



**International Labour
Organization**



Social Protection and HIV global literature review

Access to social protection and its impact on people
living with and affected by HIV and their households

Anna McCord and Carmen Leon Himmelstine

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Overseas Development Institute
203 Blackfriars Road,
London SE1 8NJ, UK

Tel: +44 (0)20 7922 0300
Fax: +44 (0)20 7922 0399
www.odi.org.uk

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Abbreviations

AIDS	Acquired immunodeficiency syndrome
ALMP	Active labour market policy
ART	Antiretroviral therapy
ARV	Antiretroviral
CABA	Children affected by AIDS
CARI	Children and AIDS Regional Initiative
CBA	Controlled before and after study
CBHI	Community-based health initiative
CCT	Conditional Cash Transfer
CD4	Cluster of differentiation 4
CHF	Community Health Fund
CHI	Community Health insurance
CHW	Community Health Worker
CIS	Commonwealth of Independent States
C-SAFE	Consortium for the Southern Africa Food Security Emergency
CT	Cash Transfer
DOTS	Directly Observed therapy, short course
ECD	Early childhood development
EMC	Educationally marginalised children
FGD	Focus Group discussion
FSP	Food Subsidy Programme
FSW	Female sex worker
HAART	Highly active antiretroviral therapy
HBC	Home-based care
HIV	Human immunodeficiency virus
IDU	Intravenous drug user
IEC	Information, education and communication
IEG	Independent Evaluation Group
IGA	Income-generation activity
ILO	International Labour Organisation
ILO/AIDS	ILO Programme on HIV / AIDS and the World of Work
KII	Key Informant Interviews
LAC	Latin America and the Caribbean
LIC	Low-income country
M&E	Monitoring and evaluation
MENA	Middle East and North Africa
MF	Microfinance
MIC	Middle-income country
MPR	Medication possession ratio
MSM	Men who have sex with men
MTCT	Mother to child transmission
MVC	Most vulnerable children
NGO	Non-governmental organisation
NPA	National Plan of Action
OVC	Orphans and vulnerable children
PHA	People living with HIV/AIDS
PLHIV	People living with HIV
PLWA	People living with AIDS
PLWHA	People living with HIV or AIDS
PMTCT	Prevention of mother-to-child transmission
PWP	Public Works Programme
RCT	Randomised control trial
SHI	Social Health Insurance
SPF	Social Protection Floor
STI	Sexually transmitted infection

TB	Tuberculosis
TFA	Targeted food assistance
UKCAD	UK Consortium on AIDS and Development
UNAIDS	Joint United Nations Programme on HIV / AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Aid
VCT	Voluntary counselling and testing
WFP	World Food Programme
WHO	World Health Organisation

Executive summary

This literature review is the first component of a wider International Labour Organisation (ILO) Programme on HIV/AIDS¹ and the World of Work (ILO/AIDS) research initiative, which aims to develop a global research product to gain knowledge on **access to** and the **effect of** social protection policies and programmes on women and men workers and their households in formal and informal economies affected by HIV. This review identifies and outlines the international literature on access to and the impact of social protection programming on people living with or affected by HIV (PLHIV) and their households in low- and middle-income countries.

The review explores 26 studies identified through a modified systematic review process. These studies are rigorous and in many instances innovative, offering evidence on impacts and/or access, and providing methodologies with potential for replication within and across regions. These 26 studies are discussed in detail and summarised for ease of reference in appendices. The findings of these studies, the research methodologies adopted, and the indicators used are presented and critically discussed in order to provide a key reference and resource for the next phase of the ILO Programme on HIV/AIDS.

Key findings

Care and support

The impact on HIV-affected household vulnerability is contingent on the nature of the social protection intervention adopted and whether the objective is to address vulnerability in terms of prevention, treatment, care or support. An intervention is likely to reduce vulnerabilities insofar as the provision of social protection in the form of cash, in-kind goods, or free or subsidised services relieves budget constraints limiting the consumption of key goods and services.

The evidence on the impact of social protection on care and support is stronger than for impacts on prevention or treatment outcomes. There is considerable evidence that the provision of social assistance promotes household-level consumption, with the extent of the impact determined by the value of the transfer relative to the poverty gap of the recipient household. However, this evidence base is drawn from the general social protection literature, which is extrapolated to apply to PLHIV, and this study did not identify a set of robust studies identifying significant household consumption impacts specific to PLHIV.

Prevention

The evidence relating to social protection and prevention has been weak until the last few years, which have seen the completion of a number of randomised control trials (RCTs) and robust observational studies, and the initiation of several more that are still ongoing, as summarised in Pettifor et al. (2012). This has encouraged the prevention discourse to expand beyond proximate indicators and to a greater accommodation of outcome indicators directly related to infection rates. This shift is, however, primarily limited to the Africa region and has yet to be trialled similarly in other regions. Apart from this recent set of studies summarised in Pettifor et al. (2012), the literature in this outcome area is primarily based on hypothesised rather than empirically attested causal links.

Treatment

In terms of treatment impacts, the literature offers more evidence, in part due to the possibility of adopting empirically recorded treatment indicators, but few studies adopt direct morbidity indicators such as CD4 counts or anthropometric data, and there is a risk of conflating antiretroviral (ARV) possession or clinic participation with actual health outcomes. Interestingly, one study reviewed illustrates the problematic nature of such assumptions, finding that increased medical possession ratios (MPRs) do not correspond with biologically measured health benefits (Cantrell et al., 2008).

Livelihoods promotion

The review failed to identify any significant body of evidence addressing the nexus between complementary livelihoods interventions, HIV and social protection provision, or the extent to which such complementary

¹ The term 'HIV and AIDS' has been used in preference to HIV/AIDS throughout the text in conformity with the UNAIDS Terminology Guidelines, with the exception of cases where direct citations are made from sources that use the term HIV/AIDS.

interventions improve the sustainability of the social protection system or improve the graduation of beneficiaries of these schemes.

Overall, this review identified a relatively limited number of high-quality studies globally from which robust insights into programme performance in relation to the three outcome areas – prevention, treatment and care – could be drawn, with research concentrated in the Africa region. The adoption of robust methodologies such as RCTs or quasi-experimental studies was limited, with the result that it is not readily possible to identify robust evidence on many programmes or to compare findings within and between countries.

Methodological overview

The literature displays a range of methodologies to address issues of social protection impact, combining quantitative analysis of survey and administrative data, literature reviews, a range qualitative approaches, and a small number of systematic reviews. Much of the literature identified adopts mixed methods. A small but growing number of large-scale quantitative studies have been carried out in recent years, primarily in relation to issues of prevention and treatment. The two systematic reviews identified and the overview analyses carried out recently in this sector highlighted the limited quality and number of robust quantitative studies as a key confounding factor in developing an evidence base and limiting the potential for robust meta-analysis and cross-programme comparisons.

Knowledge gaps

Four key knowledge gaps are identified:

- The first gap relates to the still nascent evidence base in the sector and the patchy inclusion of robust indicators in programme design against which performance can be assessed.
- The second gap relates to the significant regional disparities in the evidence base, and the need for programme evaluation activity to be enhanced in Asia, Latin America and the Caribbean (LAC), the Middle East and North Africa (MENA), and the Commonwealth of Independent States (CIS) to provide an evidence base to inform programming in these regions, building on and sharing innovations between regions and learning from the Africa region's diverse experience.
- The third evidence gap relates to an exploration of the non-financial barriers to prevention and treatment outcomes, which are emerging from the current literature as an issue of importance, as yet poorly captured with existing methodologies.
- The fourth gap relates to the limited integration of gender, livelihoods, and active labour market policy (ALMP) issues into the social protection and HIV evaluation discourse, as evidenced by the studies reviewed, despite the institutional and developmental importance of these issues.

These gaps collectively represent a significant evidence shortfall in terms of what is needed to inform policymakers in the selection of appropriate programme design and to enable informed choices among alternative instruments.

Future options

The analysis on methodologies, indicators and current research activity presented in this report point to a series of options that could promote the development of a stronger evidence base to inform future policy choice and design in this sector. We therefore recommend the following:

- Review the innovations in methodology and indicator selection identified in this report that have taken place in recent years to identify opportunities for the replicability of relevant approaches both within and between regions. Pilot the cross-regional adaptation of successful models.
- Identify and disseminate information on a core menu of effective indicators for various outcomes and effective research methodologies.
- Ensure that programmes gather data on indicators that will enable performance evaluation and promote some consistency across programmes to facilitate meta-analysis.

- Carry out systematic reviews in key areas of social protection relevant to PLHIV where programme evaluations exist, but no overview or synthesis is available. Options would include:
 - health insurance in relation to ARV access and treatment outcomes, possibly reviewing different modalities of provision
 - cash transfers (CTs) and treatment outcomes.
- Commission research into areas of social protection where the evidence base in terms of linkages with PLHIV is weak, but there is an ongoing policy interest, e.g. public works programming.
- Ensure that theories of change identify where causal linkages are hypothesised and empirically grounded, and test out the underlying assumptions empirically through evaluation, where possible.

1 Introduction

This literature review is the first component of a wider ILO Programme on HIV/AIDS² and the World of Work (ILO/AIDS) research initiative, which aims to develop a global research product to gain knowledge on **access to** and the **effect of** social protection policies and programmes on women and men workers and their households in formal and informal economies affected by HIV. The review identifies and outlines the evidence relating to the inclusion of those affected by HIV in social protection provision, and its impact on prevention, treatment and care.³

This review summarises the evidence in the studies identified in relation to the questions of access and impact, synthesising findings across the literature and summarising what is known about both questions, and specifically addresses the gender dimension in relation to the research questions, insofar as relevant analysis is available. A meta-analysis is not possible, given the diversity of the populations, interventions and outcomes under discussion, and the lack of rigorous and comparable analytical methodologies adopted. However, a review of the methodologies and indicators adopted in the more robust literature is provided offering a detailed overview of the various research options, including a review of the strengths and weaknesses of various approaches.

The report identifies analytical gaps and areas of conceptual diversity. Specifically, the review assesses and critically appraises:

- the types of social protection under discussion, identifying any specific design features of relevance
- the extent to which access or impact is addressed
- the methodology used to assess access or impact
- the indicators adopted and their relevance and adequacy
- evidence regarding issues of gender and the informal economy that are of central importance in the current social protection and HIV and AIDS debate
- the role of complementary interventions (livelihoods interventions, etc.) in relation to programme performance

1.1 Objectives

This review is the first phase of this wider ILO/AIDS-financed research project, and the objective is to identify, summarise and appraise the international literature on two key issues:

- 1 access to formal and informal social protection by PLHIV and their households
- 2 the impact of programmes on women and men living with HIV and their households

This includes literature on existing social protection policies, programmes, and schemes inclusively defined to include their public, private and community-based forms. It includes literature assessing the scale of access and constraints thereto, including barriers in relation to gender inequalities, as well as literature attempting to assess the nature and extent of the effects, whether positive or negative, from a gender perspective of social protection interventions on people living with HIV, and HIV- or AIDS-affected households.

² The term 'HIV and AIDS' has been used in preference to HIV/AIDS throughout the text in conformity with the UNAIDS Terminology Guidelines, with the exception of cases where direct citations are made from sources which use the term HIV/AIDS.

³ The objective of the review was to explore the evidence relating to three detailed sub-questions, but the evidence base was not sufficient to enable this depth of analysis to be completed. The three sub-questions were: i) Does social protection cover men and women workers affected by HIV and their households? If so, under which contingencies of social protection, e.g. health insurance, livelihood/income support, cash transfers, etc.? What are the coverage, key gaps and challenges in enhancing social protection coverage to them? ii) How does the social protection coverage contribute to reducing the impact of HIV and AIDS on affected households? To what extent does employment status, whether formal or informal (e.g. self-employment, employee or wage earner, casual work) influence the access to social protection coverage? iii) How does the social protection coverage contribute to prevent HIV and reduce the vulnerability of the target population?

A secondary objective is also to assess the extent to which the literature addresses interventions on livelihoods, the labour market or other interventions that are also part of social protection schemes. Inasmuch as such interventions are addressed in the literature, this review examines the evidence and key findings regarding the extent to which these interventions improve the sustainability of the social protection system and/or address the likelihood of the 'graduation' of women and men beneficiaries of these schemes.

1.2 Scope of the review

In order to ensure the additionality of this study, it has been designed to complement comprehensive reviews of CT programming in Africa and their impacts on PLHIV (Miller and Samson, 2012; Temin, 2010). For this reason the review summarises and builds on the findings from these earlier reviews of CT programming in sub-Saharan Africa and integrates them into a review that extends the analysis globally.

1.3 Structure

The report is structured as follows. First, the key concepts addressed throughout the report are discussed, then the methodology of the revised systematic review process adopted to identify the relevant literature is outlined and the literature identified described. Next the evidence from previous literature reviews is presented and then the findings from current literature. The evidence relating to the main social protection instruments is discussed, and then general issues relating to social protection and HIV and AIDS emerging from the literature are explored. Thereafter the lessons from relevant systematic reviews are discussed and conclusions are drawn regarding access and impact, the main evidence gaps are identified, and potential future options are outlined.

2 Discussion of key concepts

Before the findings of the literature review are presented, the key terms used in this report are discussed.

2.1 Social protection

Social protection may be more or less broadly defined and countries, development partners, and researchers adopt differing definitions, although with the consistent core objective of reducing poverty. For the purpose of this review a broad approach is used in order to ensure inclusivity in the assessment of the global literature. For the sake of clarity, and in order to set clear boundaries for the sector, the concept of social protection, and the interventions that fall within it, are based on the conceptualisation inherent in the Social Protection Floor (SPF) in terms of ILO National Social Protection Floors Recommendation, 2012 (No. 202) (ILO, 2012a).

The SPF Recommendation defines social protection as:

nationally defined sets of basic social security guarantees which secure protection aimed at preventing or alleviating poverty, vulnerability and social exclusion. The national social protection floors should comprise at least the following basic social security guarantees as enumerated in paragraph 5 of the Recommendation:

- *Access to a set of goods and services constituting essential health care including maternity care*
- *Basic income security for children*
- *Basic income security for persons in active age unable to earn sufficient income*
- *Basic income security for persons in old age or disabled (ILO, 2012a).*

The SPF approach includes both social security and social assistance under the broader term social protection, as well as essential health care. This is the definition used in this review, which also includes

provisions for both formal and informal economic sectors. A detailed definition of social protection as adopted by ILO is set out in Box 1.

Box 1: ILO definition of social protection and related terms

Social protection

Social protection is often interpreted as having a broader character than social security (including, in particular, protection provided between members of the family or members of a local community). It is also used in some contexts with a narrower meaning than social security (understood as comprising only measures addressed to the poorest, most vulnerable or excluded members of society). Thus, in many contexts the terms 'social security' and 'social protection' are used interchangeably. In this report, pragmatically, the term 'social protection' is used to mean protection provided by social security systems in the case of social risks and needs.

Social security

The notion of social security adopted here covers all measures providing benefits, whether in cash or in kind, to secure protection, inter alia, from:

- lack of work-related income (or insufficient income) caused by sickness, disability, maternity, employment injury, unemployment, old age, or death of a family member;
- lack of access or unaffordable access to health care;
- insufficient family support, particularly for children and adult dependents;
- general poverty and social exclusion.

Social security schemes can be of a contributory (social insurance) or non-contributory nature.

Social assistance

Social security benefits that are conditional on the level of income of recipient, i.e. are means tested or based on similar forms of targeting (e.g. proxy means test, geographical targeting), are generally called social assistance. They are generally a device to alleviate/reduce poverty. Benefits can be delivered in cash or in kind.

'Conditional' social assistance schemes require beneficiaries (and/or their relatives or families) in addition to other conditions, to participate in prescribed public programmes (e.g. specified health or educational programmes). In recent years schemes of this type have become known as conditional cash transfer (CCT) schemes. Social assistance schemes are usually tax-financed and do not require a direct contribution from beneficiaries.

Source: ILO (2011)

For the purposes of this study the analysis focuses on interventions that provide ongoing support for the poorest or some form of income insurance, or assist people at times of risk and heightened vulnerability, corresponding to the social protection definition adopted by the ILO, incorporating social assistance and social security, in both the formal and informal economic sectors. Interventions extending beyond this – notably social support and the provision of care services, the legislative context, and issues relating to labour market interventions that fall outside these core social protection responses – are included in this review inasmuch as they perform a critical complementary function in relation to core social protection provision (see ILO, 2012a).

In the light of this, the instruments included in the review are:

- cash transfers of all forms (old age, youth, disability etc.)
- social insurance
- public works programmes (PWPs)
- health insurance of various forms
- free health care (including antiretroviral therapy (ART) provision)
- fee waivers and subsidies (health care and education)
- food provision or subsidies.

Both in the formal and informal economy and contributory and non-contributory interventions will be included.

2.2 Livelihoods and ALMPs

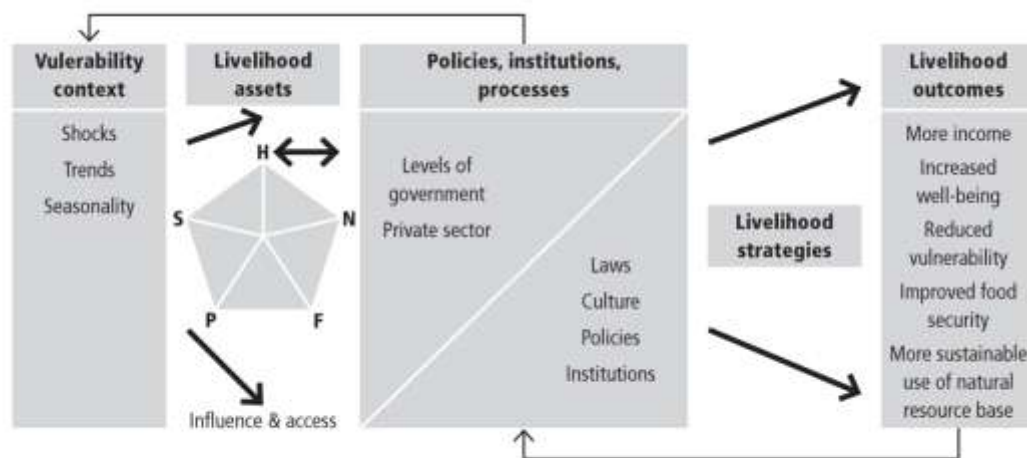
It is anticipated in the social protection literature that social protection may play a key role not only in ensuring consumption smoothing among the poor, but also in promoting livelihoods (Sabates-Wheeler and Devereux, 2011).

Livelihoods may be defined as:

the capabilities, assets – both material and social resources – and activities required for a means of living. A livelihood is sustainable when it can cope with and recover from stresses and shocks, maintain or enhance its capabilities and assets, and provide net benefits to other livelihoods locally and more widely, both now and in the future, while not undermining the natural resource bases (FAO and ILO, 2009: 10).

Social protection interventions affect livelihood outcomes by increasing financial and potentially also social capital. The beneficial outcomes are summarised in Figure 1, which also highlights the importance of a range of contextual factors in determining livelihood outcomes – a consideration that is of particular relevance in relation to HIV-related outcomes.

Figure 1: Sustainable livelihoods framework



Key: H = Human capital; N = Natural capital; F = Financial capital; P = Physical capital; S = Social capital

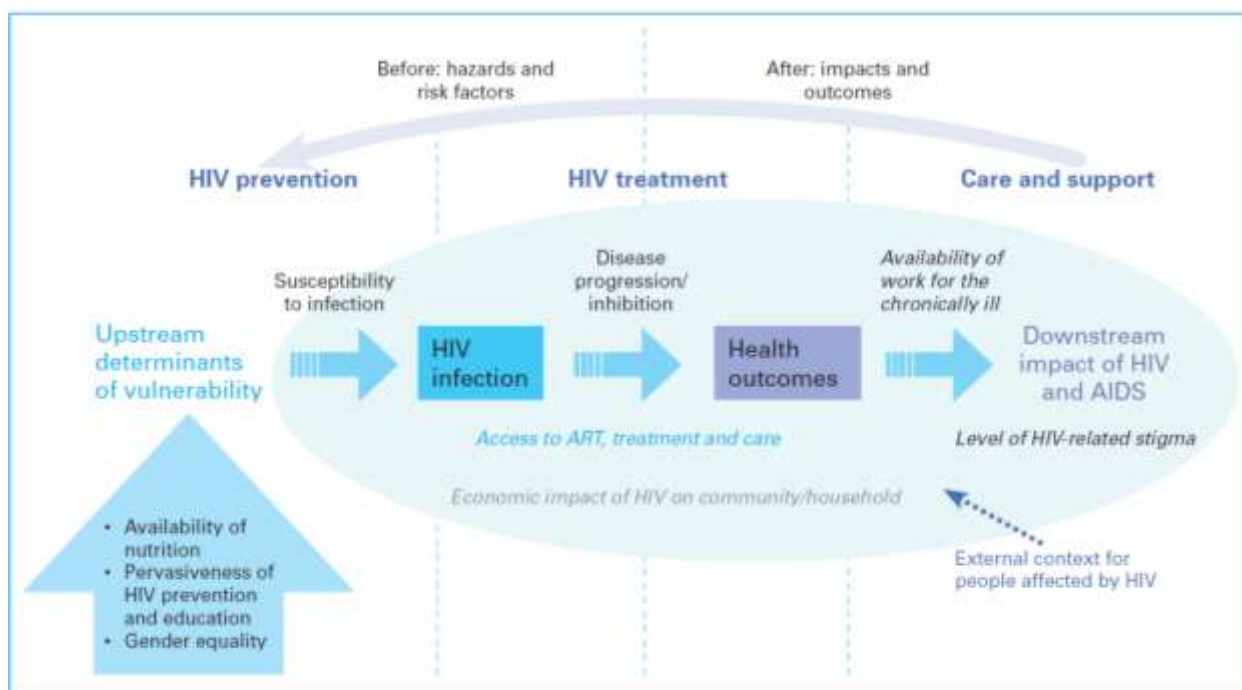
Source: DFID (1999)

Social protection is often considered in close relation to ALMP programmes that intervene in the labour market to assist the unemployed in finding work. These include state-sponsored public employment schemes, training and skills development interventions, and various forms of employment subsidies. Social protection and ALMPs are closely aligned in the recent ILO National Social Protections Floors Recommendation 2012 (No. 202), which highlighted the complementary role of ALMPs with social protection programming (ILO, 2012a). The World Bank also highlights the close linkages between the two sets of interventions in its recent social protection and labour strategy (World Bank, 2012). Such interventions are often implemented alongside social protection provision in order to promote the (re)integration into the labour market of social protection recipients.

2.3 The role of social protection in responding to HIV and AIDS

The main objective of social protection programming is poverty reduction (e.g. see ILO, 2012b). However, this report focuses not on identifying and reviewing the literature relating to the poverty reduction impact of social protection provision, which is covered extensively elsewhere in the literature (e.g. see DFID, 2011), but the role of social protection provision specifically in relation to i) prevention, ii) treatment and iii) care and support, following the three-pronged approach that is central to the global HIV response (e.g. see UNAIDS, 2010). This triad is used as the basis for categorisation and analysis of the impact of social protection provision in the literature and forms the basis of the analysis presented in this review. Changing vulnerability in terms of HIV and the three response options are illustrated in Figure 2.

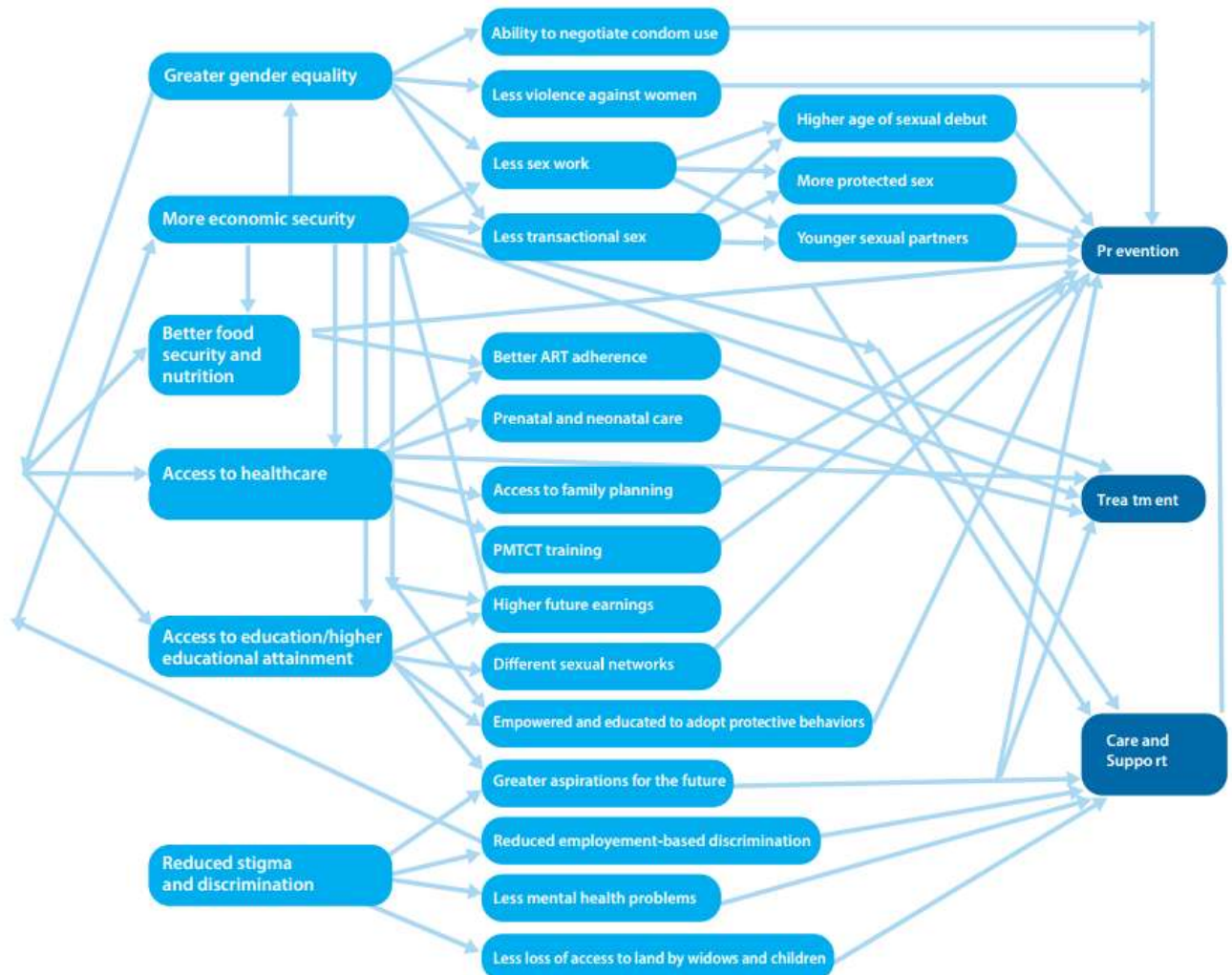
Figure 2: Vulnerability along the pathways from HIV



Source: UNICEF and EIU (2012)

As illustrated by Miller and Samson (2012), the issues of prevention, treatment and care, and support are to some degree interdependent, and the linkages between social protection provision and these outcomes are highly complex, as illustrated in Figure 3.

Figure 3: Linkages between HIV-sensitive social protection and key HIV and AIDS outcome areas



Source: Miller and Samson 2012

Outcomes are also affected by a range of external and contextual factors, such as the supply and demand of key social protection services under review (linked to coverage and the rationing of service provision), the quality of services provided (which will in turn determine whether, for example, treatment results in improved outcomes in terms of morbidity, or whether school subsidies result in increased school retention, delayed initiation of sexual activity and hence reduced infection rates), and a range of factors exogenous to the population, intervention and outcome under discussion. These include access to and the availability of a range of other services and commodities, and ongoing socioeconomic, cultural and labour market processes external to the simple population, intervention, outcome and analytical process adopted in most of the studies included (as discussed in Pettifor et al., 2012).

Moreover, some (even many) of the arrows represented in Figure 3 are based on assumptions or partial evidence and hypotheses rather than a robust evidence base. These issues are discussed in detail in the report.

2.4 Gender

Gender has been identified as a key issue within the social protection and HIV discussion, and the need to address gender vulnerability through social protection provision has been articulated in the literature. In this context UNDP (2011) has highlighted the need to:

prioritize women and girls in HIV-affected households in various social protection schemes, by making necessary changes in eligibility criteria so that they become eligible. For example, pension schemes for widows have minimum age eligibilities, which can be above 40 or 50. Many women widowed by AIDS may not be able to access such schemes, as they tend to be young. Under such circumstances, the age restriction can be relaxed to extend coverage to them. In the Indian state of Rajasthan, a special provision was made for HIV widows where the minimum age eligibility for widow pension was lowered from 40 to 16, resulting in the additional coverage of 1000 HIV widows.

In addition to ensuring the inclusion of women, significant expectations are associated with the provision of social protection within the HIV debate, as exemplified by the statement that 'Transformative social protection supports the potential to realise the rights of women in the context of HIV and AIDS' (Nolan, 2009: 158).

In order to ensure that the gender aspects of social protection programming are adequately included in the review, the gender dimensions of each of the studies identified have been explored and set out in the analysis that follows. However, it is notable that many of the studies identified do not explicitly employ a gender lens in either the methodologies they adopt or the indicators they employ to identify impacts.

3 Methodology and description of the literature

This report adopted an adapted systematic review approach (Hagen-Zanker et al., 2012) to identify and review the relevant literature relating to the research question: What literature is available on access to social protection for people living with HIV and AIDS, what is the impact of such access, and what are the key insights from this literature?

The literature search aimed to identify studies addressing i) access to social protection schemes, broadly defined, and/or ii) the impact of these schemes on PLHIV and their households in both the formal and informal economy. The search process entailed the definition of key search terms that were then used to search databases, journals, and academic and development agency websites. A detailed description of the research methodology is set out in Appendix 1.

This search process resulted in the initial identification of 105 studies addressing questions relating to the impact of and access to social protection of PLHIV globally. These studies were reviewed and inclusion and exclusion criteria were applied to identify the literature for inclusion in the review; see Box 2.

Box 2: Criteria for inclusion and exclusion

Inclusion criteria

Relates to social protection provision in low- and middle-income countries

Adopts explicit qualitative or quantitative methodology with indicators of access or impact

Presents primary evidence on:

- access to social protection provision for PLHIV
- the impact of social protection on prevention, treatment and care

Or, offers a review of evidence on the above (including, but not limited to, systematic reviews).

Exclusion criteria

Relates to CT provision in Africa (for research prior to 2012)

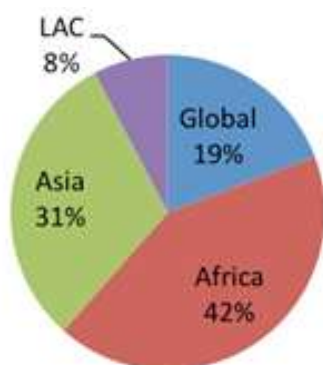
Provides only a narrative or descriptive overview

Outlines policy without reference and/or evidence on access or impact

Once these inclusion and exclusion criteria were applied, a subset of 26 papers was identified that was used as the basis for this review. The references for these papers are listed in Appendix 2 and detailed summaries are presented in Appendix 3, where for each study the key issues of relevance to the review objectives are detailed, i.e. the geographical location, the issues explored (access or impact, impact on what outcome(s)), the research methodologies and indicators adopted, and the key findings, including gender insights. A consolidated reference table outlining in brief the content of each paper is included in Appendix 4.

The 26 studies included in the review are briefly described in this section. The regional distribution of the studies is shown in Figure 4.

Figure 4: Regional distribution of the literature, by share of studies



Of the 26 studies, 19% (n=5) provided a global overview of social protection and HIV, 42% were concerned with sub-Saharan Africa (n=11), 31% with Asia (n=8) and 8% with LAC (n=2). No relevant studies were identified for the CIS, Eastern Europe, Central Asia or MENA. The fact that research is concentrated so heavily in Africa, despite the deliberate exclusion of literature relating to CTs in Africa (as opposed to other forms of formal and informal social protection instruments), indicates the high overall research activity in this region.

The methodological approaches and content of the 26 studies are summarised in Table 1.

Table 1: Descriptive statistics on the 26 studies reviewed

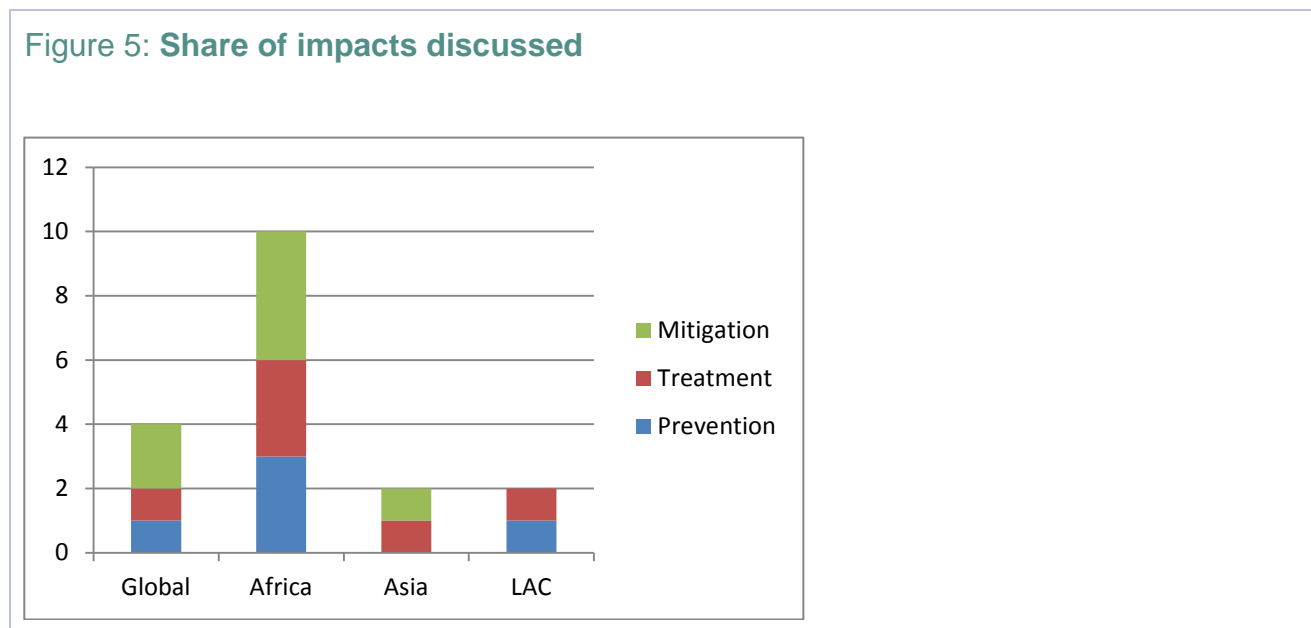
	Global n=5	Africa* n=11	Asia n=8	LAC n=2	Total n=26
Qualitative	2	7	6	1	18
Quantitative	2	5	4	1	12
Access	2	3	6	1	12
Impact	4	10	2	2	18
Prevention	1	3	0	1	5
Treatment	1	3	1	1	6
Mitigation	2	4	1	0	7

* Excludes literature on CT programming prior to 2012.

There is a slight preponderance to qualitative studies in Africa and Asia, with two-thirds of the studies being qualitative and one-third quantitative. In terms of content, 12 of the studies examined issues relating to access and 18 examined the impact of provision on prevention, treatment and mitigation (some studies examined both impact and access). The forms of social protection explored in the literature are food aid, health insurance schemes, CTs and school fee payments.

Of the 12 access studies, six were carried out in Asia (out of a total of eight studies in the region) while only three of the 11 African studies examined access issues. Of the 18 studies examining impact five examined prevention, six treatment, and seven mitigation. The distribution of impact studies by region is shown in Figure 5.

Figure 5: Share of impacts discussed



4 Evidence from previous literature reviews

This is the first review that attempts to identify and synthesise the international evidence relating to both access to social protection among PLHIV and the impact of a diversity of social protection interventions on PLHIV. However, two recent studies have synthesised current evidence relating to the impact of transfers on PLHIV in sub-Saharan Africa, one carried out by Temin in 2010 and one completed by Miller and Samson in 2012. The key findings from each are summarised below.

Temin's study examines the evidence on HIV-sensitive social protection, reviewing research on social protection and health, education, poverty, nutrition, and child protection outcomes as they relate to HIV and AIDS, and drawing on a mix of published peer-reviewed studies and grey literature. The study had intended to focus on studies based on RCT data, but given the scarcity of such data and associated literature, the review criteria were expanded to include results from research and programme evaluation inasmuch as credible experimental designs (including baselines or comparison groups) were adopted. Temin finds that few of the studies explicitly explored outcomes in terms of HIV, because monitoring and evaluation (M&E) systems were not often in place to assess HIV-specific impacts. She concludes, however, that many of the programmes examined would necessarily include significant numbers of PLHIV when implemented in areas of high HIV prevalence and so assumes that coverage would include PLHIV.

The study focused on the impact of social protection in reducing the risk of HIV infection, promoting treatment, and enhancing care and support, and examined a range of interventions, including social transfers, relevant livelihood-building approaches, social health protection, and transformative social protection approaches. The outcomes examined were programme effectiveness in minimising the risk of HIV

infection, promoting treatment, and enhancing care and support, with data gathered from a variety of epidemic settings.

In terms of preventive impacts, Temin finds that many studies showed the effectiveness of cash and food transfers in increasing school enrolment and attendance, and argues that this is indicative of their potential to expand access to the 'social vaccine' of education against HIV infection, given the association between increased participation in education and reduced risk of infection. She argues that this is particularly relevant for adolescent girls and children orphaned by AIDS, who may have a greater risk of engaging in unsafe sex than their non-orphaned peers. Similarly, programmes with demonstrated impacts on health service access, such as maternity care vouchers and the removal of user fees, have the potential to increase treatment of sexually transmitted infections (STIs), increase uptake of voluntary counselling and testing (VCT), and increase access to prevention of mother-to-child transmission (PMTCT) services, and hence, it is argued, reduced likelihood of HIV infection.

Temin finds that there is evidence of the positive impact of social transfers for nutritional recovery of patients receiving HIV and tuberculosis treatment. She argues that people starting treatment in low-income countries (LICs) often do so at very low CD4 counts, with pre-existing under-nutrition compounded by HIV-induced wasting. Food transfers can reduce under-nutrition in people living with HIV, although access to the right food (e.g. micronutrient rich, with a high energy density) is critical. Hence, both social health protection measures that expand health-care access (e.g. social health insurance, vouchers, exemptions, fee abolition) and also CTs that relieve household budget constraints can promote treatment.

There is also evidence relating to social protection instruments such as CTs promoting care and support outcomes that mitigate the impact of AIDS on vulnerable households and children:

Many of the documented benefits of social transfer programmes address the very vulnerabilities that AIDS exacerbates: reduced education and health care access, household food insecurity, poverty, and reliance on child labour (Temin, 2010: 7).

Livelihoods promotion interventions, such as PWPs, income-generation activities (IGAs) and microcredit, can also play a role, increasing households' ability to withstand shocks and reduce poverty, although again Temin notes that specific HIV-related impacts are rarely measured. Importantly, she highlights the fact that households affected by HIV and AIDS may not, however, be appropriate targets for certain types of livelihood programmes, such as PWPs or microfinance (MF)-related small businesses, although as ARV programmes are expanded, she notes that they may become increasingly relevant livelihoods interventions in the future.

In terms of gender, Temin suggests that social protection instruments targeted at girls and women may reduce gender inequality and empower women to better negotiate sexual relations and hence reduce their risk of HIV infection, although there is little empirical evidence to support the assumptions underlying these potential outcomes.

Miller and Samson carried out a follow-up state-of-the-evidence review of social protection in Africa in 2012, examining prevention treatment and care impacts, and options for expanding and sustaining HIV-sensitive social protection. The report highlights how comprehensive policy approaches integrating social protection provision have the potential to address the multiple vulnerabilities faced by PLHIV.

As with Temin, they assert social protection's potential to expand access to the 'social vaccines' of health and education, which 'have the potential to prevent HIV directly and/or indirectly' (Miller and Samson, 2012: 5). Similarly, it is hypothesised that livelihoods interventions (such as IGAs and microcredit) can reduce the vulnerability of women and girls in HIV-affected households and that through economic empowerment such programmes can 'increase their ability to insist on condom use and refuse sex, as well as reducing their need to resort to risky coping strategies (such as transactional) that would increase their susceptibility to HIV infection' (Miller and Samson, 2012: 5).

However, as with Temin, while there is evidence of impact in the broader health sector, from which it may be possible to infer regarding likely impacts on HIV outcomes, there is no HIV-specific impact evidence to support this pathway, in terms of the impact of CTs or other forms of social protection such as maternity care vouchers, or the removal of user fees on VCT, or access to PMTCT services.

Miller and Samson argue, however, that social protection can address upstream structural drivers of HIV risk and that rather than poverty itself being the driver, it

interacts with a range of other factors including mobility, social and economic inequalities and social capital, which can converge in a potent way for certain demographic groups, particularly young women in southern Africa, with specific factors identified as contributing to vulnerability to HIV risk include poverty, gender inequality, and lack of educational attainment (Miller and Samson, 2012: 5).

Inasmuch as social protection can mitigate these risk factors, it can potentially contribute to reduced HIV infection rates and also increase the uptake of critical preventive health services, such as PMTCT treatment and counselling. Lutz and Small (forthcoming) review existing evidence on the impact of CTs on HIV prevention and suggest that, given the conceptual links between the structural factors of HIV risk (inequality/poverty, education and gender) and CT provision, CTs *might* be effective for HIV prevention, but again, direct evidence on the ultimate rather than the proximate impact of social protection on HIV infection is limited. A number of studies directly explore the impact of social protection on infection rate outcomes, sometimes using STI prevalence as a proxy for HIV infection, with studies from Malawi, Tanzania and South Africa suggesting CT receipt can reduce vulnerability to infection. However, the fact that the Tanzania study found a significant reduction in the treatment group eligible for \$20 payments, but not the group receiving a \$10 payment, indicates the sensitivity of these findings to outcome drivers that are not solely due to CT receipt per se and suggests that there is a need to be mindful of a range of other potential factors driving outcomes.

Miller and Samson (2012) argue that gender is particularly important in relation to this debate, especially with reference to prevention, and Lutz and Small (forthcoming) suggest that inasmuch as AIDS as a disease of both economic and gendered inequality, targeting women and girls for certain social protection interventions in specific contexts may be the most effective strategy. But again, in much of the literature the argument is conditional and articulated as a potential, rather than empirically attested.

In relation to treatment Miller and Samson (2012: 6) note:

Social health protection (affordable health insurance or government-funded health services that protect against the economic losses and social distresses that can result from ill health) as well as measures that expand health-care access (vouchers, exemptions, fee abolition) can increase access to health services and treatment.

Evidence in relation to treatment tends to use indicators of service utilisation rather than outcomes, which are likely to be determined by a range of issues relating to quality of service provision, treatment efficacy, the availability of ARVs, additional services to address associated illness, nutritional status, etc., and so again there is a focus on evidence relating to proximate rather than ultimate outcomes, which would be more oriented to issues relating to morbidity, mortality and quality of life.

Whether releasing financial constraints to service usage more generally in the form of unconditional CTs rather than explicitly linking social protection to health service utilisation in the form of the provision of health subsidies and incentives related to the needs of PLHIV is also an open question that again would be informed by a range of contextual factors, including, inter alia, household income levels and household, rather than individual expenditure priorities, etc.

Here the nature of the social protection instrument and the extent to which it is targeted on the basis of poverty or HIV status are likely to be relevant in terms of treatment outcomes. No evidence is currently available to inform such a comparison across instruments.

One concern related to treatment is that people affected by HIV may be discriminated against or excluded from some social health protection schemes, such as health insurance, although there is little evidence of this in Africa. Programmes may sometimes implicitly exclude PLHIV, such as PWPs that require regular work inputs, but these may be designed to be sensitive to these challenges and shifts in labour availability, e.g. by permitting alternative workers when family members are sick or need to prioritise care work (McCord, 2005).

There is a greater literature exploring the impact of social protection on the care and support of HIV-affected households and children than that providing evidence on prevention and treatment outcomes. There is significant evidence that

households receiving cash transfers are more likely to seek health care for sick children, are more food secure, and more likely to invest in strategies that strengthen their livelihoods and

household economies, which all help households to absorb the impacts of AIDS (Miller and Samson, 2012: 6).

Inasmuch as social protection provision lifts financial barriers to the consumption of a range of goods and services, it is likely that it will have a positive impact on various indicators of well-being. Where social protection interventions are combined with other inputs, such as income generation, livelihoods promotion, etc., it is likely that these outcomes will be further enhanced, although again the evidence is limited. Where home-based care (HBC) is also provided, household labour is made available for other domestic or productive activities, and so is likely to provide secondary benefits in this way. Similarly, birth registration and early childhood development (ECD) programmes can promote linkages to health and other social protection services.

The other main conclusion of the African literature reviews relates to the importance of comprehensive approaches, i.e. 'social protection strategies need to be comprehensive, enabling a range of HIV-sensitive initiatives to be integrated into broader national social protection strategies that achieve both HIV and AIDS objectives and broader human development goals' (Miller and Samson, 2012: 44).

This argument is made on the basis of the argument that if executed effectively, such linkages can protect socially vulnerable groups against discrimination and abuse, changing public attitudes and behaviour, and enhancing social equity. However, Temin (2010) highlights the limits of evidence in this regard, particularly in terms of operational evidence linking different instruments to complementary services and sectors. The broader development planning approach seeks to ensure better integration and linkages between different parts of the social protection system, as well as better linkages between social protection programmes and systems with broader sectoral responses to ensure greater development impacts, but this represents a major challenge, particularly in LICs.

5 Findings on social protection instruments and HIV and AIDS

This section summarises the evidence from the studies identified in the literature search, relating to social protection access, and its impact on HIV and AIDS outcomes, and also outlines the key findings from the limited number of systematic reviews carried out in this sector.

The headline impacts from the impact studies reviewed are set out in Table 2. This illustrates the scarcity of conclusive evidence on impacts (for a more detailed outline of impacts, see Appendix 3).

Table 2: Headline impacts

Social protection intervention	Impact	Source
Conditional cash transfers (CCTs)	No significant impact on risk behaviour identified	Galaragga and Gertler, 2009
CTs	Positive effects on PLHIV as measured by ECD, improved food consumption, reduced child labour, small increase in health expenditure and decreased absence. No effect on school enrolments	Stene et al., 2009
CTs and CCTs	Nine of ten completed studies found a positive change in sexual behaviour. The one completed RCT using biological end-point data included in the review found lower prevalence rates among the intervention participants compared to the controls at the 18 month follow-up stage. One of the studies found a significant negative impact on sexual behaviour.	Pettifor et al., 2012
School fee support (various means)	Evidence of drop out reduction, but no evidence on HIV prevalence	Hallfors et al., 2011

Social protection intervention	Impact	Source
Food aid	When provided with HBC positive impacts on coping mechanisms, livelihoods, food security, and nutrition schooling treatment adherence. Impacts of food provision are not isolated from broader HBC.	Thwin, 2006
School feeding	Positive impacts on weight gain, school attendance and education outcomes of disadvantaged students. Not possible to analyse separately for PLHIV	Kristjansson et al., 2006
Targeted food aid	No evidence available	EGGE and Strasser, 2006
Therapeutic food aid (associated with ART)	No significant impact	Attawell et al., 2005
	Significant increase in ARV possession, but not weight gain or CD4 count increase	Cantrell et al., 2008
PWPs	No evidence available	
Health insurance	Inconclusive impact in terms of improvements in treatment-seeking behaviour (Community-based Health Insurance)	Chean, 2007
	Inconclusive (Community Health Fund)	Chanfreau et al., 2005
	Universal coverage scheme members had significantly lower likelihood of receiving ARVs than members of the Civil Servant Medical Benefit Scheme	Kitajima et al., 2005

The findings outlined in Table 2 should not be taken to mean that the interventions reviewed are not effective, rather the findings may be affected by the use of inappropriate evaluation methodologies or indicators that are not capturing positive (or negative) impacts. This does, however, imply that there is a need to review existing practices, since many recent evaluations have failed to determine whether programming relating to social protection is effective in terms of achieving its objectives relating to HIV impacts.

5.1 Social protection and HIV

Temin (2010) documents evidence of the positive impact of a variety of social protection instruments – including social CTs, food transfers, social health protection, vouchers, and fee exemption schemes on HIV and AIDS treatment. She argues that social protection can function either as an incentive to utilise services, when delivered in the form of a monetary payment associated with, for example, clinic attendance, testing or treatment adherence, taking the form of a positive incentive or mandatory condition; or by releasing financial barriers to service utilisation, either through free or subsidised provision, health insurance or CTs, which share the common effect of increasing the affordability of service utilisation. Pettifor et al. (2012) also share this vision of social protection in terms of CT programming, with a double function, both as an incentive to behaviour change (the downstream impact) and the cash income serving to relieve budget constraints to expenditure on the core goods and services required for a healthy life (food, basic health care and education).

The literature reviewed covers a range of social protection interventions. The access literature focuses on access to a package of interventions rather than specific instruments, while the impact literature examines a core set of instruments: CTs, food provision, health and education subsidies/fee waivers, and health insurance. PWPs, community safety nets, workplace policies and community-care interventions are not included in the literature identified for review. The main instruments and the evidence regarding their performance are outlined below.

5.1.1 Cash transfers

CTs are extremely common, even outside sub-Saharan Africa. They come across in the literature as tried and tested, and as a first resort for organisations wishing to undertake social protection programming. The Joint Learning Initiative on Children and AIDS strongly recommends CTs as the best strategy for reaching affected children; Samuels et al. (2012) suggest that CTs are the main mechanism for creating social protection as part of a holistic and coordinated response. UNAIDS (2010a) notes, however, that CTs are expanding without being embedded in the framework of a comprehensive social protection strategy and often do not undergo M&E that would allow them to demonstrate impact.

CTs are demonstrated to have good evidence for positive effects on well-being outcomes and are increasingly utilised as an HIV response (Adato and Bassett 2007). There is a great interest in the literature in demonstrating positive effects on HIV, as there is not currently much evidence on this specific question and most available evidence on CTs comes from sub-Saharan Africa. Where conditions are applied, it is usually with the intention of ensuring the transfer is spent on schooling (Baingana et al., 2008). Educational subsidies are also discussed (Hennessey, 2001; International HIV/AIDS Alliance & Family AIDS Caring Trust, 2002; MTT and UNICEF, 2005; Phiri et al., 2001; Quality Assurance Project, USAID Health Care Improvement Project and UNICEF, 2008; Subbarao et al., 2001). There is also a discussion on the 'education vaccine' function for HIV (Lutz, 2012), in which higher levels of education equate to reduced HIV risk, drawing on recent evidence from CCTs in sub-Saharan Africa. By contrast, one paper on Oportunidades (Galarraga and Gertler, 2009) shows that CCTs had no effect on sexual behaviour (although there was a positive effect on smoking reduction and high school graduation). Lutz (2012) suggests that CTs can contribute to HIV prevention in certain contexts. It is mooted that the provision of unconditional CTs and CCTs for girls and young women can induce behaviour changes that reduce HIV risk by addressing structural drivers of HIV, for example, by extending years of education in school, thereby delaying the age at first sexual intercourse and delaying marriage, as well as incentivising the uptake of voluntary counselling and testing, but the evidence is not strong or readily generalisable. A few papers discuss the provision of cash transfers for the elderly as a means of reaching orphans and vulnerable children (OVC) and AIDS-affected children who are cared for by grandparents (Richter, 2010; Slater, 2004) and CTs as an incentive to family or community members to foster orphans (Hennessey, 2001; Subbarao et al., 2001; UNICEF, 2007b), although there is evidence that this approach can create perverse incentives (Roelen et al., 2011) and result in changes in household formation. Samson (2008) concludes that there is a consensus towards providing cash transfers for women caring for HIV-affected children in Papua New Guinea. Stene et al. (2009) suggest that CTs have positive impacts on children's nutritional status and development, as described above.

Two studies in particular highlight HIV specific issues relating to CT access that may offer significant lessons for the broader community. UNDP (2011) highlights the need to accommodate the potential youth of AIDS widows who may be excluded from schemes that associate widow status with older women and hence unintentionally exclude AIDS widows. In the Indian state of Rajasthan a special provision was made for AIDS widows by lowering the age criteria for a widow's pension from 40 to 16, which resulted in access for an additional 1,000 AIDS widows. A less positive story is the perverse incentive created when access to disability-specific CTs is linked to CD4 counts, as in South Africa, and where access to household income is contingent on continued morbidity, creating an incentive for a beneficiary with AIDS not to adhere to ARV treatment in order to retain household income (Decoteau, 2008). In both cases HIV-specific considerations are central to the question of access.

Most CTs discussed in the literature are, however, the generic, non-HIV specific social assistance instruments. These are the most frequently reviewed social protection instrument in the literature, and the best supported with evidence. Literature on their performance is available from across the world, with Edström and Khan (2009) providing an overview of CTs in Asia; Galarraga and Gertler (2009) looking at CCTs in Mexico; Hennessey (2001) discussing CTs in Thailand; Mukherjee et al. (2006) discussing the role of CTs in Haiti; Samson (2008) examining CTs for women caring for children in Papua New Guinea, and UNICEF (2007c) reviewing cash transfers in China. The evidence on the impact of these non-HIV-oriented CTs is summarised in DFID (2011).

The key evidence emerging from this review is the recent evidence offered by Pettifor et al. (2012) that provides evidence of significant positive impacts on HIV prevention of CTs (see discussion above) based on findings of nine out of ten methodologically robust studies in Africa and the United States, eight of which identify positive impacts on sexual behaviour and one positive impacts on HIV incidence (the latter is novel in its use of biological end-point data rather than proxies for HIV prevention). Apart from this study, the other literature included in the review does not offer conclusive evidence.

5.1.2 Food aid

Food aid is also common, with two main sets of objectives. It is either linked to school or household feeding as a contribution to household welfare and is the mitigation component of the trinity of objectives. Alternatively, it is linked to the receipt of ARTs and provided to recipients either as an incentive to adhere to the treatment programme or to enhance the effectiveness of ART programme by improving beneficiary nutrition. In the first case food aid tends to take the form of school feeding for OVC as a form of care and support intervention or to provide incentives for extended school participation and hence (it is assumed) reduce infection risk. In the second instance food is provided for those in receipt of ARV as a treatment complement, either as an incentive to promote regime compliance and/or treatment efficacy. Slater (2004: 14) points out the different needs of food aid as a response to HIV:

There is a long debate about the possible negative impacts of food aid: disincentives to local production; impacts on local markets; dependency. However, HIV/AIDS may reinforce the need for a shift in perspective in which a degree of reliance on long-term welfare is accepted for the most destitute.

Food assistance is commonly given in addition to ARVs, with the objective of encouraging treatment adherence by incentivising attendance at clinics and improving treatment outcomes through better nutrition (Cantrell et al., 2008; Frega et al., 2010; Gillespie and Kadiyala, 2005; Mamlin et al., 2007; UNAIDS and Temin, 2010; WFP and FANTA, 2007) or as a supplement to enable households to cope better (Attawell et al., 2005; Frega et al., 2010; Himmelgreen et al., 2009; Loudon et al., 2007; Thwin, 2006; UNAIDS, 2011). This is often targeted through children, and food assistance can be given to households or through school feeding programmes. Food is sometimes suggested as an alternative to cash to incentivise fostering to ensure the transfer is used to the benefit of the child (Roelen et al., 2011). Greenblott (2007) provides an extensive discussion of the background of how and why food can help mitigate HIV; although the paper is not evidence based, it draws on the existing literature to illustrate the various stages at which food aid may be appropriate. Most of the literature on food transfers has a global perspective, but the majority of the evidence is from sub-Saharan Africa.

Kristjansson et al. (2006) find overall beneficial effects from school feeding, but are not able to distinguish children affected by AIDS (CABA) from other programme recipients, rendering conclusions regarding its use as an instrument to mitigate the effects of HIV and AIDS questionable. In contrast, Cantrell et al. (2008) and Attawell et al. (2005) both fail to find conclusive results on treatment outcomes in terms of survival, and Egge and Strasser (2006) find that their research was confounded by the lack of inclusion of appropriate outcome indicators in the design of many programme's M&E specifications, leading them to develop a menu of relevant indicator options.

5.1.3 Public works programmes

PWPs are the predominant social protection instrument in LICs and many middle-income countries (MICs) for households with working-age labour who are typically excluded from cash transfer provision in many LICs due to extremely low coverage levels and strict rationing based on labour eligibility criteria.

Such programmes are only useful to households living with HIV if there is adequate labour in the household to accommodate domestic responsibilities, including care, in addition to PWP participation. Where household labour supply is constrained PWP participation can be difficult, particularly when working age members are affected by HIV and AIDS related illnesses which reduce their ability to labour. Some PWPs explicitly recognise this constraint faced by households affected by HIV and AIDS and accommodate household fluctuations in labour availability resulting from episodic illness by permitting alternate workers from within the household to take on PWP employment, as in the case of the Zibambele programme in KwaZulu-Natal, South Africa (McCord, 2004). Other programmes have attempted to provide reduced workloads consistent with the reduced labour capacity of those experiencing AIDS-related morbidity, as in the case of C-SAFE PWP in Zimbabwe (McCord, 2005), but such programmes are scarce and their efficacy is not documented. As Temin (2010) notes, however, with greater access to treatment there may be greater opportunities for PLHIV to engage in such programmes in the future, although access to such programmes is highly rationed in most LICs and MICs, and the support they provide does not tend to be ongoing, as with other forms of social protection.

An alternative PWP design, in which workers do not create physical infrastructure, but rather are trained and employed to provide the social support required by communities facing high HIV incidence and the associated high additional burden of care, has been developed in South Africa under the social sector

component of the national Expanded Public Works Programme (McCord, 2005; ILO, 2012c), but this initiative has not yet been widely expanded outside the region.

No literature was identified in this review that assessed the impact of PWPs as an instrument of social protection in terms of prevention, treatment or mitigation.

5.1.4 Health insurance

Participation in contributory health insurance schemes tends to exclude the poorest, who are unable to pay premiums, whether as part of social health insurance (SHI) or community health insurance (CHI) schemes (Rompel, 2005), and as such the majority of informal sector workers and the unemployed irrespective of HIV status are unable to participate, with access to health services being dependent on subsidies, fee waivers or the provision of free services. In Indonesia HIV treatment was explicitly excluded from the national mandatory *Jamostek* health insurance programme for private sector workers affected individuals prior to 2009, and many private providers still maintain this exclusion: ART for HIV and chemotherapy are among the services explicitly excluded from provision in some provinces of the country (ILO, 2012b). No data were found on similar exclusions elsewhere during the review, but it is possible that similar exclusions do exist, whether explicitly or implicitly, in other countries.

Four of the studies reviewed offer evidence on the performance of health insurance interventions. Chean (2007) and Chanfreau et al. (2005) both find no conclusive evidence regarding the impact of community-based health insurance schemes on treatment-seeking behaviour, concluding that there are other barriers to participating in insurance schemes for the poor in terms of seeking treatment that may dominate the financial barrier. Kitajima et al. (2005) find that the likelihood of accessing ARVs is significantly higher among members of participants in civil service health insurance schemes than members of universal health insurance schemes. Rompel (2005) also compares the performance of different modalities of health insurance provision and explores the possibility of promoting prevention through health insurance incentives.

5.1.5 Community-based social protection

This review identified little literature relating to informal sector interventions, and community safety nets and community/informal care were not included in any of the studies identified for inclusion.

There are a number of papers on community-based social protection and community safety nets (Donahue, 1998; Foster, 2005; Hennessey, 2001; International HIV/AIDS Alliance and Family AIDS Caring Trust, 2002; ILO, 2002; Mhamba, 2004; Phiri et al., 2001; Richter et al., 2004; Ssewamala et al., 2006; Schenk, 2009; Zoll, 2008). Most describe groups of villagers joining together to either donate funds themselves or raise funds through IGAs, which are then given directly to PLHIV. This might also include in-kind assistance such as clothes donation or child care. Foster (2005) suggests that the provision of food and in-kind assistance is slightly more common than cash in sub-Saharan Africa. Creating a community garden with the objective of selling or donating vegetables is another example of such collective action interventions at the community level (e.g. see Phiri et al., 2001; Stop AIDS Now!, 2012), as are savings schemes, where caregivers/community members contribute to a fund – usually managed by a third party such as an NGO – which is then used for welfare provision. A matched funding scheme for OVC is described in Mhamba (2004), but no significant positive results are identified, due in part to the reported disinclination of community members to contribute cash for non-relatives. ILO (2002) describes the idea of health micro-insurance schemes, which are not widely referenced in the rest of social protection and HIV literature reviewed. The paper is, however, normative rather than providing evidence on either impact or access, but presents an interesting discussion of how community risk-pooling schemes can increase access to health care and provide social care and support. ILO recommends strengthening these through increased funding as an appropriate and holistic response to HIV.

HBC provided by volunteers also falls under this category. Under this form of support community health workers (CHWs), usually volunteers or relatives, visit affected households and provide a continuum of care, from delivering ARVs and food to cleaning and childcare (Phiri et al., 2001). The issue of shifting medical care away from formal clinics towards CHWs who are more able to connect with patients and deliver focused care arises several times in the literature (UKCAD, 2012; McCord, 2005). UKCAD advocates for the payment of CHWs and the formalisation of their role through compensation. In South Africa, there has been experimentation with the employment of community members within PWPs as CHWs to provide HBC training and services for households living with HIV (McCord, 2005). In this way social protection in the form of PWP provision can both provide employment and income to community members, and also relieve the burden of unpaid care work, which falls disproportionately on women household members. In this way PWPs can address the pressing *social* rather than the conventional *physical* needs of communities by providing services rather than physical infrastructure.

Community care is often provided in order to support OVC, child-headed households or children with non-parental care who are perceived to be more vulnerable than households with a living/working parent, and hence adult female-headed households may be excluded from its provision when it is rationed. Family and community are identified as the first line of response for OVC (International HIV/AIDS Alliance and Family AIDS Caring Trust, 2002; Phiri et al., 2001) and community assistance is identified as the most appropriate form of social protection to respond to this need (Zoll, 2008).

There is, however, little robust evidence of the impact of informal social protection initiatives of this kind, and no studies relating to community care were included in the review, in part due to their informal nature. Major donors such as PEPFAR are now starting to allocate resources to the evaluation of such programmes, so it is anticipated that the evidence base should improve in the near future. Schenk (2009) reviews the current evidence base on community interventions for OVC (including educational assistance, HBC, legal protection and psychosocial support) with the objective of informing policymakers about the value of ongoing investment in such initiatives, drawing on published research studies and grey literature. He identifies significant challenges associated with evaluating complex interventions such as these and highlighted the need to build the evidence base on such programmes by using a combination of quasi-experimental and process evaluation approaches, complemented by qualitative methodologies and costing studies.

Schenk (2009) concludes that while the findings of the 21 studies identified overall indicated the value of community interventions in effecting measurable improvements in child and family well-being, the quality and rigour of evidence were varied, with only five demonstrating quantifiable improvements in key outcomes. Schenk argues that a strategic research agenda is urgently needed to inform future resource allocation choices in terms of the value for money of ongoing investment in community initiatives.

5.1.6 The implications of formal- and informal sector engagement

Those working in the informal economy are excluded from social protection provision in the form of social security instruments, as these are provided through formal, often contributory workplace mechanisms (pensions, health insurance, unemployment insurance, etc.). Social security provision has not yet been widely extended to informal sector workers in LICs, although it is a little higher in MICs, and the extension of provision is currently a key concern within the international social protection sector, led by the ILO (ISSA, 2010). The resulting exclusion of informal sector workers from social protection provision was recognised in the recent DFID review of evidence relating to cash transfer programming: 'Certain vulnerable groups tend to be systematically overlooked within the current evidence base and programme strategies; [including] those located in further reaches of the informal economy' (DFID, 2011: 81).

Similarly, the Independent Evaluation Group assert that informal sector workers per se may be vulnerable in some instances, not just those in further reaches of the informal economy: 'Informal sector workers easily fall between the cracks in the absence of programs that are able to provide support for the "missing middle" of the scale' (IEG, 2012: 151).

Since the majority of workers in LICs and MICs are employed in the informal sector and only a small fraction in the formal sector, particularly in LICs, most households in such countries only have access to social assistance provision, and in many cases this access to social assistance is notional rather than actual, given the extremely low coverage rates of social assistance provision, with, e.g. CT programmes in Kenya, Malawi and Zambia each reaching less than 2% of the poor nationally in 2009 (McCord, 2009). Informal sector workers in most LICs and MICs are dependent on the receipt of social assistance (non-contributory) provision in the form of CTs or public works employment for income support, and subsidies or fee waivers for access to basic services. However, most LICs and MICs offer no form of employment or income insurance, and provision for the working-age poor, either in or out of employment, is extremely limited, often being restricted to occasional public works employment, which is typically short term and highly rationed (McCord, 2012).

5.1.7 Rationing access to social protection on the basis of labour availability

In most MICs and LICs the provision of cash transfers and subsidies is typically targeted on the basis of demographic criteria, notably age (targeted to the elderly and children) and sometimes also on the basis of disability. In most LICs and many MICs these categorical targets tend to be combined with some form of poverty targeting rather than being universal in terms of provision. In MICs social assistance tends to be provided on the basis of poverty criteria, irrespective of household labour availability, and hence poor households with members engaged in the informal economy are eligible for transfer receipt. However, access to transfer programmes in many LICs is restricted, with eligibility being limited to households lacking labour or having high dependency ratios, with a high number of non-working-age members for each member of working age. In such contexts, whether workers are engaged in the formal or informal economy is not a

determinant of access to social assistance provision, nor is whether they are employed in decent work, as vulnerable workers or not at all, as the existence of working-age household members is sufficient to exclude households from benefit eligibility.

Hence, many CTs in LICs purposively exclude households with working-age members, irrespective of employment status. The implication for PLHIV is that in contexts where access to social assistance is strictly rationed, households with HIV-positive adults of working age may be excluded from social assistance support in the form of cash or in-kind transfers unless the adult ceases to be able to work, in which case elderly or child members may become eligible for transfers or the affected adult may become eligible for disability support.

Cases where working-age members only become eligible for support at point of disability can be problematic. Evidence from South Africa, where the CD4 count is used as the measure of eligibility for disability grants, indicates that this can cause perverse incentives, with beneficiaries manipulating their own health status to the detriment of their physical well-being in order to become eligible for social assistance with a reduced CD4 count, in the absence of alternative social protection provision, as discussed below:

Since the National Treatment Plan was passed in 2004, antiretrovirals are now available in the public sector free of charge. When a person begins taking antiretrovirals and her immune system is strengthened, her CD4 count will rise. When this happens, she is no longer eligible for continued social assistance and the government will cancel her disability grant. This exact situation occurred for one of my respondents, Pheello. Pheello's disability grant was the only income he earned in order to support himself and his HIV-positive wife and daughter. Pheello decided to continue taking his medication, and since then, his disability grant has been cut. He was forced to choose between economic survival (for his family) and life-saving medication. This is one of the reasons why HIV-positive South Africans are turning down the opportunity to take antiretrovirals (Decoteau, 2008: 233).

There is, however, little empirical evidence on this question, and while it is important to be mindful of the risk, it is not known how widespread such perverse incentives may be.

5.2 Lessons from systematic reviews

Two relevant systematic reviews were included in this review, one dealing with the impacts of school feeding from a global perspective (Kristjansson et al., 2006) and the other on the impact of cash transfers on HIV prevention (Pettifor et al., 2012).⁴ The school feeding review examined the role of school feeding in improving the physical and psychosocial health of disadvantaged students, and while this included PLHIV, it was not possible to isolate experiences of this subgroup.

One additional review relating to prevention was identified that did not directly address the research questions, but offered some useful complementary insights, examining the time trends in the association between educational attainment and risk of HIV infection in sub-Saharan Africa (Hargreaves et al., 2008). The implications of this study are outlined briefly below.

Challenging the relationship between education and prevention

The review of the relationship between educational attainment and infection was based on a review of 36 published peer-reviewed articles carried out between 1987 and 2003 in 11 countries in sub-Saharan Africa providing primary data on 72 discrete populations representative of the general population totalling over 200,000 individuals (Hargreaves et al., 2008).

The review was challenged by a number of considerations, including the fact that standardised measures of educational attainment were not available and hence it was only possible to identify associations between risk of HIV infection and relative levels of education. Various potential biases were also identified, including in the case of data derived from antenatal clinic participants the fact that the sample was limited to the sexually active and those using clinics, who may be less educated, and also risks of publication bias.

Different patterns of association were identified between population groups; e.g. in Zambia, the only country with data from a wide range of regions within the country, differences were found between rural and urban populations. Other results came from single regions or towns, and it is possible that these may not reflect national patterns.

⁴ The Pettifor et al. (2012) study was completed subsequent to Miller and Samson (2012) and so is included in this review.

However, an overall pattern was identified, which changed over time. Studies on data collected prior to 1996 generally found either no association or the highest risk of HIV infection among the most educated, whereas studies conducted from 1996 onwards found a lower risk of HIV infection among the most educated. Where data over time were available, HIV prevalence fell more consistently among highly educated groups than among less educated groups, in whom HIV prevalence sometimes rose while overall population prevalence was falling. In several populations, associations suggesting greater HIV risk in the more educated at earlier time points were replaced by weaker associations over time.

This is an area where more robust research is required to explore these relationships further in order to clarify the correlation between education and infection, and the factors underlying and driving this relationship, which the study indicates may vary both temporally and spatially, and which may be more complex than is sometimes assumed, as increased years in education is not always associated with reduced HIV risk. This is a key insight, as a strong causal relationship between education and HIV prevention is the assumption underlying many intervention programmes that may not be robust, and is not usually tested through biological end-point data.

The impact of school feeding programmes on health

This systematic review assessed the effectiveness of school meal programmes for improving the health of socio-economically disadvantaged children, including CABA and the distribution of benefits between the more and less disadvantaged (Kristjansson et al., 2006). School feeding programmes were defined as those providing meals or snacks (including milk) in a school setting, and a range of physical, behavioural and social outcomes were examined.

This is also the first systematic review on the topic and it again found that much of the existing literature was primarily descriptive and did not provide rigorous outcome assessments. Eighteen rigorous studies were identified for inclusion and these adopted a range of methodologies: RCTs, non-randomised controlled clinical trials, controlled before-and-after studies (CBAs), and interrupted time-series studies. The included studies differed significantly in terms of setting, historical/policy context, sample, inclusion criteria, interventions and outcomes.

The results of the studies integrated in this review provide general insights into providing school feeding programmes across the world. In the highest-quality studies (RCTs) children fed at school gained an average of 0.39 kg more than controls over 19 months; in lower-quality studies (CBAs), the difference in gain was 0.71 kg over 11.3 months, although in terms of height, results from LICs were mixed. Children in receipt of feeding attended school more frequently than those in control groups, although the average increase was only four to six days a year per child. In terms of educational and cognitive outcomes, children fed at school gained more than controls on maths achievement and some short-term cognitive tasks. Overall, the review concluded that school meals may have small physical and psychosocial benefits for disadvantaged children, with the impact on school attendance being greatest in areas of greatest poverty.

However, the authors argue that outcomes are likely to be affected by contextual factors, independent of the existence of the programme, such as the quality of the educational environment, the quality or amount of food provided, etc., and results were found to vary by region and country, with the impact of free school meals on school attendance being found to be greatest in areas of greatest poverty. Also, while CABA were included in the study, no results disaggregated by HIV-affected status were available. As such, further work is required to ascertain both the significance of the impacts of food provision for CABA and the extent to which these outcomes are affected by contextual factors.

Egge and Strasser (2006) attempted to carry out a meta-study on the impacts of targeted food aid, but with a focus on the chronically ill, those engaged in PMTCT, and those on ART or TB treatment in Malawi, Zimbabwe and Zambia, but identified a similar absence of robust analysis of programme performance and a failure to capture the necessary impact indicators. Their study highlights a number of potential indicators for future research in this area.

Cash transfers and HIV prevention

Pettifor et al. (2012) reviewed 16 studies (of which ten were completed) implementing CTs and measured HIV or HIV-related outcomes in order to test the extent to which receipt of a CT reduces the risk of HIV infection. The rationale for the study was that the use of cash payments to reduce HIV risk has become increasingly popular in recent years, while little is known about the efficacy of this intervention in terms of its potential impact. The concern underlying the study was as follows:

There are numerous barriers to the widespread uptake and impact of these [biomedical] interventions which include economic, behavioral, structural and biological factors. At the structural level, barriers to successful implementation of biomedical interventions may include financial barriers to individual uptake or to government ability to offer interventions, and/or cultural norms that are not supportive of the behaviors required for uptake or use of interventions. Effective combination prevention approaches will require interventions that address structural and behavioral risk factors to have a maximum impact on the epidemic (Pettifor et al., 2012:1729).

Pettifor et al. reflect the distinction made by Temin (2010) that CTs can have two distinct functions. One function is to increase household income and thereby increase the affordability of health care, food and education, which are likely to improve health outcomes. In this context cash is provided to address 'upstream' structural risk factors for HIV linked to poverty and may be conditioned on social goods, such as school attendance. The other function is to provide an incentive for behaviour change, either through the adoptions of conditions or incentives relating to risk reduction outcomes, for example, providing a cash incentive for immediate measureable outcomes related to HIV, such as cash for HIV tests or negative HIV or STI test results, on the assumption that this will serve as an incentive not to engage in high-risk behaviour. The review included studies that had as their objectives either providing incentives for risk reduction outcomes or reducing financial barriers to schooling, or both.

In terms of results, of the ten completed studies reviewed, only the one large RCT using biological end-point data found lower prevalence rates among the intervention participants compared to the controls at 18 month follow up stage (Baird et al., 2012), primarily due to the fact that so few studies to date have had biological end points, illustrating a lack of evidence rather than a lack of impact on prevalence. Nine of the ten completed studies found positive impacts on sexual behaviour, with only one study finding a significant decrease in HIV prevalence related to cash payments (Kohler and Thornton, 2011). The findings of the Kohler and Thornton study lead Pettifor et al., (2012:1731) to reflect:

Despite the promise of interventions that provide cash to reduce HIV risk, it is not clear that there is a one-size fits all cash payment intervention or whether such interventions will be effective in reducing HIV infection across populations.

Furthermore, Kohler and Thornton (2011) query whether incentives address the factors that place individuals at risk, and suggest that the relationship between cash incentives and behaviour might be more complex, citing research into a programme in Malawi where incentive payments resulted in increased rather than decreased sexual activity. They conclude that further research into this question, with increased usage of biomedical end points and RCT methodologies, is required to assess whether CT programmes are a cost-effective strategy for preventing HIV.

Systematic review conclusion

Overall, it is notable that only two systematic reviews were identified that addressed issues relating to social protection impact of access in relation to PLHIV and that each study reported significant challenges in terms of i) the availability of robust quantitative or qualitative studies, ii) the comparability of research methodologies adopted and indicators used, and iii) the existence of contextual factors (both socioeconomic and cultural factors, and also the existence of other interventions in the study areas) that were difficult to accommodate in the research design and may have had a significant confounding effect on the impact of given interventions on the identified population group. This is an area where improvements in research design (e.g. greater use of RCTs or the adoption of biological end points rather than proximate indicators for HIV risk reduction) could enhance the insights to be gained from systematic review approaches in the future.

6 Conclusions regarding access to social protection

This section draws conclusions from the literature relating to the access of PLHIV and their households to social protection. The access literature is largely concerned with the question of programme targeting and the HIV or AIDS inclusivity/exclusivity debate, exploring whether programming should be explicitly targeted at PLHIV or rather should be targeted more broadly on the basis of vulnerability criteria, and include PLHIV inasmuch as they are experiencing vulnerability. The literature is almost unanimous in promoting inclusive rather than exclusive programming and arguing for the avoidance of targeting PLHIV or AIDS orphans both in terms of the potentially stigmatising effect and also in terms of the fact that neither AIDS orphan nor PLHIV status is necessarily synonymous with vulnerability. The literature argues that access should be broad-based and inclusive wherever possible, using proxy indicators to identify vulnerable and poor households rather than HIV status. This argument is presented in Adato and Bassett (2007); Edström (2007); Edström and Khan (2009); IATT (2008a); Landis (2004); Richter (2010); Roelen et al. (2011); Samuels et al. (2012); Slater (2004); Stene et al. (2009); UNAIDS (2011); Temin (2010); Miller and Samson (2011); and UNICEF and EUI (2012). Where incidence rates and coverage are high, this approach is likely to successfully promote access among the most vulnerable PLHIV, with, for example, 70% of programme beneficiaries in a Zambian CT programme targeted at the poorest being PLHIV (Schubert, 2007). However, it is social assistance that should not be targeted on the basis of HIV status and not other forms of care that relate to HIV-specific needs, such as HBC. It is suggested that participation in some forms of livelihood support programmes, e.g. IGAs for small business start-ups, may not be ideal for households affected by HIV and AIDS due to the high incidence of failure.

It is argued that access to generalised social protection interventions designed to address vulnerability services (such as social transfers, and health and education) should be provided on an inclusive basis, with PLHIV being one group among many receiving support inasmuch as they are vulnerable members of the community. However, the provision of HIV-specific interventions relating particularly to prevention among 'core' and 'bridging' populations central to the ongoing transmission of the epidemic (such as female sex workers (FSWs) and their male clients in the World Bank's West Africa study or members of other vulnerable groups, such as, in varying contexts, adolescent girls, intravenous drug users or men who have sex with men) is recommended (World Bank, 2008), although the efficacy of interventions relating to health care and condom provision is not conclusively illustrated (Shahmanesh et al., 2008). Similarly, it is suggested that it is appropriate to provide incentives explicitly for PLHIV in order to promote treatment adherence or participation in PMTCT schemes are also discussed in the literature. In such instances relating primarily to prevention and treatment rather than care and support, a case is also made in the literature for exclusive social protection provision. The limited number of such programmes explicitly addressing the needs of vulnerable populations such as intravenous drug users (IDUs), FSWS or men who have sex with men (MSM) is highlighted in the literature.

The literature also includes some discussion of marginalised groups' lack of access to services (UNAIDS, 2010a), often an unintentional consequence of excessive bureaucratic requirements. Examples are migrants lacking ID cards or proof of local residency who might have trouble accessing services (AAPN, 2009; Edström and Khan, 2009; Foster, 2005) and informal workers outside the social security system with no access to social protection or health provision (Lee, 2004; Rompel, 2005). Also, women may have more difficulty in accessing services than men (Himmelgreen, 2009; ILO, 2003; ILO, 2010). The stigma of accessing HIV services can also in some cases contribute to reluctance to access services rather than a lack of availability per se (UNAIDS 2011; Loudon et al., 2007; Hennessey, 2001). Edström and Samuels (2007) note that older teens, small children, and street children are more likely to be unintentionally excluded from service provision, and the cost of accessing even free services (travel; time away from work; child care) is a commonly cited reason why the poorest quintiles do not access services (Samson 2008; Souteyrand et al., 2008; Subbarao et al., 2001; UNAIDS, 2011).

ILO (2012b) provides a detailed description of the situation in Indonesia in which PLHIV are deliberately excluded from social protection provision. In this unique case the national health insurance scheme explicitly excludes PLHIV. In addition, migrants and those without residency cards cannot access social protection, while complicated application processes make it difficult to succeed in accessing services, a situation exacerbated by discrimination from officials related to the stigma of being identified as living with HIV. The publication provides a case study on deliberate and unintentional barriers to access.

In contrast, Chean (2007) provides a study on costs of health care in Cambodia and describes how community-based health insurance (CBHI) could provide an excellent means of accessing health care, but that most community members are unaware of these programmes. In a survey of 389 households, only six claimed to be members of a CBHI scheme. Of these, two paid for this themselves and four were paid for by the local authorities, as they were considered poor households. When asked in a community feedback meeting why so few households held CBHI, most participants simply stated that they did not know about the scheme or how to join it. Community feedback indicated that people wanted CBHI membership and were willing to pay for it, but that lack of information on where to get membership, lack of knowledge on the benefits of being a member and lack of a clear mechanism for reimbursement created significant unintended barriers to access. No further literature exploring this critical question of how lack of knowledge of available services may affect service utilisation was identified. Another study also raised lack of knowledge or services, unfamiliarity with procedures and multiple bureaucratic barriers to health insurance in Indonesia (Octavery et al., 2011).

Rompel (2005), however, finds on the basis of a global study that the impact of SHI in overcoming financial barriers to access is limited, not due to lack of information, but primarily due to the cost of participation, which tends to lead to the exclusion of the poor, with SHI schemes being mainly available for formal-sector employees (thus predominantly urban middle- and high-income earners) and CHI schemes, by contrast, being successful among the rural middle class. The consequence is that protection is mainly provided for those who can afford to belong to a health insurance scheme, as sometimes even relatively modest contributions can be too high for the poorest to pay. So both cost and lack of information are posited as potential barriers in the literature identified in the review.

In their study of the impact of Tanzania's Community Health Fund (CHF) membership on cost, frequency and type of outpatient services utilised, Chanfreau et al. (2005) explored the use of outpatient, inpatient and VCT services by PLHIV who were members of CHF compared to PLHIV who were not across a number of health facilities, and compared the difference in costs of care and service utilisation between the two groups. The study found that by creating a culture of seeking care regularly, CHF membership appeared to lower hospitalisation frequency, duration, and costs due to HIV and AIDS conditions, confirming the value of health insurance provision from both user and supplier perspectives.

The series of WHO, UNAIDS and UNICEF 'Towards Universal Access' reports (2009; 2010) are particularly valuable in providing overview data on access in terms of provision, as is the recently completed study by UNICEF into provision in Asia (UNICEF and EIU, 2012). The latter study focuses on access in terms of children and caregivers rather than PLHIV more broadly across nine countries in Asia, although both are limited by lack of reliable data on the coverage and performance of reported programmes, and are limited to the identification of larger scale and mostly government- or development-partner-managed interventions and so may omit informal and socially based provision.

The UNICEF and EIU (2012) report introduces the idea of a simple coding system for the appraisal of provision:

Across the categories examined – social assistance, social insurance, access to social services, and policies and legislation – each programme or policy was conferred a coding from 'limited' to 'extensive'. Countries with a 'limited' coding have few policy initiatives, and nascent programme activity. A 'moderate' code reflects some policy initiatives and programme activity. Evidence of a substantive policy framework and moderate programme activity earned a 'substantial' coding. Programmes and policies were deemed to be 'extensive' if the policy framework was comprehensive, and there was evidence of robust programme activity (UNICEF and EIU, 2012: 7).

This approach may be generalisable more broadly within the sector in order to permit some insight, albeit basic, into the issue of provision quality internationally.

7 Conclusions on programme impact

The limited evidence on the intersection between social protection, HIV programming and impact analysis was noted by the Quality Assurance Project, the USAID Health Care Improvement Project and UNICEF (2008), and although the literature has been growing significantly since the mid-2000s, there are still significant uncertainties regarding programme impacts and the methodological tools for assessing impacts are still in a process of development. The social protection evidence base (summarised in Adato and Bassett, 2007; DFID, 2011) indicates that there is strong evidence for the positive effects of CTs on poverty alleviation and schooling, and of food assistance effects on children's development, as well as various forms of health insurance providing improvements in health outcomes and well-being, which can be extrapolated to imply that they would also confer significant benefits for PLHIV. However, there is not yet a well-developed evidence base that provides evidence on outcomes in terms of prevention, treatment, care or support (see Pettifor et al., 2012, Miller and Samson, 2012; Temin, 2010; Edström and Samuels, 2007; Kristjansson et al., 2006). The current review indicates that a nascent second-generation evidence base is emerging that uses more robust methodologies and at the same time also extends beyond RCTs to include innovative data gathering approaches in terms of the use of clinic data sets and biological end-point data, as well as a process of rethinking and contextualising the assumptions underlying programme design choices. Recent studies such as Pettifor et al. (2012) have explicitly taken gender factors into account and there is an increasing incorporation of gender into evaluation methodologies, although research design does not yet include a gender analysis in all cases.

Despite these developments in the research methodologies adopted, many programmes continue to adopt and measure indicators based on process (e.g. numbers of children in school, dropout rates, food or drugs distributed, service utilisation rates) (MTT and UNICEF, 2005), or are proximate rather than ultimate indicators of the intended programme outcome (e.g. reduced HIV infection rates among the youth or improved treatment outcomes) rather than impact indicators relating directly to prevention, treatment, care or support outcomes.

This criticism has been levelled more generally throughout the social protection sector (e.g. see IEG, 2011) and is not unique to social protection interventions relating to HIV and AIDS. These process or proximate indicators are in many instances rigorously produced and do indicate a correlation between the intervention (the transfer) and a specific impact, although the link between the measured impact and the intended ultimate outcome in many instances remains assumed rather than empirically attested, and there is little focus on medium- to long-term impacts in relation to anticipated impacts on mortality, morbidity or economic well-being and the criticism of Landis (2004) is still valid. In this way, many policy papers recommend social protection provision in order to contribute to prevention, treatment and/or support on the basis of a series of assumed causal linkages inferred from the broad social protection literature, without indicating the specific impacts and outcomes that may be anticipated, and measure impacts in terms of internal programme coherence and design using process indicators, numbers of people enrolled, numbers accessing the service, quantities of food delivered, etc., rather than outcomes.

Of the three outcome areas, care and support is the impact area with the most robust evidence base (perhaps because household economy effects are relatively easy to identify with rigour compared to the clinical data required to assess prevention or treatment impacts), despite the fact that the UK Consortium on AIDS and International Development (2011) describes care and support as the 'forgotten pillar' of the HIV response trinity.

7.1 Prevention

A limited number of the studies that were identified addressed interventions to prevent HIV transmission. These fell in to three main areas: CT or education subsidy programmes aiming to retain children (especially adolescent girls) in school, thereby delaying the age of sexual initiation and marriage and hence delaying exposure to infection risk (Hallfors et al., 2011; Lutz, 2012); programmes promoting ART provision for pregnant women and mothers to prevent mother to child transmission; and programmes to provide information, education and communication (IEC), condoms, and health services to FSWs, with the latter being the subject of an international systematic review (Shahmanesh et al., 2008). Of the 28 HIV studies on prevention for FSWs included in the systematic review, only one included the provision of a social protection intervention, i.e. a voucher system in Nicaragua to promote the utilisation of STI services among FSWs.

The high-quality studies providing evidence on prevention were mainly based on outcomes related to education or health care. The range of indicators varied from educational attainment to school dropout, the provision of school material for children, access to family planning, HIV preventive education, and various activities intended to economically empower vulnerable populations such as MF or conditional transfers linked to education service utilisation. There is also some evidence relating to the increased income available at household level (Stene et al., 2009) on the ability of CTs to increase food consumption and health expenditures, and decrease school absenteeism.

Studies into the impact of cash transfers on HIV risk reduction among orphaned children do not readily demonstrate impact in terms of risk reduction through various forms of behaviour modification. Ssewamala et al. (2006) find that transfer receipt did not reduce HIV risk, and likewise, the study of Galarraga and Gertler (2009) shows that the receipt of a CT in Mexico had no effect on age at sexual initiation or condom use among beneficiaries.

However, while a small number of studies are starting to adopt biological end points, most of the indicators adopted in the studies relating to prevention are proximate rather than directly measuring the ultimate outcomes in terms of reduced infection. The use of such proximate indicators is based on assumptions that changes in certain behaviour will reduce the risk of HIV infection, and the chain of causal links between the impact measured and ultimate outcome is not always theoretically robust or empirically validated (e.g. see Kohler et al., 2011, discussed in Pettifor et al., 2012). In other cases the use of self-reported data can be unreliable, e.g. self-reported sexual activity. Furthermore, the outcomes reported might not take adequate account of important contextual factors contributing to outcomes, such as the quality of the educational environment, educational progress, the quality and amount of food provided, etc. Also, it is noticed that results of indicators can vary according to the region or specific country studied. Currently there is good existing first generation literature on prevention, but it is limited to the impacts of transfers and risk behaviour rather than HIV infection, but a second generation of studies is now starting to emerge, as discussed above in relation to the evaluation of CT impacts (see Pettifor et al., 2012).

7.2 Treatment

The studies focusing on treatment outcomes explore the impact of social protection interventions, especially health-care provision or health insurance, on overcoming financial barriers to access services, treatment adherence, hospitalisation frequency, ARV provision and use, and HIV testing and counselling. They also cover the impact of food assistance on adherence to ART, and the role of ARVs and HIV services in palliating stigma and discrimination.

Given the potential diversity of populations included in treatment outcome analysis – notably the mix of patients living at the various stages of the HIV disease progression – it is difficult to generalise findings to a broad population of PLHIV (Chanfreau et al., 2005). Study results tend to be representative only for the sample population (Octavery et al., 2011; Chanfreau et al., 2005; Chean, 2007) or they are based on an estimated PLHIV population extrapolated from all the beneficiaries of a social protection intervention (ILO, 2012). Besides, the population studied in one location might differ from those treated at community hospitals or private health facilities in terms of the severity of the disease (Kitajima et al., 2005). Indeed, when indicators are based on patient records (Chanfreau et al., 2005; Kitajima et al., 2005) such as outpatient visits, hospitalisation episodes, cost of treatment, duration of hospital stay and so on there is the challenge of data availability and the risk of bias from the way information is abstracted from medical records. Thus, if the population included in these studies comprises PLHIV in receipt of treatment, then they represent only a population that is both relatively well informed (knowing about the availability of services) and also able to get access to them (AAPN, 2009).

There is a dearth of studies examining and providing direct evidence of the impact of food aid on treatment adherence and outcomes, which is due, in part, to the difficulty of collecting and interpreting relevant indicators. However, Egge and Strasser (2006) propose a framework of suggested indicators to measure the impact of food aid on individuals and households living with HIV and AIDS. Cantrell et al. (2008) suggest that even if results are context based they can be replicable in settings where HIV-affected people are food insecure and that, if not addressed, this challenge could pose a serious threat to the long-term success of interventions such as ART programmes.

These studies are valuable for gaining insights into the problems that households face when they do not have any social protection to help protect them from catastrophic health expenditures or even when there is a social protection mechanism in place these studies illustrate the barriers PLHIV face, e.g. people are unaware of the scheme, there is a lack of information, and cultural barriers exist related to people trusting the

scheme and health-care providers (Cheat, 2007; Rompel, 2005). This kind of attitudinal information is mostly collected using qualitative methods such as interviews and focus groups discussions (FGDs) (Octavary et al., 2011).

7.3 Care and support

In the literature, reviews of care and support interventions dominate, with social protection interventions mainly serving to mitigate the effects of HIV on households by promoting care and support outcomes. Cash and in-kind transfers, including food transfers, are associated with a strong impact evidence base particularly in terms of care and support outcomes. UNAIDS (2010a) refers to evidence that transfers can be effective risk management mechanisms that enable poorest households to better manage the economic consequences of AIDS-related illness or death, and this conceptual approach is found in the majority of the papers reviewed. Stene et al. (2009) present a summary of evidence on the impacts of economic strengthening programmes on HIV and AIDS. This paper shows that cash transfers have positive effects on PLHIV as measured by various early childhood development (ECD) outcomes (stunting, wasting, weight); improvements in food consumption (the number of meals consumed and satiation); reductions in child labour; and small increases in health expenditures, along with decreased school absenteeism and increased retention, although no effect on school enrolment was found.

Social protection interventions focused on caregivers' income or children's nutrition will improve children's well-being, but Baingana et al. (2008) argue that these should be coupled with other integrated care and support services addressing stigma such as psychosocial counselling, HIV education and access to school. Social transfers can in principle alleviate child vulnerability (UNICEF, 2007b) and are seen as a good response to increase children's access to health and education, although while there is general data in support of this assumption (e.g. see DFID, 2011) HIV-specific empirical evidence is limited. Food support is often seen as a response to children affected by HIV more often than it is cited as a response to adults. Nutrition is important for ECD and continuing child development, and the provision of in-kind support reduces pressure on household expenditure and can help keep children in school (Thwin 2006); it also helps children look 'less sick' or 'less poor', which reduces social stigma and promotes confidence (Loudon et al., 2007).

Thwin (2006) offers a programme evaluation in Cambodia that shows quantitatively that food provision has a positive impact on coping mechanisms, livelihoods, food security, nutrition, schooling and treatment adherence. Similarly, Temin (2010) argues that there is strong evidence for the impact of both CTs and food transfers in terms of promoting treatment outcomes and also in terms of care and support through mitigating the adverse economic effects of HIV throughout Africa. Gillespie and Kadiyala (2005) and Cantrell et al. (2008) present quantitative evidence that food aid can increase treatment success, as good nutrition is necessary for ART to be effective. Mamlin (2007) adds to this with a description of a programme offering food aid to ARV patients, but the paper does not provide conclusive evidence on outcomes. Egge and Strasser (2006) provide a discussion based in primary data and programme evaluation about the Consortium for the Southern Africa Food Security Emergency (C-SAFE) programme, which provides food to PLHIV. The paper assesses the programme's efficacy in measuring impacts and shows that although many organisations advocate for incorporating food aid into HIV and AIDS programming, there is a serious lack of empirical evidence on how best to evaluate programme impact on participants who are living with or affected by HIV. Although C-SAFE partners have a great deal of experience in monitoring food aid delivery and the food security status of targeted households, most do not have systems to measure the impact of food aid on PLHIV empirically, despite strong anecdotal evidence regarding improved weight, health and consumption.

The care and support literature evaluates different social protection interventions using a wider variety of indicators to measure outcomes such as well-being, stigma and socioeconomic support. CTs are used to impact the well-being in HIV-affected households, while highly active antiretroviral therapy (HAART) and ART have been useful to increase quality of life, and they have been employed with the aim of reducing stigma or discrimination. Children affected by HIV have been the main target population of various interventions related to care and support (medical care, education, food subsidies), in addition to elderly people who have to take care of children whose parents died or are unable to work due to illness. There is also literature focused on the impact of economic strengthening initiatives on measures of well-being in HIV-affected households.

Some of the studies are focused more on the institutional dynamics of social protection in general and its expansion (IATT, 2008a; Attawel et al., 2006) rather than an evaluation of social protection programmes and their effectiveness regarding care and support. Likewise, it is noticed that the samples used can be biased when participants are those who have overcome multiple barriers to access and adherence (including

stigma, transportation costs, consultation fees) and can get access to services on a regular basis (Campbell et al., 2011).

In the case of food support, the studies clearly show their positive impact on food security, nutrition and livelihoods (Thwin, 2006; Attawel et al., 2006; KULA, 2010). However, even if indicators show an improved situation in intervention areas, they cannot statistically prove the impact of the programme (Thwin, 2006, KULA, 2010). Thwin (2006) suggests that the improvement can be also attributed to existing home-care activities and other development programmes implemented in the areas by community organisations.

7.4 Gender

In general there is a lack of gender analysis when examining both access to and impact of social protection on PLHIV. Despite the critical gender dimension of HIV, only a limited number of studies explicitly included a gender dimension or focus on women, with the most common examples of the latter being studies of vulnerable girls affected by HIV and AIDS and FSWs (World Bank, 2008).

Most of the studies addressing gender provide evidence on impact analysis in terms of different interventions, with many focusing on schooling outcomes. For example, Hallfors et al. (2011) studied the impact of supporting adolescent orphan girls to stay in school on HIV prevention in Zimbabwe. They found an increased probability of female orphans remaining in school (hence reducing HIV risk through delayed sexual initiation and marriage), assuming more equitable gender attitudes and being more concerned about the consequences of sex. Likewise, a food support programme in Cambodia was found to have had a positive impact on the schooling of OVC, especially girls (Thwin, 2006).

Economic strengthening interventions (relating to care outcomes) have been also assessed with a gender dimension. Stene et al. (2009) find that the promotion of micro-finance among women and adolescent girls was generally correlated with increased confidence, participation in social networks, and overall attitudes about their ability to address HIV and AIDS-related risks and challenges. They also suggest that micro-finance has a correlation with HIV and AIDS mitigation behaviour and attitudes, particularly among women (Stene et al., 2009). It is suggested that all these economic empowerment activities have the potential – when combined with HIV, health and gender education and training – to promote economic self-sufficiency, reduce gender inequality, and empower young women to better negotiate sexual relations and reduce their risk of HIV infection (UNICEF, 2009), although robust evidence of these outcomes was not identified in this review process.⁵

A study by AAPN (2009) examines the challenges that HIV-positive women face in getting access to ARVs and HIV services in Asia. The study finds that testing and immediate counselling are relatively easy to access, but ARVs and ongoing treatment are more difficult. However, the particularity of this study is that it was designed and conducted by women living with HIV. HIV-positive women were trained in research methods and designed the questionnaires themselves. Women were also responsible for data collection. This can be useful to gain rapport with respondents and include topics to research that are of relevance for HIV-affected women. However, one weakness is that respondents were recruited from service delivery centres (clinics, outpatient departments, peer support groups), so the study is most likely to capture the views of women who are relatively well informed of the services that are available and are able to get access to them, but not of those women who face other type of barriers.

Most studies evaluate barriers to services, stigma and discrimination using a qualitative approach. This methodology can be generalisable on overall issues about problems of access to HIV services, issues of discrimination, problems of access to ARVs and the expectations of women about the quality of services. However, results on other issues are more conceptualised, such as the amount and quality of counselling available, the issues that affect access to services, the information they have about HIV treatment and their importance.

Among the studies that have identified the different barriers to services than woman face, AAPN (2009) observes that lack of money is the major reason for not being able to access services, followed by fear of discrimination, not knowing where to go and because services were not available. However, this study notices a significant difference in satisfaction depending on where women lived. AAPN (2009) points out that women perceive they face more HIV-related discrimination and stigma than men. For example, women are judged as contracting HIV as a consequence of bad behaviour, but men are far less likely to face the same condemnation. Other women perceived that most people regard them as the ones who 'spread the virus'.

⁵ Additional data on this finding are available through the articles mentioned here: <http://www.whatworksforwomen.org/chapters/21-Strengthening-the-Enabling-Environment/sections/63-Promoting-Womens-Employment-Income-and-Livelihood-Opportunities>.

Indeed, discrimination comes from a wide range of actors, from health-care workers to family members and the community in general (AAPN, 2009). Gender also contributes to children's experiences of stigma (Abadia-Barrero and Castro, 2006) and is a reason for children with HIV-positive parents to be excluded from services (Loudon et al., 2007).

Finally, it is interesting to note that in general the literature understands AIDS as a disease of inequality, both economic and gendered (Miller and Samson, 2012). In some cases gender inequalities increase women's exposure to infection through their lower status and lower access to education, as well as their economic dependency on men (Samuels et al., 2012). As a consequence the targeting of women and girls for certain social protection interventions in specific contexts is sometimes proposed as the most effective strategy (Lutz and Small, forthcoming). Temin (2010) also makes a case for gender-targeted interventions, on the basis of the claim that social protection interventions targeted at girls and women have the potential to reduce economic and gender inequalities, and to empower women to better negotiate their sexual relations and reduce their risk of HIV infection. However, despite this analysis, many programmes do not include a gender dimension in their targeting or support (MTT, 2005), and even those that do, do not necessarily realise the potential to reduce gender inequalities or empower women, due to the limited impact of often-low-value social protection transfers at the household level.

8 Complementary interventions

The literature indicates that social protection (income support) alone cannot address all the needs of PLHIV on a sustained basis and that to be effective in terms of achieving optimal outcomes for PLHIV, programmes should adopt an approach that encompasses complementary interventions, including livelihoods and employment support.

Examples of complementary programming include psychosocial support, legal support, medical care, livelihoods promotion (training, MF, livelihoods inputs and education), HIV sensitisation, and HIV-related education and alternative care. The provision of child care, accommodation, clothing or orphanage care; and the promotion of market access, preferential education and employment opportunities for PLHIV, community dialogue, training on the identification of most vulnerable children (MVC), and systems strengthening were also mentioned in the literature.

Complementary interventions are discussed in most of the papers identified. In the context of programmes providing CTs and/or food aid, it is generally recommended that the requisite medical care is also provided. Similarly food aid is often, although not always, provided as a complement to ARV provision, as described above. It is common in the literature for IGAs, stigma reduction programmes and HIV education to be mentioned as complementary interventions, and alternative care (fostering, whether with a family member, community member or other person; or placement in an orphanage) is frequently described as a complement for OVC programmes.

However, this significant range of potential complementary interventions were not examined with the application of robust qualitative or quantitative approaches and were primarily included as part of broader programme narratives, and hence no evidence on the impact of such approaches can be gleaned from the literature identified in this review.

8.1 Economic and livelihoods responses

Livelihoods responses to address poverty are identified as key needs in accessing treatment and maintaining a quality of life. There is a well-established literature on the need for poverty reduction strategies as an HIV response (either in addition to or in place of improving health services and provision of ARVs). Stene et al. (2009) state that economic strengthening programmes are useful for HIV, as they have documented effects on general well-being outcomes, but they state that there is not a strong evidence base on livelihoods in relation to PLHIV specifically, except in the area of MF, which is well established as a response to HIV (e.g. see Parker et al., 2000) although has been problematised in the recent Temin study (2010), which questions whether enterprise development is necessarily an appropriate response in households affected by the financial (increased cost and reduced income) and labour-related uncertainties experienced among PLHIV.

Other economic strengthening initiatives do not necessarily cater for the specific needs of PLHIV or analyse their impacts in this area. Although there is a long history of economic strengthening interventions, there are few impact evaluations and little rigorous evidence on the impacts on PLHIV, except with regard to MF.

Since it is recognised that poverty is a structural determinant of HIV, there is some optimism in the literature that MF programmes have created an area in which poverty reduction and HIV prevention can come together effectively (Dworkin and Blankenship, 2009). Papers providing an overview of such programming are Datta and Njuguna (2008); Dworkin & Blankenship (2009); Caldas et al. (2010); and McDonagh (2001).

The literature suggests that MF institutions are most effective when partnered with AIDS care organisations, where the former do not try to offer care services and NGOs do not try to create their own MF products (Datta and Njuguna, 2008; Dworkin and Blankenship, 2009; Goss and Mitten, 2007; ILO, 2010). Instead, authors recommend that MF institutions should provide products that are sensitive to PLHIV needs and that these are integrated with services such as health care, counselling and awareness raising, which are better provided by other specialist organisations.

In their international literature review, Stene et al. (2009) find that that in addition to household finance benefits, IGAs and savings had positive impacts on confidence and, when integrated with health programmes and MF interventions, were found to result in to some positive behaviour change outcomes and reduction of risk factors associated with HIV and AIDS. They find that MF initiatives are linked with improvements in women's self-confidence, household decision-making authority, bargaining power and participation in community leadership roles. However, they conclude that more research is needed to assess the impact of economic strengthening programmes directly on the health and well-being of PLHIV. Key indicators to be explored include nutritional uptake; education; income diversification; and access and adherence to care and treatment of HIV and AIDS, and other health-care needs.

With reference to Africa specifically, Temin (2010) also argues that IGAs and microcredit have a role to play, and that although specific HIV-related impacts are rarely measured, such schemes can increase households' ability to withstand shocks and reduce poverty. However, on the basis of the review of evidence in sub-Saharan Africa, Temin suggests that households grappling with the uncertainty and medical expenses related to HIV may not necessarily be the most appropriate targets for certain types of livelihood programmes, given, for example, the risks associated with small business start-ups. However, Temin notes that the expansion of ARV programmes may be increasing the relevance of livelihood approaches for PLHIV and their households, and so this may also increase opportunities for public-employment-based options, if governments are able to extend provision – which is a major challenge in LICs (see McCord, 2012).

A key issue in the development of these programmes is the extent to which PLHIV should be targeted. MF has been shown to have positive effects on health outcomes in general, and it is possible that more focused programmes that aim to tackle HIV specifically will achieve even better results, but there is the associated risk of stigma and discrimination, and some recommend against targeting based on HIV status (Edström and Khan, 2009; Interagency Coalition on AIDS and Development, 2001; IATT, 2008b; Stene et al., 2009). Programmes that have a broad-based approach to targeting poor and vulnerable people through proxy indicators have had good success in including a large proportion of PLHIV through inclusive programming without explicit targeting in contexts where prevalence is high. Two papers, however, contradict this recommendation. PNUD (2012) describes a programme that targets urban women living with HIV and is implemented by local networks, while UNAIDS (2007) describes the Positive Partnerships Program in Thailand, which explicitly pairs a person living with HIV with a person not living with HIV as business partners. This programme seems to be successful, and part of its aim is to reduce discrimination by encouraging a business relationship to reduce fear and stigma.

Despite the generally positive attitude to MF in the literature and its relatively long history of complementary programming, there is a lack of rigorous evidence on its impact in terms of the key HIV or AIDS outcome areas. Projects providing good evidence are the Intervention with Microfinance for AIDS and Gender Equity Project in South Africa (Pronyk et al, 2008); the Zambuko Trust in Zimbabwe (Barnes et al., 2001); FINCA in Uganda (Parker et al., 2000); and Opportunity International (Parker et al., 2000).

While there is much evidence on the positive effects of MF on well-being indicators in the broader literature, all the authors cited in this review argue for more rigorous studies to establish impacts in relation to PLHIV, but also point out some of the difficulties in terms of establishing causality and disaggregating impacts on PLHIV and others (Anderson et al., 2002; Caldas et al 2010).

No literature was identified dealing with complementary programming relating to livelihoods sustainability, training, graduation or employment assistance that also related to social protection provision and HIV, and so this aspect of the detailed research sub-questions could not be answered by the literature identified.

8.2 Methodologies and indicators

The included studies used a range of methodologies. Most of the studies examining the question of access combining literature review, policy review and key informant interviews with some budgetary analysis. The studies exploring impact issues adopted a mix of qualitative and quantitative approaches, including case studies gathering primary data either through survey or qualitative approaches, the analysis of administrative or clinical data, and literature reviews synthesising experience from existing studies. RCT methodologies generally provide the high-quality results that would be desirable for developing an evidence base on the impact of social protection on aspects of HIV (Kristjansson et al., 2007; Temin, 2010), but few studies in this sector have adopted an explicit RCT approach (e.g. see Pettifor et al., 2012), and the absence of RCTs has led some authors to revise their analytical approaches. The absence of RCT or other robust evaluation data can be problematic when attempts are made to compare findings across programmes or carry out meta-analysis in systematic reviews. However, given the importance of contextual factors (Pettifor et al., 2012), it may be that RCT trials are not the optimal approach.

In terms of the main qualitative methods adopted, most of studies used interviews with key informants including government officials, technical advisors, programme managers and implementing agency staff, including field staff. Interviews were also conducted with beneficiaries, and non-beneficiaries (Abadia-Barrero and Castro, 2006; Campbell et al., 2011; Chean 2007, Galarraga and Gertler, 2009; KULA, 2010). FGDs are a common way of eliciting insights into both access and impact, and are frequently used in qualitative studies (Loudon et al., 2007; Octavery et al., 2011; Samuels et al, 2012), particularly to explore issues not amenable to reduction to quantitative exploration, such as barriers to service access, personal experiences of stigma and discrimination, and different vulnerabilities faced by PLHIV.

Discussion of the methodologies adopted in each of the 26 studies is included in Appendix 3. This provides details of the methodologies and indicators adopted, together with a review of their strength and weaknesses, and their findings.

8.3 Indicators

A range of indicators relating to the evidence base on impact are set out in Table 3 to illustrate the range of options currently being explored in the literature (further detail on each is included in Appendix 3). These indicators were selected from among those used in the studies reviewed in order to illustrate the diversity of possible options.

Table 3: Examples of indicators adopted in key areas of impact

Impact	Intervention	Methodology	Impact	Indicator	Reference	Country/ region
Prevention	School fees	RCT	HIV risk reduction	School dropout, sexual activity, marriage, pregnancy rates	Hallfors et al., 2011	Zimbabwe
	CCT	Quantitative	Reduction in risky sexual behaviour	Self-reported survey questions relating to sexual behaviour using voice recording approaches rather than enumerator interviews in order to reduce inaccuracies and bias	Galaragga and Gertler, 2009	Mexico
	School fee reduction (various mechanisms)	Qualitative	School retention, HIV risk reduction	School attendance, retention	MTT, 2005	Africa
	CT/CCT	Systematic review (includes RCTs)	HIV prevention	HIV test results, condom use, engagement in risky sexual behaviour, child bearing, use of reproductive health services, beginning sexual intercourse, school dropouts, HIV incidence and prevalence	Pettifor et al., 2012	Africa and US
Treatment	Food aid	Quantitative	ARV adherence	MPR (calculated from clinic records): a measure of the percentage of time a patient has access to medication, CD4 count, weight gain	Cantrell, et al., 2008	Zambia
	Health insurance	Quantitative	Frequency and type of outpatient services used	Number and frequency of outpatient visits, number of hospitalisation episodes, duration of hospital stay (clinic data)	Chanfreau, et al., 2005	Tanzania
	Health insurance	Qualitative and quantitative	Service utilisation and protecting livelihoods	Service utilisation and livelihoods (survey plus ethnography)	Chean, 2007	Viet Nam
	Food aid	Review	Nutritional improvements and treatment adherence	Anthropometric measurements, strength and stamina, diarrhoea prevalence, treatment uptake and efficacy, treatment completion (DOTS), treatment adherence, quality of life, level of household food insecurity (proposed)	Egge and Strasser, 2005	Malawi, Zimbabwe and Zambia
	Health insurance	Quantitative (regression)	Impact of health insurance on ARV	Data on outpatient and inpatient visits (duration of hospital stay, diagnosis, ARV use) data gathered	Kitajima et al., 2005	Thailand

Impact	Intervention	Methodology	Impact	Indicator	Reference	Country/ region
		analysis)	usage	from referral hospitals using nurses to complete questionnaires		
	Health insurance	Qualitative	Usage of health-care services	Health expenditure, treatment	Octavery et al., 2011	Indonesia
Mitigation	School feeding	Systematic Review	Improvement in health	Weight gain, school attendance, educational outcomes, provision of food	Kristjansson et al., 2006	Global
	Cash transfers, MF and IGAs	Qualitative	Improved well-being	Nutritional status, health service utilisation, educational enrolment, ownership of school supplies, proxy measures of self-esteem, participation in social networks	Stene et al., 2009	Global
	Food aid	Quantitative	Improved well-being	Food security, livelihoods, nutrition, coping strategies, school attendance, ARV adherence	Thwin, 2006	Cambodia

A review of the indicators adopted in the reviewed studies indicates an ongoing reliance on the use of proximate rather than ultimate indicators of impact and hypothesised impacts, inferred from the wider literature, particularly in relation to prevention. In relation to some outcomes, this may be appropriate, as in the case of using STI prevalence and treatment as proxies for HIV prevalence and treatment behaviour (although there may be instances where even this proxy is problematic). But where school retention, for example, is used as a proxy indicator for HIV prevention, the correlation may be far weaker and significantly over-determined by a range of other contextual factors, rendering school retention a weak proxy for effective prevention outcomes, as illustrated by Hargreaves et al. (2008).

Hence, many of the indicators relating to prevention are not directly linked to biomarkers indicating HIV infection rates, but rather to proximate indicators linked frequently to extended school attendance or other factors that are hypothesised to reduce vulnerability to HIV, and hence infection rates. Nine of the ten completed studies reviewed in the Pettifor et al. (2012) study show a close association between transfers and reduced risk behaviours, and given that the causality between changed behaviour and HIV infection is well established, this suggests that the adoption of risk behaviour indicators may be adequate, since studies using HIV biomarkers are still fairly rare. The fact that increasing numbers of studies are demonstrating impact on the basis of risk behaviour indicators rather than, for example, extended school participation represents progress compared with previous practices, although there is a need to be mindful of the challenges bias in gathering data on risk behaviour. Galaragga and Gertler (2009) developed an innovative technological way of gathering this data in an attempt to reduce this potential bias, using voice recorders rather than enumerators in their study into the impact of CCTs on HIV prevention.

Interestingly, one study based on a systematic review indicates that the relationship between HIV and educational attainment has reversed since 1996 in Africa (from a correlation between high educational attainment and high incidence, to a correlation between low educational attainment and high incidence) (Hargreaves et al., 2008), highlighting the complexity of the assumed unidirectional relationship between education and prevention.

Similarly, analysis of treatment impact in terms of ARV provision is problematic without morbidity and mortality indicators, inasmuch as the impact of ARV provision is highly determined by a range of contextual factors (nutrition, adherence, etc.) and the impact in terms of health outcomes and quality of life (measured, for example, in terms of disability-adjusted life years or quality-adjusted life years) would vary significantly as a result. The indicators adopted in some studies examining the effects of social protection on treatment take this into account. For example, Cantrell et al.'s (2008) study examining the role of food aid provision on treatment efficacy in Zambia used ARV adherence, CD4 count and weight as indicators. Studies examining treatment effects have also adopted service utilisation indicators. In their studies into the impact of different forms of health insurance on treatment Chanfreau et al. (2005) and Chean (2007) both used process indicators relating to service utilisation, with the former using clinical data recording the number and frequency of outpatient visits, number of hospitalisation episodes and duration of hospital stay and ARV receipt, and the latter using survey-based self-reported utilisation data. Interestingly, Chean's (2007) finding suggest that at 12 months after ART initiation, food supplementation had no statistically significant effect on clinical outcomes measured in terms of weight, CD4 count or survival.

Interestingly, Egge and Strasser (2006) find that no data on indicators against which to assess the impact of targeted food assistance (TFA) was being gathered in the C-SAFE Southern Africa programme they were reviewing and that there was little evidence internationally on the impact of TFA on nutrition in the context of HIV and AIDS.

The description and analysis of impacts in the literature confirms the concern articulated made by both Temin (2010) and Miller and Samson (2012) in relation to the African literature that despite recent advances (as per Pettifor et al., 2012), there is still a somewhat uncritical reliance on hypothesised rather than empirically attested linkages between interventions and outcomes within the social protection and HIV literature and the theories of change that underlie much programming.

9 Conclusions: Evidence, Methodologies and Gaps

The conclusions presented here relate to the evidence presented in the literature and the methodologies adopted, and are presented to address the key questions underlying this review.

9.1 Evidence on social protection access resulting in reduced vulnerability

This review has attempted to identify the evidence on whether having access to social protection schemes reduces HIV-affected households' vulnerabilities.

The evidence base is limited in terms of the extent to which the implementation of social protection programmes directly reduces HIV-affected households' vulnerabilities. Impact on household vulnerability is contingent on the nature of the social protection intervention adopted and whether the objective is to address vulnerability in terms of prevention, treatment, care or support. Inasmuch as the provision of social protection in the form of cash, in-kind goods, or free or subsidised services relieves budget constraints limiting consumption of key goods and services, the intervention is likely to reduce vulnerabilities.

Where the transfer/subsidy is targeted at individuals (e.g. in the form of ARV provision or specific medical services), the benefits are not likely to be shared within the household, but where the use of the transfer is discretionary, it is likely to be used more generally to address household rather than individual vulnerabilities and as such may not have the intended impact, for example, in terms of ARV effectiveness.

The evidence on the impact of social protection on care and support is stronger than for impacts on prevention or treatment outcomes. There is considerable evidence that the provision of social assistance promotes household-level consumption, with the extent of the impact determined by the value of the transfer relative to the poverty gap of the recipient household. However, this evidence base is drawn from the general social protection literature, which is extrapolated to apply to PLHIV, and this study did not identify a set of robust studies identifying significant household consumption impacts specific to PLHIV.

The evidence relating to the impact of the range of economic supports (such as IGAs and MF) to provide mitigation is weaker, and it is not possible to make generalised statements, due to the highly variable and context specific nature of such interventions.

The evidence relating to social protection and prevention has been weak until the last few years, which have seen the completion of a number of RCTs and robust observational studies, and the initiation of several more that are still ongoing, as summarised in Pettifor et al. (2012). This has encouraged the prevention discourse to expand beyond proximate indicators and to a greater accommodation of outcome indicators directly related to infection rates. This shift is, however, primarily limited to the Africa region and has yet to be trialled similarly in other regions. Apart from this recent set of studies summarised in Pettifor et al. (2012), the literature in this outcome area is primarily based on hypothesised rather than empirically attested causal links.

In relation to treatment impacts, the literature offers more evidence, in part due to the possibility of adopting empirically recorded treatment indicators, but few studies adopt direct morbidity indicators such as CD4 counts or anthropometric data and there is a risk of conflating ARV possession or clinic participation with actual health outcomes. Interestingly, one study reviewed illustrates the problematic nature of such assumptions, finding that increase MPRs do not correspond with biologically measured health benefits (Cantrell et al., 2008).

Overall, this review identified a relatively limited number of high-quality studies globally from which robust insights into programme performance in relation to the three outcome areas – prevention, treatment and care – could be drawn. The adoption of robust methodologies such as RCTs or quasi-experimental studies was limited, with the result that it is not readily possible to identify robust evidence on many programmes or to compare findings within and between countries.

9.2 Availability of evidence on complementary livelihoods interventions

In the broader social protection literature the role of interventions relating to livelihoods promotion and labour market performance has been identified as an important complement, in terms of promoting sustainable poverty reduction outcomes (see for example Sabates-Wheeler and Devereux, 2011). However, this review failed to identify any significant literature addressing the nexus between complementary livelihoods interventions, HIV and social protection provision, or the extent to which such complementary interventions improve the sustainability of the social protection system or improve the graduation of beneficiaries of these schemes.

9.3 What methodologies have been adopted to answer these questions?

The literature adopts a range of methodologies to address issues of social protection impact, combining quantitative analysis of survey and administrative data, literature reviews, and a range qualitative approaches (primarily semi-structured interviews and FGDs), as well as a small number of systematic reviews. Much of the literature identified adopts mixed methods. A small but growing number of large-scale quantitative studies have been carried out in recent years, primarily in relation to issues of prevention and treatment. The two systematic reviews identified and the overview analyses carried out recently in this sector highlighted the limited quality and number of robust quantitative studies as a key confounding factor in developing an evidence base and limiting the potential for robust meta-analysis and cross-programme comparisons.

9.4 What are the gaps in current knowledge and research methodologies?

Four main areas where there are significant gaps relating to current knowledge on access and impact of social protection on PLHIV and their households, and the research methodologies adopted have been identified on the basis of the literature reviewed.

The first gap is the limited number of studies explicitly examining either access or impact in relation to PLHIV internationally, and the weakness of the indicators adopted in much of the existing literature against which performance can be assessed. This relates to the still nascent evidence base in the sector and inconsistency in methodologies and indicators adopted.

The second gap is the significant regional disparity in the quality and extent of the evidence base. There is a need for programme evaluation activity to be enhanced in Asia, LAC, MENA and the CIS to provide an evidence base to inform programming in these regions, building on and sharing innovations among regions and learning from the Africa region's diverse experience in terms of evaluation practice.

The third evidence gap relates to non-financial barriers to prevention and treatment outcomes. These issues are emerging from the current literature as an issue of importance, but are as yet poorly captured using existing methodological approaches, and are addressed in only a limited number of studies.

The final gap relates to the limited integration of i) gender, ii) livelihoods and iii) ALMP issues into the social protection and HIV evaluation discourse, despite the institutional and developmental importance of these issues.

These gaps collectively represent a significant evidence shortfall in terms of what is needed to inform policymakers in the selection of appropriate programme design and to enable informed choices among alternative instruments.

10 Future options

The evidence on methodologies, indicators and current research activity outlined in this report points to a series of future options that could promote the development of a stronger evidence base to inform future policy choice and design in this sector. We therefore make the following recommendations for future action:

- Review the innovations in methodology and indicator selection identified in this report that have taken place in recent years to identify opportunities for the replicability of relevant approaches both within and between regions. Pilot the cross-regional adaptation of successful models.
- Identify and disseminate information on a core menu of effective indicators for various outcomes and effective research methodologies.
- Ensure that programmes gather data on indicators that will enable performance evaluation and promote some consistency across programmes to facilitate meta-analysis
- Carry out systematic reviews in key areas of social protection relevant to PLHIV where programme evaluations exist but no overview or synthesis is available. Options would include:
 - health insurance in relation to ARV access and treatment outcomes, possibly reviewing different modalities of provision
 - cash transfers and treatment outcomes.
- Commission research into areas of social protection where the evidence base in terms of linkages with PLHIV is weak, but there is an ongoing policy interest, e.g. PWPs.
- Ensure that theories of change identify where causal linkages are hypothesised and where they are empirically grounded, and test out the underlying assumptions empirically through evaluation where possible.

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Appendix 1: Methodology

The literature identification process adopted in this review used a combination of three approaches, i) search-term-based database and journal searches, ii) hand searching in key websites, and iii) backward and forward snowball techniques, based on key documents identified by experts in the field, using citations of these studies and their references to identify further relevant literature.

The literature identification process was based on key search terms relating to the target population and the intervention, i.e. i) PLHIV and their households and ii) social protection. An emphasis was given to searching for literature covering social health insurance and livelihoods and labour market interventions. The literature review also identified the extent to which gender issues are addressed in the literature and took into account – inasmuch as data are available – gender differentials and age effects.

The search process

The search and identification process identified the key literature on the subject of social protection and HIV and AIDS relating to the question:

What literature is available on access to social protection for people living with HIV and AIDS, and its impact, and what are the key insights from this literature?

The literature search aimed to identify all studies addressing i) access to social protection schemes, broadly defined, and/or ii) the impact of these schemes on PLHIV and their households in both the formal and informal economy.

To better understand the research question, the population was described as individuals (including women, men, boys and girls) and households infected or affected by HIV and AIDS who were in receipt of social protection. This was defined to include all forms of non-contributory CTs and grants (in all regions except sub-Saharan Africa); public works programmes; and contributory social security schemes, including health insurance, unemployment insurance, health fee waivers, school subsidies or fee waivers, and asset transfers. The literature identification was global, with a focus on MICs and LICs, and studies on CTs in sub-Saharan Africa were purposively excluded unless they also addressed the provision of other, non-CT social protection instruments. Only literature relating to CTs in Africa written subsequent to the completion of Miller and Samson’s comprehensive 2012 study was included.

A wide set of interventions were included in the initial literature identification process to ensure that the breadth of the existing literature could be appraised, and as such limiting criteria relating to formality/informality, conditionality/unconditionality and contributory/or non-contributory were not applied.

Search terms

The search terms adopted followed the convention ‘HIV’ or ‘AIDS’ or ‘PLHIV’ or ‘PLWHA’⁶ (multiple terms were used in order to promote likelihood of identifying relevant literature), plus a social protection term. The term ‘gender’ was not used at this initial data identification stage in order not to limit the search function.

The search terms used are listed in Table 4.

Table 4: Search strings adopted

Search strings
AIDS
HIV
PLHIV

⁶ Although the term PLWHA (people living with HIV or AIDS) is not consistent with UNAIDS terminology, it is widely used by agencies outside the UN system, and so was deliberately adopted in the search strategy. However, throughout this report the term PLHIV is adopted to be consistent with UN conventions.

PLWHA
Safety net
Social protection
Social transfers
Cash transfer
Asset transfer
Food aid
Public works
Workfare
Fee waiver
School support
Health service provision
Subsidies/subsidy
Health insurance
Unemployment benefit
Unemployment insurance

Multiple databases and journals were searched, as well as key institutional websites in order to ensure that relevant studies were successfully identified. Five academic databases and five key journals were explored, together with the websites of leading development agencies and development research organisations. In addition, search engines were searched by hand for relevant literature. The databases, journals and websites searched are listed out in Table 5.

Table 5: Media searched

Academic Search Elite	
Databases	EconLit,
	Ebsco
	Scopus/Elsevier
	Science Direct/Elsevier
	Web of Science/Web of Knowledge
Journals	Journal of Development Studies
	Development and Change
	World Development
	HIV/AIDS

	HIV and AIDS Review
Websites	ILO
	World Bank
	UNAIDS
	Eldis
	IATT-CABA
	UNICEF
	UNDP
	GESS
	ISSA

The greatest number of relevant studies was found in GESS (Global Extension of Social Security), World Bank, UNAIDS, IATT/CABA, UNICEF, ILO and UNDP, as well as the search engine Google. The bibliographies of studies located through the journals and websites were reviewed to identify further relevant articles as part of a literature snowballing process. Key informants working in the sector were also consulted to complete the process and the articles recommended were reviewed for relevance, with the bibliographies also being reviewed in order to identify further relevant material.

Descriptive overview of the literature identified

This search process resulted in the identification of 105 studies addressing questions relating to the impact of and access to social protection of PLHIV globally. The majority of the studies were identified using snowball techniques and hand searching in key websites. An analysis of the characteristics of this literature is presented below to provide an overview of the regional distribution of the available literature on impact and access, the content of the literature, in terms of the social protection instruments discussed, and the methodologies adopted. The full list of studies identified is set out in Appendix 2.

A large number of these papers are policy documents, conceptual papers, guidelines or summary papers that collate evidence from literature to put forward an agenda. Of the studies that present data, most were qualitative, adopting mixed methods, most notably semi-structured interviews and FGDs. Most papers used interviews with programme or agency staff and a limited number were based on beneficiary interviews. As a result, much of the available evidence is context-specific, providing case study insights, but is not necessarily generalisable either to the broader situation nationally or internationally. This is in part due to the fact that much of the qualitative data aimed at assessing provision of and access to services available in a specific area rather than looking at provision or impacts of programmes or services more widely.

Studies arising from the health sciences, including several of nutrition studies and those measuring HIV impact, tend to adopt quantitative methods, using clinic records or medical data. These include AAPN (2009); Campbell et al. (2011); Cantrell et al (2008); Kitajima et al. (2005); Thwin (2006); Tsai et al. (2011), and Baird et al. (2012) cited in Pettifor et al. (2012).

The inclusion and exclusion criteria listed below were applied to the 105 papers identified, resulting in the final inclusion of 26 papers in the study.

Box 3: Inclusion and exclusion criteria

Inclusion criteria

Relates to social protection provision in LICs and MICs

Adopts explicit qualitative or quantitative methodology with indicators of access or impact

Presents primary evidence on:

- access to social protection provision for PLHIV
- impact of social protection on prevention, treatment, and care
-

Or, offers a review of evidence on the above (including, but not limited to, systematic reviews)

Exclusion criteria

Relates to cash transfer provision in Africa (for research prior to 2012)

Provides only a narrative or descriptive overview

Outlines policy without reference to access or impact

Regional distribution

The regional distribution of the literature is shown in Figure 4 in the main body of the report. Of the 26 studies 18% (n=5) provided a global overview of social protection and HIV, 43% were concerned with sub-Saharan Africa, 28% Asia and 11% LAC. No relevant studies were identified for the CIS, Eastern Europe, Central Asia or MENA.

The fact that research is concentrated so heavily in Africa despite the deliberate exclusion of literature relating to cash transfers in Africa (as opposed to other forms of formal and informal social protection instruments) indicates the high overall research activity in this region.

The content of the 28 studies is summarised in Table 1 in the main body of the report.

In terms of content, 12 of the studies examined issues relating to access and 20 examined the impact of provision on prevention, treatment and mitigation.

Of the 12 access studies, six were carried out in Asia (out of a total of eight studies in the region), while only three of the 12 African studies examined access issues. Of the 20 studies examining impact, five examined prevention, six treatment and nine mitigation. The distribution of impact studies by region is shown in Figure 5 in the main body of the report.

Appendix 2: Studies included in the review

- AAPN (2009) *Challenges to women's access to HIV services in Asia*. Bangkok: Women's Working Group of APN+.
- Attawell, K., Chitty, J. and Purvis, G. (2005) *Assessment: CARE Tumaini program*. Dar es Salaam: USAID.
- Cantrell, R. A. et al. (2008) 'A pilot study on food supplementation to improve adherence to anti-retroviral therapy among food insecure adults in Zambia'. *Epidemiology and Social Science* 49(2): 190-95.
- Chanfreau, C., Musau S. and Kidane, L. (2005) 'Costing HIV/AIDS services for community health fund members and non-members in Hanang district, Tanzania'. *Tropical Medicine and International Health* 10(1): 11-18.
- Chean, R. M. (2007) *Community social protection and income security for households experiencing major illness including HIV/AIDS in selected communities around Phnom Penh*. Geneva and Phnom Penh: ILO.
- Egge, K. and Strasser, S. (2006) 'Measuring the impact of targeted food assistance on HIV/AIDS-related beneficiary groups: Monitoring and evaluation indicators'. In Gillespie, S., ed. *AIDS, poverty, and hunger: challenges and responses*. Washington, DC: International Food Policy Research Institute.
- Galarraga, O. and Gertler, P. (2009) 'Conditional cash and adolescent risk behaviors: Evidence from urban Mexico'. Policy Research Working Paper. December.
- Hallfors, D. et al. (2011) 'Supporting adolescent orphan girls to stay in school as HIV risk prevention: Evidence from a randomized control trial in Zimbabwe'. *Research and Practice* 101(6): 1082-88.
- IATT (Inter-Agency Task Team on Children affected by HIV and AIDS) (2008) *National responses for children affected by AIDS: Review of progress and lessons learned*. Working Group on National Plans of Action. New York: UNICEF.
- ILO (International Labour Organisation) (2012) *Social Protection Assessment-based National Dialogue (ABND) in Indonesia*. Jakarta and Geneva: ILO.
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- Kristjansson, B. et al. (2006) 'School feeding for improving the physical and psychosocial health of disadvantaged students'. *Campbell Systematic Reviews* 14.
- KULA (2010) 'Non-contributive pension of elderly age HIV/AIDS and the employment situation in Africa: A qualitative research in Mozambique'. Maputo: KULA.
- Loudon, M., Bhaskar, M., Bhutia, Y., Deshpande, A., Ganesh, V., Mohanraj, R., Prakasam, C. P., Nelson, K., Royal, S. and Saor, B. (2007) *Barriers to services for children with HIV positive parents*. New Delhi: UNICEF India in association with the Government of India Ministry of Women and Child Development and National AIDS Control Organisation.
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- Miller, E. and Samson, M. (2012) *HIV-sensitive social protection: State of the evidence 2012 in sub-Saharan Africa*. New York: UNICEF and EPRI.
- MTT (Mobile Task Team) and UNICEF (2005) *Education access and retention for educationally marginalised children: Innovations in social protection*. New York: MTT Health Economics and HIV and AIDS Research Division and UNICEF.
- Octavery, Kamil et al. (2011) *Analysis of HIV-sensitive social protection schemes in Indonesia*. Jakarta and Geneva: ILO.
- Pettifor, A. MacPhail, C., Nguyen, N. and Rosenberg, M. 2012. 'Can money prevent the spread of HIV? A review of cash payments for HIV prevention'. *AIDS and Behavior* 16(7): 1729-38.
- Roelen, K., Edström, J., Sabates-Wheeler, R. and Davies, M. (2011) *Lessons from the Children and AIDS Regional Initiative (CARI): Child- and HIV-sensitive social protection in Eastern and Southern Africa*. Brighton: Centre for Social Protection, IDS.
- Rompel, M. (2005) *Financing HIV/AIDS prevention through social health insurance: A cross-cutting issue for public health in developing countries challenges – implications – questions*. San Francisco: Health.
- Samuels, F. et al. (2012) 'HIV vulnerabilities and the potential for strengthening social protection responses in Nigeria'. London: ODI.
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- Thwin, A. (2006) *Food support to PLHA and OVC with home based care: Evaluation and baseline survey 2006 Cambodia*. Phnom Penh: KHANA/USAID/WFP.
- UNICEF (2009) 'Taking evidence to impact: Making a difference for vulnerable children living in a world with HIV and AIDS'. New York: UNICEF.
- UNICEF and EIU (Economist Intelligence Unit) (2012) *Mapping of social protection measures for children affected by HIV and AIDS in Asia and the Pacific*. New York: UNICEF.

Appendix 3: Summaries of studies examining access to and impacts of social protection

Author	AAPN (2009)
Title	<i>Challenges to women's access to HIV services in Asia</i>
Country(ies)	Cambodia, China, India, Indonesia, Thailand and Viet Nam
Access/impact examined	Access This study examines the challenges that HIV-positive women and children face in getting access to ARVs and HIV services in Asia.
Methodology	The study was designed and conducted by women living with HIV under the direction of the Women's Working Group of the APN+. This study builds on previous research conducted by APN+, which indicated that among people living with HIV, women experience discrimination. Two HIV-positive women leaders from each of six countries were trained in peer-based qualitative and quantitative research methods. In each country at least two women were responsible for data collection. A new questionnaire was administered to a total of 1,306 women living with HIV: Cambodia (268), China (334), India (236), Indonesia (180), Thailand (87), Viet Nam (201). Respondents were recruited via snowball sampling through support groups and health clinics. Questionnaires were analysed using standard statistical software. Thirty-eight FGDs were conducted with women living with HIV (Cambodia 4; China 2; India 12; Indonesia 8; Thailand 3; Viet Nam 9). Each focus group included between six and 20 participants. All information provided by participants was voluntary, anonymous and confidential.
Population, intervention and outcomes measured	<i>Population:</i> In Cambodia, India, Indonesia and Viet Nam (not China and Thailand), respondents were women and children living in drawn both from urban and rural areas, ranging in age. <i>Intervention:</i> HIV services, ARV adherence, medical care, psychological support, perceptions of discrimination in the health sector, family and community <i>Outcomes measured:</i> Access to services, stigma, discrimination
Strengths and weaknesses of the approach, gender dimensions, and general lessons from the study	<i>Strengths and weaknesses:</i> Because it is not possible to select a random sample of women living with HIV, respondents were drawn from service delivery centres (clinics, outpatient departments, peer support groups), so the study is most likely to capture the views of women who are relatively well informed of the services that are available and are able to get access to them. It can be assumed, therefore, that women living further away from service delivery centres may have much greater difficulties in gaining access to the services they need. <i>Gender dimensions:</i> The study showed that there is an urgent need to tackle income-generation issues for women living with HIV, and provide job opportunities within the health sector and projects to increase women's income-generation opportunities. One in three women in the study was dissatisfied with the quality of HIV services in their area and one in three had difficulty getting access to services. Given that this study captured women who were connected to support groups or outpatient clinics, the level of satisfaction and access to services of HIV-positive women in the general community is likely to be significantly lower than that of the women captured in this study. <i>Stigma and discrimination:</i> Half the women reported experiencing HIV-related discrimination in the public health system in the previous two years, and perceived that they faced more HIV-related discrimination and stigma than men. In China and Viet Nam, respondents said that while HIV-positive women were judged to have contracted HIV as a consequence of socially unacceptable behaviour, men were far less likely to face the same condemnation, and that many people regard women as responsible for 'spreading the virus', especially if they took a new partner. Some affected women faced isolation from family members and eviction from their homes, and were reluctant to seek health services because of fear of discrimination from their communities. <i>General lessons:</i> This methodology is generalisable in terms of exploring problems in accessing HIV services and ARVs, issues of discrimination, the expectations

	<p>of women about the quality of services, and the barrier to access represented by lack of financial resources. However, some issues such as the availability of counselling or tests to provide CD4 counts that affect access to services, or the information available regarding HIV treatment is highly context specific and need to be contextualised. One innovation of this study is that HIV-positive women were trained in research methods and designed the questionnaires themselves. Also, women were responsible for data collection. This can be useful in terms of creating a rapport with respondents and ensuring that the topics researched are of relevance to HIV-affected women.</p>
Indicators	<p>Local HIV services availability Accessibility of ARVs ARV adherence Provision of specific services: counselling, legal services, treatment for STIs, CD4 testing, viral load testing, provision of paediatric ARVs</p>
Prevention/treatment or care	Treatment
Strengths and weaknesses of the indicators	<p>The indicators of this study are focused more on HIV service availability, including access to ARVs and ARV adherence, rather than outcomes. Therefore there is a focus on evidence relating to proximate rather than ultimate outcomes.</p>
Findings	<p>This study finds that the major determinants of women's access to HIV services and treatment are i) the physical location of their homes, ii) the income available for health expenditure, and iii) the information to which they have access. While on average 63% of women were satisfied with the HIV services available in their area, there were significant differences in satisfaction depending on where women lived: 82% of those living in capital cities were satisfied, 67% in other cities, 74% in towns and 58% in villages.</p> <p>Satisfaction was also correlated with age and allowing for the difference in location. In rural villages women over 40 years of age were markedly less satisfied with available HIV services than younger women (59% compared to 68%).</p> <p>Just over half of women (54%) reported that ARV access in their area was easy, compared to 34% who said access was difficult or very difficult (13% did not know). Women living in capital cities were significantly more likely to have easy access to ARVs than women in rural areas (62% vs. 51%). Many HIV services for women and children living with HIV are available only in large urban centres.</p> <p>Most women (79%) said they did not have adequate financial resources to access HIV services, including transport, and 60% reported that they did not have sufficient income to meet their health needs (ranging from 41% in Indonesia to 75% in China), while 29% said their income was barely adequate and only 12% reported sufficient income to maintain their health (ranging from 5% in China to 24% in Indonesia). The majority of women had received counselling or training on how to take ARVs (71%), but 18% of 1,222 respondents said they did not know why they had to take ARVs every day and at regular intervals (ranging from 6% in Cambodia to 32% in China). In 50% of cases services were free, while 46% of women reported having to pay for some or all of the services they received. Lack of money was the major reason cited for not being able to get access to the services they needed (29%), with other reasons being fear of discrimination (16%), not knowing where to go (12%), and lack of services availability (10%).</p> <p>The availability of CD4 count analysis services was found to vary greatly across countries. Even where it is a free service, as in India, government hospital staff sometimes attempted to elicit charges or requested clients to attend private clinics.</p>

Author	Attawell et al. (2005)
Title	<i>Assessment: CARE Tumaini program</i>
Country(ies)	Tanzania
Access/impact examined	Impact

	The impact of programme implementation on palliative care provision (part of a broader programme assessment, including recommendations for future programming)
Methodology	<p>This study was a programme evaluation that focused on a range of issues (leadership, structure, mechanisms, practices and staffing of the USG/Tanzania management), in addition to the impact of the provision of food aid and care support. It was carried out in 2005 by a team of two consultants and an advisor from the Office of the US Global AIDS Coordinator.</p> <p>The methodology entailed a review of background and programme documents; briefing sessions with USAID and CARE Tanzania; interviews with CARE, Counsenuth, FHI, HI, HST and MUCHS staff; meetings in Dar es Salaam with representatives from the Tanzania Commission for AIDS, Ministry of Health National AIDS Control Programme and Department of Social Welfare and other HBC stakeholders, including CDC, AMREF and Pathfinder; visits to three of the five regions covered by Tumaini programme (Arusha, Iringa and Mwanza) for meetings with Tumaini regional coordinators, regional and district government officials; group discussions with grantees, volunteers and supervisors, People Living with HIV/AIDS (PHA) clients and OVC; site and home visits to observe grantee activities; and meetings with the regional coordinator and grantees from the Coast Region.</p>
Population, intervention and outcomes measured	<p><i>Population:</i> Adults, adolescents and children living with HIV and AIDS and their families</p> <p><i>Intervention:</i> Delivery of food aid and HBC</p> <p><i>Outcomes measured:</i> Quality care and treatment services; reduced stigma and discrimination; the provision of counselling, psychosocial support and palliative care services; comprehensive management of opportunistic infections; nutrition; and integrated HIV and AIDS/TB care</p>
Strengths and weaknesses of the approach, gender dimensions, and general lessons from the study	<p>Most of the evaluation focused on organisational and strategic issues relating to the Tumaini Alliance.</p> <p>The study also includes an assessment of the services provided in terms of their appropriateness in relation to access, availability, quality and accountability. However, it lacks clear indicators to measure the quality of provision and is more a technical review than an assessment of services provided to the HIV-affected population.</p> <p>No gender dimensions were discussed.</p>
Indicators	<p>Delivery of food aid</p> <p>Provision of health, educational and socioeconomic support (process indicators)</p>
Prevention/treatment or care	Care
Strengths and weaknesses of the indicators	The study identifies the need to develop and monitor indicators for key programme outcomes. The findings are process oriented and not readily generalisable.
Findings	<p>The report documents the provision of HBC and food support to 7,127 PHA clients over the year evaluated together with the provision of food-related IGA support; and the provision of one or more of the following services for over 10,000 OCV: school fees, school supplies, school uniforms, counselling, nutritional support, medical care, treated bed nets, legal assistance and food-based IGAs.</p> <p>The study points out that while HBC is considered an essential element of comprehensive care in Tanzania and is higher on the agenda than before, many stakeholders see its primary purpose as promoting ART adherence at the community level and the concept of a multisectoral approach to HBC is relatively new in Tanzania. The study finds that the government's recent focus on ART adherence risks minimising the scope and importance of other HBC activities and creates pressure on HBC volunteers and supervisors to support an area in which they receive limited training and support.</p>

Author	Cantrell et al. (2008)
Title	'A pilot study on food supplementation to improve adherence to anti-retroviral therapy among food insecure adults in Zambia'
Country(ies)	Zambia
Access/impact examined	Impact The impact of food supplementation on adherence to ART among food-insecure adults in Lusaka, Zambia
Methodology	<p>This study reviewed a home-based adherence support programme implemented in eight government clinics and assessed impact on food insecurity.</p> <p>Between 1 May 2004 and 31 March 2005 eight participating clinics enrolled 1,335 adults into the home-based adherence support programme, of whom 636 (48%) met criteria for household food insecurity. These included 50% patients at the four participating food clinics and 43% of patients at the four control clinics. Four clinics provided food supplementation and four acted as controls. The analysis compared adherence (measured in terms of MPR), CD4 count and weight-gain outcomes among food-insecure patients enrolled at the food clinics with those enrolled at the control clinics.</p> <p>Food-insecure patients received monthly rations provided by WFP. The initial commitment was for six months of food supplementation, with the option to receive a further six months if the household still met the criteria on reassessment. This approach offered an opportunity for the authors to take advantage of a staggered rollout of the pilot food supplementation programme to make outcome comparisons, with the patients in the clinics assigned to begin ration distribution in September 2004 as the 'food' group and patients in the four clinics assigned to begin ration distribution at a later time as the control.</p> <p>Adherence to ART was measured during the first 12 months of therapy by timeliness of pharmacy visits using a variation of the MPR. The number of days' delay in claiming pharmacy refills was divided by total days on therapy in the first year and this percentage subtracted from 100% to calculate the MPR. A person was not counted as late until after three days to account for extra pills received. The MPR estimates the amount of time that a patient had medication on hand during the first 12 months of therapy.</p>
Population, intervention and outcomes measured	<p><i>Population:</i> 636 food-insecure adult HIV patients on ART who were enrolled in a voluntary home-based adherence support programme (over the age of 15), of whom 65% were female</p> <p><i>Intervention:</i> Food aid</p> <p><i>Outcomes:</i> Impact of food security on adherence to medications</p>
Strengths and weaknesses of the approach, gender dimensions, and general lessons from the study	<p><i>Strengths and weaknesses:</i> This study is situation-specific, but the findings illustrated general outcomes of the relationship between food aid and adherence to medication. It is potentially replicable in settings where HIV-affected people are food insecure and where, if not addressed, this could pose a serious threat to the long-term success of ART programming outcomes.</p> <p>The main limitations of the study are the small patient numbers and limited follow-up time to observe the full effect of the food intervention, particularly in terms of adherence to therapy, given there is known to be a considerable delay between poor adherence and the failure of ARV regimens. This is especially relevant in terms of the observed clinical effects. Another unmeasured and potentially confounding limitation is the lack of information on patient access to and consumption of sources of food other than the food aid. The authors suggest that a definitive study would need to be much larger, have longer patient follow-up and include virologic suppression as the major outcome to be assessed.</p>
Indicators	MPR CD4 count Weight gain Food supplementation

Prevention/treatment or care	Treatment
Strengths and weaknesses of the indicators	Both adherence and outcome indicators were measured.
Findings	<p>Although this study does not definitely demonstrate a direct clinical benefit of food supplementation on ART outcomes, it found that food supplementation was associated with better adherence to therapy.</p> <p>At 12 months post-ART initiation, 84% of patients remained alive and in the programme. The distribution of alive, dead, and withdrawn or lost at 12 months was not significantly different across groups. In the food group 83% were alive, 6% were dead, and 11% had withdrawn or were lost compared with 85%, 8%, and 7%, respectively, in the control group (P=0.23). A statistically significant effect of food supplementation on the clinical outcomes of weight and CD4 cell response was not found. However, it was found that the modest benefit of provision was marginally stronger among men.</p> <p>The results suggest that providing food to food-insecure patients initiating ART may improve adherence to medication regimens and that food supplementation with commodities that are cheap and easily available locally is feasible as part of a comprehensive adherence support programme and can be evaluated in a rigorous way.</p>

Author	Chanfreau et al. (2005)
Title	'Costing HIV/AIDS services for community health fund members and non-members in Hanang district, Tanzania'
Country(ies)	Tanzania
Access/impact examined	Impact Impact of CHF on cost, frequency and type of outpatient services utilised
Methodology	<p>This study explored the use of outpatient, inpatient and VCT services by PLWHA who are CHF members compared to PLWHA who are non-CHF members, the difference in costs of care, and differences in the services provided between the two groups.</p> <p>This study was a multi-facility retrospective analytical analysis of HIV and AIDS service utilisation for the year 2002. Medical utilisation data were identified through a review of facility records, and 1,666 medical charts relating to 464 PLWHA were analysed. Complementary data also used consisted of the direct costs of providing HIV and AIDS services within the CHF package of benefits, such as personnel time and materials (drugs, laboratory and imaging tests, and other supplies). Data were not available for capital costs. Data collectors were trained prior to fieldwork, so as to ensure their conceptual understanding of the project and their familiarity with the data collection instruments. The study found that there was not significant over-utilisation due to scheme membership (moral hazard).</p> <p>The reliability and validity of data collected were ensured through a series of checks, notably i) pre-testing of questionnaires before the training, redesign, and testing after the training to reflect data collectors' feedback, ii) questionnaire design to maximise the use of the Ministry of Health routine HMIS reports, iii) HIV and AIDS data collectors' knowledge of the HIV and AIDS condition was refreshed prior to data collection, and iv) quality control during fieldwork done to ensure that questionnaires were thoroughly checked and edited.</p>
Population, intervention and outcomes measured	<p><i>Population:</i> PLWHA aged 18 and older in the Hanang district who attended the 14 facilities selected as study sites during year 2002</p> <p><i>Intervention:</i> CHF</p>

	<p><i>Outcomes measured:</i> Service utilisation by PLWHA who are CHF members and non-members, estimated annual care cost by level of care and care setting, differences in patterns of HIV and AIDS service utilisation by CHF members and non-members</p>
<p>Strengths and weaknesses of the approach, gender dimensions, and general lessons from the study</p>	<p>Those included in the sample are in the latest stage of the disease (mostly the AIDS stage) and the majority have been clinically diagnosed by their physicians. The sample is not representative of the total population of the Hanang district living with HIV, because it does not reflect the mix of patients living at the various stages of disease progression. A broader sample of PLWHA, with people diagnosed HIV-positive at an earlier stage of infection, would give a more representative picture of the cost and use of HIV and AIDS services in the district.</p> <p>While the findings of this study show that by creating a culture of seeking care regularly, CHF membership appears to lower hospitalisation frequency, duration, and costs due to HIV and AIDS conditions, additional research is needed to confirm that the findings of this study will be made for PLWHA tested HIV-positive and in an earlier stage of disease progression.</p> <p>One strength of the approach is that the selection of data collectors from among health workers ensured that they had the necessary skills both to review patient data and to understand confidentiality issues. However, selecting health workers as data collectors may induce reporting bias because of the intimate knowledge they had regarding specific PLWHA.</p>
<p>Indicators</p>	<p>Number and periodicity of outpatient visits Frequency of hospitalisation episodes Duration of hospital stay Cost of treatment</p>
<p>Prevention/treatment or care</p>	<p>Treatment</p>
<p>Strengths and weaknesses of the indicators</p>	<p>Comprehensive data on patient clinical events; use of outpatient, inpatient and laboratory services; and use of medical supplies were captured from patient charts and facility records. Data on costs of outpatient, inpatient, and laboratory services and medications were gathered from each facility and where necessary from the district accountant as well. Only recurrent (routine operating) costs were available and so data on capital costs (equipment, vehicles and buildings) were not collected. The study looked retrospectively at patient records, increasing the risk of bias in the way information was abstracted from medical records.</p> <p>The records reviewed were generated for clinical purposes, and accurate information retrieval was dependent on the extent to which health practitioners kept relevant information in medical records.</p>
<p>Findings</p>	<p>Use of outpatient services is on average 2.5 visits per year for CHF members, compared to 2.1 visits for non-members. This difference shows that the use of outpatient services does not vary greatly with membership status. However, CHF members use outpatient services more regularly than non-members. By doing so, CHF members seem to lower the frequency of their inpatient care. Not only are members less frequently hospitalised, but they require shorter inpatient stays. CHF members have an average length of stay at health centres where member inpatient admissions are usually 8.9 days, compared to non-members' average stay of 10.5 days.</p> <p>VCT services were underused in the district. There was no difference in the ranking of the health conditions affecting PLWHA between members and non-members. No data were consistently available with regards to the seriousness of conditions at the time of the consultation.</p> <p>By creating a culture of seeking care regularly, CHF membership appears to lower hospitalisation frequency, duration and costs due to HIV and AIDS conditions. The earlier that patient follow-up begins, the broader the range of alternative interventions available to manage HIV and AIDS conditions and the less the likelihood of hospitalisation.</p>

Author	Chean (2007)
Title	<i>Community social protection and income security for households experiencing major illness including HIV/AIDS in selected communities around Phnom Penh</i>
Country(ies)	Cambodia
Access/impact examined	Access The impact of catastrophic health expenditures on household savings and livelihoods and the role of CBHI in promoting access to HIV-related services and protecting livelihoods.
Methodology	<p>The study aims to promote understanding of the role of the extension of social protection (SHI) on health for poor households living in poor communities on the outskirts of Phnom Penh city, Cambodia. It also examines the socioeconomic impacts of major illness on households in general and on households that are HIV-vulnerable or HIV-positive in particular.</p> <p>Both quantitative and qualitative research methods were used to collect data at the household level. The quantitative component consisted of a survey of households in low-income communities. The qualitative component utilised in-depth interviews of key decision-makers within households who were identified through the household survey as having high levels of needs for social protection related to health-care costs. For the quantitative survey component a randomised household sample was selected. A total of 389 households were interviewed. For the qualitative study participants were selected after completion of the household survey. Since the purpose of the in-depth study was to obtain detailed information on issues of migration, knowledge of and access to HIV and AIDS services, and the socioeconomic impact on households with major illnesses, 30 households were selected based on household characteristics relating to migrant status, the presence of PLWHA, and experience of serious illness. Community feedback meetings were organised at the end of the exercise to obtain households' feedback on the findings and explore issues emerging from the study.</p>
Population, intervention and outcomes measured	<p><i>Population:</i> 389 households affected by major illness including HIV and AIDS were included in the quantitative survey and 30 in the qualitative study, comprising ten migrant households, ten households where there were people living with HIV and ten households with family member/s who had suffered a serious illness over the past year.</p> <p><i>Intervention:</i> Social health insurance as a means of social protection</p> <p><i>Outcomes measured:</i> Households poverty, illness over past month, health-care expenditure, socioeconomic impacts of serious illness</p>
Strengths and weaknesses of the approach, gender dimensions, and general lessons from the study	
Indicators	Access to and use of services Access to CBHI Access to social and financial support
Prevention/treatment or care	Treatment
Strengths and weaknesses of the indicators	
Findings	This small-scale study gives insights into the problems that faced by households without any form of social protection to protect them from catastrophic health expenditures. Households suffering from major illnesses were found to spend a high proportion of their savings or borrow money to finance health care. Although

	<p>CBHI is being implemented, few people are aware of the scheme, owing to lack of information and cultural barriers related to people trusting the scheme and health-care providers.</p> <p>Thirty per cent of households reporting serious illness over the past year received inpatient care. The major reason for not seeking inpatient treatment for serious illness was cost. Households with a family member suffering from major illness spent significant resources on treatment at private clinics and on purchasing medicine at pharmacies. Households with family members suffering from serious illness also lost significant working time, which had an adverse impact on household income generation.</p> <p>In the household survey only six out of 389 households held CBHI. Of these, two paid their own membership and four were paid for by the local authorities, as they were considered poor households. When asked in a community feedback meeting why so few households held CBHI, most participants stated that they did not know about it and that there was no clear information or explanation available regarding how to become a member.</p> <p>Households pay substantially more for health care out of pocket than they would for CBHI membership; if households paid for CBHI membership on a monthly basis over a year they would pay less much for medical treatment and would avoid indebtedness, especially poor households. Information gathered from the community feedback meeting indicated that people wanted CBHI membership and were willing to pay for it, but that the main barriers to access were lack of information on where to get membership, unclear knowledge on the benefits of being a member and lack of a clear mechanism for reimbursement.</p> <p>All HIV-/AIDS-positive households living in the community have access to free treatment and some limited social support – from a range of institutions, rather than in the form of an integrated programme. However, there is little access to social protection provision or support for livelihood activities to compensate for health-care costs or loss of income. Despite the free treatment and the social care and assistance they receive, many HIV-/AIDS-positive households are in debt because of health-care costs, and as a result they are in need of financial support, which they seek from informal sources such as relatives.</p>
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Author	 Egge and Strasser (2006)
Title	'Measuring the impact of targeted food assistance on HIV/AIDS-related beneficiary groups: Monitoring and evaluation indicators'
Country(ies)	Malawi, Zimbabwe and Zambia
Access/impact examined	Impact Impact of TFA on HIV and AIDS beneficiary groups
Methodology	<p>The aim of this research was to investigate current practices for measuring the impact of TFA on four HIV and AIDS-related beneficiary groups.</p> <p>The study included a literature review on nutritional status and the impact of TFA in the context of HIV and AIDS. Because the literature is limited, a wider review was done, including disease progression, nutrition, treatment impact and psychosocial issues. Because of the lack of available papers in peer-reviewed journals, 'grey' literature was also reviewed. Information was also gathered through key informant interviews, group discussions, observational visits, and analysis of M&E data in each country. For each intervention type analysis focused on objectives, strengths and weaknesses of current practices, gaps, and recommendations for integrating impact measurements into future activities.</p>
Population, intervention and outcomes measured	<p><i>Population:</i> Four HIV and AIDS-related beneficiary groups in each country; i) the chronically ill; ii) women and infants engaged in PMTCT programmes; iii) individuals on ART; and iv) individuals on TB treatment</p> <p><i>Intervention:</i> Food assistance</p> <p><i>Outcomes measured:</i> Impact measurement</p>

<p>Strengths and weaknesses of the approach, gender dimensions, and general lessons from the study</p>	<p>This work highlights the paucity of studies addressing the impact of TFA on PLWHA and serious lack of documentation on measuring the impact of food aid on PLWHA. Practical tools to assess the impact of TFA on households and nutritional outcomes for PLWHA are not widely available.</p> <p>This review was innovative in proposing a framework of potential indicators for use in measuring the impact of TFA programmes on individuals and households living with HIV and AIDS.</p> <p>Proving causal attribution of an impact to food aid is difficult because of HIV disease complexity and numerous factors influencing beneficiaries' experiences. Indeed, indicators such as morbidity, mortality, length of hospital stay, and community ability to care are influenced by many factors, and only an extensive and rigorous evaluation design could establish whether an impact was related to food aid versus rainfall, government policy, quality of local medical facilities and similar issues.</p>
<p>Indicators</p>	<p><i>Proposed future indicators include:</i></p> <ul style="list-style-type: none"> Anthropometric measurements Strength and stamina Diarrhoea prevalence Treatment uptake and efficacy Treatment completion (DOTS) Treatment adherence Quality of life Level of household food insecurity
<p>Prevention/treatment or care</p>	<p>Treatment</p>
<p>Strengths and weaknesses of the indicators</p>	<p>Because many indicators are difficult to collect and interpret, the study proposes a list of potential indicators. It points out that a decision as to which of the indicators to use will depend on perceived feasibility by implementing agencies.</p>
<p>Findings</p>	<p>Indicators to measure the direct impact of TFA on PLWHA are not widely used in the studies. Although C-SAFE partners have a great deal of experience monitoring targeted households' receipt of food aid and food security status, most do not have systems to measure the impact of food aid on PLWHA. Although anthropometric, clinical and performance measures are collected at the clinic level, they do not inform food programming and often only qualitative or anecdotal data are gathered.</p> <p>Despite the lack of empirical evidence, the report presents testimonials from HIV-positive beneficiaries and programme staff giving examples of TFA impacts on the chronically ill and the generally agreed importance of food aid as a key component of comprehensive HIV and AIDS services. Although no quantitative data exist to demonstrate the impact of food aid on PLWHA in C-SAFE programmes, almost all beneficiaries and stakeholders gave anecdotal evidence of positive impacts of food aid. After receiving food beneficiaries experienced improved body weight, strength, ability to work and overall well-being.</p> <p>In general terms there is no significant evidence of TFA impacts being measured among PLWHA.</p>

<p>Author</p>	<p>Galarraga and Gertler (2009)</p>
<p>Title</p>	<p>'Conditional cash and adolescent risk behaviors: Evidence from urban Mexico'</p>
<p>Country(ies)</p>	<p>Mexico</p>
<p>Access/impact examined</p>	<p>Impact Impact of CCTs on sexual behaviour of youth</p>

Methodology	<p>This paper explores whether CCTs can alter life the course decisions of adolescents at risk of suffering from excess morbidity and mortality due to the consumption of tobacco and alcohol products, and engaging in unsafe sex. The paper tests a model with data from the Oportunidades programme in Mexico. The study uses data from two main sources: the Oportunidades urban evaluation questionnaires: <i>Encuesta de Evaluación de los Hogares Urbanos</i> (ENCELURB, 2004) (SEDESOL, 2007); and the expanded adolescent risk-behaviour module implemented in 2004 (INSP, 2004). Risk-behaviour data were collected from 3,743 young people aged between 12 and 24 (52% females and 48% males) in urban areas.</p> <p>Data were collected from both beneficiaries and non-beneficiaries of the programme as part of a national evaluation of the anti-poverty campaign. The expanded risk-behaviour module was implemented using audio computer-assisted self-interviews to reduce response and social desirability biases, and also to ensure confidentiality, improved response rates and the veracity of the information. The authors utilised data from all households in the sample, regardless of whether or not they had participated in Oportunidades, and identified households in receipt of the transfer using administrative data sources. To ensure comparability in terms of socioeconomic status between treated and control individuals and households, the authors restricted the analytical sample to households in the lowest wealth deciles.</p>
Population, intervention and outcomes measured	<p><i>Population:</i> 3,743 young people aged between 12 and 24 (52% females and 48% males) in urban areas of Mexico</p> <p><i>Intervention:</i> CCTs (Oportunidades)</p> <p><i>Outcomes measured:</i> Adolescent risk behaviour and future expectations</p>
Strengths and weaknesses of the approach, gender dimensions, and general lessons from the study	<p>The study highlighted a significant challenge for the estimation of an impact of the urban Oportunidades programme on adolescent risk behaviour in participating households and thus adolescents therein who had self-selected into the programme. It may be that particular household characteristics that make a family more likely to enrol in the programme may also affect youth risk behaviour and expectations for the future. The authors attempt to address this by using instrumental variables (potential cumulative transfers and the proportion of households at the block level where someone knew about the programme) to predict treatment choice (programme participation and cumulative transfers) independently of outcomes.</p> <p>For female adolescents, participation in the Oportunidades programme reduces consumption of tobacco and alcohol, and increases the expectation of finishing high school.</p>
Indicators	<p>Current levels of smoking Alcohol consumption Age of sexual initiation Condom use during first and most recent act of sexual intercourse Graduation from high-school</p>
Prevention/treatment or care	<p>Prevention</p>
Strengths and weaknesses of the indicators	<p>The indicators used by the study were not intended to evaluate the impact of CT receipt on HIV prevention in Oportunidades households.</p> <p>The use of condoms or delayed sexual initiation could potentially be used as proximate indicators of how CCTs are affecting decisions among young beneficiaries and thereby reducing the likelihood of HIV infection. However, the study finds that the decision to become sexually active and whether or not to use a condom during the first and most recent act of sexual intercourse was not correlated with CCT receipt, and other influences seem to be stronger.</p>
Findings	<p>Overall, the paper shows that the Oportunidades programme in Mexico reduces drinking and smoking, but it finds no effect on sexual initiation or condom use among either males or females.</p> <p>The authors finds that in terms of risk behaviour and expectations, adolescents males in participating households were less likely to smoke, less likely to drink, and more likely to use a condom during their last act of sexual intercourse, as well as more likely to expect to graduate from high school. Beneficiary households were</p>

	<p>more likely to be female-headed, had younger heads of household with less years of formal education, were more likely to speak an indigenous language and were more likely to be financially poorer. Female adolescents living in beneficiary households were less likely to drink than the non-beneficiary counterparts. Over half of respondents initiated sex after joining the programme, but of these only 25% of female respondents used a condom during the first act of sexual intercourse and 17% during the last act of sexual intercourse.</p> <p>This paper contributes to the growing evidence that CCT programmes can improve various child, adolescent, and young adult health and education outcomes, but do not provide evidence on HIV-risk reduction.</p>
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Author	Hallfors et al. (2011)
Title	'Supporting adolescent orphan girls to stay in school as HIV risk prevention: Evidence from a randomized controlled trial in Zimbabwe'
Country(ies)	Zimbabwe
Access/impact examined	Impact Impact of payment of school fees and uniform provision on reducing school dropout of adolescents girls
Methodology	A randomised controlled trial was used to test whether comprehensive support to keep orphan adolescent girls in school could reduce HIV risk. Five rural geographical clusters were identified in the Zimbabwe province of Manicaland. Each cluster included two high schools (one Methodist and one government) and their main feeder primary schools, as part of an overall study design to test the impact of support to stay in school and type of high school on HIV risk factors. Each high school's feeder primary schools were then randomised to intervention or control status. All girls with one or both parents deceased (described as 'orphans') in grade 6 were identified by school staff and invited to participate. A total of 26 primary schools and 335 orphan girls were identified and agreed to participate in the baseline survey conducted in September 2007. All primary schools received a universal daily feeding programme, and intervention participants received fees, uniforms, school supplies, and a school-based helper to monitor attendance and resolve problems. The study conducted annual surveys and collected additional information on school dropout, marriage and pregnancy rates. The data were analysed using generalised estimating equations over three time points, controlling for school and age at baseline.
Population, intervention and outcomes measured	<p><i>Population:</i> All orphan girls in grade 6 in 25 primary schools in Manicaland, Zimbabwe</p> <p><i>Intervention:</i> School support through daily feeding programme, fees, uniforms, exercise books, other school supplies and a school-based helper</p> <p><i>Outcomes measured:</i> School dropout</p>
Strengths and weaknesses of the approach, gender dimensions, and general lessons from the study	<p>This is a significant study in spite of the small sample size and the young age of participants, as there is only one similar peer-reviewed published report in Malawi. However, while this is a novel study based on primary data collection with the survey administered annually in the classroom setting, findings can only be generalised to rural orphan girls in eastern Zimbabwe.</p> <p>An important limitation is the variability of the intervention, particularly when intervention group students went to secondary school. All intervention group students at the studied high schools received underpants, soap, pens and exercise books, and some received formal or informal boarding. Such add-ons were not anticipated at the start of the project.</p>
Indicators	<p>School dropout</p> <p>Sexual activity</p> <p>Marriage</p> <p>Pregnancy rates</p>

Prevention/treatment or care	Prevention
Strengths and weaknesses of the indicators	<p>The limitations of the present study include the use of self-reported data. A key outcome (self-reported sexual intercourse) was found to be unreliable among girls who reported ever having had sexual intercourse at any one of the survey time points. Marriage and pregnancy were more reliable measures for sexual intercourse, but probably underestimated sexual risk for both groups.</p> <p>The indicators are proximate, being associated with, but not directly indicating HIV risk prevention.</p>
Findings	<p>After two years of exposure to an intervention supporting them to stay in school, orphan girls had increased chances of remaining in school and reduced HIV risk through early marriage. By the end of the first year of high school the intervention reduced school dropout rates by 82% and marriage rates by 63%. Effects were especially striking as students matriculated into high school after grade 7. Without support, it is difficult for orphan girls to continue into secondary school in rural Zimbabwe. Compared with control participants, the intervention group reported greater school bonding, better future expectations, more equitable gender attitudes and more concerns about the consequences of sex. Finally, intervention participants were more likely than control participants to report over time that the consequences of sex were an important factor in their desire not to have sexual intercourse.</p>

Author	ILO (2012)
Title	<i>Social Protection Assessment-based National Dialogue (ABND) in Indonesia</i>
Country(ies)	Indonesia
Access/impact examined	<p>Access</p> <p>The extent to which inclusion of health care for PLHIV is included under existing social protection provision</p> <p>The cost of basic provision for PLHIV</p>
Methodology	<p>The Assessment-based National Dialogue (ABND) exercise aimed to assess overall social security provision using the SPF framework. Existing social security schemes and social protection programmes are described, and policy gaps and implementation issues are identified. The assessment is then completed by a rapid costing exercise to estimate the cost of introducing any additional social protection provisions required.</p> <p>The methodologies and approaches used to carry out the assessment include: literature review of studies, reports, laws and regulations, statistical reports technical consultations (face-to-face and through workshops) on existing schemes and their implementation status a costing exercise.</p>
Population, intervention and outcomes measured	<p><i>Population:</i> Groups targeted for social security and social protection provision (including PLHIV)</p> <p><i>Interventions:</i> Provision of basic health care for PLHIV</p> <p><i>Outcomes measured:</i> Cost of provision of services for PLHIV extrapolated from generalised all-beneficiary data</p>
Strengths and weaknesses of the approach, gender dimensions, and general lessons from the study	<p>This is an assessment of the social security schemes and social protection programmes in Indonesia using the SPF. The assessment targets all the beneficiary population and then extrapolates the impact on PLHIV who are part of these programmes. There are very few issues regarding specific questions of access or impact relating to HIV, although some important issues relating to exclusion from health-care provision for PLHIV emerge.</p> <p>Gender dimensions relating to HIV and AIDS are not explored.</p>

Indicators	Costs of ARV provision, mother-to-child transmission (MTCT) treatment and health care for PLHIV Inclusion of PLHIV in health-care provision
Prevention/treatment or care	Treatment
Strengths and weaknesses of the indicators	
Findings	<p>ART for HIV and chemotherapy are among the services explicitly excluded from provision in some provinces. Certain diseases, including HIV, are currently excluded under most existing SPF schemes. Although <i>Jamsostek</i> recently changed its policy to include HIV, private insurance providers have not made similar changes.</p> <p>The results regarding costs show that closing the SPF gap for health care (all basic services, including those relating to HIV) is estimated to cost between 0.05% of gross domestic product in the 'low-cost' scenario and 0.62% in the 'high-cost' scenario by 2020. The lower bank includes the extension of <i>Jamkesmas</i> to the uncovered poor, the inclusion of HIV testing for the most-at-risk populations, regular checkups for all PLHIV and ARV treatment for those eligible, as well as the introduction of a universal package to reduce MTCT for both HIV and syphilis. The high-cost scenario includes the provision of higher benefit levels to all informal economy recipients, the inclusion of HIV testing for the sexually active population (aged 15-49), regular checkups for all PLHIV and ARV treatment for those eligible, and the universal MTCT package. The dialogue also highlighted the need to improve maternal and child health by providing tests and treatments for a range of serious diseases that can be transmitted from mother to child to all pregnant women.</p>

Author	IATT (2008)
Title	<i>National responses for children affected by AIDS: Review of progress and lessons learned</i>
Country(ies)	Global
Access/impact examined	Access and impact Impact of National Plans of Action (NPAs) and other national responses on access to social protection by children affected by AIDS and other vulnerable children
Methodology	This study is based on a literature review, key informant interviews and expert consultation.
Population, intervention and outcomes measured	<p><i>Population:</i> Children affected by AIDS and other vulnerable children</p> <p><i>Interventions:</i> NPAs and other national-level responses to children affected by AIDS</p> <p><i>Outcomes:</i> National responses for children affected by AIDS and other vulnerable children</p>
Strengths and weaknesses of the approach, gender dimensions, and general lessons from the study	Although an attempt was made to represent different regions and epidemiological contexts, the selection of key informants and consultation was largely opportunistic. Based on the availability of literature and key informants, Zimbabwe, India and Jamaica were examined in detail. Although not representative of other countries, these examples provide useful insights into challenges and problem solving in the development and implementation of national responses for children affected by HIV and AIDS and other vulnerable children in differing contexts.
Indicators	HIV prevalence

	ART provision Health expenditure Government commitment and political will
Prevention/treatment or care	Care
Strengths and weaknesses of the indicators	There is more evidence available on the situation of children affected by HIV and AIDS and the content of NPAs than on programme coverage, the effectiveness of various interventions or the process of developing national responses. The limitations of this review include the absence of primary data and standardised tools for assessing national responses. There is potential for bias in the opportunistic selection of key informants and the absence of data on coverage and quality of national responses.
Findings	Orphanhood alone is not a consistent predictor of vulnerability. Other child and household criteria, such as poverty and food insecurity, are more robust in identifying vulnerability. These findings highlight the need for targeting definitions that incorporate specific vulnerability criteria rather than relying solely on sociodemographic categories such as 'orphan' status. Many of the national responses for children affected by AIDS are newly endorsed or still under development. None has yet been fully implemented with documented evidence in terms of resource mobilisation and allocation, programme coverage, quality of services and support, intervention effectiveness or children's outcomes.

Author	Kitajima et al. (2005)
Title	'Access to antiretroviral therapy among HIV/AIDS patients in Khon Kaen province, Thailand'
Country(ies)	Thailand
Access/impact examined	Impact Impact of type of health insurance on ARV use
Methodology	<p>This study examined the factors associated with use of ARVs among HIV and AIDS patients in two large public hospitals in Khon Kaen province, Thailand. Data were collected from one public tertiary hospital and one specialised hospital for infectious diseases for each outpatient visit on age, sex, health insurance, laboratory tests, diagnosis and prescription.</p> <p>For inpatient cases the length of stay and reasons for discharge were collected in addition to the above data. Nurses in each department collected the data from medical charts and prescription forms, and entered the data into questionnaires. A single variable statistical analysis was carried out to examine the relationship between the use of ARVs and the characteristics of the patients, and then a logistic regression analysis was conducted with the variables that were significant in order to identify the factors associated with use of ARVs.</p>
Population, intervention and outcomes measured	<p><i>Population:</i> HIV and AIDS patients aged 20 years old and above, using in- and outpatient services in two hospitals in Khon Kaen province, Thailand</p> <p><i>Intervention:</i> Health insurance status</p> <p><i>Outcomes measured:</i> Use of ARVs</p>
Strengths and weaknesses of the approach, gender	This study had several important limitations.

dimensions, and general lessons from the study	<p>Firstly, data were collected from the referral hospitals in the province, thus the patients in the study might be different from those who were treated at community hospitals and private health facilities in terms of the severity of the disease.</p> <p>Secondly, insufficient information was available to enable the identification of individuals from the data collected, and so it is possible that the same person was counted more than once when the relationships between the use of ARVs and the characteristics of the patients was analysed. Hence the results of the statistical analysis must be interpreted with caution.</p> <p>Thirdly, the study could not accommodate variables such as a history of drug injection, education level or socioeconomic status, which are often associated with the use of ARVs and may have confounded the findings.</p>
Indicators	<p>Outpatients visits ARV receipt</p>
Prevention/treatment or care	Treatment
Strengths and weaknesses of the indicators	
Findings	<p>The study indicated that there were inequalities in access to and use of ARVs among HIV and AIDS patients by health insurance status. The type of health insurance scheme that the patient was covered by affected the likelihood of use of ARVs after adjusting for age and HIV stage.</p> <p>This study is limited to the context of Thailand and the various health insurances that are in place. However, the study shows that in countries where financial barriers for ARVs are low and providers are ready to provide the therapy to patients, these services are still not equally used by the population. Hence it is important to identify the demand-side barriers, such as geographical access and stigma for the utilisation of the therapy, and to remove them.</p>

Author	Kristjansson et al. (2006)
Title	'School feeding for improving the physical and psychosocial health of disadvantaged students'
Country(ies)	Global
Access/impact examined	<p>Impact Impact of school feeding on improving the health of socioeconomically disadvantages children</p>
Methodology	<p>This systematic review assessed the effectiveness of school meal programmes for improving the health of socioeconomically disadvantaged children. It also explores whether these programmes are benefiting those children who are more disadvantaged children at least as much as those who are more advantaged. Studies were included that reviewed feeding carried out in schools and where the majority of participants were socioeconomically disadvantaged. Data from RCTs, non-randomised controlled clinical trials, CBAs, and interrupted time-series studies were reviewed.</p> <p>Relevant studies were identified from databases, grey literature sources were searched for relevant studies, reference lists of included studies and key journals were hand searched, and selected experts in the field were also contacted to provide references to include in the review.</p>
Population, intervention and outcomes measured	<p><i>Population:</i> Children from five to 19 years of age (mostly primary school children) included in 18 studies incorporated in the review</p> <p><i>Intervention:</i> School feeding programmes, including those providing meals (breakfast or lunch) or snacks (including milk) administered in a school setting</p>

	<p><i>Outcomes:</i> Physical, psychological, and behavioural outcomes, including stigmatisation, dependency, disruptive behaviour at school, and obesity or excessive weight loss</p>
<p>Strengths and weaknesses of the approach, gender dimensions, and general lessons from the study</p>	<p>This is an innovative study, being the first systematic review on the topic of school feeding, and as such provides a valuable starting point for future analysis. During the course of the review it was found that much of the literature on school feeding did not use rigorous outcome assessments. Many articles simply provide descriptions of the nutritional quality of school meals and/or the dietary intake of participants, while others describe programme operation, management or cost, and others carry out simple surveys of participants, parents or providers.</p> <p>One group of studies comprise cross-sectional comparisons of participants and non-participants and some are longitudinal, although lacking controls. The 28 studies included in this review are the only studies found that assessed effectiveness with a reasonable degree of rigour. These studies differ significantly in terms of setting, historical/policy context, sample, inclusion criteria, interventions and outcomes.</p> <p>It is therefore important to learn whether or not this is an effective and cost-effective intervention for improving the health, nutritional status, school enrolment and school performance of disadvantaged children.</p>
<p>Indicators</p>	<p>Weight gain School attendance Educational outcomes Provision of food to children</p>
<p>Prevention/treatment or care</p>	<p>Care</p>
<p>Strengths and weaknesses of the indicators</p>	<p>The results of the 18 studies integrated in this review provide general insights into providing school feeding programmes across the world. However, outcomes may be affected by factors other than the existence of the programme, such as the quality of the educational environment, the quality or amount of food provided, etc., and results were found to vary by region and country, with the impact of free school meals on school attendance being found to be greatest in areas of greatest poverty.</p>
<p>Findings</p>	<p>Overall, school meals may have some small benefits for disadvantaged children, but there is no analysis of impacts to separate out those beneficiaries affected by HIV or their households.</p> <p>In the highest-quality studies (RCTs from LICs), children who were fed at school gained an average of 0.39 kg more than controls over 19 months; in lower-quality studies (CBAs), the difference in gain was 0.71 kg over 11.3 months. Children who were fed at school attended school more frequently than those in control groups, with an average increase of four to six days a year per child. In terms of educational and cognitive outcomes, children fed at school gained more than controls in terms of maths achievement and some short-term cognitive tasks. Results from higher-income countries were mixed, but generally positive. For height, results from LICs were mixed. The study concludes that school meals may have small physical and psychosocial benefits for disadvantaged pupils.</p>

<p>Author</p>	<p>KULA (2010)</p>
<p>Title</p>	<p>'Non-contributive pension of elderly age HIV/AIDS and the employment situation in Africa: A qualitative research in Mozambique'</p>
<p>Country(ies)</p>	<p>Mozambique</p>
<p>Access/impact examined</p>	<p>Impact Impact of the Food Subsidy Programme (FSP) on households of elderly beneficiaries affected by HIV and AIDS</p>

Methodology	The main objective of this study was to develop a case study in two districts of two provinces in Mozambique that examined the effects of the FSP on the households of elderly beneficiaries affected by HIV and AIDS. A qualitative approach was adopted with data collected through individual semi-structured interviews and two sets of FGDs, one with beneficiaries and one with non-beneficiaries. Interviews were conducted with community leaders, FSP representatives, INAS officers at the district level, and representatives of NGOs with programmes for the elderly. Interviews and FGDs explored topics such as household composition, employment and family income; the impact of a pension in the household; the elderly in the community; and the impact of HIV and AIDS. Interviewees were selected on the basis of beneficiary information provided by the implementing agency (INAS) at district level.
Population, intervention and outcomes measured	<i>Population:</i> Beneficiaries and non-beneficiaries of the FSP <i>Intervention:</i> FSP <i>Outcomes measured:</i> Relative vulnerability of beneficiary households and access to HIV-related services and support
Strengths and weaknesses of the approach, gender dimensions, and general lessons from the study	This study explored the effects of the FSP in two provinces and was not able to draw comparisons with other food support programmes in Mozambique, since beneficiaries differed across programmes. Thus, in general terms the study shows that the main approach to mitigate HIV and AIDS effect in Mozambique is based on the community and what this study recommends is promoting NGOs and community-based organisations to implement actions at the community level to create base community structures to ensure necessity satisfaction of potential beneficiaries.
Indicators	Access to health services Death related to HIV or other reasons Quality of life
Prevention/treatment or care	Treatment
Strengths and weaknesses of the indicators	
Findings	<p>These indicators revealed a range of vulnerabilities within the beneficiary communities, including PLHIV. Gender issues, stigma and discrimination were also mentioned as influencing access to and use of health services. It was also found that the value of the pension was low in relation to the high number of beneficiaries dependent on the elderly, including orphaned children and the sick. There were no significant findings in terms of the impact of the pension on health care within beneficiary households, as although benefits were reported across a range of outcomes, the value of the pension was small and it was used primarily for food consumption.</p> <p>In addition to satisfying basic consumption needs, the pension was also used to finance small investments to improve living conditions, for small commercial activities, and to finance access to basic social services like education and health for household members. The limited use of the FSP for HIV and AIDS-related expenditure is due to the use of the subsidy to satisfy basic needs within the household. In the communities studied increasing numbers of older people are heading families and taking responsibility for AIDS-orphaned children who have as a consequence increased household expenses relating to food, education and clothing.</p>

Author	Loudon et al. (2007)
Title	<i>Barriers to services for children with HIV positive parents</i>
Country(ies)	India

Access/impact examined	Access Access to services and benefits by children affected by HIV and AIDS
Methodology	The study examined the extent to which children affected by HIV and AIDS are excluded from services and benefits compared to other children. The study was qualitative and conducted in two phases, the first being focus group discussions with 'service consumers' (affected children and their adult caregivers) who were recruited by NGOs and networks of positive people, and the second being key informant interviews with selected 'service providers' in education, public health and social welfare. Research was undertaken in 45 sites in five states.
Population, intervention and outcomes measured	<i>Population:</i> Children affected by HIV and AIDS <i>Intervention:</i> Medical care, education, alternative care <i>Outcomes measured:</i> Exclusion from services and benefits
Strengths and Weaknesses of the approach, gender dimensions, and general lessons from the study	This study did not investigate the medical treatment of HIV-positive children, the prevention of child HIV infection (either through behaviour modification among adolescents or the prevention of vertical transmission (MTC)), or custodial issues for affected children (such as family reconstruction, fostering, adoption and institutional care). The study did not collect household demographic or economic data on respondents, nor were focus groups conducted with children and adults not affected by HIV and AIDS for control purposes.
Indicators	Barriers to education and health-care service utilisation Support from extended families and communities, Experiences of discrimination and exclusion among affected children
Prevention/treatment or care	Care
Strengths and weaknesses of the indicators	The barriers exposed by the study do not represent the experience of most affected children (the majority live in secret, or do not know they are affected and are therefore not treated differently to other children), but the study provides clear evidence of children affected by HIV and AIDS and their vulnerabilities and exclusion in five states.
Findings	Poverty was not the barrier most frequently cited by affected children and their caregivers. One likely reason for this difference relates to the research method: focus group participants were asked to identify barriers that are unique to children affected by HIV and AIDS, and to exclude those which also affect their neighbours. Another likely reason is that most children from poor households in India have nominal access to essential public services. However, many are excluded from these services by social factors such as gender, caste, parental expectations and, most recently, HIV and AIDS. Although poverty is unquestionably linked to HIV and AIDS in India, as it is elsewhere, the immediate problem may be that the stigma attached to HIV and AIDS prevents people from accessing the very services that will allow them to escape their poverty. Neighbours and relatives treat these children differently to other children. Affected children said they are teased, shunned, shouted at or ignored in their homes and neighbourhoods. Discrimination was reported by workers in giving food aid, while subsidised food grains did not reach affected children. Both affected children and caregivers said the main reason for their exclusion was other peoples' fear of HIV and AIDS, while the widespread belief that children affected by HIV and AIDS pose a public health risk and need to be separated or treated differently to other children also leads to their exclusion from service provision. People exclude themselves from benefits and services provided for PLHIV for fear that their participation will result in stigmatisation. Indeed, members of affected households want to be treated like everyone else, not singled out for special benefit.
Author	McCord (2005)

Title	<i>Public works in the context of HIV/AIDS</i>
Country(ies)	South Africa, Zimbabwe, Ethiopia and Malawi
Access/impact examined	Impacts Impacts of PWPs in East and Southern Africa in terms of addressing the needs of OVC and households affected by HIV and AIDS
Methodology	The first phase of the research involved the preparation of an inventory of PWP designed to impact on the livelihoods of OVC and households affected by HIV and AIDS, based on literature and web research, and interviews carried out by the research team at the University of Cape Town. In the second phase a detailed study was made of examples of each of the six programme types identified in the typology of PWPs, drawing on examples from four case study countries in the region: Ethiopia, Malawi, South Africa and Zimbabwe. The case study research involved a literature review relating to the selected programmes and a country visit during which interviews were held with implementing agencies, donors and social protection agencies, as well as FGDs with beneficiaries.
Population, intervention and outcomes measured	<i>Populations:</i> OVC and HIV-affected households <i>Interventions:</i> PWP <i>Outcomes:</i> Benefits of PWP participation to OVC and HIV-affected households
Strengths and weaknesses of the approach, gender dimensions, and general lessons from the study	The research only entailed limited evaluation or discussion with programme beneficiaries, relying primarily on programme documentation and pre-existing evaluation documentation.
Indicators	Employment offered to HIV and AIDS-affected households or indirect benefits, wage level, duration of employment, free distribution of wage food/assets to those unable to work, service provision for HIV and AIDS-affected households, programmes including IEC activity (including social mobilisation and peer education)
Prevention/treatment or care	Care
Strengths and weaknesses of the indicators	Throughout the region the lack of M&E renders discussion of impact problematic and the lack of disaggregated public works budget information renders discussion of cost-effectiveness equally difficult.
Findings	<p>Most PWPs in the region currently play a limited role in terms of the social protection for OVC and households affected by HIV and AIDS, and the work requirement at the heart of PWP design means that many people are in practical terms excluded from their benefits. PWPs are problematic in terms of the support they offer to labour-constrained households, which includes many with OVC and those with HIV and AIDS-affected members, who are often labour constrained due to domestic demands of caring, and the loss of labour to sickness and death. PWPs tend to exclude those who are not able bodied and as a consequence, in the absence of alternative or complementary interventions, social protection based on the provision of public works employment will necessarily exclude some of the most needy and labour-constrained households.</p> <p>Several programmes in the region have been designed in recognition of the fact that households affected by HIV and AIDS and those living positively are often excluded from regular PWPs due to the work requirement. Some programmes offer employment directly to those living positively, some with reduced labour demand, while others attempt to extend employment opportunities to households affected by the virus.</p> <p>PWPs may be designed in such a way as to respond to the needs of households and communities affected by HIV and AIDS, e.g. i) producing assets of real and sustained socioeconomic value linked with complementary HIV and social development initiatives, and ii) taking into account innovations in the region such as public works employment in the social sector (providing, for example, HBC or ECD services for PLHIV, as well as more conventional physical infrastructure</p>

	<p>creation).</p> <p>Public works may not be a cost-effective means of delivering social protection to vulnerable groups compared to alternative approaches such as direct CTs.</p>
Author	Miller and Samson (2012)
Title	<i>HIV-sensitive social protection: State of the evidence 2012 in sub-Saharan Africa</i>
Country(ies)	Sub-Saharan Africa
Access/impact examined	<p>Access and impact</p> <p>Access to and impact of social protection instruments on HIV objectives. The study identifies evidence for HIV-sensitive social protection and translates findings into recommendations for effectively designed and implemented policies and interventions.</p>
Methodology	<p>A literature review, incorporating key documents identified by reviewing key topics in the HIV and AIDS literature (prevention, treatment, care and support, mitigation) and social protection literature. A wide range of terms were included in searches and the included literature focused on RCTs, rigorous observational studies and qualitative studies.</p>
Population, intervention and outcomes measured	<p><i>Population:</i> People affected by or living with HIV</p> <p><i>Intervention:</i> Three broad categories of interventions were examined: i) financial protection through predictable transfers of cash, food, or other transfers for those affected by HIV and those who are most vulnerable; ii) access to affordable quality services, including treatment, health care and education services; and iii) policies, legislation and regulation to meet the needs and uphold the rights of the most vulnerable and excluded.</p> <p><i>Outcomes measured:</i> Access and effectiveness of HIV-sensitive social protection</p>
Strengths and weaknesses of the approach, gender dimensions, and general lessons from the study	<p>This research provides a resource for countries with existing programmes to further develop, modify, and create linkages that will improve their HIV sensitivity. Although many social protection programmes were not set up with HIV as a primary focus, especially in lower prevalence contexts, their potential to contribute to a comprehensive HIV response has been increasingly recognised.</p> <p><i>Gender dimensions:</i> The study points out that in sub-Saharan Africa more women than men are living with HIV (59%) and that young women aged 15-24 are eight times more likely than men to be living with HIV, which is the result of upstream determinants of gender inequities that interact with other structural factors such as economic inequalities, laws, policies and social norms to reinforce HIV risk. An understanding of HIV and AIDS as a disease of inequality, both economic and gendered, implies that targeting women and girls for certain social protection interventions in specific contexts may be the most effective strategy.</p>
Indicators	Reaching people with HIV-sensitive social protection programmes, achieving core HIV and AIDS impacts, enhancing impacts, expanding and sustaining HIV-sensitive social protection
Prevention/treatment or care	Prevention, treatment and care
Strengths and weaknesses of the indicators	
Findings	<p>HIV-inclusive rather than HIV-exclusive social policies are more feasible and may better reach the households most in need. General principles of 'good targeting' can promote the inclusion of people affected by HIV. Targeting that maintains or increases inequalities may be less effective or even counterproductive.</p>

	<p>Furthermore, targeting marginalised groups, such as AIDS orphans or people living with HIV, could make public information that people would prefer to remain private, and reinforce social divisions and stigma.</p> <p>While the evidence base examining why people living with HIV and AIDS fail to access or adhere to treatment is growing, more evidence is needed on access barriers (e.g. to shed light on different rates of ART uptake in different settings) and whether investments in supply- or demand-side responses will have the greatest impact. While there is a stronger evidence base for social and economic care and support than for prevention and treatment, significant gaps remain. There is a strong demand for guidance on programme design, so that social protection can most efficiently achieve the desired care and support outcomes.</p> <p>The report highlights how comprehensive and integrated approaches effectively address the multiple vulnerabilities faced by PLHIV and how the application of the development-planning framework to HIV-sensitive social protection is a relatively new approach, with policymakers requiring a more comprehensive methodology for mobilising evidence. Overall, there is a need for government capacity to be developed over time, so that national governments can implement and monitor programmes at the national and district levels over the short, medium and long terms.</p>
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Author	MTT and UNICEF (2005)
Title	<i>Education access and retention for educationally marginalised children: Innovations in social protection</i>
Country(ies)	Kenya, Lesotho, Mozambique, Namibia, Tanzania, South Africa, Swaziland, Zambia, and Zimbabwe
Access/impact examined	Impact Impact of social protection on access to school and retention, particularly among educationally marginalised children, and the identification of factors critical for their learning achievement
Methodology	Research was conducted in two stages in 2005. Firstly, a questionnaire was used to gather information to create an inventory of programmes and projects with direct or indirect education social protection outcomes for educationally marginalised children (EMC). These questionnaires were sent to implementing and funding agencies identified by the 15 UNICEF country offices in the East and Southern Africa region that chose to participate in the review. Next a literature search was carried out to enrich the inventory and a number of key informant interviews were also conducted in order to document existing social protection mechanisms that demonstrated positive education outcomes, and potential for replication and scale-up. In the second stage 16 case studies were selected from ten countries representing a range of programmes judged to be more or less innovative, with the potential to provide insights and lessons for scale-up and replication.
Population, intervention and outcomes measured	<i>Population:</i> OVC and EMC <i>Intervention:</i> Programmes designed with educational benefits as a primary or secondary outcome <i>Outcomes measured:</i> Educational benefits for OVC or EMC
Strengths and weaknesses of the approach, gender dimensions, and general lessons from the study	In conducting the research, the following limitations were noted: Given that 'social protection in the education sector' is a new and emerging concept, one limitation was the variable interpretations of this concept by the various UNICEF country offices. In some instances this may have led to some inadvertent bias in the development of country contact lists and therefore to some relevant programmes being missed. Implementing and funding agencies had differing interpretations of the concept and this influenced decisions regarding which projects were proposed for inclusion in the review. The fact that in-country data collection did not form part of the initial methodology meant that there was little control over the nature and scope of information gathered during the initial stage. There was a bias in favour of well-established projects with sound track records, as these tended to be the ones best known by the UNICEF country offices and best documented. Cost benefit assessment did not form a core component of the study.

	<i>Gender dimensions:</i> Only a limited number of programmes recognise a gender dimension in their targeting or support.
Indicators	School attendance Education access Retention Policy design (fee-paying versus free primary education, availability of school feeding schemes, non-formal education opportunities) innovations (such as alternative learning arrangements)
Prevention/treatment or care	Prevention
Strengths and weaknesses of the indicators	A further limitation was that projects measured and monitored their success in terms of getting children into school and keeping them there, but rarely considered outcomes related to educational progress, actual learning or HIV outcomes.
Findings	<p>For those interventions that were primarily designed with educational benefits in mind, the majority targeted vulnerable children. For these children, a range of interventions are being implemented, many focusing on school fee remission in some form, as fees are one of the major barriers to education. All interventions providing school fee remission are non-contributory. Although the fee requirement forms a major barrier to education, it is not the only one, and for some vulnerable households, especially child-headed ones, fee remission alone will not be sufficient to enable children to enter or return to the school system. For those interventions where achieving educational benefits is a secondary outcome, most focused on the household level with few focussing on the community level.</p> <p>Programmes focused on different target groups. Some targeted children, others focused on the development of schools, while others looked at providing support to households and communities. Programme reach and coverage varied, with some focusing on providing a wide range of services to a few recipients within a defined target group and others aiming to reach as many recipients within a target group as possible and providing limited services.</p> <p>Criteria for targeting are sometimes AIDS-related, but mostly not, using, for example, regular school attendance as a requirement for the provision of ongoing funding, but all have education access and retention as expected outcomes, whether these are specific objectives or indirect benefits.</p> <p>A review of the case studies suggests that while all the programmes provide some measure of social protection to EMC, the scale of some programmes and the lack of coordination with others may limit their impact and value. Most – if not all – of these programmes have the potential to achieve much more in a coordinated environment, with appropriate levels of management and resourcing. A strategic combination of these (and other) programmes in an integrated basket of support would be an important step forward.</p>

Author	Octavery et al. (2011)
Title	<i>Analysis of HIV-sensitive social protection schemes in Indonesia</i>
Country(ies)	Indonesia
Access/impact examined	Access Access to health services and health care by PLHIV
Methodology	This research assesses the possibility of having a social protection policy that promotes access to health care by PLHIV. It was carried out in four cities: Jakarta, Yogyakarta, Semarang and Pontianak. Data were collected in two ways: firstly, by collecting secondary data related to policies, procedures and previous research on social protection in Indonesia; and secondly, by collecting primary data through in-depth interviews and FGDs in each city. A total of 70 informants participated in the study. Data analysis was done through triangulation, where the data collected from different sources in a certain category are compared and reviewed to obtain

	insights.
Population, intervention and outcomes measured	<p><i>Population:</i> PLHIV</p> <p><i>Intervention:</i> SHI, ART provision, MF, training</p> <p><i>Outcomes measured:</i> Access to health care</p>
Strengths and weaknesses of the approach, gender dimensions, and general lessons from the study	<p>This research is the first specifically to study the use of social protection by people infected with HIV and their families, and the barriers to accessing health insurance. It provides a study of the implementation of various policy documents on social protection, particularly SHI, that are available in Indonesia, providing insights into the gap between policy and practice in health insurance at the field level. Although the data illustrate the implementation of SHI, it is not appropriate to apply the results in other contexts because of the specificities of the three research locations, which mean that these case studies cannot describe the health insurance implementation situation in other provinces. Indeed, as a qualitative research study, this research, by design, has limitations with regard to describing the broader aspects of problems found in the field. Finally, because the definition of the concept of 'social protection' is so broad, it gives rise to a vast array of interpretations about the different policies and activities covered.</p> <p><i>Gender dimensions:</i> The study recommends the development of social protection interventions that are sensitive to gender needs, taking into consideration the fact that the socioeconomic impact of HIV and AIDS on women, including sex workers and female IDUs, as well as households headed by women, is more severe.</p>
Indicators	<p>Barriers to access health insurance</p> <p>Health expenditure</p> <p>Treatment</p> <p>Perceptions of stigma and discrimination</p>
Prevention/treatment or care	Treatment and care
Strengths and weaknesses of the indicators	
Findings	<p>A number of social assistance or SHI schemes available in Indonesia have been utilised by PLHIV for their health care. However, many PLHIV still have to finance, out-of-pocket, some health-care components themselves, such as the purchase of drugs, certain inpatient costs, and transport for referrals to health services. The coverage of SHI schemes is quite problematic, with existing schemes failing to reach all poor families or individuals in a province/district. Other PLHIV rely on free services provided by NGOs, health centres and referral hospitals that are supported by projects funded by Global Fund grants. The types of service that have been accessed include VCT, ARV therapy, CD4 and viral load tests, and childbirth (PMTCT). Most PLHIV reported that when they suffer from opportunistic infections they have utilised health-care services that require hospitalisation, with the support of locally available health insurance schemes. Some PLHIV use <i>Jamkesmas</i> facilities if they are registered as <i>Jamkesmas</i> participants in certain areas or use an SKTM (certificate of disadvantage). Some PLHIV have utilised <i>Jamkesmas</i> through NGOs that assist people not registered as residents of a particular area to get <i>Jamkesmas</i> membership. Few PLHIV reported having access to such services through <i>Jamkesda</i> schemes, because they are permanent residents of a city or district, but are not listed as <i>Jamkesmas</i> participants. A number of PLHIV or their families reported that they have obtained social assistance from the Social Affairs Office in their province or city to start a business or boost their income. Communities that receive social assistance include the sex worker, transgender and PLHIV communities, including children with HIV. This assistance is intended to provide initial capital to enable recipients to start a business after they have taken part in training on business development.</p> <p>Barriers to health insurance include not being a resident of a certain district; having limited information on the available SHI schemes; and the perception that the procedure to obtain social security is complicated, that it takes a long time before services can be accessed, and that applicants need to go back and forth between institutions to complete the administrative requirements. The lack of information also causes people to be denied health services due to the fact that they have not followed the procedures required by health-service offices and/or social security-implementing bodies. Some respondents reported incidences of stigma and discrimination by health-service providers, as well as a lack of clear information regarding the types and coverage of services that can be accessed by PLHIV. The behavioural history of PLHIV who are IDUs, sex workers or transgendered is also often an obstacle to accessing social protection.</p>

Author	Pettifor et al. (2012)
Title	'Can money prevent the spread of HIV? A review of cash payments for HIV prevention'
Country(ies)	Africa and the US
Access/impact examined	Impact Impact of CTs on HIV infection
Methodology	Meta-review of RCT (15/16) and one observational study with controls. The studies measure a variety of outcomes including sexual behaviours and intentions (12/16), STI status (2/16) and HIV status (5/16) and consider both incentive and poverty reduction vectors of impact.
Population, intervention and outcomes measured	Those at risk of HIV infection Provision of CTs Extent of HIV infection or activities likely to increase risk of infection
Strengths and weaknesses of the approach, gender dimensions, and general lessons from the study	This is the first review of the available evidence based on sound methodological basis of the effect of CTs on HIV prevention. It takes into account both behavioural (downstream) factors and upstream poverty factors. It recognises that factors external to the cash payment may drive behaviour. It identifies the scarcity of robust research into the question that is central to assumptions underlying many current programmes. However, only one study has released results on HIV outcomes: six of 16 studies are ongoing; 15 of the 16 studies are RCTs.
Indicators	HIV prevalence, HIV incidence, sexual behaviour, use of reproductive health-care services, learning HIV test results, STI incidence, school dropout
Prevention/treatment or care	Prevention
Strengths and weaknesses of the indicators	The use of biological end-point indicators (HIV incidence) is a significant new development in relation to previous focus on behavioural risk factors or proxies such as school dropout.
Findings	The one large RCT reviewed using biological end-point data has found lower prevalence rates among the intervention participants compared to the controls at the 18-month follow-up stage. 9/10 completed studies found a positive change in sexual behaviour. To date only one study has found a decrease in HIV prevalence related to cash payments, but this is primarily due to the fact that few studies to date have had biological end points, although the vast majority of studies have found positive impacts on sexual behaviour.

Author	Roelen et al. (2011)
Title	<i>Lessons from the Children and AIDS Regional Initiative (CARI): Child- and HIV-sensitive social protection in Eastern and Southern Africa</i>
Country(ies)	East and Southern Africa: Angola, Botswana, Lesotho, Swaziland, South Africa, Malawi, Mozambique, Namibia and Tanzania

Access/impact examined	Access Access of children to HIV-sensitive social protection
Methodology	A policy review was carried out to provide a narrative overview of child and HIV-sensitive social protection, including key concepts, instruments and measures, global trends and evidence, and an overview of regional initiatives within and beyond CARI.
Population, intervention and outcomes measured	<i>Population:</i> Children affected by HIV and AIDS <i>Interventions:</i> Social transfers, social insurance, social services, policies, legislation, regulations and interventions addressing social vulnerabilities (to further explore in the second part of this study) <i>Outcomes:</i> Provision of child-sensitive social protection
Strengths and weaknesses of the approach, gender dimensions, and general lessons from the study	The review of policy documents in the region shows that the majority of frameworks and strategies do not explicitly refer to child- and HIV-sensitive social protection.
Indicators	Interventions that include guiding principles that reflect the notions of child-specific and child-intensified vulnerabilities in the context of HIV and AIDS
Prevention/treatment or care	Prevention
Strengths and weaknesses of the indicators	
Findings	<p>Despite the fact that a review of policy documents in the region shows that the majority of frameworks and strategies do not explicitly refer to child- and HIV-sensitive social protection, there is widespread recognition that social protection can play an important role in addressing the issues faced by children affected by HIV and AIDS.</p> <p>Although it is widely recognised that the informal safety nets offered by extended families in many countries have been severely undermined by the epidemic and should thus be strengthened, there is also acknowledgment that a lack of provisions for children outside of family contexts might exclude the most vulnerable and marginalised children from programming. As such, exclusion is likely to further exacerbate the situation of already disadvantaged children. Child- and HIV-sensitive social protection should be broad based and reach beyond children directly affected by HIV and AIDS, although infected or orphaned children might require specific clinical and psychosocial support that would not be of relevance to children less directly affected by HIV and AIDS.</p> <p>Although many social protection schemes were not set up with HIV as a primary focus, especially in lower-prevalence contexts, their potential to contribute to a comprehensive HIV response is increasingly recognised. Instruments of particular relevance to HIV-sensitive social protection include transfers (cash or food); CTs or subsidies to ensure that the poor and marginalised have access to essential health and education services; and non-discriminatory access to financial resources (savings, insurance and credit).</p> <p>Poverty is a better indicator of vulnerability than orphanhood. Combining social protection (CCT and food inputs) with complementary interventions addressing non-income-based needs, including counselling and psychosocial support, can be more effective.</p>
Author	Rompel (2005)

Title	<i>Financing HIV/AIDS prevention through social health insurance: A cross-cutting issue for public health in developing countries challenges – implications – questions</i>
Country(ies)	Global
Access/impact examined	Access Impact of SHI in overcoming financial barriers to access
Methodology	The report is based on a series of key informant interviews, in conjunction with an assessment of the relevant literature and conference papers.
Population, intervention and outcomes measured	<i>Population:</i> Young people vulnerable to HIV and AIDS <i>Intervention:</i> SHI <i>Outcomes measured:</i> Impact of SHI in overcoming financial barriers to access to health care and the prevention of infection
Strengths and weaknesses of the approach, gender dimensions, and general lessons from the study	The approach explored is new in the context of developing countries, in terms of looking at how to finance prevention through SHI. An analysis of the current research literature shows that there has been little discussion of this topic and little practical experience in the field. Given this lack of past experience, this report explores the issue via brainstorming rather than elaborating the topic systematically.
Indicators	Cost of treatment Coverage Prevention activities Promotion activities
Prevention/treatment or care	Prevention and treatment
Strengths and weaknesses of the indicators	
Findings	A common critique of SHI schemes is that they exclude the poor, especially with regard to prevention. The available evidence suggests that SHI schemes are mainly available for formal sector employees (thus predominantly urban middle- and high-income earners). CHI schemes, by contrast, are most successful among the rural middle class. The consequence is that protection is mainly provided for those who can afford to belong to a health insurance scheme, as sometimes even relatively modest contributions can be too high for the poorest to pay. It has been suggested in the context of HIV and AIDS treatment that a variety of different schemes should be tested, depending on the HIV status of SHI/CHI beneficiaries. However, the high costs associated with the treatment of opportunistic infections or ART are a challenge to the financial sustainability of the schemes. The aim of prevention, in addition to promoting health and avoiding illness, is naturally also a cost-reducing factor for any insurance scheme, at least in the long run. The best way to save money is to avoid demand for curative services. Hence, investment in HIV and AIDS prevention is one means for SHI and CHI schemes to avoid the costs of for HIV and AIDS care and treatment (assuming that this is covered by the schemes). In short, prevention activities can lower health providers' costs – a key benefit that may persuade schemes to offer preventive services.
Author	Samuels et al. (2012)
Title	'HIV vulnerabilities and the potential for strengthening social protection responses in Nigeria'

Country(ies)	Nigeria
Access/impact examined	Impact Impact of institutional responses on the vulnerabilities faced by PLHIV and the drivers of HIV
Methodology	<p>This report reviews secondary data and presents four cases studies carried out in four states in Nigeria. The case studies were chosen on the basis of HIV-prevalence rates (with at least two in high-prevalence states); specific child protection vulnerabilities; state poverty profiles and susceptibility to shocks and stresses; and geographical spread. The objective of the case studies was to illustrate the types of vulnerabilities faced by people living with HIV, the drivers of HIV and the range of institutional responses at the state level.</p> <p>One HIV intervention per state was chosen to highlight programmatic responses. The study used key informant interviews (KIIs), FGDs and in-depth interviews with programme participants disaggregated by sex and age where feasible in order to capture specific gender and lifecycle experiences.</p>
Population, intervention and outcomes measured	<p><i>Population:</i> Vulnerable groups such as youth (mainly young women), pregnant women, OVC and the elderly</p> <p><i>Intervention:</i> A range of social protection interventions, including CCT, health subsidies, health fee waivers, nutrition programmes and PWP</p> <p><i>Outcomes measured:</i> Policy and programming responses to HIV</p>
Strengths and weaknesses of the approach, gender dimensions, and general lessons from the study	<p>The research team encountered some limitations in terms of the methodological approach relating to the case studies, including the participation of HIV programme implementers.</p> <p><i>Gender dimensions:</i> Unequal gender norms have a great impact on men's and women's differentiated risks and vulnerabilities to HIV infection, as well as on their access to prevention, treatment, care and support. Women are biologically more susceptible to HIV and more vulnerable due to their socioeconomic status. Gender inequalities increase women's exposure to infection through their lower status and lower access to education, as well as their economic dependency on men, and increase women's risk of HIV infection due to abuse, sexual exploitation and trafficking. However, the picture is complex and where gender inequality is low, HIV prevalence may still be high and there is no universal causal relationship. Other drivers are related to religion, low HIV and AIDS awareness, multiple sexual partners, and low condom use.</p> <p>HIV and AIDS awareness in Nigeria is highly gendered and related to wealth and education (especially in the northern zones and rural locations).</p>
Indicators	<p>Distribution of health infrastructure and personnel</p> <p>Targeting and design of programmes</p> <p>Implementation</p>
Prevention/treatment or care	Treatment and care
Strengths and weaknesses of the indicators	
Findings	<p>HIV-affected households have reduced levels of income and declining agricultural production and family assets, and household composition includes elevated numbers of widows and orphans, and a higher prevalence of elderly- and child-headed households compared to non-affected households. High numbers of OVC have led to an increase in dependency ratios and household sizes. Linked to this, heightened pressure for health services has greatly increased the workload of health providers. HIV and AIDS mortality and morbidity are also affecting health professionals and their families, resulting in increased demand and a simultaneous pressure on the supply of health-care provision. Generally, inadequate and unsustainable funding for social protection provision is an issue of key concern at the state level, limiting the ability to provide consistent services or increase coverage. More ownership and responsibility by government is identified as a key factor.</p>

	<p>Informal coping mechanisms for dealing with poverty include diversifying household income, engaging in multiple occupations, migration, child labour, borrowing, reducing food and fuel consumption, withdrawing children from school, reducing health-care-related costs, selling assets, engaging in illegal activities (e.g. selling black market fuel), commercial sex work and marrying girls off early.</p> <p>While HIV and AIDS-related programming in Nigeria is not currently framed in terms of social protection, a number of interventions include HIV-sensitive social protection components and target – either directly or indirectly – people affected by or infected with HIV and AIDS. These schemes improve access to education, health care and food security for vulnerable people, including those affected by HIV and AIDS. However, these programmes remain scattered or in the pilot stage, do not cover the full range of HIV-related risks and vulnerabilities, and are poorly coordinated. Similarly, the approach is often vertical, with limited cross-sectoral engagement. There is little evidence generated on impacts, M&E is limited and usually focuses on outputs and numbers of people reached, and implementers lack the capacity and resources to scale up or link to complementary initiatives.</p> <p>Formal CT programmes can promote food security and in terms of access to services, and there is some evidence that community-based social protection approaches support linkages with maternal and child health programmes. In terms of policies and legislation, while some laws aim to protect the rights of vulnerable PLHIV, awareness of these rights is limited and the extent to which they are enforced is negligible.</p>
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Author	Stene et al. (2009)
Title	'Economic strengthening programmes for HIV/AIDS affected communities: Evidence of impact and good practice guidelines'
Country(ies)	Global
Access/impact examined	Impact Impact of economic strengthening initiatives on well-being in HIV-affected households
Methodology	<p>This literature review explores the extent to which economic strengthening interventions affect the well-being (financial, nutritional, health status, school enrolment) of PLHIV and how the impact of such interventions can be assessed.</p> <p>The research methodology comprised a literature review and interviews with key informants. The desk review included literature published in peer-reviewed journals and grey material from donor agencies and implementers working in the respective sectors. Phone interviews were held with key actors in the health and economic development sectors working in donor agencies, implementing organisations, consulting firms and academia. The interviews were semi-structured and explored evidence relating to economic strengthening initiatives, the identification of relevant programmes and practices, and challenges related to the monitoring and evaluation of multisectoral programmes.</p>
Population, intervention and outcomes measured	<p><i>Population:</i> PLHIV</p> <p><i>Interventions:</i> CTs, savings and MF interventions, IGA programmes</p> <p><i>Outcomes measured:</i> Improvement of well-being</p>
Strengths and weaknesses of the approach, gender dimensions, and general lessons from the study	<i>Gender dimensions:</i> See results
Indicators	<p>Nutritional status or food consumption</p> <p>Health service utilisation</p> <p>Educational enrolment and attendance</p>

	Ownership of school supplies Proxy measures of self-esteem Participation in social networks
Prevention/treatment or care	Prevention and care
Strengths and weaknesses of the indicators	
Findings	<p>Several components of well-being among HIV and AIDS-affected households (economic status, nutrition, self-reported health status, assets and school material ownership) are positively affected by economic strengthening interventions. CTs are effective in improving the well-being of HIV and AIDS-affected households. Even small grants can have dramatic impacts on the nutritional status, cognitive growth and development of young children. CT programmes demonstrated a reduction in severity of destitution as measured by improvements in food consumption, reductions in child labour and small increases in health expenditures. School enrolment impacts, however, were limited, although absenteeism among already enrolled students and ownership of school supplies and uniforms improved considerably. Taken together, these aggregate improvements in well-being may be seen as a way to reduce the poverty that often encourages high-risk behaviours.</p> <p>Savings services were found to impact positively on household welfare and the ability to cope. Where measured, successful saving among women and adolescent girls was generally correlated with increased confidence, participation in social networks, and overall positive attitudes about their ability to address HIV and AIDS-related risks and challenges.</p> <p>Of the economic strengthening programmes reviewed, MF had the strongest correlation with HIV and AIDS-mitigation behaviour and attitudes, particularly among women. Integrated health and MF programmes were found to result in to some positive behaviour change outcomes and the reduction of risk factors associated with HIV and AIDS. MF initiatives are linked with improvements in women's self-confidence, household decision-making authority, bargaining power and participation in community leadership roles. These initiatives also led to improved food consumption and increased utilisation of health-care services, especially among OVC.</p> <p>Different types of IGA programmes are implemented for specific groups affected by HIV and AIDS, notably adolescents and women. These efforts have largely centred on the provision of business loans and vocational training and have tended to remain small in scale. Few initiatives have rigorously considered broader market linkages when designing programmes for PLHIV.</p> <p>More research is needed to assess the impact of economic strengthening programmes on the health and well-being of PLHIV. Key indicators to be explored include nutritional uptake, education, income diversification, access to and adherence to care and treatment of HIV and AIDS, and other health-care needs.</p> <p>The study suggests avoiding targeting based on HIV and AIDS status in order to avoid concerns about stigma, equity, and validity due to challenges in accurately identifying HIV and AIDS-affected populations.</p>
Author	Temin (2010)
Title	'HIV-sensitive social protection: What does the evidence say?'
Country(ies)	Africa
Access/impact examined	Access and impact Impact of social protection in reducing the risk of HIV infection, promoting treatment, and enhancing care and support

Methodology	The study reviews research on social protection and health, education, poverty, nutrition and child protection outcomes, and HIV and AIDS, drawing on published peer-reviewed studies, as well as grey literature, including unpublished studies. The study aimed to focus on data from RCTs; however, as few such studies were available, the criteria were expanded to include results from research and programme evaluation inasmuch as credible experimental designs, including baselines or comparison groups, were adopted.
Population, intervention and outcomes measured	<p><i>Population:</i> Populations with an increased risk of HIV exposure</p> <p><i>Interventions:</i> Social transfers, relevant livelihood-building approaches, social health protection and transformative social protection approaches</p> <p><i>Outcomes measured:</i> Programme effectiveness in minimising the risk of HIV infection, promoting treatment, and enhancing care and support</p>
Strengths and weaknesses of the approach, gender dimensions, and general lessons from the study	<p>While most of the literature and examples included in this review come from sub-Saharan Africa, the results are globally relevant. Data are also drawn from a variety of epidemic settings, including areas experiencing concentrated epidemics, where this information is available.</p> <p><i>Gender dimensions:</i> Social protection instruments targeted at girls and women have the potential to contribute to a levelling of the economic playing field, reduce gender inequality, and empower women to better negotiate sexual relations and reduce their risk of HIV infection. However, few empirical studies have explored these causal pathways. The relevant instruments include CTs and microcredit programmes that provide small loans and often financial training. Empowering FSWs through access to economic assets, social mobilisation and legislation can reduce HIV risk in this key population.</p> <p>Child protection and programmes for OVC must also be sensitive to gender, as boys and girls face different vulnerabilities, especially as they reach adolescence, and need different approaches accordingly. Evidence from a number of sub-Saharan countries reveals that adolescent girls orphaned by AIDS are more likely to be sexually active than non-orphaned peers; the impact also differs if they lost their mothers, fathers or both parents.</p>
Indicators	HIV prevention measures, HIV and AIDS treatment, financial barriers to health care, stigma-related barriers
Prevention/treatment or care	Prevention, treatment and care
Strengths and weaknesses of the indicators	
Findings	<p>Few of the studies explicitly explore outcomes in terms of HIV, although many of these programmes discussed will include PLHIV when operating in areas of high HIV prevalence. This is not widely documented, because M&E systems are not often in place to assess HIV-specific impacts.</p> <p><i>Prevention:</i> There is a wealth of evidence relating to certain social protection instruments (including CTs) that mitigate the impact of AIDS on vulnerable households and children. The evidence for the HIV-related impacts of other instruments is more limited. Many studies show the effectiveness of cash and food transfers in increasing school enrolment and attendance, revealing their potential to expand access to the 'social vaccine' of education against HIV infection. This is particularly important for adolescent girls and children orphaned by AIDS, who often have a greater risk of unsafe sex than their non-orphaned peers. In similar vein, programmes with demonstrated impacts on health-service access, such as maternity care vouchers and the removal of user fees, have the potential to increase treatment of STIs, increase uptake of VCT, and increase access to PMTCT services.</p> <p><i>Treatment:</i> There is evidence of the positive impact of social transfers for nutritional recovery of patients receiving HIV and TB treatment. People starting treatment in LICs often do so at very low CD4 counts, with pre-existing under-nutrition compounded by HIV-induced wasting. Food transfers can reduce under-nutrition in people living with HIV, although access to the right food (e.g. micronutrient rich, with a high energy density) is critical. The range of social health protection measures that expand health-care access (e.g. social health insurance, vouchers, exemptions, fee abolition) are also relevant to treatment.</p> <p><i>Care and support:</i> Many of the documented benefits of social transfer programmes address the vulnerabilities that HIV and AIDS exacerbate: reduced education and health-care access, household food insecurity, poverty, and reliance on child labour. Combining transfer schemes with social work and child protective services can reduce exclusion errors and expand coverage to those commonly excluded. Livelihoods promotion interventions, such as PWP, IGAs and microcredit, can</p>

	<p>also play a role. Although specific HIV-related impacts are rarely measured, these schemes can increase households' ability to withstand shocks and reduce poverty. However, households grappling with the uncertainty and medical expenses related to HIV may not be appropriate targets for certain types of livelihood programmes, e.g. in light of the risks associated with starting small businesses. Nevertheless, expanding ARV programmes may increase the relevance of livelihood approaches for people living with HIV and their households.</p>
Author	Thwin (2006)
Title	<i>Food support to PLWHIV and OVC with home based care: Evaluation and baseline survey 2006 Cambodia</i>
Country(ies)	Cambodia
Access/impact examined	Impact Impact of food support as part of integrated HBC services on mitigation of HIV
Methodology	<p>In the absence of baseline data, the study analyses the difference between treatment and control areas (i.e. areas which have received HBC, but not food support). The sample size and random sampling methodology followed the Probability Proportion to Population Size method in order to ensure statistical significance of the findings. A cross-sectional multistage cluster survey was carried out with 485 PLHIV and 299 OVC and their households, together with 28 qualitative analyses of community and HBC providers in 29 health centres in six provinces.</p> <p>The survey studies the effects of integrated food support and HBC programmes in mitigating the impact of HIV and AIDS on PLWHA, OVC and their families. It also attempts to analyse the programme's effect in reducing the impact of HIV and AIDS on nutritional outcomes.</p>
Population, intervention and outcomes measured	<p><i>Population:</i> PLWHA and OVC</p> <p><i>Interventions:</i> Integrated food support and HBC provision</p> <p><i>Outcomes measured:</i> Improvement of food security and other livelihoods outcomes in HIV-affected families</p>
Strengths and weaknesses of the approach, gender dimensions, and general lessons from the study	<p><i>Gender dimensions:</i> More than half of the PLWHA and OVC household were headed by females in both treatment and control areas. Among children not currently enrolled in school, the average number of years missed is significantly higher among females in control areas (compared to intervention areas). For most of the schooling indicators there are no significant differences between genders and between areas. Only the mean duration of time missed from school (in years) is significantly longer in control areas and among females. The food support programme was found to have a positive impact on the schooling of OVC, especially for girls, with the proportion of female OVC enrolled in school being significantly higher in treatment areas. Among the OVC not currently enrolled, girls in control areas had missed school for a significantly longer period than girls in treatment areas.</p>
Indicators	<ul style="list-style-type: none"> Coping strategies Livelihoods Food security Nutrition School attendance Treatment ARV adherence
Prevention/treatment or care	Mitigation

Strengths and weaknesses of the indicators	A significant impact on food security, nutrition and better involvement of beneficiaries in development programmes was identified. However, other indicators, while showing a generally improved situation in treatment areas, did not show any statistically significant impacts. In these cases it may be that the improvement can be attributed to existing home-care activities and other development programmes implemented in the areas by community organisations, which may have confounded the findings.
Findings	<p>Food support (rice, oil, and salt) resulted in statistically significant improvements in households' consumption of high-nutritional value food, with available income being used to purchase higher-nutritional value food items).</p> <p>The proportions of OVC who received health care did not differ significantly by area, although the reasons for not getting treatment did differ significantly. Compared to treatment areas, other commitments were the main reason for a significantly higher number of OVC in control areas not receiving health care.</p> <p>Although statistically not significant, positive changes in both PLHIV and OVC households were found in treatment areas in terms of coping mechanisms: loans were used more for agricultural investment than illness in treatment areas.</p> <p>While PLHIV in both areas were receiving ARV treatment, more PLHIV under the food support programme were regularly attending ARV treatment regimes for longer durations than their counterparts in the control areas. Other impacts identified in treatment areas were that more OVC girls were fostered and more OVC were participating in all variety of livelihood trainings.</p> <p>The study concludes that the food support programme should continue as it had a positive impact on food security, nutrition and livelihoods, although it should be provided in a comprehensive manner as part of a longer-term development strategy.</p>

Author	UNICEF (2009)
Title	'Taking evidence to impact: Making a difference for vulnerable children living in a world with HIV and AIDS'
Country(ies)	Global, with a focus on sub-Saharan Africa
Access/impact examined	Impact Impact of various social protection interventions on access to services in HIV-affected households
Methodology	This paper, based on a literature and policy review and KIs, informed the development of appropriate responses for children affected by HIV and AIDS, building on the principles and approaches from the 2004 Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living with HIV and AIDS, bringing in new academic and programmatic experience, and translating evidence into normative guidance for policymakers and programmers.
Population, intervention and outcomes measured	<p><i>Population:</i> Children and families affected by HIV and AIDS</p> <p><i>Interventions:</i> Social transfers (e.g. cash and food); programmes to ensure effective access to health, education and other services; social support services (e.g. family strengthening services); and legislation and policies to ensure equity and non-discrimination in access to services and employment/livelihoods (e.g. the abolition of school fees)</p> <p><i>Outcomes measured:</i> Access to services among children affected by AIDS</p>
Strengths and weaknesses of the approach, gender dimensions, and general lessons from the study	<p><i>Gender dimensions:</i> For children (especially girls) exploited in sex work, priorities include ensuring access to HIV prevention, treatment, care and support; providing protection from exploitation and abuse; building supportive environments; expanding life choices; and reducing their vulnerability by addressing structural issues. Economic empowerment approaches – when combined with HIV, health and gender education and training – hold promise for girls as a way to promote economic self-sufficiency, reduce gender inequality, and empower them to better negotiate sexual relations and reduce their risk of HIV infection.</p>

Indicators	HIV-specific service provision Access to services Prevention interventions Psychosocial support provision
Prevention/treatment or care	Care
Strengths and weaknesses of the indicators	
Findings	<p>While this report recognises that CABA have particular needs as a result of loss of parental care, HIV-related stigma and exclusion and coping with the disease itself, it also recognises that HIV-sensitive – rather than HIV-specific – approaches are more appropriate in most HIV-affected environments. For example, programming to improve access to education or livelihoods for children and households more broadly can be an effective way of scaling up support for CABA, particularly in contexts with high HIV prevalence.</p> <p>In addition to progress in school attendance, recent evaluations of social protection programmes in high-prevalence countries such as Kenya and Malawi show how CTs are improving food security, nutrition, education, and health outcomes in some of the poorest and most vulnerable households, including those affected by HIV and AIDS. Another area where there has been notable progress is paediatric treatment. The evidence from high HIV-prevalence, low-income settings suggests that non-conditional CTs are as effective as CCTs for improving vulnerable children’s school access. The increasing effectiveness and availability of ART means that thousands of children born with HIV are surviving into adolescence.</p> <p>Many HIV-affected children continue to face enormous challenges, including the burden of care for sick relatives, trauma from the loss of parents, economic distress due to declining incomes and high health costs, and the risk of early sexual debut and abuse, which in turn can make children – particularly girls – more susceptible to HIV infection. In settings where epidemics are still relatively concentrated, HIV-affected children often have parents who are highly marginalised and stigmatised, and they may be highly vulnerable to HIV themselves. Keeping parents alive is key to maintaining strong families and protecting children. Yet despite strong evidence on the prevention, treatment and care benefits of involving the whole family, HIV-related services continue to target individuals rather than households. A package of HIV-related services for the entire family within a continuum of care is missing.</p> <p>Expanding ART coverage is increasing labour availability in HIV-affected households, thereby heightening the relevance of programmes that promote household production. Different social-protection approaches make sense for different groups (e.g. labour-constrained households) may need CTs, while poor or marginalised families with untapped labour potential may benefit more from income-generation programmes. Livelihood programmes such as PWPs, IGAs, and microcredit have the potential to reduce the economic impact of HIV and other shocks. Households that are labour constrained due to AIDS, as well as ultra-poor households, may not always be appropriate targets for livelihood programmes that involve starting small businesses in light of the economic risks associated with such IGAs.</p>

Author	UNICEF and EUI (2012)
Title	<i>Mapping of social protection measures for children affected by HIV and AIDS in Asia and the Pacific</i>
Country(ies)	Bangladesh, Cambodia, China, Indonesia, Nepal, Pakistan, Viet Nam, Papua New Guinea, Thailand
Access/impact examined	Access Access to social protection provision
Methodology	This study reviews the extent to which children and households affected by HIV are being supported within existing national social protection frameworks in nine countries: Bangladesh, Cambodia, China, Indonesia, Nepal, Pakistan, Papua New Guinea, Thailand and Viet Nam. The study aimed to promote understanding of country trends relating to implementation, funding, coverage, mechanisms for monitoring and delivery, and national priorities.

	<p>An analytical review of secondary data and documentary evidence was conducted to identify key policies and programmes designed to meet the needs of children, with the intention of identifying the initiatives with the widest scope and scale. Using an objective set of criteria, these policies and programmes were then reviewed through an HIV-sensitive lens to understand the extent to which key social protection initiatives for all vulnerable children are able to address the needs of children affected by HIV.</p>
Population, intervention and outcomes measured	<p><i>Population:</i> Children affected by HIV and their caregivers</p> <p><i>Interventions:</i> CTs; food grants; social insurance schemes; access to drugs; livelihood inputs; access to health care, education, welfare, psychosocial support, livelihood training and alternative care; policies and legislation</p> <p><i>Outcomes measured:</i> The extent to which key social protection initiatives for all vulnerable children are able to address the needs of children affected by HIV</p>
Strengths and weaknesses of the approach, gender dimensions, and general lessons from the study	<p>This review was limited to social protection initiatives of significant scale and reach, and in general captured only those managed by government agencies or major development partners. Information on the coverage and impact of existing programmes was collected from the public domain, but there were many cases where monitoring and impact data was not publicly available. Several programmes notable for innovation in design and delivery were highlighted as examples of how social protection instruments can be adapted nationally.</p> <p><i>Gender dimensions:</i> HIV has had a marked impact on educational prospects for girls, as illustrated by the gap in dropout rates between boys and girls in Indonesia and China. Almost twice as many girls drop out of school in affected households compared to boys in Indonesia, whereas the opposite trend is true of unaffected households.</p>
Indicators	<p>Absolute numbers covered by social protection provision Coverage as % of those who are eligible Health-care spending Education attendance</p>
Prevention/treatment or care	Care
Strengths and weaknesses of the indicators	
Findings	<p>Reduced household incomes, increased costs, and diminished educational prospects for children, particularly girls, due to HIV and AIDS emerged as key findings. The impact of cash and in-kind support to households appeared to have an impact in alleviating the economic impact of income loss and additional health-care expenditure, as illustrated by findings from Cambodia and Indonesia. However, research suggests that discrimination and stigma at the community level remain major challenges.</p> <p>Children affected by HIV and AIDS experience divergent needs, and addressing the urgency of nutritional needs may be more appropriate in some settings, while sustainable support for care and treatment may be a priority in others. Enabling access to social services, employment initiatives, ART, and the provision of essential services is challenging by virtue of the resourcing requirements and difficulties associated with coordination and outreach. Yet there is a proliferation of schemes addressing barriers to social service access, despite the low-resource settings examined in the nine countries covered. Programme activity that included children affected by HIV and AIDS was limited in most countries, particularly in relation to accessing essential services, and the availability of suitable livelihood initiatives was also limited, although livelihood initiatives, featuring a cash or in-kind component, were gaining popularity as a model, particularly in South Asia, where food and cash have been used as incentives to encourage attendance at skills-training programmes.</p>

Appendix 4: Summary table of robust studies

Author	Title	Year	Region	Access/ impact	Area of access/ impact	Qualitative/ quantitative	Methodology	Findings
AAPN	<i>Challenges to women's access to HIV services in Asia</i>	2009	Asia	Access	Access to testing, counselling, ARVs and ongoing treatment	Quantitative and qualitative	Survey administered to 1,300 women from clinics, support groups and FGDs	Evidence of greater difficulty accessing services by poor and rural and migrant women. Testing and immediate counselling relatively easy to access, ARVs and ongoing treatment less so.
Abadia-Barrero and Castro	'Experiences of stigma and access to HAART in children and adolescents living with HIV/AIDS in Brazil'	2006	LAC	Impact	Impact of access to HAART on stigma and self-image	Qualitative	Life histories	Both stigma and self-image found to be positively affected
Attawell et al.	<i>Assessment: CARE Tumaini program</i>	2005	Africa	Impact	Impact of delivery of food aid, drugs and care	Qualitative	Programme evaluation including KIIs, document review	No significant impact findings. Food aid may be shared among family members, reducing nutritional impact on PLHIV
Campbell et al.	'“We ... the AIDS people”: How antiretroviral therapy enables Zimbabweans living with HIV/AIDS to cope with stigma'	2011	Africa	Impact	Impact of ART on social outcomes (stigma, quality of life, positivity)	Qualitative	KIIs and FGDs with patients and clinic workers	Evidence that ART increases quality of life, but may not reduce stigma
Cantrell et al.	'A pilot study on food supplementation to improve adherence to anti-retroviral therapy among food insecure adults in Zambia'	2008	Africa	Impact	Impact of food supplementation on adherence	Quantitative	Empirical analysis of bio-medical data from 8 clinics (4 treatment and 4 control)	Significant increase in ARV possession, but not weight gain or CD4 count reduction
Chanfreau et al.	'Costing HIV/AIDS services for Community Health Fund members and non-members in Hanang district, Tanzania'	2005	Africa	Impact	Impact of CHF on cost, frequency and type of outpatient services utilised	Quantitative	Medical utilisation data from 14 facilities and medical charts of adult PLHIV	May create culture of seeking care, thereby lowering hospitalisation frequency, duration and costs due to HIV/AIDS-related conditions, but not conclusive
Chean	<i>Community social</i>	2007	Asia	Access and	Impact of CBHI on	Qualitative and	Survey of low-income	Inconclusive in terms of impact. Lack of access to

	<i>protection and income security for households experiencing major illness including HIV/AIDS in selected communities around Phnom Penh</i>			impact	treatment-seeking behaviour	quantitative	households and KIIs	CBHI among the poor – key barriers identified
Edge and Strasser	'Measuring the impact of targeted food assistance on HIV/AIDS-related beneficiary groups: monitoring and evaluation indicators'	2006	Africa	Impact	Impact of food assistance on PLHIV using indicators in programme M&E system	Qualitative	Literature review, KIIs, FGDs and review of existing monitoring data	No impact assessment possible regarding outcomes for beneficiaries due to M&E indicators adopted in programme. Proposed outcome indicators include: anthropometric measurements strength and stamina diarrhoea prevalence treatment uptake and efficacy treatment completion (DOTS) treatment adherence quality of life
Galarraga and Gertler	'Conditional cash and adolescent risk behaviours: Evidence from urban Mexico'	2009	LAC	Impact	Impact of CCT on sexual behaviour of youth	Quantitative	Survey data drawn from standard Oportunidades monitoring survey	No significant impacts identified
Hallfors et al.	Supporting adolescent orphan girls to stay in school as HIV risk prevention: Evidence from a randomized control trial in Zimbabwe'	2011	Africa	Impact	Impact of payment of school fees and uniform provision on reducing school dropout rates of adolescents girls	Quantitative	RCT across 25 primary schools	Evidence of dropout reduction identified, but not evidence on HIV prevalence
ILO	<i>Social protection and HIV in Indonesia</i>	2012	Asia	Access		Qualitative	Literature and policy review, KIIs, FGDs with those with HIV and AIDS and officials	Concludes that NGOs and peer support groups played a significant role in assisting people with HIV to access social protection. PLHIV are both directly and indirectly excluded from accessing existing services.
IATT	<i>National responses for children affected by AIDS: Review of progress and lessons learned</i>	2008	Global	Access		Qualitative	Literature review and KIIs with representatives from international agencies	Diversity in national access – indicator is significant policy momentum and programme implementation (political will; resources; involvement of NGOs; committed individuals; consultative processes;

								global and regional advocacy)
Kitajima et al.	'Access to antiretroviral therapy among HIV/AIDS patients in Khon Kaen province, Thailand'	2005	Asia	Impact	Impact of type of health insurance on ARV use	Quantitative	Regression analysis of medical data from two hospitals	Type of health insurance scheme that the patient was covered by affected the likelihood of use of ARV (Civil Servant Medical Benefit Scheme members significantly or likely to receive ARVs than those covered by Universal Coverage Scheme, a publicly funded medical insurance)
Kristjansson et al.	'School feeding for improving the physical and psychosocial health of disadvantaged students'	2006	Global	Impact	Impact of school feeding on vulnerable children	Systematic review	Review of 18 quantitative studies	School feeding improves weight gain, school attendance, and educational outcomes of disadvantaged students, including those with HIV/AIDS, but the impacts on this group were not separately analysable.
KULA	'Non-contributive pension of elderly age HIV/AIDS and the employment situation in Africa: A qualitative research in Mozambique'	2010	Africa	Impact	Impact of CTs to mitigate effects of HIV, including care of grandchildren	Qualitative	FGDs and KIIs	No significant findings – reported benefits across a range of outcomes, but the value of the pension is small and it is mainly used for food
Loudon et al.	<i>Barriers to services for children with HIV positive parents</i>	2007	Asia	Access	Access to services and benefits available to those not affected by HIV and AIDS	Qualitative	FGDs and KIIs at 45 sites	Importance of awareness of transmission mechanisms to reduce stigma, and removal of economic barriers to the provision of financial assistance
McCord	<i>Public works in the context of HIV/AIDS</i>	2005	Africa	Access		Qualitative	Literature review, FGDs, KIIs and case studies	PWPs effective for providing social protection to PLHIV (only some kinds); regular, flexible and accessible to those with limited labour. Other forms of social protection without work requirement may be more appropriate.
Miller and Samson	<i>HIV-sensitive social protection: State of the evidence 2012 in sub-Saharan Africa</i>	2012	Africa	Access and impact		Qualitative	Literature review	Reviews literature on access and impact (prevention, treatment and care) in sub-Saharan Africa and finds major evidence gaps in all areas
MTT and UNICEF	<i>Education access and retention for</i>	2005	Africa	Impact	Impact of social protection	Qualitative	Questionnaire, literature review, KIIs	Identification of which types of social protection are effective for promoting

	<i>educationally marginalised children: Innovations in social protection</i>				on school access and retention		and case studies	increased numbers of OVC in schooling
Octavery et al.	'Analysis of HIV-sensitive social protection schemes in Indonesia'	2011	Asia	Access		Qualitative	Literature review, KIIs and FGDs in four cities	PLHIV access a range of services, but lack access to insurance schemes, many of which do not reach the most vulnerable, and treatment is formally denied to HIV patents.
Pettifor et al.	'Can money prevent the spread of HIV? A review of cash payments for HIV prevention'	2012	Africa and US	Impact	Impact of CTs on HIV prevention	Review	Review of 15 RCTs and one observational study, 10 of which are completed	9/10 completed studies found a positive change in sexual behaviour. The one completed RCT using biological end-point data found lower prevalence rates among the intervention participants compared to the controls at the 18-month follow-up stage.
Roelen et al.	<i>Lessons from the Children and AIDS Regional Initiative (CARI): Child- and HIV-sensitive social protection in Eastern and Southern Africa</i>	2011	Africa	Access		Qualitative	Literature review, KIIs and FGDs in five countries	Poverty a better indicator of vulnerability than orphanhood. Highlights value of combining social protection (CCTs and food inputs) with complementary interventions addressing non-income-based needs, including counselling and psychosocial support
Rompel	<i>Financing HIV/AIDS prevention through social health insurance: A cross-cutting issue for public health in developing countries challenges – implications – questions</i>	2005	Global	Access	Impact of SHI in overcoming financial barriers to access	Qualitative	KIIs and literature review	Provides evidence that SHI is a more effective method for HIV health care than a national health system, with CHIs and SHIs covering particular social groups, enabling effective targeting. Evidence of differential groups benefiting from CHI and SHI. SHI can exclude the poor and mainly includes formal sector employees, with CHI offering more potential to reach the vulnerable. Also provides evidence for role of insurance in prevention
Samuels et al.	'HIV vulnerabilities and the potential for strengthening social protection responses in Nigeria'	2012	Africa	Impact	Impact of CTs on access to services, treatment adherence and outcomes, and care and support	Qualitative	Literature review, KIIs and FGDs	Literature review suggests CTs increase access to services, treatment adherence and outcomes, and care and support

Stene et al.	<i>Economic strengthening programs for HIV/AIDS affected communities: Evidence of impact and good practice guidelines</i>	2009	Global	Impact	Impact of CTs on measures of well-being in HIV-affected households	Quantitative and qualitative	Review of impact evaluations and KIIs	CTs have positive effects on PLHA and HIV-affected households as measured by ECD, improvements in food consumption, reduced child labour, small increases in health expenditures, and decreased truancy, but no effect on school enrolments
Temin	<i>HIV-sensitive social protection: What does the evidence say?</i>	2010	Africa	Impact and access				More literature addresses the impact of social protection on care and support than prevention and treatment. Households receiving CT are more likely to seek health care, are more food secure, and are more likely to invest in strengthening livelihoods. HBC programmes strengthen households' economic status. There is limited evidence on the impact of livelihood programmes on HIV outcomes. Regarding access, there is a concern that PLHIV are discriminated against or excluded from social health protection schemes.
Thwin	<i>Food support to PLHA and OVC with home based care: Evaluation and baseline survey 2006 Cambodia</i>	2006	Asia	Impact	Impact of food support as part of integrated HBC services on mitigation of HIV	Quantitative and qualitative	Intervention/control analysis Cross sectional multi-stage cluster survey KIIs and FGDs	Integrated HBC services, including food provision found to have positive impact in terms of coping mechanisms, livelihoods, food security, nutrition, schooling, treatment adherence. Specific impacts of food provision are not isolated.
UNICEF	'Taking evidence to impact: Making a difference for vulnerable children living in a world with HIV and AIDS'	2009	Global	Access and Impact	Impact of CTs on children in HIV-affected households	Qualitative	Literature review and KIIs	Argues the need for social transfers, social support services, and legislation to promote access to social services and reduce stigma. Need diverse social protection approaches for different groups. Cites evidence that predictable social transfers, such as cash grants to ultra-poor HIV-affected households, enhance children's nutritional status, improve human capital and even increase lifetime earnings
UNICEF and EIU	<i>Mapping of social protection measures for children affected by</i>	2012	Asia	Access	Access to social protection provision	Quantitative	ADB survey data	Focuses on access to large-scale social protection and HIV-sensitive social services managed by government agencies or development

	<i>HIV and AIDS in Asia and the Pacific</i>							partners for children and caregivers affected by HIV, with provision in each country coded from limited to extensive. Not a study of efficacy or impact
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