Disability and social protection programmes in low- and middle-income countries: A systematic review

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# **ABSTRACT**

This paper systematically reviews the evidence on whether persons with disabilities in low- and middle-income countries are adequately included in social protection programmes, and assesses the financial and non-financial impacts of participation. Overall, we found that access to social protection appears to fall far below need. Benefits from participation are mostly limited to maintaining minimum living standards and do not appear to fulfil the potential of long-term individual and societal social and economic development. However, the most notable finding of this review is that there is a dearth of high-quality, robust evidence in this area, indicating a need for further research.

**Keywords:** disability, social protection, social assistance, insurance, vulnerability

# **INTRODUCTION**

With the proliferation of development policies and programmes, there is an urgent need to collate and evaluate existing knowledge on their effectiveness. Establishing this evidence-base on “what works” can then inform decision-making in order to maximize desired outcomes. As a relatively new strategy in low- and middle-income countries (Barrientos & Hulme, 2009), social protection has been rapidly gaining traction as a strategy and a set of instruments to prevent and alleviate poverty among individuals or groups vulnerable to deprivation (Devereux & Sabates-Wheeler, 2004; Gentilini & Omamo, 2011). Given high levels of poverty and marginalization (Banks & Polack, 2014; World Health Organization & World Bank, 2011), persons with disabilities are often explicitly or implicitly targeted by social protection programmes. However, little is known about whether persons with disabilities are being adequately included in existing social protection programmes or what the financial and non-financial impacts are on the lives of beneficiaries with disabilities from participation.

## *1.1 Social protection framework*

Social protection is usually defined as actions to help individuals, households and communities prevent, mitigate or cope with risks which can temporarily or permanently lead to or exacerbate poverty and deprivation beyond a level considered acceptable in a given society (Conway & Norton, 2002) (see Figure 1).

Though its central objective has been to protect minimum living standards so that all persons can meet their basic needs, social protection increasingly aims to promote a “springboard” or transformative function as well. This means that it intends to help individuals move beyond the subsistence level, so that they can invest in productive assets and human capital which allow for the development of stronger livelihoods and an escape from long-term poverty traps (Barrientos, Hulme, & Shepherd, 2005; Devereux & Sabates-Wheeler, 2004; World Bank, 2001). In the longer term, it is believed that the aggregate of these individual gains will lead to increased national economic growth and development as well as promote more equitable and cohesive societies (Devereux & Sabates-Wheeler, 2004; Ellis, White, Lloyd-Sherlock, Chhotray, & Seeley, 2008; Gentilini & Omamo, 2011).

Strategies listed under the umbrella of social protection to bring about these gains vary across frameworks. Typically, social assistance and insurance are seen as the dominant models for delivering social protection. In low- and middle-income countries, social assistance (i.e. non-contributory transfers in cash or kind to groups deemed eligible because of deprivation) has been the dominant model in use (Barrientos & Hulme, 2009; Gentilini & Omamo, 2011). Increasingly, however, forms of insurance (e.g. health insurance, old age pensions), previously more the purview of higher-income countries, are being adopted, particularly in middle-income countries (Barrientos & Hulme, 2009). Finally, under more extensive definitions, programmes and policies which ensure equitable access to basic services and reforms that protect the rights of vulnerable groups are being included as components of social protection (Devereux & Sabates-Wheeler, 2004; Gentilini & Omamo, 2011).

*1.2 Social protection and disability*

Persons living in poverty or facing other forms of marginalization face higher exposure to many risks which could lead to or exacerbate poverty and vulnerability, but they often have fewer independent means at their disposal for preventing, mitigating or coping with these risks (World Bank, 2001). Social protection programmes thus often target individuals or groups considered particularly vulnerable to and from such risks. One such vulnerable group is persons with disabilities, who are significantly more likely to be living in poverty and face a wide-range of social, economic and cultural forms of exclusion (World Health Organization & World Bank, 2011). Consequently, many social protection schemes either implicitly or explicitly include persons with disabilities in their eligibility criteria. Complementing this needs-based argument for disability-inclusive social protection, the right to social protection for persons with disabilities is enshrined in the Universal Declaration of Human Rights (Article 25: the right to adequate standards of living and security) and the United Nations Convention on the Rights of Persons with Disabilities (Article 28: adequate standards of living and social protection).

The combination of these arguments provides the normative basis for efforts to achieve the full inclusion of persons with disabilities within social protection policies and programmes at the global, regional and national level. There are a number of international frameworks for social protection – including the Social Protection Floor initiative by the International Labour Organization with endorsement from the World Health Organization, various United Nations bodies, the World Bank, donor agencies, non-governmental organizations and others (International Labour Organization, 2012). Whilst these frameworks recognize the needs and rights of persons with disabilities to social protection, comprehensive strategies beyond simply identifying persons with disabilities as a vulnerable group are lacking.

The absence of clear strategies for making social protection disability-inclusive may lead to the exclusion of persons with disabilities. As evidenced with the Millennium Development Goals - which made no reference to disability in any of its Goals, Targets or Indicators - failure to address barriers to inclusion may propagate the continued economic and social marginalization of persons with disabilities (United Nations, 2011). Specific barriers which prevent persons with disabilities from accessing and realizing the benefits of social protection programmes may include: inaccessibility of administration and service procedures and centres, discriminatory attitudes of administrators, certain conditions attached to receipt of benefits (e.g. school attendance) and limited awareness of the availability and eligibility for programmes (Gooding & Marriot, 2009).

Furthermore, the use of a standard income-based poverty line for assessing eligibility in all applicants and the provision of fixed benefits to all recipients may mask actual levels of need of persons with disabilities. Notably, as persons with disabilities often encounter additional disability-related expenses (e.g. extra transport, medical and rehabilitation costs, purchase of assistive devices), they tend to have higher expenditure needs than people without disabilities (Marriot & Gooding, 2007; Mitra, 2005). Persons with disabilities may then have to forgo or decrease consumption of essential items and services if unable to sustain these extra expenses. For example, in low-income countries, persons with disabilities are over 50% more likely than people without disabilities to cite costs as a reason for not accessing needed health care (World Health Organization & World Bank, 2011). In the long-term, paying out-of-pocket or forgoing essential expenditures can lead to further restrictions in participation in areas such as school and employment and may impede the development of human capital, reduce household earnings and ultimately keep individuals in long-term poverty traps (World Health Organization, 2001). Therefore, social protection programmes may need different eligibility criteria and benefit packages for recipients with disabilities (Gooding & Marriot, 2009); failure to incorporate this in the programmes may lower access and reduce the impact of social protection programmes for persons with disabilities.

Given the emphasis placed on social protection as an important development tool for spurring and equalizing social and economic growth – particularly for vulnerable groups such as persons with disabilities – there is a pressing need to determine whether these programmes are adequately reaching persons with disabilities and whether participation is producing the desired impacts among this group of target beneficiaries. To address this gap in knowledge, we use a systematic review methodology to select, assess and analyse the published evidence on access to and impact of social protection among persons with disabilities in low- and middle-income countries. Through this process, we explore questions such as whether existing programmes are sufficiently disability-inclusive, and how to better tailor programmes and policies for full and effective inclusion of persons with disabilities not just within social protection programmes themselves but also in the broader processes of social and economic growth.

# **METHODS**

While systematic reviews are relatively new in the field of international development (Van Rooyen, Stewart, & de Wet, 2012), this method is well-established within medicine, public health and social science as a robust and transparent means of gathering, summarizing and evaluating existing evidence on a given topic (Moher, Liberati, Tetzlaff, & Altman, 2009). By striving to produce a comprehensive, objective overview of available research, systematic reviews can then be used to guide policy decisions or identify priorities for further research if evidence is lacking.

This systematic review was conducted in line with standard procedures as outlined in the PRISMA statement, the evidence-based, expert-endorsed guidelines for systematic review methodology(Moher et al., 2009).

* 1. *Search strategy*

Eight electronic databases relevant to the topic of disability and social protection were searched between July-December 2014: Web of Science; EconLit; ERIC; ProQuest Health and Medicine Complete; ProQuest Political Science; Pro Quest Research Library; ProQuest Social Science Journals; and ProQuest Sociology. Additional sources were then identified through searching the reference lists of included studies and by recommendations from experts in the fields of social protection and/or disability.

Search terms for disability, social protection and low- and middle-income countries were identified through MeSH as well as from other reviews on similar topics (Iemmi et al., 2013) (for full search string, see web annexes). Searches were limited to English-language titles, and to capture more recent trends, the date of publication was restricted to 1990 onwards.

*2.2 Inclusion/exclusion criteria*

Any peer-reviewed article presenting original research which focused on access to or impact of social protection programmes among persons with disabilities in low- and middle-income countries was eligible for inclusion. For the purpose of this paper we focused on publicly provided social assistance and insurance schemes, as these components form the core of social protection across the varying definitions. We included both mainstream programmes (i.e. persons with disabilities not explicitly specified as intended beneficiaries but implicitly targeted due to higher levels poverty and other types of vulnerability) and targeted programmes (i.e. those where disability is an explicit criteria for eligibility). Studies and social protection programmes defining disability using both medical model definitions of disability (i.e. specific impairments or disorders) as well as broader classifications (e.g. functional or activity limitations, participation restrictions) were eligible for inclusion.

No restrictions were placed on study design, with papers using either quantitative or qualitative methods eligible for inclusion.

*2.3 Papers selection, screening and quality assessment*

Articles were screened sequentially by abstract, title and full text by two of this paper’s authors to determine inclusion in the final sample. To evaluate the risk of various types of bias in the included studies, articles were separately evaluated by two of this paper’s authors using modified versions of the assessment tools RATS and STROBE, for qualitative and quantitative studies, respectively (Clark, 2003; Von Elm et al., 2007) (for list of assessment criteria, see web annexes). Assessment focused on the risk of potential biases arising from study design, sampling methods, data collection and data analysis/interpretation. Studies were categorized as: (1) “low” risk of bias if all or almost all of the criteria were fulfilled, and those not fulfilled were thought unlikely to alter the conclusions of the study; (2) “medium” risk of bias if some of the assessment criteria were fulfilled, but those not fulfilled were thought unlikely to alter the conclusions of the study; or (3) “high” risk of bias if few or no criteria were fulfilled, and the conclusions of the study were thought to potentially be altered with their inclusion. As this was a broad review – with included studies varying widely in terms of research questions, methodologies used, study populations and outcomes measured – no strict cut-offs were used in assigning classifications; instead, papers were holistically evaluated to assess their overall risk of bias. Differences between reviewers in categorizations for the quality assessment were discussed and a consensus in ranking was reached on all papers.

* 1. *Data extraction and analysis*

The following information was extracted from studies included in the final sample:

* Study characteristics (design, site of recruitment, location)
* Study population characteristics (disability/impairment type, composition of comparison group, size, age range, gender)
* Characteristics of social protection programmes (type, implicit or explicit targeting scheme)
* Research outcomes (main findings related to access to and impact of social protection for persons with disabilities)

In classifying study outcomes related to the impact of social protection in extraction tables, if participation in a particular programme produced any evidence of a desirable outcome in a particular domain (e.g. decreased barriers in meeting basic needs, reduction in poverty, increased employment), then that programme was deemed to have a positive impact. If participation led to undesirable outcomes (e.g. increased unemployment, poverty), the programme was classified as having a negative impact. Social protection programmes were also classified as having no impact if participation did not result in discernible changes among recipients, and as having mixed impact if the programme led to a combination of positive and negative outcomes.

For studies using a comparison group (e.g. social protection recipients with disabilities compared to participants without; recipients versus non-recipients with disabilities) all impacts were classified in relation to the comparator.

# **RESULTS**

Searches of the electronic databases yielded 598 records, of which 554 were rejected in screening by title or abstract. After a further 32 articles were excluded after reviewing their full text and an additional 3 articles added through expert recommendations or from searching the reference lists of other studies, a final selection of 15 studies was obtained (see Figure 2).

## *3.1 Description of the studies*

All included studies were published in 2004 or later, reflecting the recent interest in this area. By study location, approximately half of the studies (n=8, 53%) were conducted in South Africa, with the remainder based in China (n=2), Vietnam (n=3) and Namibia (n=1). One study was a multi-country analysis (Argentina, Brazil, Colombia).

By study design, most were quantitative (n=11, 73%), of which all but one (an ecological study) used cross-sectional surveys. Three studies were purely qualitative and one used mixed methods.

Concerning types of social protection programmes (see Table 1), most studies focused solely on social assistance (n=10, 67%), of which nine were programmes targeted to persons with disabilities and one examined both targeted and mainstream structures. Three articles focused on insurance (health insurance, pensions), and two covered a mix of social protection schemes.

While most studies included participants with all types of disabilities (n=12, 80%), some focused on specific impairments (n=3).

From the quality assessment, five studies were ranked as having low, six as medium, and four as high risk of bias. Most sources of potential bias arose from the sampling methods, with small samples sizes, non-population based sources and convenience strategies for recruitment, limiting the generalizability of results. Specific sources of potential bias can be found in the web annexes and the implications of these sources of potential bias are discussed in more detail throughout the paper.

## *3.2 Access of persons with disabilities to social protection*

Eight studies presented findings on barriers faced by persons with disabilities in accessing social protection programmes (see Table 2). All but one study (Palmer & Nguyen, 2012) in this category refer to targeted social assistance programmes in South Africa.

Three studies in the final sample included quantitative measures to gauge access among persons with disabilities, with all finding evidence of exclusion (Mitra, 2010; Palmer & Nguyen, 2012; Saloojee, Phohole, Saloojee, & Ijsselmuiden, 2007). Both Mitra*.* (2010) and Palmer & Nguyen(2012) analysed national survey data to estimate exclusion error rates; that is, the percentage of eligible individuals who are not participating in a given social protection programme. Mitra (2010) reported a high rate of exclusion from disability grants in South Africa, with 42% of eligible individuals not enrolled. The inclusion error rate was also high (34%) – indicating problems in the sensitivity of targeting; however, authors noted that exclusion errors were more serious, as excluded households fared worse in terms of food security (Mitra, 2010). Palmer & Nguyen(2012) also noted that the exclusion rate from mainstream health insurance in Vietnam was high, as 66-80% of eligible persons with disabilities were not enrolled. Similarly, Saloojee *et al.* (2007) found in a smaller cross-sectional study in South Africa that only 45% of eligible families with children with disabilities were receiving care dependency grants. No studies provided measures of equity in coverage between people with and without disabilities, although Palmer & Nguyen (2012) noted that the percentage of persons with disabilities accessing health insurance in Vietnam was similar to the total population (19%). However, this figure only indicates the proportion of total population – not the eligible population – and thus persons with disabilities may still have lower access relative to need.

In the two studies exploring differences in characteristics between persons with disabilities receiving and not receiving social protection, no common themes were evinced. In South Africa, recipients of social protection programmes were significantly more likely to be older, have a disability resulting from work and be less educated than non-recipients (Mitra, 2010). In a separate study from South Africa, living in a rural area and having an impairment which limited mobility were associated with better access to social assistance (Jelsma, Maart, Eide, Toni, & Loeb, 2008). However, no differences were found in age, gender, impairment type, marital status and employment status when comparing recipients and non-recipients with disabilities.

The most commonly cited barrier to accessing social protection programmes related to disability assessment processes for targeted social assistance programmes (Berry & Smit, 2011; Goldblatt, 2009; Graham, Moodley, & Selipsky, 2013; MacGregor, 2006; Saloojee et al., 2007). Means of assessing disability were deemed subjective, with evaluators commenting on a lack of clear assessment criteria with which to judge applicants (MacGregor, 2006). Consequently, some authors noted that assessments excluded persons with certain types of disabilities, such as chronic conditions and temporary, mild or moderate disabilities, instead only picking up severe and highly visible forms of disability (Berry & Smit, 2011). Furthermore, applicants often were unclear about how decisions were made and felt discriminated against by evaluators (Graham, Moodley, & Selipsky, 2012; Jelsma et al., 2008; MacGregor, 2006). Lack of confidentiality and respect for applicants during the assessment process was also reported (Goldblatt, 2009).

Difficulties with the application process were also commonly reported as a barrier to access (Goldblatt, 2009; Graham et al., 2012; MacGregor, 2006; Saloojee et al., 2007). Persons with disabilities were frequently unaware of the existence of certain programmes or that they met eligibility criteria (Goldblatt, 2009; Graham et al., 2012; MacGregor, 2006). Additionally, respondents reported being unclear on application requirements, lacking correct documentation or having difficulties accessing grant offices (Goldblatt, 2009; Graham et al., 2012; MacGregor, 2006; Saloojee et al., 2007). Bureaucratic complications, such as inconsistent policies and practices between regions, were also noted (Goldblatt, 2009). Finally, in addition to application fees, some participants reported incurring expenses while seeking social protection which were prohibitive for them – for example, for transport, child care, or assistance (Goldblatt, 2009).

Even when accepted into a social protection programme, some struggled to receive benefits. Inaccessible pay points posed problems, even if they were physically close to recipients; additionally, safety was a concern, particularly for women, when attending pay points to collect stipends (Goldblatt, 2009).

*3.3 Impact of social protection for beneficiaries with disabilities*

Twelve studies presented findings on the impact of social protection for persons with disabilities (see Table 3).

3.3.1 Impact on poverty: meeting basic needs and reducing poverty

Seven of eight studies found that inputs from social protection played an important role in helping individuals and their households meet basic needs (Berry & Smit, 2011; Goldblatt, 2009; Graham et al., 2012; Levine, van der Berg, & Yu, 2011; Li et al., 2013; Loyalka, Liu, Chen, & Zheng, 2014; Mitra, 2008, 2010; Palmer et al., 2012). Beneficiaries often pointed to the vital role that social protection played in helping their household cope financially – for buying essential items such as food, clothes, electricity and basic healthcare – which they would otherwise struggle to afford. However, not all programmes were sufficient to protect minimum living standards for recipients: for example, in Vietnam, the value of cash transfers was found to be inadequate in covering minimum daily food intakes of persons with disabilities (Palmer et al., 2012).

In assessing whether social protection could help persons with disabilities to escape poverty, findings were less positive. Though one multivariate analysis of national survey data in Namibia found that participation in various social protection programmes significantly reduced a person with a disability’s probability of living in a poor household (Levine et al., 2011), most studies indicated that social protection contributions were insufficient to provide an escape out of poverty (Goldblatt, 2009; Graham et al., 2013; Loyalka et al., 2014; Palmer, 2014). Notably, social protection schemes failed to cover disability-related expenses – such as assistive devices, extra medical and transport costs – which were often a significant financial burden to households (Goldblatt, 2009; Graham et al., 2012; Loyalka et al., 2014; Palmer, 2014). Disability-associated costs can be substantial – one included study found them to account for 18-31% of total household income (Loyalka et al., 2014) – and reduce the standard of living for a given income threshold. The failure of programmes to compensate the extra associated costs with disability may propagate economic inequalities between recipients with and without disabilities: for instance, in Vietnam, although health insurance protected against catastrophic health expenses, compared to other groups persons with disabilities were at increased risk of poverty due to continual out-of-pocket expenditures for items not covered in their plans (e.g. medication, specialized services, transport) (Palmer, 2014).

3.3.2 Impact on healthcare access, mental health and employment

Seven studies (Goldblatt, 2009; Jelsma et al., 2008; Loyalka et al., 2014; Mitra, 2008; Palmer, 2014; Palmer et al., 2012; Vazquez et al., 2011) examined the impact of social protection in domains other than poverty.

Evidence from three studies examining healthcare access was mixed, but indicated that health insurance schemes were inadequate in covering the healthcare needs of recipients with disabilities. For example, although health insurance in Vietnam significantly increased recipients with disabilities’ use of health services (Palmer, 2014), there were some issues around the sufficiency of coverage, particularly in comparison to recipients without disabilities. While health insurance was found to help recipients cope with minor health issues, for instance, it was insufficient to cover more complex health care needs, which persons with disabilities may be more likely to require (Palmer et al., 2012). Consequently, persons with disabilities reported spending four times more on healthcare – even with insurance – compared to other groups without disabilities (Palmer, 2014). Similarly, in China, health insurance recipients with disabilities reported that only 18% of their medical expenses were covered (Loyalka et al., 2014).

Additionally, evidence from two studies indicated that there may be some negative mental health impacts associated with receiving social assistance. For example, a multi-country study found that among people with bipolar disorder, receiving targeted social assistance was significantly associated with increased self-perceived stigma (Vazquez et al., 2011). Additionally, participants in one study noted that while social assistance was integral to their household’s economy, fear of losing the grant caused emotional distress (Goldblatt, 2009).

Finally, some experts have questioned whether social assistance deters engagement in work: in analysing national survey data in South Africa, it was found that a 10% increase in coverage of disability was associated with a 15% drop in employment rates among persons with disabilities (Mitra, 2008). However, a smaller study found no difference in employment status between recipients and non-recipients with disabilities (Jelsma et al., 2008).

# **DISCUSSION**

Perhaps the most notable finding of this review is that there is a dearth of high quality, robust evidence which comprehensively evaluates access to and impact of participation in social protection programmes for persons with disabilities in low- and middle-income countries. The research and policy implications emerging from the existing evidence gathered from this systematic review is discussed below.

*4.1 Access to social protection*

Studies exploring access of persons with disabilities to social protection found evidence of exclusion. For example, from the exclusion error rates provided in two studies (Mitra, 2010; Palmer & Nguyen, 2012a), it appears that many eligible persons with disabilities are not covered in existing social protection programmes. In addition to evaluating overall access, it is important to determine equity in access, both among persons with disabilities and in comparison to the broader eligible population for mainstream programmes; however, no study in this review measured relative access between eligible persons with and without disabilities, indicating an area in urgent need for further research. For differences in access among persons with disabilities, there is some indication that persons with impairments affecting mobility (Jelsma et al., 2008) or which are work-related (Mitra, 2010) are more likely to receive disability grants in South Africa. This may reflect biases in the assessment process towards ‘visible’ and ‘socially acceptable’ forms of disability, though more evidence is needed.

It should be noted that few studies provided robust, programme-wide measures on access of persons with disabilities to social protection. Much of the evidence came from small-scale qualitative studies and thus the evidence provided is often anecdotal, with limited generalizability. From a research perspective, measuring access presents several methodological challenges. To determine coverage among persons with disabilities, information on both the percentage of persons with disabilities in the overall population and the proportion who are enrolled in social protection programmes is needed. Then, to establish if a programme is sufficiently reaching its target beneficiaries, data on the percentage of persons with disabilities who meet eligibility criteria for a particular programme in the catchment population will also be required. However, it may be difficult to find accurate, reliable estimates for this (Yeo, 2001), especially in mainstream schemes which may not record the disability status of participants. One approach has been to extrapolate survey or census data; however, this method may have limitations as national data collection often suffers from inaccuracies and incompleteness, and measurements of factors such as disability and poverty may be inconsistently measured across sources (Yeo, 2001).

Nevertheless, from a policy perspective, a clear finding from this review is the need for improved design and implementation of social protection eligibility in order to avoid the exclusion of persons with disabilities who, based on need, should actually be included in programmes (Berry & Smit, 2011; Goldblatt, 2009; Graham et al., 2012; MacGregor, 2006). For example, a key criteria, particularly for social assistance, is that recipients are below a certain poverty threshold, which is usually based on income (Gooding & Marriot, 2009). However, few programmes account for the extra costs of disability, which can substantially deplete a household’s income and lower standards of living. Without this adjustment, assessments of the number of households or persons with disabilities who are living in poverty will likely be underestimated (Cullinan, Gannon, & Lyons, 2011; Loyalka et al., 2014).

Similarly, tailoring of disability assessments to determine eligibility in targeted social protection programmes is needed to ensure contextually appropriate approaches which do not lead to the exclusion of persons with certain types of disabilities. Although often assumed to be an “easily identifiable trait” similar to age or sex (Devereux, 2006; Gooding & Marriot, 2009), determining who has a disability is complex. Definitions of disability employed in assessments vary widely: some models take a more medical approach of focusing on specific impairments, while others attempt to incorporate a social model which views the disability as resulting from inaccessible societies where the physical, cultural and policy environments are not accommodating of individuals with functional limitations or impairments. Both models present difficulties in assessing disability for eligibility in social protection programmes. For example, assessments with medical model criteria – which currently most social protection programmes tend to use – may be biased against invisible or episodic impairments (e.g. some mental health disorders) and require trained personnel and medical services, which may be unavailable or insufficient in certain settings (Gooding & Marriot, 2009). Attempts to incorporate social model approaches (e.g. measuring the ability to function within a given environment) have been criticized as being too subjective and open to fraud (Marriot & Gooding, 2007; Schneider, Waliuya, Munsanje, & Swartz, 2011). Within the disability literature, defining disability in line with the International Classification of Functioning, Disability and Health (ICF), which attempt to combine both medical and social approaches, is generally preferred; use of ICF in social protection eligibility assessments has thus far been limited, due in part to complex assessment procedures difficult to implement at the programme level (Gooding & Marriot, 2009).

Finally, other criteria attached to eligibility are often difficult to assess (Gooding & Marriot, 2009). For example, many schemes include stipulations that the disability causes an individual to be “unable to work”, a determination which is highly subjective and may rely more on external social, environmental and personal factors than on limitations posed by a specific impairment (Gooding & Marriot, 2009). Consequently, many persons with disabilities who would otherwise be targeted for inclusion may not be recognized as having a disability according to the programme criteria, putting into question whether those programmes are reaching the most vulnerable.

*4.2 Impact of social protection*

Referring to the intended impacts of social protection outlined in Figure 1, evidence from this review indicates that actual impacts among recipients often fall short in certain domains.

In the most central function of protecting a minimum living standard, the majority of included studies indicated that social protection programmes performed well. All but one study (Palmer et al., 2012) found that social protection played an important role in helping recipients meet their most basic needs.

However, in assessing the ability of social protection to help beneficiaries move beyond a subsistence level, develop stronger livelihoods and ultimately escape poverty, findings were more mixed. Only one study (Levine et al., 2011) indicated that access to social protection decreases the likelihood of living in poverty, while all others found no or mixed effects. The failure of social protection programmes to account for extra costs associated with disability was cited as a major reason for their limited impact (Goldblatt, 2009; Graham et al., 2012; Loyalka et al., 2014; Palmer, 2014). Not only can disability-associated expenses be substantial (Loyalka et al., 2014), but when financial constraints lead to the forgoing of these often-essential expenditures, the ability to develop stronger livelihoods and escape poverty may be hindered in the long-term. For example, not purchasing assistive devices or accessing needed medical care can worsen activity limitations, which in turn restrict participation in areas such as school or work. Not accounting for these extra costs when designing benefit packages could therefore minimize the potential of social protection as a tool for long-term poverty alleviation and development.

In addition, some studies indicated a deterrent effect on employment, likely arising from stipulations in eligibility criteria that beneficiaries be ‘unfit to work’ (Mitra, 2008). As employment leads to income generation and typically greater economic self-sufficiency, dissuading beneficiaries from engaging in work undermines the ability of social protection to foster more sustainable, gainful livelihoods and may lead to longer dependence on benefits (Mitra, 2005).

Similarly, unmet health needs can propagate long-term poverty and impede livelihood development (World Health Organization, 2001) Although social protection – particularly health insurance – has been cited as a means of lowering barriers to accessing needed health services, findings from this review on its impact for persons with disabilities were mixed. Most studies indicated that, although insurance provided some benefits, coverage was typically insufficient to meet the full range of health needs of recipients with disabilities. This inadequacy was particularly apparent when analysed in relation to beneficiaries without disabilities. For example, due to caps on expenditures and other non-covered costs, health insurance recipients with disabilities experienced greater out-of-pocket payments than their counterparts without disabilities, leading to higher levels of poverty (Palmer, 2014). As persons with disabilities often have greater health needs and thus require more health services than people without disabilities to maintain similar levels of health (Rimmer & Rowland, 2008), failure to target benefit packages to fit the needs of persons with disabilities may limit the potential of social protection to alleviate poverty and lead to the propagation of health and income inequalities.

Concerning whether the more lofty goals of promoting social justice and spurring economic growth and development are being met, evidence is non-existent. While it may be assumed that reducing poverty and increasing the social and economic participation of persons with disabilities could lead to aggregate gains on a larger scale, no studies provided empirical corroboration. Similarly, although no included studies explicitly examined the impact of social protection on promotion of social justice, some evidence indicates that this goal is far from being fulfilled. For example, findings related to mental health and social protection – such as that persons with bipolar disorder on social protection experienced higher rates of stigma compared to non-recipients (Vazquez et al., 2011) – would seem to counter aims of social protection as a vehicle for empowerment and reduced marginalization. Furthermore, the one study comparing impacts between recipients with and without disabilities (Palmer, 2014) highlights issues in equity: as benefits of participation were not shared equally between groups, it suggests that social protection, if not targeted properly, may continue to propagate social inequality.

*4.3 Limitations of the review*

Several limitations should be taken into account when interpreting the findings of this review. Firstly, there was extremely limited data available as very little has been published on this topic. Where available, over half of included studies were based in South Africa, which is an upper middle-income country (World Bank, 2015) and has a relatively well-developed, comprehensive social protection system (Devereux, 2010). This means that findings may not be generalizable to the situation in other low- to middle-income countries. More research from other countries and regions, with different social protection schemes, would be useful for enriching the evidence base, enabling comparisons across diverse contexts and ultimately increasing the power with which to guide policy decisions.

Furthermore, only a third of included studies could be ranked as being of “high” quality. While the other studies were still useful in addressing the research questions, the conclusions drawn in these studies are more at risk from potential bias. Notably, many studies were small in scale, lacked comparison groups and may have introduced biases through their sampling strategies (e.g. convenience sampling), which could limit the validity of the evidence they generated.

Finally, restrictions to English language-only texts very likely excluded potentially relevant articles, particularly from Latin America where social protection systems are widespread (Ferreira & Robalino, 2010)).

# **CONCLUSION**

Social protection has been gaining visibility within the international policy discourse as a tool for preventing and alleviating poverty and reducing social and economic inequalities. Recognizing the overrepresentation of persons with disabilities amongst the economically and socially marginalized, international frameworks and national programmes and policies are increasingly advocating for greater inclusion of persons with disabilities in social protection. Given this directive, this systematic review sought to compile and evaluate existing evidence on access to and impact of social protection for persons with disabilities in low- and middle-income countries. In doing so, this review began to explore whether programmes are adequately disability-inclusive and, if not, then what are some of the means through which to improve access and impact for this target group.

Perhaps the most notable finding of this review is that there is a dearth of high quality, robust evidence which comprehensively evaluates these central questions. To better guide policy and programmatic decisions, further research in the following areas is urgently needed.

Firstly, more research utilizing comparison groups drawn from the general population is needed in order to determine equity in access and impact. Among included studies in this review, only one assessed the difference in impacts and none compared access between beneficiaries with and without disabilities. Such an analysis is needed to assess whether persons with disabilities are accessing and capturing the same benefits from participation as other eligible persons without disabilities. As social protection seeks to improve social and economic equality, unequal access and lower impact from participation may propagate the continued marginalization and vulnerability experienced by many persons with disabilities.

Secondly, as persons with disabilities are not a homogeneous group, understanding how access and impact are modified by compounding factors such as gender, age and impairment types would be useful for gaining a more nuanced view on how the influences of these elements can promote or hinder participation among persons with disabilities.

Thirdly, as most of the studies on impact focused on a relatively limited subset of the intended functions of social protection – namely, protection of minimum living standards – broader assessments would help elucidate the effects of participation across the full spectrum of social protection’s intended outcomes.

Fourthly, as most of the included studies focused on targeted social assistance in South Africa, more research covering a diverse array of types of social protection – particularly mainstream schemes – in a variety of locations would add greater breadth to the evidence base. As what works well in one situation may not transfer well to another, widening the evidence base to include a more diverse mix of programmes and contexts can be more informative for identifying common barriers as well as strategies with broad-based effectiveness.

Finally, in conducting further studies, emphasis should be placed on robust study designs and methods – with large, representative samples, appropriate comparison groups and controls for confounding. Among the quantitative included studies, all were cross-sectional and one was ecological, so other, more robust study designs which present less of a risk of bias would be valuable. For qualitative studies, more transparent reporting of methods and representative sampling is needed.

Even though more research on this topic is urgently needed, the evidence emerging from this review indicates that access to social protection likely falls far below need, and that benefits from participation are mostly limited to maintaining minimum living standards and do not appear to hold the promise espoused in the social protection literature of long-term individual and societal social and economic development. A clear finding from the review is that in designing and implementing social protection programmes, a more nuanced approach is required to ensure they are appropriately disability-inclusive. Programmes need to improve their ability to both accurately assess disability as well as tailor interventions to address the specific needs of recipients with disabilities. Currently, there is broad recognition among policymakers of disability as a dimension of vulnerability and acknowledgment that persons with disabilities need to be considered whenever there is a concern with ensuring programmes truly address the needs of the most vulnerable. However, if dedicated attention is not given to the specific needs of persons with disabilities – or any other ‘vulnerable group’ – it is highly unlikely that actions taken will properly reflect their concerns or address their needs.

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| --- | --- | --- | --- | --- |
| *Citation* | *Setting* | *Type of social protection* | *Description of programme* | *Name of programme* |
| Berry & Smit (2011) | South Africa; unknown if rural or urban | Social assistance, targeted and mainstream | Non-contributory cash transfer to caregiver of a child with a severe disability | South African Care Dependency Grant |
| Goldblatt (2009) | Rural and urban South Africa | Social assistance, targeted | Non-contributory cash transfer to adults living in poverty, found medically unfit to work (permanently or temporarily) | South African Disability Grant |
| Graham et al (2012) | Urban South Africa | Social assistance, targeted | Non-contributory cash transfer to adults living in poverty, found medically unfit to work (permanently or temporarily) | South African Disability Grant |
| Jelsma et al (2008) | Urban and rural South Africa | Social assistance, targeted | Non-contributory cash transfer to adults living in poverty, found medically unfit to work (permanently or temporarily) | South African Disability Grant |
| Levine et al (2011) | Namibia (national) | Social assistance, targeted | Non-contributory cash transfer to individuals over 16 with temporary/permanent disability; no minimum means requirement | Namibian Disability Grant |
| Li et al (2013) | Urban and rural China | Insurance (pension), targeted | Old-age pensions (no further details) | Not stated |
| Loyalka et al (2014) | China (national) | Social assistance and insurance, mainstream | Social assistance: minimum life allowance, relief assistance; Insurance: pension, medical, unemployment, maternity, work accident insurance, rural cooperative medical and pension insurance | Not stated |
| Macgregor (2006) | Urban South Africa | Social assistance, targeted | Non-contributory cash transfer to adults living in poverty, found medically unfit to work (permanently or temporarily) | South African Disability Granted |
| Mitra (2008) | South Africa (national) | Social assistance, targeted | Non-contributory cash transfer to adults living in poverty, found medically unfit to work (permanently or temporarily) | South African Disability Grant |
| Mitra (2010) | South Africa (national) | Social assistance, targeted | Non-contributory cash transfer to adults living in poverty, found medically unfit to work (permanently or temporarily) | South African Disability Grant |
| Palmer & Nguyen (2012) | Vietnam (national) | Insurance (health), mainstream and targeted | Non-contributory insurance for severe disability, incapacity to work and without a source of income; other non-disability targeted schemes for poor (non-contributory) or general population (contributory) | Compulsory Health Insurance, Voluntary Health Insurance or Health Insurance for the Poor |
| Palmer et al (2012) | Vietnam (national) | Social assistance and insurance (health), mainstream | Non-contributory health insurance, cash transfers | Not stated |
| Palmer (2014) | Vietnam (national) | Insurance (health) | Health insurance, both contributory and non-contributory (depending on poverty, disability status)y | Social Health Insurance |
| Saloojee et al (2007) | Peri-urban South Africa | Social assistance, targeted | Grant to adults living in poverty, found medically unfit to work | South African Disability Grant |
| Vazquez et al (2011) | Argentina, Brazil, Colombia | Social assistance, targeted | Grant to caregiver of a child with a severe disability | South African Care Dependency Grant |
| *Table 1*: *Description of social protection programmes in included studies* | | | | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| *Source of evidence* | | | | |  | | *Measure of access* | |  | *Barriers to and differences in access* |
| *Citation* | *Study design* | *Setting* | *Source of sample* | *Type of social protection* |  | *Indicator* | | *Outcome* |  |  |
| Berry & Smit (2011) | Cross-sectional | South Africa; unknown if rural orurban | 18 children with disabilities or chronic illness (recruited from tertiary care centres) | Social assistance, targeted and mainstream |  |  | |  |  | Assessment instrument discriminates against chronic illnesses, temporary health conditions and mild/moderate disabilities |
| Goldblatt (2009) | Qualitative | Rural and urban South Africa | 93 individuals, including experts and people with disabilities (recruited from clinics, grant offices) | Social assistance, targeted |  |  | |  |  | Administration difficulties (e.g. complicated grant process, individuals not aware they're eligible, inconsistencies between provinces in administration practices/procedures), inaccessible facilities (pay points, offices), problems with assessment panels (subjective, lack of confidentiality/respect), additional expenses (for application, transportation, assistance, childcare), safety concerns especially for women when accessing pay points |
| Graham et al (2012) | Mixed methods | Urban South Africa | 94 people with disabilities (population-based recruitment) | Social assistance, targeted |  |  | |  |  | Not having correct documentation, inability to access the grant offices, not knowing how to apply and lack of clarity from health professionals abut type and severity of disability and the impact it has on his/her work. |
| Jelsma et al (2008) | Cross-sectional | Urban and rural South Africa | 305 people with cognitive, physical or sensory impairments (population-based recruitment) | Social assistance, targeted |  |  | |  |  | No differences between recipients and non-recipients with disabilities in age, gender, marital status, impairment type or employment status. Recipients were significantly more likely to live in rural areas and report a mobility limitation. |
| Macgregor (2006) | Qualitative | Urban South Africa | Observations from a psychiatric clinic involved in disability grant assessments | Social assistance, targeted |  |  | |  |  | Patients not always aware of procedures for being assessed for a disability grant; patients felt they would be more likely to receive the grant if they were on medication; medical staff felt patients should find own solutions to their economic problems rather than seeking a disability grant; disability grant was withheld until patients were compliant with medication. |
| Mitra (2010) | Cross-sectional | South Africa (national) | General Household Survey 2005 | Social assistance, targeted |  | 1. Exclusion error rate  2. Inclusion error rate | | 1. 42%  2. 34% |  | Disability grant recipients are significantly more likely to have a work disability and be older, substantially less educated and three times more likely to be illiterate compared to non-beneficiaries. |
| Palmer & Nguyen (2012) | Cross-sectional | Vietnam (national) | National survey of 158,000 individuals | Social assistance/ health insurance, mainstream |  | 1. Coverage among people with disabilities  2. Exclusion error rate | | 1. 19%  2. 66.4-80.1% |  | Coverage among people with disabilities was reported to be “similar” to that of the general population. |
| Saloojee et al (2007) | Cross-sectional | Peri-urban South Africa | Caregivers of 156 children with disabilities | Social assistance, targeted |  | Percentage of eligible children receiving grant | | 45% |  | Unaware that child qualifies (29%), lack of documentation (28%), administration/bureaucratic obstacles (20%) |

N.B. Blank spaces indicate that particular study did not assess the given measure.

*Table 2: Access to social protection programmes*

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| *Source of evidence* | | | | |  |  | *Evidence of Impact* | | | | | |
| *Citation* | *Study design* | *Setting* | *Source of sample* | *Type of social protection* | *Comparison* |  | *Meeting basic needs* | *Reducing poverty* | *Employment* | | *Health access* | *Mental health* |
| Berry & Smit (2011) | Cross-sectional | South Africa; unknown if rural or urban | 18 children with disabilities or chronic illness (recruited from tertiary care centres) | Social assistance, targeted and mainstream | Non-recipients with disabilities |  | + |  |  |  | |  |
| Goldblatt (2009) | Qualitative | Rural and urban South Africa | 93 experts, including people with disabilities (recruited from clinics, grant offices) | Social assistance, targeted | None |  | + | No effect |  |  | | **-** |
| Graham et al (2012) | Mixed methods | Urban South Africa | 94 people with disabilities (population-based recruitment) | Social assistance, targeted | None |  | + | No effect |  |  | |  |
| Jelsma et al (2008) | Cross-sectional | Urban and rural South Africa | 305 people with cognitive, physical or sensory impairments (population-based recruitment) | Social assistance, targeted | Non-recipients with disabilities |  |  |  | No effect |  | |  |
| Levine et al (2011) | Cross-sectional | Namibia (national) | 2003-2004 Namibia Household Income and Expenditures Survey | Social assistance, targeted | Non-recipients with disabilities |  | + | + |  |  | |  |
| Li et al (2013) | Cross-sectional | Rural and urban China | 826 individuals over 60 either bedridden or with dementia (population-based) | Insurance (pension), targeted | None |  | + |  |  |  | |  |
| Loyalka et al (2014) | Cross-sectional | China (national) | National Survey of Disabled Persons (2006) | Social assistance and insurance, mainstream | None |  | + | No effect |  | Mixed | |  |
| Mitra (2008) | Ecological study | South Africa (national) | General Household Surveys (2002-06), October Household Surveys (1998-99) | Social assistance, targeted | All people with disabilities in South Africa |  |  |  | **-** |  | |  |
| Mitra (2010) | Cross-sectional | South Africa (national) | General Household Survey 2005 | Social assistance, targeted | Non-recipients with disabilities |  | + |  | **-** |  | |  |
| Palmer et al (2012) | Cross-sectional | Vietnam (national) | 27 households with a member with a disability (population-based) | Social assistance and insurance (health), mainstream | None |  | No effect |  |  | Mixed | |  |
| Palmer (2014) | Cross-sectional | Vietnam (national) | 2006 Vietnam Household Living Standards Survey | Insurance (health) | Other recipients without disabilities |  |  | Mixed |  | + | |  |
| Vazquez et al (2011) | Cross-sectional | Argentina, Brazil, Colombia | 241 individuals with bipolar disorder (recruited from inpatient/outpatient programmes) | Social assistance, targeted | Non-recipients with disabilities |  |  |  |  |  | | **-** |

N.B. Blank spaces indicate that particular study did not assess the given measure.

*Table 3: Impact of social protection on poverty, employment, health access and mental health*



*Figure 1: Social protection framework (adapted from Devereux & Sabates-Wheeler, World Bank, 2001)*

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*Figure 2: Flow chart of included studies*