems, and in this context, further comparative research into the design and management of social protection responses across countries could identify valuable policy lessons on social protection and pandemics.

To become truly inclusive of vulnerable and key populations and to be responsive to their needs, social protection systems need to take into account HIV and TB responses. The specific needs and challenges faced by key and vulnerable populations further underline the limitations of many national social protection systems where the sickness contingency – as described in the ILO Social Security (Minimum Standards) Convention, 1952 (No. 102) – is often poorly covered. In this perspective, epidemic response, including for HIV and TB, should be mainstreamed into the tools used by social protection practitioners at the global and country levels.



1

▶ 1. Introduction

Through target 3.3 of the Sustainable Development Goals (SDGs), the international community has committed itself to ending the epidemics of AIDS and tuberculosis (TB) by 2030. In addition, several other SDGs are relevant to the response to HIV, AIDS and TB. These include:

- ▶ SDG 1, and its target 1.3 on implementing nationally appropriate social protection systems and measures for all, including social protection floors;
- ▶ SDG target 3.8 on universal health coverage; and
- ▶ SDG 8, and its target 8.8 on protecting labour rights and promoting safe and secure working environments for all workers, including migrant workers, in particular women migrants, and those in precarious employment.

With a view to monitoring progress towards the achievement of SDG target 3.3, milestones have been defined for both TB and HIV. For TB, the World Health Organization's (WHO's) global End TB Strategy defines the three targets for 2020 (WHO 2015). First, at least 90 per cent of all people with TB must be reached and placed on appropriate therapy (first-line, second-line and preventive therapy, as required). Second, at least 90 per cent of the key populations – defined as the most vulnerable, underserved, at-risk populations – must be reached. Lastly, at least 90 per cent treatment success for all people diagnosed with TB must be achieved by ensuring affordable treatment services, adherence to complete and correct treatment, and social support.

The Global AIDS Strategy 2021–2026 focuses on the 95-95-95 testing and treatment targets, which are expected to be achieved within all subpopulations, age groups and geographic settings, including children living with HIV. By 2025, 95 per cent of all people living with HIV must know their status; 95 per cent of all those living with HIV must receive antiretroviral therapy (ART); and 95 per cent of people receiving ART must achieve viral suppression (UNAIDS 2021). The Global AIDS Strategy includes social protection under results area 9, which focuses on integrated systems for health and social protection schemes that support wellness, livelihoods and an enabling environment for people living with, at risk of and affected by HIV.

Reaching those milestones and SDG target 3.3 requires, among other elements, ensuring that populations who are living with, at risk of or affected by HIV and/or TB can effectively access prevention, diagnosis and treatment services. In this regard, social protection systems have a pivotal role to play through the following entry points:

- ▶ the coverage of direct medical costs of prevention, diagnosis and treatment under adequate social health protection schemes;
- ▶ the coverage of direct non-medical costs (including transport and nutrition services) either by social health protection schemes with an extended scope or by other integrated social protection programmes (transfers in cash or in-kind);
- ▶ the coverage of income loss due to the disease (linked to incapacity to work or to time lost while seeking care) by adequate social protection sickness benefit schemes.

When looking at ensuring coverage of people vulnerable to HIV and TB, it is of particular importance to consider that these groups may be facing discrimination. Therefore, to be inclusive, social protection systems may need to proactively create linkages with new partners to ensure prevention and referral functions, such as workplace occupational health services (OHS) and community-led programmes.

This paper focuses on the contributions that social protection schemes can make to the three entry points above related to the costs and income loss incurred by patients. It aims at identifying institutional practices that improve the inclusiveness and the responsiveness of social protection schemes to HIV and TB. In other words, practices that allowed social protection schemes to effectively include vulnerable populations and respond to the need for social protection related to HIV and TB prevention, diagnosis and treatment.

The paper first provides an overview of the social protection coverage gaps worldwide and how those affect people who are vulnerable to or affected by HIV and TB. It then identifies examples of institutional practices aimed at making social protection schemes more inclusive of and responsive to the needs of people vulnerable to or affected by HIV and TB across the different design features of social protection systems. Such examples of practice were identified through a review of available grey and academic literature. Based on the studies and reports identified, 18 countries were selected for an in-depth search for information following a standard template.¹ The detailed search methodology and the country selection criteria are specified in Annex 1.

► **Box 1. Social protection**

Social protection comprises a set of measures aiming to ensure access to healthcare without hardship and income security throughout the life cycle. It provides protection against impoverishment and effective access to services across life contingencies.

Universal social protection refers to comprehensive, sustainable and adequate protection over the life cycle along three core dimensions:

- **Universal coverage in terms of persons protected** – All in need should have effective access to social protection throughout the life cycle.
- **Comprehensive protection with regard to the social risks and contingencies that are covered** – This includes access to healthcare and income security across life contingencies (such as, sickness, maternity, unemployment, etc.) and protection against new and emerging risks, such as needs related to long-term care.
- **Adequate protection** – Preventing poverty, vulnerability and social exclusion, and allowing people to lead healthy and dignified lives.

Universal social protection is firmly grounded in the international human rights framework: The Universal Declaration of Human Rights; the International Covenant on Economic, Social, and Cultural Rights; the Social Security (Minimum Standards) Convention, 1952 (No. 102), and the Social Protection Floors Recommendation, 2012 (No. 202). To achieve this vision, the ILO advocates a two-dimensional strategy to be pursued through national social protection policies anchored in corresponding legal frameworks. In this regard, Recommendation No. 202 calls upon ILO Member States to:

1. **Establish and maintain social protection floors** – This is referred to as the horizontal dimension. These are floors and not ceilings; hence Member States should also –
2. **Progressively ensure higher levels of social security** – This is referred to as the vertical dimension.

1 The 18 countries are Algeria, Botswana, Cambodia, Costa Rica, Ecuador, Indonesia, Kazakhstan, Kenya, Malaysia, Mexico, Morocco, Nepal, Oman, Romania, Rwanda, South Africa, Thailand and Viet Nam.

► Box 1. Social protection (continued)

As part of the 2030 Agenda for Sustainable Development, the extension of social protection is a direct contribution to two complementary goals on universal social protection systems: social protection floors (SDG 1.3) and universal health coverage (SDG 3.8).

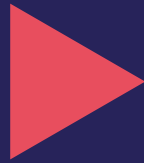
Social protection can be provided by a range of policy instruments. Social insurance refers to social protection schemes that are financed by contributions of workers, employers and (sometimes) government subsidies. Social assistance refers to social protection schemes that are usually financed by general government revenues, and may be universal (for all), categorical (for specific age groups for example) or means-tested (eligibility related to income status). Both social insurance and social assistance schemes deliver benefits in cash and/or in kind (for example, services).

► Box 2. Occupational health services

Occupational health – and by extension, occupational health services (OHS) – can provide support to social protection schemes by facilitating access to preventive services for the working population and by providing referral information on social protection entitlements in a systemic manner. Structures put in place to ensure OHS¹ may also act as efficient and sustainable entry points for HIV and TB programmes in the workplace. Lastly, OHS can institutionalize prevention programmes on HIV and TB in the workplace by including them in training/OHS manuals and curriculums.

OHS are an essential element of existing infrastructures to protect and promote workers' safety, health and well-being. While the main purpose of OHS is to prevent work accidents and occupational diseases, emerging challenges created by the changes in work organization, production technologies and the environment have required OHS to address general environmental and non-occupational hazards that may affect the working capacity and well-being of workers. In this sense, the Occupational Health Services Recommendation, 1985 (No. 171), promotes the collaboration of OHS with the health authorities within the framework of public health programmes.

1 The Occupational Health Services Convention, 1985 (No. 161), in its Article 2(a) defines occupational health services as “services entrusted with essentially preventive functions and responsible for advising the employer, the workers and their representatives in the undertaking on: (i) the requirements for establishing and maintaining a safe and healthy working environment which will facilitate optimal physical and mental health in relation to work; and (ii) the adaptation of work to the capabilities of workers in the light of their state of physical and mental health”.



2

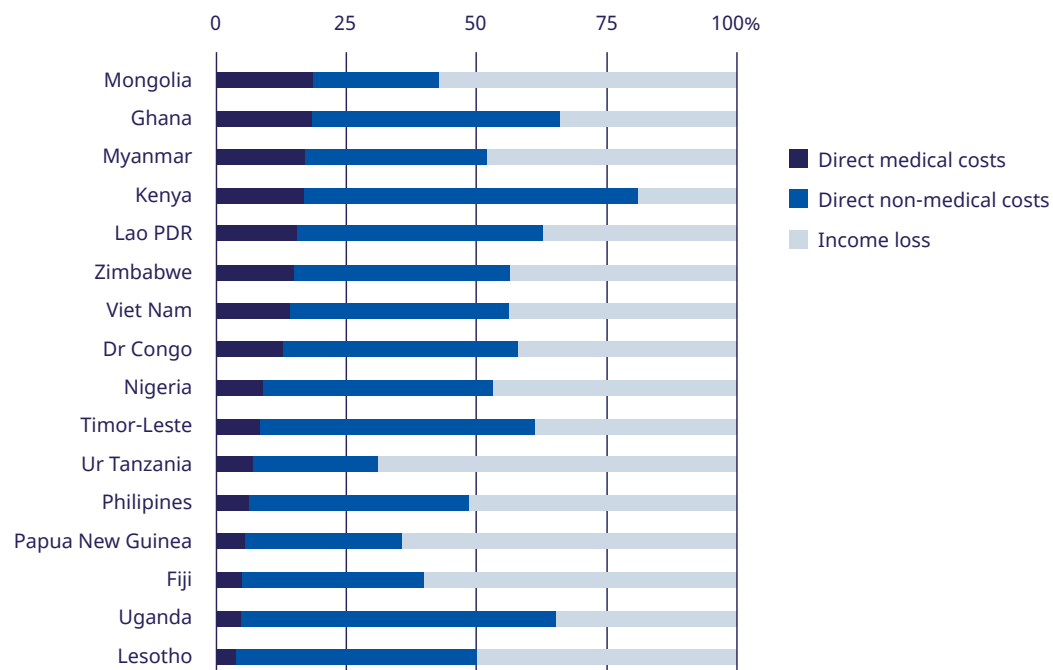


► 2. Social protection: Global coverage gaps and their consequences for people living with HIV and TB

2.1. Social protection in the context of the responses to HIV and TB

The decline in health caused by HIV and/or TB has far-reaching consequences on the lives and livelihoods of those affected. Recent evidence provided by patient cost surveys for TB conducted in several high-burden countries, shown in Figure 1 below, illustrates patients' need for comprehensive coverage of direct medical and non-medical costs as well as income loss (WHO 2017; Pedrazzoli et al. 2018; Hoa and Nhung 2019). For HIV, patient cost surveys similarly find that patients are burdened with significant direct medical and non-medical costs as well as income loss (Mudzengi et al. 2017).

► **Figure 1. The need for comprehensive social protection: The heavy burden of income loss, medical and non-medical costs for TB patients and their households – Snapshot of cost distribution (in percentage of total incurred costs) by country**



Lao PDR = Lao People's Democratic Republic; DR Congo = Democratic Republic of Congo; UR Tanzania = United Republic of Tanzania. Source: WHO 2020.

An extensive amount of research has shown that HIV and TB disproportionately affect certain key populations, both in terms of risk of infection as well as the severity of its impact. Key populations for HIV include men who have sex with men, transgender persons, sex workers, people who inject drugs and prisoners. For TB, these include prisoners, migrants, refugees, indigenous populations and people living with HIV (PLHIV). The stigma and discrimination faced by these populations – especially in the case of HIV or TB infection – has a double impact, making them both more hesitant to seek healthcare in the first place as well as less likely to receive appropriate care once they do seek it. Similarly, they are less likely to have knowledge of and/or seek other social protection benefits and social care, and more likely to receive inappropriate responses when they do seek such benefits and care (ILO 2014).

► **Box 3. The ILO response to HIV and AIDS**

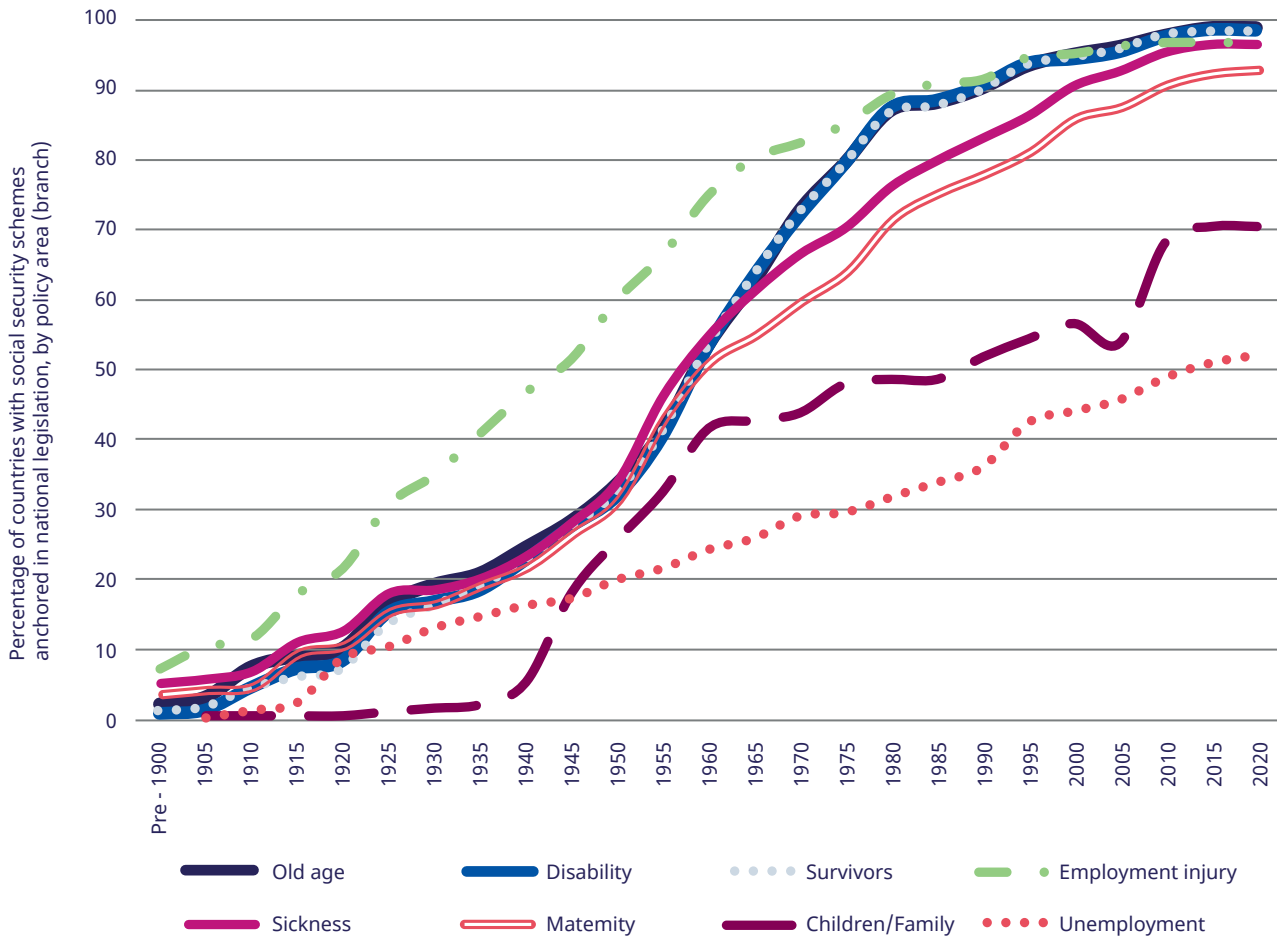
The ILO recognizes that HIV can have a devastating impact on labour and productivity, and represents an enormous burden for working people, their families and communities, enterprises and national economies. HIV-related stigma and discrimination threaten fundamental rights at work and undermine the opportunities for workers to obtain decent and sustainable employment and to benefit from social protection.

In June 2010, at the International Labour Conference, governments, employers' representatives and workers' representatives from ILO Member States adopted the HIV and AIDS Recommendation, 2010 (No. 200). The Recommendation is the first international labour standard on HIV and AIDS in the world of work, and harnesses the opportunities provided by workplace interventions to support national responses to HIV and AIDS.

2.2. Social protection coverage gaps and their impact on vulnerable populations

Social protection systems can act as an effective way to improve access to health services by reducing demand-side barriers – including for HIV and TB – and help to mitigate the social and economic impacts of illness on people. While an unmistakable historical trend is the development of social protection and the corollary existence of social protection schemes in many countries (see figure 2), the right to comprehensive social protection is still not a reality for the majority of the global population (ILO 2021c).

► Figure 2. Development of social protection programmes anchored in national legislation by policy area, pre-1900 to 2020 (percentage of countries)



Note: Based on the information available for 186 countries. The policy areas taken into consideration are those in Convention No. 102. Source: ILO, [World Social Protection Database](#), based on the ILO Social Security Inquiry; International Social Security Association (ISSA) and US Social Security Administration (SSA), [Social Security Programs Throughout the World](#); ILOSTAT; national sources.



► Box 4. Monitoring social protection coverage

Estimates of the scope of legal coverage usually measure the number of social security areas by which – according to existing national legislation – a population or specific groups within it are covered. Measurements of effective coverage reflect how the legal provisions are implemented in reality. Effective coverage is usually different from (and usually lower than) legal coverage because of non-compliance, problems with enforcement of legal provisions, or other deviations of actual policies from the text of the legislation, such as discriminatory practices (ILO 2021c).

The ILO World Social Protection Database (WSPDB)¹ is the leading global source of in-depth country-level statistics on various dimensions of social protection systems, including key indicators for policymakers, officials of international organizations and researchers. It is used for both the United Nations' monitoring of SDG targets on social protection (UN 2017; UN 2021; UN, Economic and Social Council 2017) and national monitoring of social protection indicators.

The key indicators, including SDG 1.3.1, are collected through the ILO Social Security Inquiry, an administrative survey submitted to governments, dating back to the 1940s.² The data from the ILO Social Security Inquiry are complemented by other sources – notably the ISSA/SSA Social Security Programs throughout the World database (aka, ISSA Social Security Country Profiles) – as the main source on legal information and characteristics of social protection programmes.³

1 See: <http://www.social-protection.org/gimi/gess/ShowTheme.action?id=4457>.

2 See: <http://www.social-protection.org/gimi/gess/ShowTheme.action?id=10>.

3 Other sources include (in alphabetical order) the:

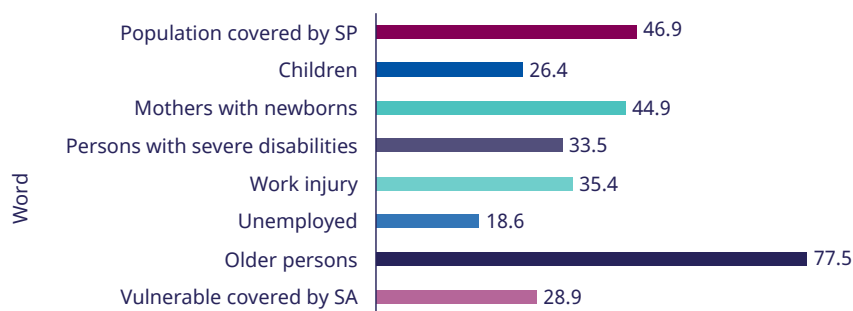
- Asian Development Bank's Social Protection Index;
- Economic Commission for Latin America and the Caribbean and other regional commissions of the United Nations;
- Statistical Office of the European Commission (Eurostat), including the Eurostat European System of Integrated Social Protection Statistics (ESSPROS);
- Organisation for Economic Co-operation and Development's Social Expenditure;
- World Bank HDNSP pensions database and the Atlas of Social Protection Indicators of Resilience and Equity (ASPIRE); and
- WHO Global Health Observatory and National Health Accounts.

The ILO's WSPDB also draws on national official reports and other sources, which are usually largely based on administrative data, and on survey data from a range of sources including national household income and expenditure surveys, labour force surveys, and demographic and health surveys, to the extent that these include variables on social protection.

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While measuring coverage remains a complex task encompassing various dimensions (see box 4), large gaps in coverage, comprehensiveness and adequacy remain, and the human right to social protection is not yet a reality for half of the world's population. Only 46.9 per cent of the global population are effectively covered by at least one social protection cash benefit (SDG target 1.3.1, see figure 3), while only two-thirds are protected for healthcare (ILO 2021c). The remaining 4 billion people are left unprotected. Behind this global average there are significant variations across and within regions, with Asia and the Pacific, the Arab States and Africa featuring pronounced coverage gaps relative to the global average (ILO 2021c). Those regions also include the great majority of countries with a high HIV and TB burden.

► **Figure 3. Effective social protection cash benefits coverage, global and regional estimates by function, 2020 (SDG indicator 1.3.1)**



Notes: SP = social protection; SA = social assistance.

Source: ILO 2021c; World Social Protection Database, based on the ILO Social Security Inquiry; ILOSTAT; national sources.

Aggregate coverage rates further hide inequalities across countries, types of benefits and population groups. For instance, while it is estimated that a third of vulnerable populations worldwide are benefiting from social assistance cash benefits, this proportion is less than 10 per cent in the Africa region and in low-income countries (ILO 2021c). Looking at population groups, there is an important gender gap in legal social protection coverage, whereby legal coverage around comprehensive social protection is more than eight percentage points lower for women and girls than the rate for men and boys (ILO 2021c). Differences across the types of benefits provided also exist, with significant gaps in short-term benefits (such as family benefits, benefits in case of sickness, unemployment or disability, etc.).

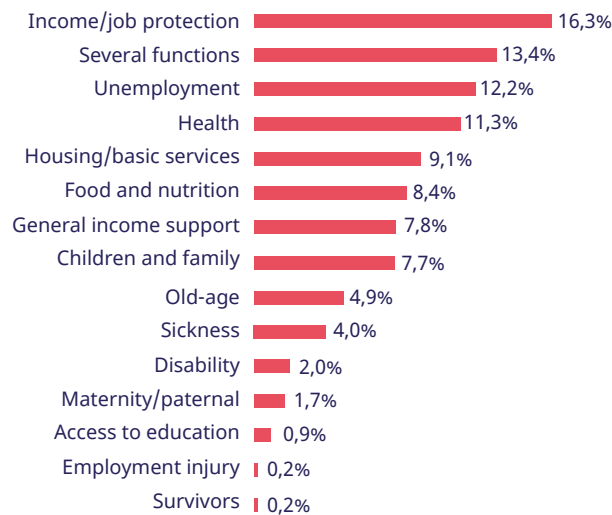
In countries with significant coverage gaps – whether because of differences in legal versus effective coverage, or due to fully uncovered population groups – those at the margins of society are especially likely to be left behind. For example, while a country may provide legal coverage to all residents, undocumented persons may be unable to prove their eligibility and therefore would not enjoy effective coverage, and they may also be deterred from claiming their entitlements from public institutions they do not trust. Given the characteristics of the key populations for HIV and TB (that is, groups at high risk of contracting HIV and TB), it is crucial to ensure that special attention is given to the inclusion of these populations in social protection systems, both due to equity considerations as well as for epidemiological reasons.

Lastly, the COVID-19 crisis has emphasized the importance of guaranteeing access to healthcare without hardship and basic income security for all over the life cycle (ILO 2021d; 2021c). Countries have adopted a wide spectrum of social protection benefits to respond to the crisis (see figure 4). While this is true, most such measures have been announced as temporary, in the form of special allowances rather than sustainable social protection benefits to cover specific contingencies (such as sickness or family benefits), and many social protection responses were maladapted and inattentive to the realities of people in

poverty (Alston 2020). Given the communicable nature and uncertain future trajectory of COVID-19, lessons learned from the fight to end HIV and TB – such as ensuring effective social protection across the continuum of care, ensuring no one is left behind, and battling stigma – may prove valuable in adapting social protection schemes to the new reality.

Conversely, the experience of the pandemic may also provide lessons on how to adapt social protection to support public health efforts to contain HIV and TB. The pandemic has shown that with the requisite will social protection can be adapted quickly to new realities and risks. For instance, many countries have recognized COVID-19 as an occupational injury in order to ensure easier and faster access to associated benefits under the work injury insurance system, in particular for workers in the most exposed sectors. Furthermore, the management of debilitating long COVID-19 and ensuring income security of sufferers and their possible reinsertion into work through workplace adaption may have important policy implications for the management of HIV and TB.

► Figure 4. Percentage of COVID-19 social protection measures announced, by type and function



Source: ILO 2020c. See also the associated [Methodological note](#).



3

▶ 3. Integrating HIV and TB in social protection systems: Examples of practice

As evidenced in the previous section, populations living with, at risk of or affected by HIV and TB are usually confronted with various contingencies and would therefore require a comprehensive social protection package providing different types of benefits, in particular:

- ▶ Healthcare benefits that cover the cost of medical care and, often an extension of the benefit package, that cover both transportation and nutrition needs, as well as long-term care if needed.
- ▶ Sickness benefits to ensure income security and to cover income loss due to the inability to work or the opportunity cost of seeking care, but also disability and survivors' benefits when the disease results in permanent incapacity to work or death, in order to ensure income security to the patient as well as their household. Lastly, income support for caregivers and children in affected households, to compensate for the opportunity cost or any income loss due to care-giving responsibilities within the affected households.

While a number of countries have such types of benefits, it cannot be presumed that coordination between these benefits automatically occurs (Schwarzer, Tessier and Gammage 2014; Holmes et al. 2018). Improving this coordination may reduce practical barriers of access for people living with, at risk of or affected by HIV and TB. In addition, while healthcare benefits are increasingly delivered through social insurance, tax-financed programmes or a combination of both sickness benefits and, to a lesser extent, disability and survivors' benefits historically have been strongly linked with formal employment status. People living with, at risk of or affected by HIV and TB who work in the informal economy often lack access to such benefits. For this reason, measures to extend social protection coverage to workers in the informal economy are essential for improving access to health protection and income security (ILO 2021a). Lastly, sickness benefits in many countries have been set up as the employer's liability rather than as a proper social insurance scheme or social assistance programme. This creates a disincentive for employers to employ or keep workers living with, at risk of or affected by HIV and TB.

Considering these practical constraints, some institutional responses have emerged for people living with, at risk of or affected by HIV and TB, and some examples of practice were found in the studied countries. The literature review showed that there is evidence that when properly coordinated within a comprehensive package that includes health and care services, institutional responses can lessen risky sexual behaviours, increase uptake of biomedical and behavioural services for HIV prevention, and facilitate voluntary counselling and testing, as well as access to HIV treatment. Moreover, the effects of cash transfers can be improved when combined with other interventions, such as adolescent-sensitive clinical care (UNICEF 2017). Beyond cash transfers, care programmes have also had proven effects on both HIV treatment as well as HIV prevention (Chandan and Richter 2008; Cluver et al. 2014). However, it is acknowledged that cash alone cannot alleviate non-financial and structural barriers to care.

3.1. Benefit design: Access to healthcare without hardship

Healthcare benefits provided by social health protection schemes need to respond effectively to the needs of people living with, at risk of or affected by HIV and TB. Adequate healthcare benefits encompass several dimensions:

- i. the comprehensiveness of the benefit package in terms of services covered;
- ii. the proportion of the costs incurred for such services that are covered by the scheme, and the proportion, if any, left to the beneficiary (out-of-pocket spending); and
- iii. the effective availability of quality services corresponding to the benefit package.

3.1.1. Benefit package

It is of paramount importance that policymakers implement an integrated social protection portfolio for people living with, at risk of or affected by HIV and TB. Benefit packages should include HIV- and TB-related services in a comprehensive fashion, as per ILO standards, (including preventive and curative care) as an entitlement. For instance, specific needs in terms of prevention (for example, condoms, voluntary medical male circumcision and pre-exposure prophylaxis (PrEP)); the treatment of opportunistic infections; as well as costs related to monitoring of viral loads, CD4 counts, drug resistance and adverse side effects are of particular importance for people living with HIV (PLHIV).

Through the literature review, it was not possible to identify a systematic review at the global or regional levels of benefit packages under social health protection schemes or the degree to which they include HIV and TB services. Therefore, it was not possible to look at global trends when it comes to such integration. This represents an information gap. Nevertheless, it was possible to identify the level of integration of HIV and TB services in benefit packages in selected countries.²

Most HIV and AIDS diagnosis and treatment services and drugs were included in reviewed benefit packages in high-income and even in middle-income countries with a high rate of PLHIV. Specifically, antiretroviral therapy (ART) was most commonly universal and free of charge³ (see box 5 for an example). In some instances, ART was covered only for the poorest (such as in South Africa). Similarly, treatment for TB and drug-resistant TB was mentioned in most benefit packages. Testing as well as health interventions to prevent mother-to-child transmission of HIV were also common features included in benefit packages (see box 6 for examples). While treatment was consistently included in benefit packages (the experience of Thailand, covered in box 7, illustrates an evolution in this respect), the level of inclusion of other services, particularly those of a preventive nature, varied widely across various countries and schemes.

Interestingly, in countries such as Indonesia and Algeria, TB- or HIV-related health services were included in the benefit package of social health protection schemes when reforms were conducted to integrate existing scattered schemes into a single national risk pool or management institution. In Algeria, in relation to TB, various social security schemes were integrated in the 1990s, which led to the inclusion of TB services into the general system (Algeria 2011). In Indonesia, the national social health insurance scheme – Jaminan Kesehatan Nasional (JKN) – was launched in January 2014 by consolidating previously fragmented social health insurance schemes and assistance programmes at the national and provincial levels, including those for public sector employees (ILO 2019a). On this occasion, it was decided to include

2 Benefit packages were not always detailed for each scheme within each country. Some schemes had positive lists of services (listing all the services included in the scheme); while others had negative lists (a list only detailing excluded services); and some schemes did not have explicit packages (that is, it was not possible to know precisely what services were covered or not).

3 This was the case in Algeria, Botswana, Ecuador, Indonesia, Malaysia, Mexico, Nepal, Oman, South Africa, Thailand, Viet Nam.

both HIV and TB diagnostic and treatment services in the benefit package (Health Policy Plus 2018). As of May 2019, JKN had reached a coverage level of 83 per cent of the population, a considerable achievement in a country of 264 million people spread across 8,000 inhabited islands (Health Policy Plus 2019).

Some healthcare benefit packages also need to be expanded when they do not cover long-term care; which is often the case, as there is a global coverage deficit for this type of service (Scheil-Adlung 2015). Botswana offers an example of responses with the Community and Home-Based Care (CHBC) programme (see box 10).

► **Box 5. Inclusion of ART and medications in relation to opportunistic diseases in the benefit package of the Caisse Nationale d'Assurance Sociale (CNAS) in Algeria**

In Algeria, the social insurance system CNAS considers HIV as a long-term disease for which free ART and free medications in relation to opportunistic diseases are provided (Oulebsir 2011). Prevention, diagnosis and treatment are part of the benefit package. Moreover, testing and counselling are available in 60 centres that have been integrated into the local health structures of the wilayas (counties) between 2010 and 2014. The Comité National de Prévention et de Lutte contre les IST/SIDA (CNPLS, or the National Committee to Fight Sexually Transmittable Diseases and AIDS) is responsible for providing guidance and recommendations, as well as the coordination, monitoring and evaluation of all the activities related to the prevention and fight against sexually transmitted infections and HIV (Algeria 2012).

► **Box 6. Integration in the benefit package of HIV testing and prevention of mother-to-child transmission**

Botswana was the first country in Africa to introduce routine HIV testing and among the first to launch a national ART programme. The programme was directly integrated into the existing health delivery system in order to avoid parallel programmes and to build capacity within the existing system (United States 2004). HIV tests are offered as part of routine health check-ups in public and private clinics. However, mandatory HIV testing was made legal in Botswana. This has been contested by many civil society and human rights organizations (Avert, n.d.), arguing that it could contribute to increased stigma and discrimination within the country. ¹

In 2018, Malaysia became the first country in the Western Pacific Region to be certified as having eliminated mother-to-child transmission of HIV and syphilis. Malaysia started prevention of mother-to-child transmission (PMTCT) services in 1998 when testing among antenatal mothers was initiated across the whole country. Mothers living with HIV were given free antiretroviral therapy; ART prophylaxis was given to HIV-exposed infants; and routine use of polymerase chain reaction tests was strictly observed.

Oman introduced a universal antenatal care screening policy in 2009. The PMTCT programme has highlighted the importance of counselling as part of HIV testing, which is expected to contribute to the re-establishment of voluntary counselling and testing services that will allow access to (voluntary) testing for those groups who are currently not picked up by screening programmes (Oman 2014).

1 The ILO HIV and AIDS Recommendation, 2010 (No. 200) and the Code of Practice on HIV/AIDS and the World of Work assert that testing must be genuinely voluntary and free of any coercion.

► **Box 7. HIV and AIDS in the benefit packages of Thailand's social health protection schemes**

The National AIDS Programme in Thailand is implemented by the Ministry of Public Health and the National Health Security Office (NHSO). The Ministry acts as a health regulator and health service provider. The NHSO is the purchaser and system manager in the health system, and is responsible for providing HIV and AIDS treatment and care, HIV testing and counseling, and positive prevention (described as a way of reducing HIV transmission by involving PLHIV in prevention work). The Social Security Scheme and the Civil Servant Medical Benefit Scheme act as purchasers for employees and civil servants, respectively. The Universal Coverage Scheme is for citizens not covered by the two government schemes mentioned; it is managed by the NHSO and funded through general government taxation (UNDP and Thailand 2017). Thailand's prevention and treatment efforts have significantly reduced the incidence of new infections over the last two decades. Key components of the strategy to achieve this goal include scaling up HIV screening programmes to facilitate early HIV diagnosis and investment in mechanisms to support immediate initiation of ART (Muccini et al. 2019). Since 2014, Thailand's national guidelines recommend pre-exposure prophylaxis (PrEP) as part of combination HIV prevention packages for people who are HIV-uninfected but at high-risk of HIV acquisition, and PrEP is available under all benefits schemes from fiscal year 2020 (Sangiam 2019).

► **Box 8. The Community and Home-Based Care (CHBC) programme in Botswana**

The Government of Botswana introduced the CHBC strategy in 1995 to provide comprehensive care services at home and at the community level in order to meet the physical, psychological, social and spiritual needs of the terminally ill, including PLHIV and their families. The programme is implemented through a partnership between the Ministry of Health and the Ministry of Local Government's Division of Destitute Persons and Old Age Pension.

The Government of Botswana implements the programme jointly with NGOs and community-based organizations. The Ministry of Health is in charge of formulating policies and protocols for professional guidance; while the Ministry of Local Government, through the Department of Social Services, is responsible for the development of policies and standards for the provision of technical guidance on the social welfare component. The CHBC provides medical care, nursing care, psychosocial support, information, education and communication services for behavioural change, counselling and spiritual support. The most important means of support are:

- i. a food basket that patients receive monthly;
- ii. transportation of CHBC patients requiring medical check-ups.

The number of CHBC-supported patients has declined over the last few years, mostly because of the introduction of free ART treatment and the resulting reduction in death rates due to HIV infection, with numbers dropping from a high of 12,988 beneficiaries in 2003/2004 to 1,208 as of May 2013. The CHBC was designed 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, such as diabetes, that require special diets (Ellis et al. 2010).

3.1.2. Benefit levels and financial protection against healthcare costs

As mentioned previously, treatment and (to some extent) diagnosis services were included in a number of the reviewed health packages. When they were, the cost of treatment – and in particular the cost of drugs (ART, drug-resistant TB) – was usually covered fully or with very small copayments by patients. For example, HIV benefits in Morocco have been incorporated into the System of Medical Assistance (Regime d'assistance médicale, or RAMED), which aims to assist the vulnerable and poor to access medical care. PLHIV who meet the eligibility criteria benefit from RAMED cards, in addition to antiretroviral drugs (ARVs) and free access to other services (laboratory, drugs, etc.) (Morocco 2014). The poor and vulnerable populations enrolled in RAMED are exempted from fees in public hospitals.

Due to a number of factors, out-of-pocket payments can still occur and represent an important share of households' income for both HIV and TB. The following factors were encountered in the review:

- Lack of awareness of their rights and entitlements on the part of patients, but sometimes also on the part of providers.

- Limited comprehensiveness of the services covered, with an absence of coverage (or with a low level of cost coverage) for necessary health services related to the disease – for example, only providing drugs free of charge, with patients still having to cover consultation costs.

- Some schemes follow a referral system between the different levels of care. Such a system is established as a good practice to rationalize the use of care and to put the emphasis on primary care. In this setting, beneficiaries are tied to a local health service provider for their primary level of care. However, fear of stigma can push people to seek HIV- and TB-related care outside of their assigned facilities, incurring additional transportation costs but also limiting their capacity to be covered for the related costs. For example, in Thailand, Universal Coverage Scheme members need to register with the District Health System in their district of residence and do not have free access to providers outside their registered network unless they are referred (UNDP and Thailand 2017).

- Direct non-medical costs of treatment may be incurred and not covered within the benefit package or by any other social protection scheme. Examples of such direct non-medical costs include transportation costs to the place of treatment and nutrition costs incurred by necessary changes of diet to improve treatment effectiveness. For example, in Indonesia, a benefit incidence analysis found significant inequities in the distribution of JKN hospital care benefits across geographic and socioeconomic groupings (Health Policy Plus 2019), highlighting the need to cover transportation in benefit packages. Transportation costs seem to be reported often, and their importance is enhanced by the level of centralization of HIV- and TB-related services, as well as the level of stigma related to the disease, which may push individuals to seek care further away from their usual place of residence in order to guarantee anonymity. Stock-outs of medicines, particularly in remote areas where availability of quality health services is often a challenge, may also lead individuals to incur additional transportation costs to get to providers with sufficient stocks.

In addition to high out-of-pocket payments, patients may also suffer from a loss of income related to seeking care and/or being incapable of working due to the disease and not benefitting from any sickness cash benefits or other social protection benefits (see section 3.2 below on income support).

For example, Nguyen et al. (2017) suggest that PLHIV in Viet Nam and their families are at high risk of financial burden due to out-of-pocket payments even when ART is provided freely, and prior studies have indicated that more than one-third of households with PLHIV suffered catastrophic expenditures. The authors point to a lack of information on social health insurance, particularly accurate information on the benefits in regards to reimbursement, quality of services and information protection.

In the case of multidrug-resistant TB, these factors are particularly important, as the disease is long-lasting. A 2018 TB Patient Cost Survey conducted in Kenya highlighted that despite progress being made in the provision of free TB diagnosis and treatment, there was still a high proportion of TB-affected households experiencing catastrophic costs due to TB.⁴ Overall, 26.5 per cent of TB-affected households, including 86.4 per cent of drug-resistant TB-affected households, experienced catastrophic costs. Costs were related to diagnosis and treatment, as well as non-medical costs due to nutrition or food supplements. To cope, 27.8 per cent of TB patients used dissaving mechanisms like taking a loan, use of savings and sale of assets to meet the expenses (Kenya 2018). Similar findings were evident in Viet Nam in 2016, where an estimated 63 per cent of TB patient households and 98 per cent of the multidrug resistant TB patient households experienced catastrophic costs. The cost incurred per household on average was US\$1,068 for an episode of drug-susceptible TB and US\$4,289 per episode of multidrug-resistant TB. The proportion of households below the international poverty line increased from 3.7 per cent before TB to 21.4 per cent after TB (Hoa and Nhung 2019).

3.1.3. Availability of adapted health services

To effectively end AIDS and TB, and more broadly to achieve universal health coverage, the reach of health service providers needs to be widened. While efforts have been made to improve access to prevention, diagnosis, treatment, care and support for PLHIV – in particular via training and the use of community health workers in several countries – efforts to develop the human resources and infrastructure required to deliver and sustain these services within national health systems have often lagged. In Cambodia, in 2014, there were only 0.17 physicians per 1,000 people, with many doctors subsidizing their income outside of public clinics (WHO 2019b). The capacity of the Government to effectively conduct oversight to ensure that private providers implement national guidelines has been reported by some as limited (Allinder and Dattilo 2017). Hence, external funding and provision of HIV-related health services by NGOs is still dominant in Cambodia, and due to funding constraints and the drive for improved efficiencies, the number of NGOs supported through grants from the Global Fund to Fight AIDS, Tuberculosis and Malaria (hereafter “the Global Fund”) will be reduced from 19 to six (UNAIDS 2018d). In Viet Nam, access to the broad benefit package of the national health insurance scheme is said to be hindered by limited health facility equipment and the low quality of services at the primary level (ILO 2019c). A similar concern was raised in Indonesia regarding the availability of HIV services in health providers empaneled by JKN (World Bank and University of Indonesia 2016). Persistent centralization of HIV treatment services in secondary and tertiary health facilities reduces the success of treatment. In KwaZulu-Natal, South Africa, rates of treatment utilization decline as the distance an individual needs to travel to obtain treatment services increases (UNAIDS 2014).

The quality of care and service, particularly the attitude from health professionals and health facility staff towards patients is vital in engaging people and ensuring retention. Lertkanokkun et al. (2013) outlined that almost 60 per cent of the providers had negative attitudes towards TB patients in Thailand. Furthermore, a study of a sample of Thai nurses working in 1,200 bed hospitals in Bangkok found that 37 per cent reported unwillingness to care for HIV and Hepatitis C infected patients (Ishimaru et al. 2018). Evidence from Cambodia suggests that stigma and discrimination continues to be a barrier to attracting key and vulnerable populations into testing and services. Continued efforts are required for increasing the quality and credibility of government health services to maximize their utilization (Morishita et al. 2016). In Nepal, the Government has recognized the need to improve the capacity of health service providers. The Ministry of Health, in coordination with the Ministry of Education, plans to train all health workers in HIV prevention, diagnosis, treatment and care as part of the formal medical and nursing curriculum (Nepal 2017).

4 “Catastrophic” is defined, as per the standard WHO definition, as the total costs due to TB in excess of 20 per cent of the annual household income.

In addition, establishing a positive safety and health culture and providing appropriate professional education can help reduce stigma towards patients and can improve quality of care further (Ishimaru et al. 2018). When healthcare workers are unwilling to care for patients, this reinforces the stigma and fear surrounding the diseases. In addition, health providers may be subjected to stigma themselves. With this in mind, countries have developed national guidelines and policies to protect the safety and health of medical personnel, specifically due to the increased risk of transmission in healthcare settings (WHO and ILO 2010). For example, Malaysia developed guidelines for healthcare workers to prevent and manage TB after an increase in the incidence of TB among health workers (Malaysia 2012). South Africa's 2014 National Tuberculosis Management Guidelines includes infection control measures for healthcare workers and addresses the influence the attitude and behaviour of healthcare workers can have on the treatment compliance of TB patients (South Africa 2014).

3.1.4. Adapted administrative procedures

There is evidence that administrative procedures can be important barriers to accessing health services for people working in the informal economy and for specific vulnerable groups. Still, administrative practices adopted specifically for populations vulnerable or living with HIV and TB remain insufficiently documented. Some examples of efforts towards inclusiveness are found for specific groups, such as migrants. In the case of migrant or mobile workers, additional administrative challenges are faced, such as the lack of portability of services across borders and discontinuity of care. Many social protection systems recognize the need to provide free or affordable services for non-citizens. For example, in Botswana, since September 2019, the government has decided to provide free HIV treatment to non-citizens residents (UNAIDS 2019). Ecuador also guarantees healthcare for refugees and migrants living with HIV, and Algeria provides migrants and refugees with free ART (UNAIDS 2018b; 2017b). Box 9 provides an illustration for Thailand.

► Box 9. Examples of accessibility features for migrants in Thailand

Migrants are key and vulnerable populations in the response to HIV and TB. Their vulnerability to discrimination creates a particular challenge for social protection coverage and requires specific investments in outreach (ILO 2017; 2019b). It has been reported that migrants coming into contact with health services struggle with financial, language, cultural and legal issues, and consequently find it difficult to adhere to treatment for the full duration of the course. Fear of losing employment also negatively affects treatment completion (Thailand 2017).

Under the Compulsory Migrant Health Insurance, innovative migrant-friendly services have been established in Thailand, which include the use of volunteer community health workers, mobile clinics for migrant communities, bilingual (mostly Thai and Myanmar language) signposts and information in health facilities, and outreach services in the workplace (Tangcharoensathien, Thwin and Patcharanarumola 2017). In addition, a TB screening mechanism for migrant workers was established by the Ministries of Health and Labour. Hospitals in areas with large concentrations of migrant workers provide annual health checkups, treatment, health promotion activities, disease prevention and intensive surveillance. When migrant workers undertake health checkups, they are tested for TB. If the result is positive, concerned migrant workers are allocated to a support group for TB patients (Vittaporn and Boonmongkon 2016).

Some countries offer no cost access to HIV and TB services as part of a benefit package open only to population groups meeting specific eligibility criteria. The administrative processes by which such eligibility is assessed (especially when the schemes are means-tested) can constitute important barriers to health services access for people living with HIV and TB. Often, such means tests are purely based on an estimated income irrespective of the medical costs incurred by the beneficiary, which may exclude people living with HIV and TB who may have an income superior to the designated poverty line but who may fall below it when taking into account their actual medical costs. Box 10 provides an illustration of policy reflections around eligibility criteria for social health protection and HIV services in Cambodia.

► **Box 10. Poverty targeting and eligibility to social protection benefits for people living with HIV in Cambodia**

In Cambodia, PLHIV are eligible for enrolment under the Health Equity Fund, a social health protection scheme providing financial protection against healthcare costs. The National AIDS Authority required evidence on the cost implications of expanding Health Equity Fund coverage to more people living with HIV in Cambodia in order to determine the most effective and sustainable approach in implementing components of SorChorNor No. 213¹¹. Health Policy Plus, a US Agency for International Development project, conducted this analysis, which showcases three scenarios with their associated cost implications:

- Scenario 1: baseline coverage reflecting the current situation in which 18 per cent of PLHIV hold an IDPoor card.
- Scenario 2: considers both the population of eligible PLHIV who already have an IDPoor card (18 per cent) plus PLHIV who are eligible for but do not have an IDPoor card (an additional 20 per cent).
- Scenario 3: Health Equity Fund coverage for all PLHIV, as stated in SorChorNor No. 213, irrespective of their socioeconomic status.

The National AIDS Authority (NAA) applies periodic surveys to identify PLHIV with the deepest needs, and evaluates whether they were identified through the IDPoor process. The NAA's 2017 survey estimated that out of 27,117 people living with HIV, 18 per cent already hold an IDPoor card, and another 20 per cent were identified as being eligible for an IDPoor card but were not in possession of one. Based on SorChorNor No. 213, the NAA is currently working with the Ministry of Planning to identify mechanisms to enroll all PLHIV who do not have IDPoor cards.

11 A policy circular ratified by the Council of Ministers with the Prime Minister's approval in February 2019; it recognizes all people living with HIV as a vulnerable population eligible for the equity cards for the Health Equity Fund.

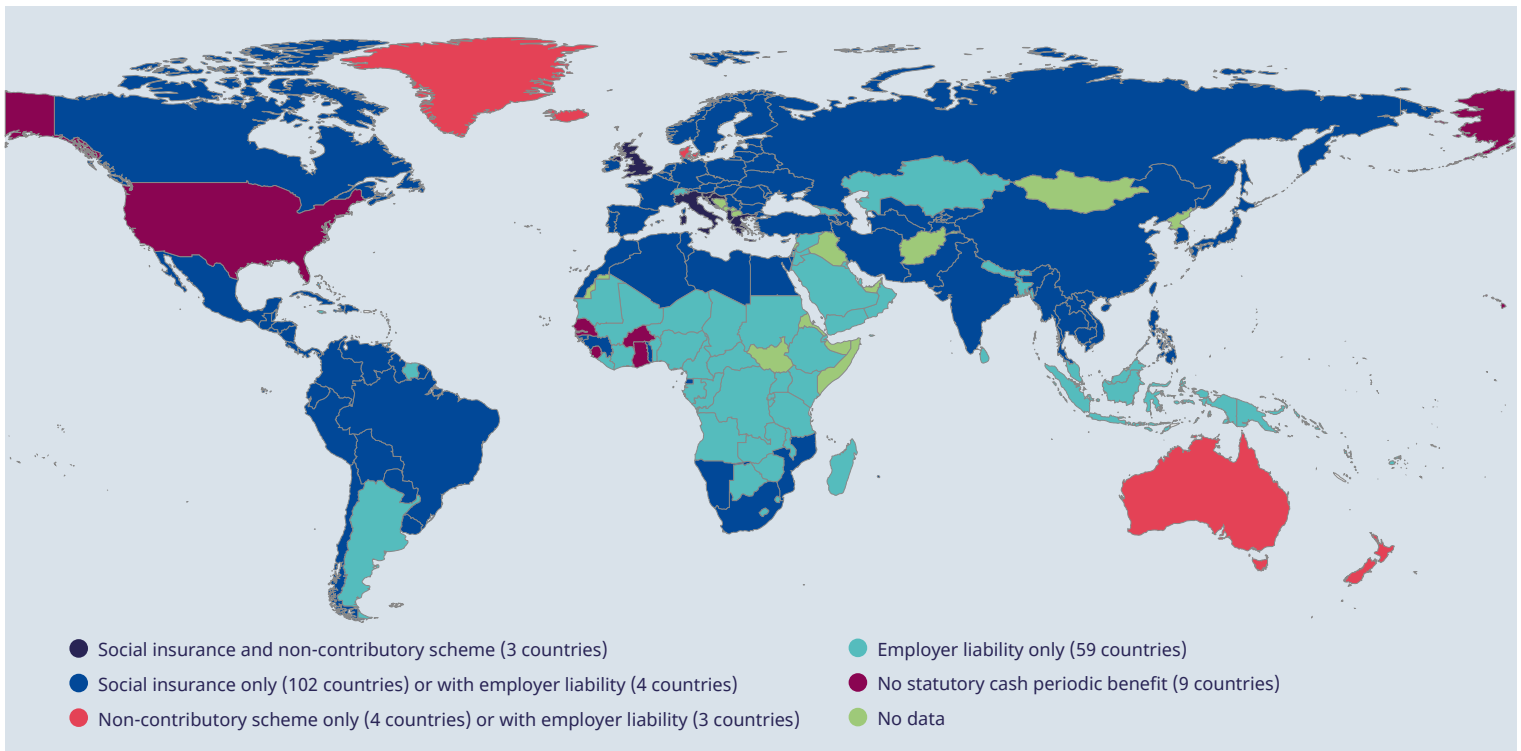
Source: Jain and Srey 2020, and National AIDS Authority 2018, as cited in Kolesar, Jacobs, and Chan, forthcoming.

Lastly, administrative procedures can have an impact on the financial protection people are effectively afforded. For instance, ill-adapted and complex procedures may encourage patients to seek care outside of the network of healthcare providers covered by a scheme. For example, studies in Viet Nam indicated that a lack of confidentiality is a considerable barrier to expanding free HIV testing among key and vulnerable populations (Viet Nam 2014). Similarly, for people on long-term treatments, some care needs to be given to ensuring that the periodicity by which they can renew and fill their prescription is adapted. As exemplified by the response of many social health protection schemes during the COVID-19 crisis, filling prescriptions every three to six months through geographically accessible providers reduces the administrative burden on the patient (ILO 2021b).

3.2. Benefit design: Income security

ILO social security standards identify the need for workers and households to be supported when sick or seeking care so as to ensure their income security. The dedicated vehicle for such protection is sickness cash benefits. However, such schemes often do not exist in high-burden countries, as illustrated by figure 5. Indeed, legal coverage for income support in case of sickness is not a reality in many countries with high HIV and TB burdens, especially in Africa where the responsibility is largely put on the employer rather than the social protection system, which mostly excludes workers in the informal economy (ILO 2020a; 2020b). Therefore, considering the needs of HIV and TB patients in terms of income loss and in absence of sickness benefit schemes, some countries have decided to grant HIV and/or TB patients and their families access to either dedicated HIV and TB benefits or other existing social protection programmes, such as disability benefits or cash transfers for families.

► Figure 5. Income security in case of ill-health, legal protection by type of scheme, latest available year



Source: World Social Protection Database, based on the ILO Social Security Inquiry; ISSA/SSA, Social Security Programs Throughout the World; ILOSTAT; national sources.

The reviewed literature identified that social protection programmes focusing solely on PLHIV could enhance stigma and discrimination, pointing instead to the need to integrate PLHIV as beneficiaries into wider social protection programmes. The arguments put forward were that social protection schemes would do little for the HIV and AIDS response if they exclude or are not appropriate and accessible to people living with, at risk of or affected by HIV (ILO 2017), and that multi-sectoral interventions are needed to address the drivers and impacts of HIV and AIDS, reduce HIV prevalence, provide care and treatment to PLHIV, and mitigate the impact of the epidemic.

As mentioned above, complementing the healthcare benefit package with nutrition is often required. The TB Patient Cost Survey in Kenya highlights the need for social protection programmes to support TB patients during their treatment and recovery. The survey found that half of TB patients have moderate to severe malnutrition at diagnosis. It also highlighted the double burden faced by people with the disease due to reduced income and increased expenses on items like food and nutritional supplements, propelling people (further) into poverty. The report emphasized the need to go beyond the medical aspects and include patient nutrition/food support and transportation needs, in order to lower the financial burden imposed on patients and to truly assure patient-affordable healthcare (Kenya 2018). Likewise, the survey results in Viet Nam called for national policies to reduce both direct and indirect costs incurred by patients (Hoa and Nhung 2019). In Botswana, the Vulnerable Group Feeding Programme – which offers unconditional in-kind food transfers – distributes meals and nutritional supplements to people who are vulnerable to malnutrition and to women of child bearing age from poor or low-income households during drought, as well as to TB patients.

Some countries have decided to grant HIV and/or TB patients access to disability benefits, for example in the form of non-contributory benefits (ILO and UNAIDS 2014). It may be that sickness benefit schemes do not exist in a given country, and therefore HIV and AIDS and TB benefits are integrated under an existing disability benefit scheme, as illustrated in box 11.

► **Box 11. Access to disability benefits for HIV and TB patients**

In Ecuador, the “Bono Joaquín Gallegos Lara” programme provides the caregiver/relative of a child who has a severe disability or a catastrophic illness such as HIV with conditional cash transfers. The purpose is to improve the quality of life of people with disabilities and long-term illnesses, and in turn support the caregiver to be able to attend to them full time (Ecuador 2012).

South Africa also provides a Disability Grant for PLHIV, if the disease causes activity limitation and if the person’s CD4 count is below a certain threshold. This is the only non-contributory scheme for South Africans that provides income security in the event of loss of work capacity due to HIV infection as well as free healthcare (World Bank and ILO 2016).

Social assistance programmes providing cash transfers for vulnerable families with children are a widely used and documented form of social protection benefit that some countries have used as an entry point to extend social protection to people vulnerable to or affected by HIV or TB. In some countries, such social assistance programmes have included eligibility criteria related to HIV or TB status in the household. This is the case in high-burden countries where many deaths have been incurred by the diseases, but the countries did not possess a strong survivors’ benefit scheme. In Botswana, the Orphan

Care Program Short Term Plan of Action on Care Orphans – a cash transfer for households caring for an orphan – is available to children living with HIV. It provides children and their care givers with assistance for educational needs, free medical services in government health facilities, transportation allowances and other income support assistance. Elsewhere in sub-Saharan Africa, where the phenomenon of “missing middle generation” families owing to HIV/AIDS can be commonplace, social pensions can act as de facto family benefits, allowing grandparents to care for orphaned grandchildren.

3.3. Adapting administrative procedures and building partnerships for prevention and referral

Even when social protection programmes exist and are open to key and vulnerable populations, a lack of information, complicated procedures, fear of stigma and discrimination, and lack of documentation that confers eligibility, such as national identity cards (in cases where this is required) can prevent them from accessing it. Therefore, key and vulnerable populations in need may avoid seeking social protection, which presents a particular challenge in trying to reach them.

This is particularly crucial for prevention and referral interventions. In this respect, two types of organizations are of particular relevance:

- **Community-based organizations** – Often, such organizations have been playing several roles: identification, organization and voice representation, and information and referral, but also direct provision of health services (prevention and promotion but also sometimes treatment follow-up) as well as social support.

- **Workplaces** – Occupational safety and health committees composed of employers and workers as well as OHS can provide a significant entry point and access to a large number of vulnerable workers. In terms of TB and HIV, the workplace offers good opportunities for education messages and behaviour change programmes, and workers’ regular presence in the same location can facilitate early diagnosis and treatment adherence (UNAIDS, ILO, and WHO 2012). As highlighted in the strategy adopted by the ILO’s Governing Body – The ILO’s Response to HIV and AIDS: Accelerating Progress for 2030 (October 2019) – comprehensive HIV and TB workplace policies and programmes implemented in partnership with other stakeholders facilitate daily access to prevention, treatment, care and support by reaching men and women workers where they spend most of their daily lives. In addition, allowing workers the flexibility to adapt their working hours or location in response to any (temporary) changes in the severity of their disease would enable them to continue participating in the labour market, thereby enhancing overall productivity (ILO 2019d). Such policies would also benefit workers suffering from long COVID.

This section explores examples of partnerships for prevention and referral services that have led to better provision in the community or at the workplace.

3.3.1. Outreach, prevention and referral through community-based organizations

Some countries have community-led services, with the service providers being members of the population they aim to serve. This creates a client-friendly atmosphere and aims to address some of the challenges of access and discrimination. For example, in Cambodia, since 2017, an integrated case management approach has been implemented through a community mechanism. The community action approach includes the full involvement of community groups and civil society organizations (CSOs) in the provision of prevention and treatment services and serves as a bridge between community and service sites. In Nepal, PLHIV communities across the country are involved in supporting treatment and

care as well as the overall well-being of more than 13,000 PLHIV. The Community and Home-Based Care programme implemented across 40 districts by and for PLHIV has played a key role in patient retention and adherence to treatment. According to the 2018 Nepalese Country Progress Report, the credit of maintaining a retention rate of more than 85 per cent on ART after 12 months of initiation should be attributed largely to the programme (Nepal 2018).

Some countries have put in place contracting mechanisms whereby community-based organizations are delegated a number of services by the social protection system and can refer beneficiaries to relevant social protection schemes. In Mexico, community organizations and NGOs have a long history of involvement in the HIV response, especially in relation to key and vulnerable populations. Since the 1990s, civil society has been pushing the National Center for Prevention and Control of HIV and AIDS (CENSIDA) for all Mexicans to have access to ART. CENSIDA started to work on programmes with NGOs to better reach its target audience. It developed a system of calling for projects each year – on education, prevention, HIV testing, condom and needle distribution – to be implemented by NGOs. CENSIDA spent a yearly budget of 110 million pesos (nearly US\$5.5 million) in recent years on its collaborations with NGOs. However, in February 2019, the Government blocked the funds allocated to NGOs with a view to avoid corruption and the use of intermediaries. Hence, there is a risk that vulnerable populations, who are often unable to travel to the treatment centres, will lose access to proper testing and treatment (Agren 2019). In Malaysia, the Government works with the Malaysian AIDS Council (MAC), an umbrella organization linking roughly 50 civil society partner organizations. The MAC provides technical support and oversight to partner organizations to carry out HIV prevention programmes in Malaysia, and operates in the context of a national approach, in partnership with the Government. Since 2003, through the MAC, the Government has extended its funding to CSOs, equaling more than US\$26.7 million per year, which is nearly half of the total domestic expenditure on HIV (Malaysia 2015). In Costa Rica, Law 8718 requires that the Social Protection Board allocates 1 per cent of the national lottery profits for HIV prevention, care and research implemented by CSOs (Costa Rica 2009). However, accessing such resources for CSOs is not always an easy process, as the organizations sometimes lack the management structure and professionalization required to be eligible for public funding. This is an important point of attention for social protection institutions, because it illustrates that contracting CSOs may be necessary to perform appropriate outreach to populations that are very vulnerable. At the same time, this process may require social protection institutions to set up an enabling contracting framework for such partnerships to be acceptable to both the public finance authorities and the organizational structure of CSOs.

Outreach and partnership can also be a way around targeting systems for social assistance programmes with high exclusion errors, therefore alleviating the administrative burden faced by PLHIV and TB patients in accessing social protection. In some countries, social protection programmes are available for those identified as poor and vulnerable or for key and vulnerable populations. Such means-tested benefits are often dependent on poverty targeting systems, since in many countries with large informal economies access to administrative income records is challenging. Poverty targeting systems have been the subject of much debate in the social protection sphere, since the identification process is often complicated and costly, with a high risk of inclusion or exclusion error (Kidd, Gelders, and Bailey-Athias 2017). The process usually primarily focuses on income considerations, which are not necessarily the most important factors when it comes to households affected by HIV and TB, as their incurred costs are also much higher (see box 10 for an illustration).

3.3.2. Outreach, prevention and referral provided at the workplace

Most countries have existing guidelines, policies, laws and codes to address the transmission of HIV and TB in the workplace, providing guidance to employers and employees to manage the diseases. While TB tends to fall under general occupational safety and health guidelines, many governments have developed specific guidelines for the implementation of HIV prevention and control in the workplace, recognizing

the negative impacts of HIV on businesses and workplaces (for example, Botswana, Cambodia, Indonesia, Malaysia and Viet Nam). Guidelines generally include the establishment of organizational systems and policies to prevent and control HIV in the workplace and the planning and implementation of activities in the workplace. In Malaysia, the workplace committee is responsible for drafting a workplace policy on HIV and AIDS that is sent to the Department of Occupational Safety and Health for review and approval (ASEAN Secretariat 2015). Similarly, in 2006, the Cambodian Ministry of Labour and Vocational Training issued the *Prakas*⁵ on the Creation of the HIV and AIDS Committee in Enterprises and Establishments and the Prevention of HIV and AIDS in the Workplace.

While such workplace mechanisms have a great potential role in prevention and referral towards the social protection system, coordination thereof is poorly documented. Within the review, coordination between social protection and workplace programmes was explicitly defined where HIV and TB was recognized as an occupational disease. In Viet Nam, under the Law on Occupational Safety and Health (2015) workers who get infected with HIV due to an occupational accident are entitled to a cash benefit under the work injury and occupational disease benefit, as well as to all health services provided through the national health insurance scheme (with mandatory registration under the social health insurance scheme), unless the employee is not affiliated (in which case the employer must cover the costs).⁶

Workplaces can provide voluntary counselling and testing programmes, which are an interesting platform to directly provide prevention interventions but also to provide referral services and to help workers navigate the social protection system. Box 12 illustrates the example of an intervention in Kenya that aimed at enhancing the potential of linking workplace health promotion and the social protection system.

► **Box 12. Articulating workplace health promotion and social protection in the context of the HIV response in Kenya**

With 84 per cent of workers being in the informal economy, and few of them covered by social protection programmes, Kenya launched voluntary modes of affiliation that have had limited success. While the National Hospital Insurance Fund (NHIF) covers more than 3 million workers, only 10 per cent of these are voluntarily registered in the scheme. Many workers and their families are not aware of the scheme's benefits, or of how to enrol. This is an important issue for people living with HIV: although ART is free through the National AIDS and Sexually Transmitted Infection Control Programme, other costs, such as medical consultations, are not covered. Affiliation with the NHIF is therefore complementary, as it provides access to those.

Under the Voluntary Counselling and Testing for Workers' Initiative (VCT@WORK Initiative) launched in 2013, Kenya enhanced access to HIV testing among workers in both the formal and the informal economies, and facilitated their access to national social protection schemes (ILO and UNAIDS 2017). In particular, the programme incorporated advice on and support for enrolling with the NHIF.

5 A *prakas* is a decree issued at the ministerial level.

6 Protection from employment injury has been the object of a number of Conventions and Recommendations adopted by the ILO from its early days. According to ILO Convention No. 102 (Part VI), any condition that impacts negatively on health and which is due to a work accident or an occupational disease, and the incapacity to work and earn that results from it, whether temporary or permanent, total or partial, must be covered. The Employment Injury Benefits Convention (No. 121) and Recommendation (No. 121), 1964, set higher standards, mainly in terms of population coverage and the level of benefits to be provided.



3.4. Governance and participation

The participation of communities and key populations in governance and decision-making processes on social protection is important (Ooms and Kruja 2019; PITCH 2019) and has been strongly underlined in particular within the HIV response. The umbrella term “communities” includes PLHIV, their groups and networks, but also organizations, NGOs, AIDS service organizations and faith-based organizations (UNAIDS 2016). Community-led and -based organizations also include organizations of key populations and other populations affected by HIV and AIDS, including people affected by TB. It is acknowledged that they have been at the forefront in the AIDS response, in the delivery of non-medical services such as advocacy and prevention (Jay et al. 2016) and in the uptake of services (UNAIDS 2016). These communities are vital participants in the governance of and national decision-making processes on the issues (UNAIDS 2016). Therefore, many researchers emphasize the importance of their participation in designing new or adapting existing social protection and health systems (Cluver et al. 2014). Annex 2 provides an overview on the inclusion of HIV in social protection policies in the countries studied.

In terms of social protection, the participation of vulnerable and key populations is central for the following reasons:

- While these institutions usually have some formal participation and consultation processes, they often fail to include very remote and vulnerable groups who face multi-dimensional deprivation, creating a situation in which their needs are poorly taken into account in the design of social protection benefits and services offered.

- It is difficult for social protection schemes to monitor the coverage of those populations and to have a picture of the coverage gaps. Indeed, HIV and TB status is not recorded in administrative data on coverage by social protection institutions, neither is it recommended to do so in order to avoid any opportunity for discrimination or stigma. Hence, if regular surveys are not conducted among key and vulnerable populations asking specifically about access to social protection schemes, it is difficult for social protection institutions to know the extent and drivers of coverage gaps among them. Participation in governance and monitoring processes can partially rectify this situation.

- Participation can ensure that specific barriers of access linked to scheme design or administrative procedures can be identified and lifted. Within this perspective, the UN system developed an assessment tool that supports the identification of such barriers and could be of use to such participatory processes (UNAIDS 2017a).

While significant progress has been made in the integration of participatory processes in regards to the institutions specifically in charge of the HIV and TB responses⁷ (Burrows et al. 2016; UNAIDS 2018; PITCH 2019), less evidence was found within the review that this was the case within social protection institutions and processes. Emerging literature explores the potential impact that could stem from integrating community-provided services into decision-making and advocacy, particularly on the emergence of innovative health service delivery models, human rights advances, and access to health services by all people (UNAIDS 2016; Ooms and Kruja 2019). The impact and practices within the social protection arena are yet to be studied.

7 In some cases, the creation of dedicated mechanisms is necessary to ensure that communities are not defunded. Those could take several shapes, such as civil society delegations, participation in governing bodies and in coordination mechanisms of the Global Fund, but also national HIV prevention coalitions.

► **Box 13. Participatory governance practices from the HIV response**

In Nepal, the Young Key Affected Population (YKAP) Group, consisting of young people who inject drugs, female sex workers, men who have sex with men, and transgender people participated in developing the National HIV Strategic Plan 2016–2021. YKAP helped in identifying gaps and needs that must be addressed in the Strategic Plan through thematic discussions held with key stakeholders (Nepal 2018).

The National Aids Authority in Cambodia, along with partners including CSOs and community groups, is working towards creating an enabling environment and empowering PLHIV and key populations so they can meaningfully participate in national HIV response planning, implementation, monitoring and reporting processes (UNAIDS 2018a).

In Malaysia, the Malaysian AIDS Council is a member of the Inter-Ministerial Committee on HIV and AIDS and the National Coordinating Committee on AIDS Intervention (NCCAI) in order to represent the voice of civil society and to strengthen community systems for an effective response to the epidemic. Furthermore, to ensure meaningful social impact mitigation, PLHIV and vulnerable populations have been involved in decision-making at the national level through their participation in the NCCAI and in the Global Fund's Country Coordinating Mechanism (Malaysia 2015).

3.5. Financing

At the turn of the twenty-first century, the epidemics of HIV, TB and malaria were causing staggering loss of life globally, while high drug prices and a general shortage of resources in high-burden countries made tackling these diseases a huge challenge. The communicable nature of these diseases also meant that unless they were tackled across all countries and all population groups, any progress would be at risk of being set back by rising infections elsewhere. Although big steps were being taken in reducing the severity of the diseases, care was out of reach for many. This was especially true for marginalized groups, whose specific needs were often ignored in national health efforts and strategies due to stigma and discrimination. As a consequence, in many countries specific arrangements were made to manage the response in a somewhat different fashion than for other diseases. This involved the support of external funding in a number of instances – using novel funding approaches such as the Global Fund, a public-private partnership – as well as the intervention of external and internal partners outside of the traditional public health system in some places. The absorption of the cost of prevention, diagnosis and treatment of such diseases by governments as part of domestic public resources is an important step towards integrating such programmes within national social protection and health systems (see box 14).

In countries where funding is in part borne by international donors, domestic public spending is intended to increase as they prepare for donors to reduce their financial support. Countries such as Cambodia, Indonesia and Viet Nam are recognizing the need for more strategic use of available resources while preparing to take on an increasing share of the financial burden of response (UNAIDS 2018a). In part this is due to countries moving to a middle- or high-income status and becoming ineligible for funding support, for example, from the Global Fund or the US President's Emergency Plan for AIDS Relief (PEPFAR).⁸ In Viet Nam, a major decrease of funding for ARVs from PEPFAR was expected, which the

8 PEPFAR, established in 2003, is the largest commitment by any nation to address a single disease, and to date has contributed more than US\$90 billion, including funding for the Global Fund. Although the last US Administration (2017–2021) proposed to significantly reduce funding, the US Congress has thus far rejected the proposed spending cuts.

national health insurance scheme is likely to absorb. Viet Nam recognized the use of the PEPFAR scheme as a key pathway to sustainably finance the maintenance and expansion of HIV care and treatment. The integration of HIV services was seen as an efficient strategy, but also as a way to facilitate its political sustainability in the long term.

Quite uniquely, since 2006, the Global Fund has been helping Rwanda to reach universal health coverage by providing subsidies to the poorest families that cover social health insurance contributions. It has funded contributions – in full or in part – for approximately 2 million Rwandans, including orphans, PLHIV and the poorest segment of the population (Nyandekwe, Nzayirambaho and Kakoma 2014; Zeng et al. 2014).

► **Box 14. Transition to domestic funding**

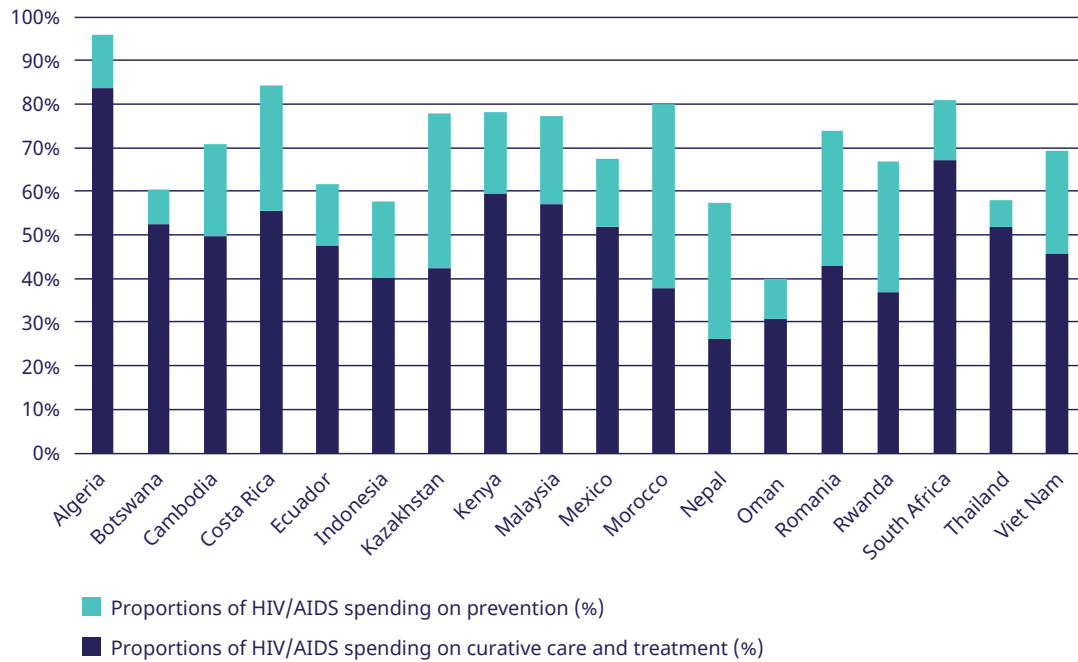
The availability of domestic resources is crucial to the long-term sustainability of HIV and AIDS programmes, and they have constituted the majority of worldwide spending on HIV since 2000. Government resources have continued to grow in all income groups. In the countries studied, development assistance for health constituted most HIV and AIDS spending in low-income countries and countries with extremely high prevalence.¹¹ For example, one study found that among all of the HIV and AIDS services in Cambodia, ART is the most donor dependent, with upwards of two-thirds of all costs financed by the US Government or the Global Fund. The bulk of this spending is for procurement of ARVs and procurement for disease specific HIV drugs (Thin, Prum, and Johns 2019). In high- and upper-middle-income countries, the HIV and AIDS response is predominantly financed by domestic public spending (80 per cent in Algeria, 89 per cent in Thailand and 95 per cent in Ecuador), though there are some exceptions. For example, over a third of spending on HIV and AIDS in Botswana comes from international sources, despite the country being classified as upper-middle income since 2005.

According to the WHO (2019a), the fight against TB remains underfunded. It estimated the shortfall for TB prevention and care in 2019 at US\$3.3 billion, even though funding for TB in the same year reached US\$6.8 billion, up from US\$6.4 billion in 2018. Domestic resources amounted to 87 per cent of available funding. This aggregate figure is strongly influenced by the BRICS group of countries (Brazil, Russian Federation, India, China and South Africa). The BRICS countries account for 53 per cent of the available funding in 2019, and 95 per cent of their funding is from domestic sources (WHO 2019c). In other low- and middle-income countries, international donor funding remains crucial, accounting for 38 per cent of the funding available in the 25 high TB burden countries outside BRICS and 49 per cent of the funding available in low-income countries. International funding, critical in many low- and middle-income country programmes, amounted to US\$0.9 billion or 13 per cent of all TB funding in 2019, with 73 per cent coming through the Global Fund (WHO 2019c). The largest bilateral donor is the US Government, which provides almost 50 per cent of total international donor funding for TB when combined with funds channeled through and allocated by the Global Fund (WHO 2019c). Among the studied countries, domestic funding for TB appeared to be dominant, followed by a relatively equal split between domestic and international funding. Only in Rwanda did international funding account for 97 per cent of total TB expenditure.

1 Global Burden of Disease Health Financing Collaborator Network 2018.

Although some social health protection programmes include aspects of HIV and AIDS prevention services, the majority of funding is focused on treatment (see figure 6). The funding gap for prevention services in the studied countries was predominantly covered by international sources, sometimes with programmes delivered primarily by NGOs (such as in Algeria, Cambodia and Indonesia). Interestingly, in Thailand, the Government has legislated earmarked “sin taxes” for health promotion – known as ThaiHealth – using an additional 2 per cent surcharge on tobacco and alcohol excise taxes to fund civil society campaigns on various key health risks, including HIV and AIDS (Asia Pacific Observatory on Health Systems and Policies 2015).

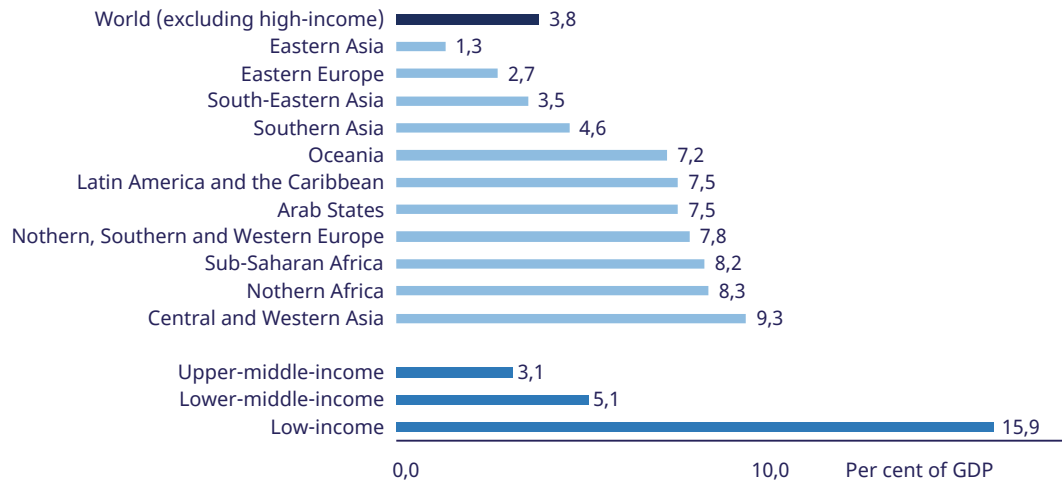
► Figure 6. Proportion of spending on HIV treatment and prevention, selected countries, 2018



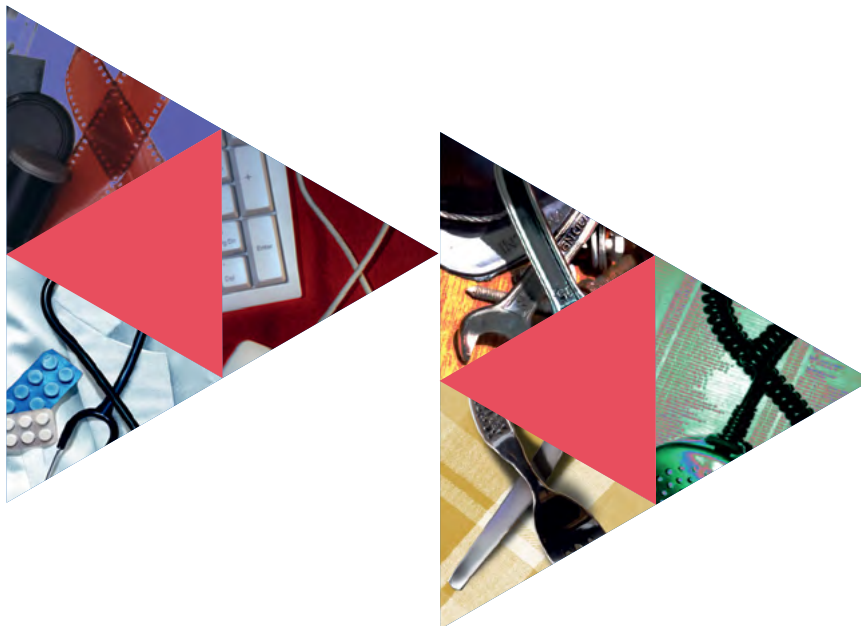
Source: Global Burden of Disease Health Financing Collaborator Network 2018.

Most of the social protection coverage gaps discussed in the first section of this study relate to an under-investment in social protection and health systems. In this respect, progress towards the inclusion of people vulnerable to or affected by HIV and TB in social protection schemes and the adaptation of such schemes to respond to their specific needs cannot be envisaged without advocating for more and better resources. As illustrated by figure 7, the annual financing gap to achieve SDG targets on social protection and universal health coverage remains important, especially in Africa.

► **Figure 7. Annual financing gap in achieving SDG targets 1.3 and 3.8, by region and income level, 2020 (percentage of GDP)**⁹



9 The cost estimate is based on the following generic benefit package: (a) child benefits for all children aged 0–5, set at 25 per cent of the national poverty line; (b) maternity benefits set at 100 per cent of the national poverty line during four months around childbirth; (c) disability benefits for persons with a severe disability, set at 100 per cent of the national poverty line; (d) old-age benefits for all persons aged 65 and above, also set at 100 per cent; and (e) access to essential healthcare as estimated by the World Health Organization (WHO) (Stenberg et al. 2017). Source: ILO, [World Social Protection Database](#), based on the ILO Social Security Inquiry; IMF; ECLAC; WHO; national sources.





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► 4. Conclusion and Recommendations

With a view to expand social protection coverage to people vulnerable to HIV and TB and to making social protection systems more HIV- and TB-sensitive, recommendations can be made along three key dimensions.

Improving the responsiveness of social protection systems – The increased mobilization of domestic resources and the progressive horizontal integration of HIV and TB programmes into national systems are necessary to maintain effective and efficient HIV and TB responses. An emphasis on responsiveness is necessary to ensure that prevention, diagnosis, treatment and other non-medical costs are effectively included within social protection schemes and national health financing strategies. Adjusting features of social protection schemes to improve their responsiveness to the special needs of people living with HIV and/or TB is also necessary, especially in terms of securing access to an adapted health benefit package, access to nutritious food, transport to care facilities and addressing income loss. It is also important to ensure an effective coordination across different social protection schemes to ensure the effective combination of care and income support.

Improving inclusiveness – Effective HIV and TB responses entail a high level of inclusiveness: people who are most at risk and people living with HIV and TB are often hard to reach, and key and vulnerable populations often suffer from stigma and marginalization. Social protection systems often have difficulties in extending sustained coverage to key and vulnerable populations affected by or at risk of TB and HIV. They encounter barriers to access due to multiple vulnerabilities, such as remoteness, social exclusion, stigma, marginalization and limited capacity to contribute to a social insurance scheme, but also face difficulties in meeting eligibility criteria for social assistance schemes. In addition, there are legal barriers, as the criminalization of certain behaviours – such as same-sex relationships or sex work – and lack of identity papers – as in the case of transgender people – prevent or make it very difficult for some key populations to access social protection programmes. Ensuring that people at risk or living with HIV and/or TB and their families are included in existing social protection schemes, and extending the coverage of these schemes, are not only necessary, but central to the agenda for sustainable development tagline of leaving no one behind.

Enhance participation and partnerships – To be truly inclusive, key and vulnerable populations need to be heard in the governance structure of social protection systems. This necessarily involves an active effort by such schemes and systems to effectively implement participatory governance principles, enforce transparency and employ efficient grievance mechanisms. It also involves creating linkages with community-based organizations and workplaces.

When considering the above recommendations, it is important to note that the reliance on secondary data, reports and literature available in the public domain has limited the findings of this working paper to what is publicly reported and already documented. There was, however, a particular lack of systematic reviews and longitudinal studies. Information gaps were identified in regard to four key aspects, which offer opportunities for further research:

- First, there is limited information available on existing OHS and workplace health promotion practices and their linkages with social protection systems, with the exception of recognition of HIV and TB as occupational diseases. Similarly, evidence on the necessary conditions and administrative arrangements for social protection institutions to delegate some prevention and referral functions to NGOs and CSOs remains anecdotal. Indeed, as key populations may be suffering multidimensional deprivations and may feel remote from the institutional environment, CSOs, community-based organizations and NGOs may be indispensable channels for social protection institutions to reach them. Global financing mechanisms have traditionally put an important emphasis on funding these

type of organizations. But as countries transition out of such global financing mechanisms and absorb more of the costs related to prevention, diagnosis and treatment, it is important that mechanisms to partner with organizations that are the closest to vulnerable populations continue to be explored. Though conceptually the possible linkages and the rationale for coordination are clear, documentation of such institutional practices for coordination is limited, especially for low- and medium-income countries.

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- Second, very few studies focused on documenting effective practices to improve access to social protection from an institutional perspective. Most of the literature reviewed provides evidence on barriers to access health services, but there is little guidance on best practices for social protection institutions to ensure effective outreach, affiliation, financing, etc., of services for vulnerable and key populations confronted with such barriers. The absence of such documentation is problematic when it comes to formulating practical recommendations for such institutions to take rapid action and change their practices.
-
- Third, the statistics on social protection coverage of key and vulnerable populations are limited. This makes it difficult to judge the scale of inclusiveness of existing social protection schemes. While it is not recommended that such schemes track the HIV or TB status of their beneficiaries or any personal characteristics that could identify them as key populations, it would be good for surveys of vulnerable and key populations to estimate social protection coverage on a regular basis and with consistent methods. This would provide the evidence base that could inform gaps in population coverage in a more precise way.
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- Fourth, in cases where social protection programmes are specifically targeted towards PLHIV or those affected by HIV or TB, they may be unwilling to receive the benefits due to fear of stigma and discrimination, issues of confidentiality and attitudes from healthcare providers, or simply a lack of information. It is, therefore, important that key and vulnerable populations be included in the development of strategies and programmes as well as in the delivering of services, ensuring that these services are responsive to their specific needs and following non-discrimination and quality standards.
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The findings and limitations suggest directions for further research, including via the collection of firsthand empirical data on the aforementioned dimensions. Additionally, to become truly inclusive of vulnerable and key populations and responsive to their needs, social protection systems would need to systematically take into account HIV and TB responses. Within this perspective, it would be important to mainstream HIV and TB into the tools used by social protection practitioners at the global and country levels. The ILO – as co-lead of the UN Social Protection Floor Initiative, the Social Protection Inter-Agency Cooperation Board and the Global Partnership for Universal Social Protection (USP2030) – is uniquely positioned to lead such work. Lastly, the COVID-19 pandemic has revealed opportunities in terms of enhancing the shock responsiveness of social protection systems and, in this context, further comparative research into the design and management of social protection responses across countries could identify valuable policy lessons on social protection and pandemics.

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► Annexes

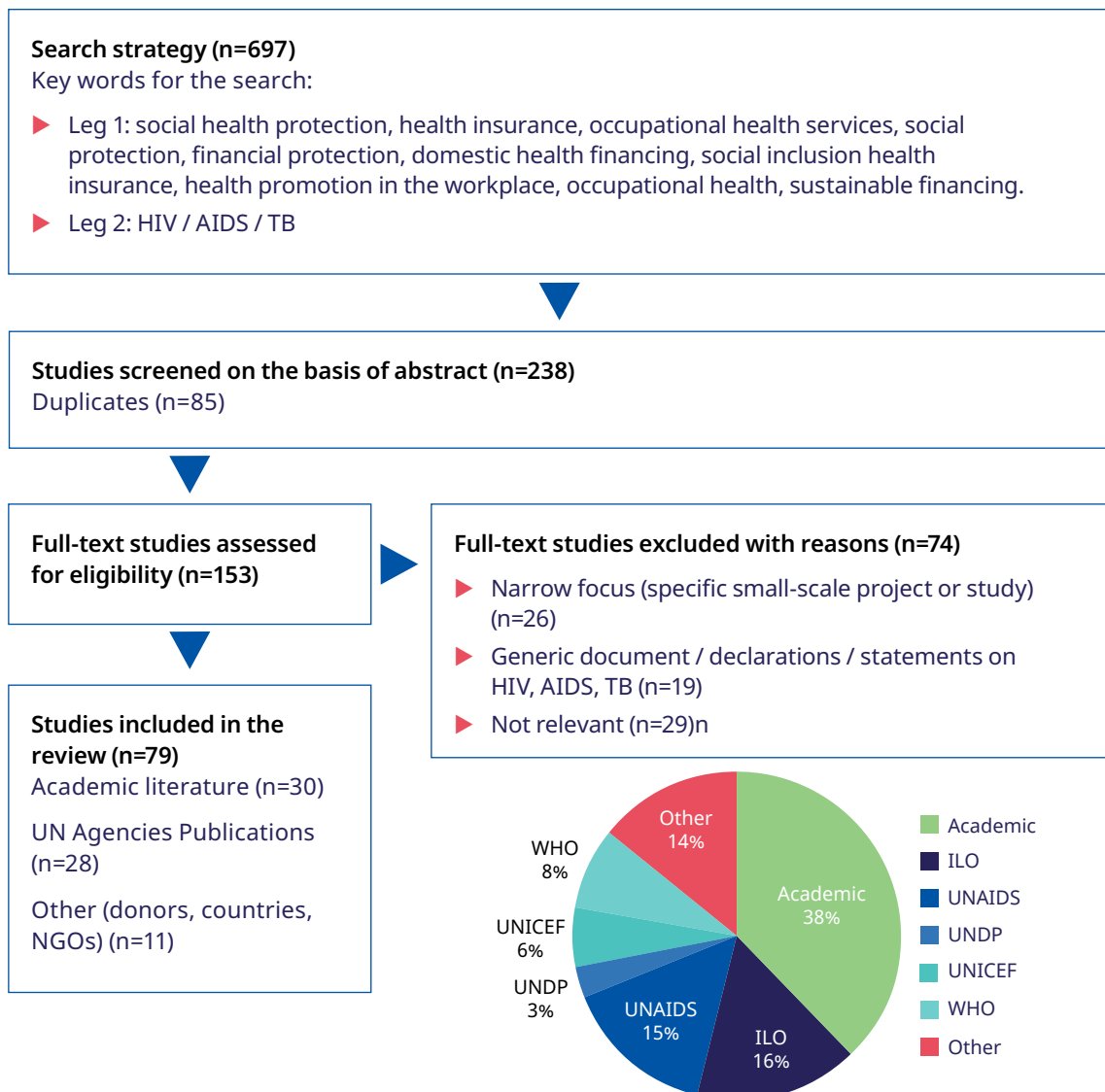
Annex 1. Methodology

During the initial search process, a wide range of documents accessible either within ILO or public databases were considered, which included academic journals, unpublished research, grey literature, institutional reports, and project and programme reports.

Based on the research questions, a number of searches were performed with various combinations of keywords, going from the most specific combinations, which yielded little results, towards the drop of one or more concept(s) and the use of broader terminology with a view to increasing sensitivity. Searches were performed on Google, Google Scholar, Medline and the Cochrane database of systematic reviews.

Figure A1 illustrates the number of documents identified, selected for a review of abstract or executive summary, and selected for a full review.

► Figure A1. First literature review



This first review of literature aimed at identifying the breadth of information that was available on the topic and whether any prior research focusing on this issue and drawing from a geographically diverse number of country studies had already been conducted. The review of 79 pertinent documents revealed that much of the literature and available evidence at the global level on social protection and/or occupational health services and HIV and TB was focused on documenting three major topics: (i) the social protection needs of people living with, at risk of or affected by HIV and TB; (ii) the barriers to access faced by these populations when it comes to social protection; and (iii) the role of occupational safety and health and related workplace services when it comes to HIV and TB in specific economic sectors (and in particular in the health sector).

In the global studies and reports reviewed, the level of detail often did not allow for the identification of specific practices or measures adopted by social protection institutions and/or occupational health services to effectively include populations at risk of or affected by HIV and TB. Instead, an in-depth analysis of these systems in a selection of countries was deemed more appropriate to identify such institutional practices as well as any good practices that may be relevant elsewhere. Figure A2 illustrates the country selection process.

► **Figure A2. Country selection process**



Database compiling the following indicators:

- Adults / children living with HIV
- HIV prevalence among adults
- New HIV infection among adults / children
- HIV incidence among adults / children
- Number / coverage of women who received ARV for PMTCT
- Percentage of people living with HIV who know their status / are on ART / who achieve viral suppression (90-90-90 target)
- Expenditure on HIV prevention, diagnosis, treatment (total, domestic, private and international)
- Change in HIV incidence / AIDS-related mortality / TB mortality / TB incidence
- Out-of-pocket HIV and AIDS spending
- Proportion of HIV and AIDS spending on curative care and treatment / prevention
- Change in percent of domestic expenditure on HIV
- Existence of a reference to HIV within social protection policies / recognition of people living with HIV as beneficiaries / key population participation in the governance of the system
- Global Fund transition status for HIV
- Existence of a national OHS regulatory framework / OHS programme provided by law / policies

Scoring: For each indicator, countries were attributed a score from 0 (lowest) to 1 (highest) with 4 possible scores: 0, 0.33, 0.66 and 1. The 15 scores were weighted according to the relevance of each indicator and averaged to provide a final score to rank the countries.

Additional considerations:

- Countries for which the first literature review had identified reported good practices in terms of the integration of HIV and TB in social protection and occupational health services;
- countries in which the ILO intervened on the integration of HIV in either social protection or OHS systems;
- countries where the social protection system has been dynamic in tackling issues of extension of coverage;
- including a mix of low-, middle- and high-income countries; and
- countries in which the ILO has existing specialists who can be called upon to verify facts and collect documents as necessary.

► **Making universal social protection a reality for people living with, at the risk of, and affected by HIV or Tuberculosis**

A global database was created, encompassing information for 250 countries and territories on their epidemiology concerning HIV and TB; expenditure on HIV and TB; the social protection system and its recognition of TB and HIV; governance structures and key and vulnerable population participation in policy/guideline/strategy development related to their health; and existence of national occupational safety and health programmes and policies. The indicators used and their sources are available in table A1 below. On this basis, an initial short list of 50 countries was established for which a scoring exercise was conducted. The scoring, as well as additional practical consideration for the research,¹⁰ were used to select 18 countries¹¹ for which a systematic search for information was conducted as per a standard template and key research questions (box A1).

► **Table A1. Indicators used to select country case studie**

Indicator	Source
► Adults living with HIV	UNAIDS/AIDSINFO (2018), figures based on modelled HIV estimates
► Children living with HIV	
► HIV prevalence among adults	
► New HIV infection among adults	
► New HIV infection among children	
► HIV incidence among adults	
► HIV incidence among children	
► Number of women who received ARV for PMTCT	
► Coverage of women who received ARV for PMTCT	
► Percentage of PLHIV who know their status	
► Percent of people who know their status who are on ART	
► Percent of people on ART who achieve viral suppression	
► Total HIV expenditure	
► Domestic HIV expenditure	
► Private HIV Expenditure	
► International HIV expenditure	
► Incidence in HIV/TB Co-infections	WHO TB Burden Estimates (2017)
► TB incidence	
► Number of adults infected by TB	
► Number of children infected by TB	
► Change in TB incidence since 2010	
► TB mortality	
► Change in TB mortality among people living with HIV since 2010	
► Change in HIV incidence	UNAIDS/AIDSINFO (2018), figures based on modelled HIV estimates
► Change in AIDS-related mortality	

10 Additional considerations:

- i. countries for which the first literature review had identified reported good practices in terms of the integration of HIV and TB in social protection and occupational health services;
- ii. countries in which the ILO intervened on the integration of HIV in either social protection or occupational safety and health systems;
- iii. countries where the social protection system has been dynamic in tackling issues of extension of coverage;
- iv. including a mix of low-, middle- and high-income countries; and
- v. countries in which the ILO has existing specialists who can be called upon to verify facts and collect documents as necessary.

- 11 Algeria, Botswana, Cambodia, Costa Rica, Ecuador, Indonesia, Kazakhstan, Kenya, Malaysia, Mexico, Morocco, Nepal, Oman, Romania, Rwanda, South Africa, Thailand and Viet Nam.

Indicator	Source
▶ TB treatment success rate	WHO TB Treatment Outcomes (2016), data provided by countries for the Global TB Report
<ul style="list-style-type: none"> ▶ Total TB expenditure ▶ Domestic TB expenditure ▶ Domestic TB expenditure as share of total expenditure ▶ International TB expenditure as share of total expenditure 	WHO TB budget (2018), data provided by countries for the Global TB Report
<ul style="list-style-type: none"> ▶ Out-of-pocket HIV and AIDS spending as a share of total HIV and AIDS spending ▶ Proportion of HIV and AIDS spending on curative care and treatment ▶ Proportion of HIV and AIDS spending on prevention ▶ Change in percent of domestic expenditure on HIV 	<i>The Lancet</i> (2018), modelled
<ul style="list-style-type: none"> ▶ Social protection policy: <ul style="list-style-type: none"> ▶ Refers to HIV ▶ Recognizes people affected by HIV as key beneficiaries ▶ Recognizes PLHIV as key beneficiaries ▶ Recognizes key populations as key beneficiaries ▶ Existing national strategy/policy guiding AIDS response ▶ National monitoring integrating AIDS response ▶ HIV prevention / diagnosis / treatment included in the health benefit package of the national health insurance / health coverage scheme ▶ Social protection coordination mechanism/platform ▶ National AIDS Council includes SP entities 	UNAIDS, Laws and Policies Analytics (2018), country responses
<ul style="list-style-type: none"> ▶ National policy indicates WRD as the initial diagnosis test for all people presumed to have TB ▶ National policy indicates universal access to DST ▶ Free dx follow-up 	WHO TB Policies and Services (2017), updated by countries
▶ Proportion of people living with HIV receiving TB preventive therapy	UNAIDS – AIDSInfo Portal (2017)
▶ The Global Fund transition status for HIV	The Global Fund (2018)
<ul style="list-style-type: none"> ▶ National occupational safety and health programme offered by law/policy ▶ National occupational safety and health regulatory framework ▶ National occupational safety and health policy/ programme includes health promotion or HIV policy/ strategy/plan 	ILO Global Database on Occupational Safety and Health Legislation (LEGOSH)

► **Box A1. Guiding research questions for the case studies**

When considering the inclusiveness of schemes, the paper aimed at identifying efforts made by social protection institutions to effectively include populations living with, at risk of or affected by HIV and TB. Such inclusiveness supposes that:

- ▶ The governance structure of the institutions provides a space for the voices of populations living with, at risk of or affected by HIV and TB to be heard.
- ▶ Administrative procedures for affiliation and accessing benefits are effectively accessible and adapted to the target population, who may be remote to institutional set-ups.
- ▶ For groups particularly vulnerable and difficult to cover, outreach programmes and partnerships are made with relevant entities to inform/refer/facilitate the affiliation of those groups.

When considering responsiveness, the paper aimed at identifying efforts made by social protection schemes and institutions to respond to the needs of the populations living with, at risk of or affected by HIV and/or TB. Such responsiveness supposes that:

- ▶ The funding for those interventions is sustainable and managed by the institutions in charge of covering health for the entire population.
- ▶ The benefit package includes the necessary health services to ensure prevention, diagnosis and treatment are available and affordable.
- ▶ The health services have the available equipment, processes and trained resources to cater to the needs of the target population.
- ▶ The health benefits are accompanied by and coordinated with other social protection benefits that facilitate access to health (such as, transport, nutrition, compensation from loss of income).

When considering coordination, the paper aimed at identifying existing links and collaboration mechanisms established between social protection schemes and institutions and OHS. Such collaboration supposes that:

- ▶ The world of work is integrated, in policy and practice, into the national HIV and AIDS and TB strategies.
- ▶ If prevention is not delivered only by public health facilities, the appropriate coordination mechanisms and funding channels are in place with the competent organizations (which may be occupational health services or non-governmental organizations (NGOs) collaborating with workplace health promotion programmes).
- ▶ Safety and health measures to prevent workers' exposure to HIV and TB are in place, especially in occupations most at risk, including in the healthcare sector.
- ▶ Voluntary counselling and testing are offered in the workplace or through the workplace in coordination with national HIV and TB programmes, and referral mechanisms are put in place to facilitate access to treatment and care.

Annex 2. Overview of HIV/AIDS inclusion in social protection policies in study countries

Countries	Social Protection Policy				Existing national strategy/ policy guiding AIDS response	Social protection coordination mechanisms/ platform
	Refers to HIV	Recognizes people affected by HIV as key beneficiaries	Recognizes PLHIV as key beneficiaries	Recognizes key populations as key beneficiaries		
Algeria	Yes	Yes	Yes	No	Stand-alone AIDS strategy	Yes, including representatives of the Nat. AIDS Programme
Botswana	Yes	Yes	Yes	No	Stand-alone AIDS strategy	Yes, including representatives of the Nat. AIDS Programme
Cambodia	Yes	Yes	Yes	No	Stand-alone AIDS strategy	Stand Yes, including representatives of the Nat. AIDS Programme
Costa Rica	Yes	Yes	Yes	Yes	Stand-alone AIDS strategy	Yes, but excluding representatives of the Nat. AIDS Programme
Ecuador	Yes	Yes	Yes	Yes	Health strategy integrating AIDS	Yes, including representatives of the Nat. AIDS Programme
Indonesia	Yes	Yes	Yes	Yes	n/a	Yes, including representatives of the Nat. AIDS Programme
Kazakhstan	Yes	Yes	Yes	Yes	Health strategy integrating AIDS	Yes, including representatives of the Nat. AIDS Programme
Kenya	Yes	Yes	Yes	No	Stand-alone AIDS strategy	Yes, including representatives of the Nat. AIDS Programme
Malaysia	Yes	Yes	Yes	No	Stand-alone AIDS strategy	Yes, including representatives of the Nat. AIDS Programme

Countries	Social Protection Policy				Existing national strategy/ policy guiding AIDS response	Social protection coordination mechanisms/ platform
	Refers to HIV	Recognizes people affected by HIV as key beneficiaries	Recognizes PLHIV as key beneficiaries	Recognizes key populations as key beneficiaries		
Mexico	Yes	No	Yes	Yes	Stand-alone AIDS strategy	Yes, including representatives of the Nat. AIDS Programme
Morocco	No	Yes	No	No	Stand-alone AIDS strategy	Yes, including representatives of the Nat. AIDS Programme
Nepal	Yes	Yes	Yes	Yes	Stand-alone AIDS strategy	Stand Yes, including representatives of the Nat. AIDS Programme
Oman	No	No	No	No	No	Yes, but excluding representatives of the Nat. AIDS Programme
Romania	n/a	n/a	n/a	n/a	n/a	n/a
Rwanda	Yes	Yes	Yes	n/a	Stand-alone AIDS strategy	Yes, including representatives of the Nat. AIDS Programme
South Africa	Yes	Yes	Yes	No	Health strategy integrating AIDS	Yes, including representatives of the Nat. AIDS Programme
Thailand	Yes	Yes	Yes	Yes	n/a	Yes, including representatives of the Nat. AIDS Programme
Viet Nam	Yes	n/a	Yes	Yes	Stand-alone AIDS strategy	n/a

n/a = Information not available; Nat. = National.

Annex 3. Snapshot of the database of the 18 selected countries

Countries	EPIDEMIOLOGY															Year		
	Algeria	15 000	<500	<0,1	1 200	<100	0,05	0,01	0,43	324	74	86	93	68	0,25	0,01	54%	31 899 471
Botswana	350 000	14 000	20,3	8 200	<500	7,4	1,27	144	12 359	>95	91	92	>95	-0,39	-0,19	-62%	158 991 774	2017
Cambodia	70 000	3 300	0,5	<1000	<200	0,1	0,06	8,2	619	85	82	>95	>95	-0,25	0,14	-68%	21 820 542	2015
Costa Rica	15 000	n/a	0,4	<1000	n/a	0,4	n/a	0,86	35	n/a	n/a	n/a	n/a	-0,24	-0,09	-36%	48 044 490	2018
Ecuador	43 000	<1000	0,4	2 200	<100	0,2	0,03	5,7	368	>95	76	75	89	-0,33	0,37	100%	15 614 260	2018
Indonesia	620 000	18 000	0,4	43 000	3 500	0,3	0,14	14	1 818	15	51	33	n/a	-0,25	-0,54	-37%	173 477 066	2016
Kazakhstan	25 000	<500	0,2	2 600	<100	0,2	0,03	2,9	360	59	88	66	65	0,00	-0,19	19%	33 594 038	2018
Kenya	1400 000	120 000	4,7	38 000	7 600	1,62	1,12	91	57 523	91	89	77	n/a	-0,39	0,29	-57%	1174 884 586	2017
Malaysia	87 000	<500	0,4	5 600	<100	0,31	<0,01	5,7	257	>95	86	55	n/a	-0,06	0,11	-14%	36 935 753	n/a
Mexico	230 000	2 300	0,2	11 000	<200	0,14	0,02	2,7	n/a	n/a	76	93	89	-0,13	n/a	108%	n/a	n/a
Morocco	21 000	<1000	<0,1	<1000	<100	0,04	0,02	1,1	216	61	76	86	91	n/a	n/a	0%	39 062 783	2017
Nepal	29 000	1 400	0,1	<1000	<100	0,05	0,03	3	146	51	71	79	n/a	-0,64	-0,36	n/a	15 759 395	2018
Oman	3 200	n/a	0,2	<500	n/a	0,1	n/a	0,08	35	n/a	48	84	87	0,00	0,01	0%	4 324 861	2014
Romania	18 000	<100	0,1	<1000	<100	0,1	<0,01	n/a	232	>95	87	78	80	0,00	-0,29	-55%	70 977 789	2017
Rwanda	210 000	12 000	2,5	3 200	<500	0,5	0,2	13	8 552	>95	94	93	85	-0,62	-0,33	-48%	217 589 955	2015
South Africa	7500 000	260 000	20,4	220 000	14 000	8,7	n/a	340	247 690	87	90	68	87	-0,44	-0,10	-32%	2432 035 050	2017
Thailand	480 000	3 200	1,1	6 300	<100	0,2	0,01	16	3 787	>95	94	80	>95	-0,50	-0,42	-62%	287 278 782	2013
Viet Nam	220 000	5 000	0,3	5 400	<500	0,1	0,04	4,7	1 932	81	n/a	n/a	n/a	-0,67	-0,416184971	-73%	95 446 487	2012

Country	EPIDEMIOLOGY						PROGRAMME SPENDING					SOCIAL PROTECTION SYSTEM			
	TB incidence in 2017 (per 100 000)	Number of adults infected by TB, 2017	Number of children infected by TB, 2017	Change in TB incidence since 2010	TB treatment success rate, 2016 (%)	TB mortality (per 100 000)	Total TB expenditures (\$)	Domestic TB expenditure (\$)	Domestic TB expenditure (% of total expenditure)	International TB expenditures (\$)	International TB expenditures (% of total expenditure)	National policy indicates WRD as the initial diagnosis test for all people presumed to have TB	National policy indicates universal access to DST	Free dx follow-up	Proportion of people living with HIV receiving TB preventive therapy (2016/2017)
Algeria	70	25 000	3 900	-9,1	n/a	7,7	n/a	n/a	n/a	0	n/a	No	Yes	Yes	n/a
Botswana	300	80 000	11 000	-42,1	79	52	8 238 455	5 838 455	70,9%	2 400 000	29,1%	Yes	Yes	Yes	n/a
Cambodia	326	46 000	6 500	-25,2	94	22	13 288 714	4 559 546	34,3%	8 729 168	65,7%	No	No	Yes	21
Costa Rica	9,7	420	56	-30,7	84	1	n/a	n/a	n/a	0	n/a	No	Yes	Yes	n/a
Ecuador	43	6 300	840	7,5	72	4,1	481 322	481 322	100,0%	0	0,0%	No	Yes	Yes	5,9
Indonesia	319	792 000	49 000	-6,7	86	44	149 445 763	101 565 995	68,0%	47 879 768	32,0%	Yes	Yes	Yes	15,6
Kazakhstan	66	11 000	1 200	-54,5	88	1,1	133 845 328	126 856 666	94,8%	6 988 662	5,2%	Yes	Yes	Yes	44
Kenya	319	138 000	21 000	-39,9	81	86	26 780 771	13 794 399	51,5%	12 986 372	48,5%	Yes	Yes	Yes	n/a
Malaysia	93	26 000	3 800	22,4	80	4,9	15 980 000	15 980 000	100,0%	0	0,0%	Yes	Yes	Yes	78,8
Mexico	22	25 000	3 000	4,8	79	2,2	12 013 738	12 013 738	100,0%	0	0,0%	No	No	Yes	2,3
Morocco	99	31 000	4 200	-2,0	87	8,3	16 295 500	15 520 000	95,2%	775 500	4,8%	No	Yes	Yes	27
Nepal	152	40 000	5 100	-6,7	91	24	17 779 708	9 782 800	55,0%	7 996 908	45,0%	Yes	Yes	Yes	n/a
Oman	6,7	280	35	-44,2	51	0,5	n/a	n/a	n/a	0	n/a	n/a	n/a	n/a	n/a
Romania	72	13 000	1 600	-31,4	86	4,9	13 539 670	10 250 000	75,7%	3 289 670	24,3%	No	Yes	Yes	n/a
Rwanda	57	6 400	590	-30,5	86	7,5	6 423 616	219 484	3,4%	6 204 132	96,6%	No	Yes	Yes	n/a
South Africa	567	283 000	39 000	-40,2	82	138	268 895 236	247 352 379	92,0%	21 542 857	8,0%	Yes	Yes	Yes	52,9
Suriname	29	140	19	-37,0	68	3,7	818 806	401 026	49,0%	417 780	51,0%	Yes	Yes	Yes	n/a
Thailand	156	100 000	8 100	-13,8	83	18	25 860 749	22 387 230	86,6%	3 473 519	13,4%	Yes	Yes	Yes	n/a
Viet Nam	129	109 000	15 000	-16,8	92	13	27 367 269	7 917 308	28,9%	19 449 961	71,1%	No	Yes	Yes	31,4

Country	GOVERNANCE – KEY POPULATION PARTICIPATION in policy/guidelines/strategy development related to their health:						OSH			
	MSM	Sex workers	People who inject drugs	Transgender people	Former / current prisoners	OHS offered by law-policy	OSH national policy / programme includes health promotion or HIV / policy / strategy / plan	SH national policy/programme includes linkages with social health protection scheme / national health insurance	prevention / diagnosis / treatment is offered by workplace health services to workers affected by HIV / TB;	
Algeria	Yes	Yes	Yes	No	Yes	No data available.	n/a			
Botswana	Yes	Yes	No	Yes	No	No data available.	Code of Good Practice: HIV/AIDS and Employment. Botswana National Policy on HIV/AIDS			
Cambodia	Yes	Yes	Yes	Yes	No		n/a			
Costa Rica	Yes	Yes	No	Yes	No		Yes. Decreto núm. 27894-S, reglamento de la ley general sobre VIH-SIDA. (§§ 26-28)	The Ministry of Labour and Social Security through the Department of Social Welfare, has an Occupational Safety and Health Office.		
Ecuador	Yes	Yes	No	Yes	No	No data available.	Yes. Acuerdo Ministerial núm. 00398 que prohíbe despedido a los trabajadores que padecen de VIH/SIDA. (§§ 1-5)	The Ministry of Labour and Social Security through the Department of Social Welfare, has an Occupational Security and Health Office which aims to improve the OSH working conditions in all private or public workplaces and institutions.		
Indonesia	n/a	n/a	n/a	n/a	n/a		n/a	n/a		
Kazakhstan	Yes	Yes	Yes	No	Yes	No data available.	n/a	n/a		
Kenya	Yes	Yes	Yes	Yes	Yes	Yes.	n/a	The "Ministry of Labour, Social Security and Services" is the competent national authority for safety and health at work.		
Malaysia	Yes	Yes	Yes	Yes	Yes		"(1) The Minister may make regulations for or with respect to the safety, health and welfare of persons at work in order to achieve the objects of this Act.			
Mexico	Yes	Yes	Yes	Yes	Yes	No.	n/a	The Secretariat of Labour and Social Welfare is responsible for the overall administration of OSH matters. The Secretariat of Labour and Social Welfare has a Department of Occupational Safety and Health..		
Morocco	Yes	Yes	Yes	No	No	No data available.	n/a	n/a		
Nepal	Yes	Yes	Yes	Yes	Yes		n/a	n/a		

Country	GOVERNANCE - KEY POPULATION PARTICIPATION in policy/guidelines/strategy development related to their health:						OSH			
	MSM	Sex workers	People who inject drugs	Transgender people	Former / current prisoners	OHS offered by law-policy	OSH national policy / programme / strategy / plan	OSH national policy/programme includes linkages with social health protection scheme / national health insurance	prevention / diagnosis / treatment is offered by workplace health services to workers affected by HIV / TB;	
Oman	No	No	No	No	No	Yes.	n/a	The Ministry of Manpower is the main institution responsible for ensuring overall OSH issues, There is also a National Committee on OSH and an occupational safety and health department of the directorate general of labourers welfare		
Romania	n/a	n/a	n/a	n/a	n/a	Yes.	n/a	The Ministry of Labour is the OSH national authority. Other institutions with competences in OSH issues: <ul style="list-style-type: none"> ▲ The Ministry of Health is in charge of occupational medicine. ▲ The Labour Inspection. ▲ The National Research and Development Institute for Work Protection, 		
Rwanda	Yes	Yes	No	No	No	No data available.	"The Workplace Health and Safety Committee has the following responsibilities, among others: to sensitize workers on workplace health and safety related issues and develop a culture of prevention of occupational accidents and hazards and the fight against AIDS or any other public health danger."	The Ministry of Public Service and Labour is the competent national authority for safety and health at work.		
South Africa	Yes	Yes	Yes	Yes	Yes	No data available.	An employer has a duty to provide and maintain, as far as is reasonably practicable, a workplace that is safe and without risk to health of its employees. In addition, an employer is obliged to ensure that the risk of HIV transmission in the workplace is minimal.	The law requires the Minister of Labour to designate an officer serving in the Department as chief inspector for the purposes of the OHSA		
Thailand	n/a	n/a	n/a	n/a	n/a	Yes.	Issues on HIV in the workplace are not prescribed under the OSH Act 2011.	The Department of Labour Protection and Welfare (DLPW) -Ministry of Labour, is the main organization in charge of OSH administration and enforcement of the OSH Act		
Viet Nam	Yes	Yes	Yes	Yes	No	Yes.	The Law of control of HIV/AIDS contraction 64/2006/QH11 stipulates that:			