Lasting Benefits

The role of cash transfers in tackling child mortality

Save the Children
UK

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Michael O'Donnell

We're the world's independent children's rights organisation. We're outraged that millions of children are still denied proper healthcare, food, education and protection and we're determined to change this.

Save the Children UK is a member of the International Save the Children Alliance, transforming children's lives in more than 100 countries.

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Cover photo: A young mother walks across fields with her baby in the early morning in the Hanamerant area of Meket, Ethiopia. (Photo: Frederic Courbet/Panos)

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Abbreviations

CSG	child support grant
DFID	Department for International Development
GDP	gross domestic product
HAZ	height-for-age
ILO	International Labour Organization
IDB	Inter-American Development Bank
MDG	Millennium Development Goal
NGO	non-governmental organisation
PSNP	Productive Safety Net Programme
RPS	Red de Protección Social
WB	World Bank

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Executive summary

An estimated 9.2 million children die each year under the age of five. Ninety-nine per cent of these deaths occur in the developing world, most of them caused by easily preventable or treatable diseases and medical conditions.

At the UN Millennium Summit in 2000, the world's governments committed themselves to eight targets for poverty reduction and development. Millennium Development Goal 4 called for a reduction by two-thirds in the under five mortality rate between 1990 and 2015. Despite some progress in some countries, at current rates of progress that target will not be achieved globally until 2045.

Cash transfers have a role in child survival

This report argues that cash transfers – predictable, regular transfers of cash to individuals or households by governments – can play a critical role in accelerating reductions in child mortality.

Which children die needlessly is not random. Across and within countries, the poorest and most marginalised children are more likely to die, and are less likely to have access to the services and interventions known to reduce child mortality. While more emphasis and resources for the development and strengthening of good-quality health systems are vital, a policy approach that concerns itself only with 'supply-side issues' will not succeed in dramatically reducing child mortality. A range of economic barriers prevent families from being able to protect their children from early deaths. In this respect, the growing consensus on the removal of user fees is an important step, but will not address the whole range of demand-side issues.

The evidence presented here suggests that well-designed cash transfer programmes can help tackle many of the determinants of child mortality, most immediately by increasing access to healthcare and reducing malnutrition. Across a number of countries, particularly in Latin America and Africa, cash transfers have helped poor people to access food and healthcare, and to enhance the status of women (itself one of the most significant determinants of child survival). Contrary to common assumptions, cash transfers also have important positive economic benefits, helping to create livelihood opportunities, increase labour productivity and earnings, stimulate local markets, and cushion families from the worst effects of crises.

Cash transfers are affordable

The current global financial crisis is placing greater demands on aid budgets and government resources, at a time when the need for cash transfer schemes is increasing. But, even for the poorest countries, these schemes are not necessarily unaffordable. A growing number of developing countries are now implementing social protection schemes and

are reaping the benefits from doing so. Although what is affordable depends on the scale of the transfer and other features of the programme, these examples point the way to how cash transfer programmes can be affordable in different contexts. Save the Children UK estimates current costs, and finds that child and maternity benefits are possible on a large scale, even in developing countries. In middle-income countries and many countries in Asia, universal maternity benefits and benefits for children under five are possible. For low-income countries, the appropriate mixture of age-based and geographical targeting should be determined based on national child poverty profiles.

Recommendations

1. **Countries with high rates of maternal and child mortality should invest in maternity and child benefits as an integral part of child survival efforts. National governments should set targets for expanding coverage of benefits over time, at pace with national budget and administrative capacity.**

   Design features such as the size, duration and targeting of transfers are central to the success of cash transfer programmes. Governments must learn both from programmes that have had high impact and those that have had low impact in choosing the right design for their context.

2. **Cash transfers are an important tool for reducing child mortality and supporting economic development, but national governments and donors need to implement them in combination with other policies and programmes, in order to produce mutually reinforcing outcomes.**

   In particular, we call on national governments and donors to: strengthen investment in the availability and quality of healthcare; remove user fees for essential healthcare services; use maternity and child benefit programmes as an opportunity to increase birth registration; and implement a broad and inclusive economic development policy.

3. **National governments and donors should introduce equity targets within the existing MDG framework, and into future development commitments, so that the poorest and most marginalised are not left behind. Countries should routinely report these statistics disaggregated by wealth groups, gender, age, disability and – where appropriate – ethnic or religious groups.**

4. **The Partnership for Maternal and Newborn Child Health should include child and maternal benefits in the package of interventions for reducing child mortality, particularly among the poorest, in Countdown-to-2015 countries.**

   The Countdown to 2015 initiative, which looks at the performance of 68 countries that collectively account for 97% of child deaths in the world, sets out and tracks a package of interventions required to increase child survival. Further progress in reducing the number of preventable child deaths requires addressing inequality and the economic drivers of child mortality. Cash transfers are a key demand-side intervention that must be an integrated part of the package, not simply left to be dealt with by separate poverty reduction strategies.

5. **Donors should commit to increase their investment in social protection programmes, particularly in countries with high maternal and child mortality. Donors need to set aside predictable, multi-year funding for the financing of cash transfers.**

Introduction

Each year more than 9 million children die before the age of five – one child every three seconds. Many of these children die silently in remote places, far from seats of power and media attention. Seeking to break the complacency towards this suffering, Save the Children, in partnership with others, aims to galvanise action by the world's governments to live up to their commitment – as set out in Millennium Development Goal (MDG) 4 – to reduce the under-five mortality rate by two-thirds.

In order to meet this goal, both developing country and donor governments need to do much more. Progress in reducing under-five mortality will partly be driven by better coverage of those solutions that are already known to work. However, it will also require new responses. These responses must include tackling the underlying causes of child mortality – structural factors of poverty, inequality and discrimination, which explain why certain children are more vulnerable to ill-health, and are much less likely to recover.

The need to address these factors is even more urgent in the context of the current global financial crisis, which threatens the gains that have been made so far. The World Bank has estimated that child deaths in developing countries could be, on average, 200,000 to 400,000 per year higher between 2009 and 2015 than they would have been had the global financial crisis not happened.[1]

As a contribution to accelerating progress on child survival, this report examines the case for cash transfers as a tool for reducing child mortality. Bringing together key debates on poverty and child health currently happening in parallel fields, this report examines three key questions:

- What contribution can cash transfers make to reducing child mortality?
- What are the broader economic benefits of investing in cash transfers?
- How can child-focused cash transfers be affordable in developing countries?

What do we mean by cash transfers and social protection?

In this report, we use the term 'cash transfers' to describe predictable, regular transfers of cash to individuals or households by governments for the purposes of addressing poverty, vulnerability and children's development.*

Cash transfers are one component of 'social protection'. Social protection programmes and polices aim to help poor and vulnerable people to counter deprivation and reduce their vulnerability. Other components of social protection that aim to promote children's survival include the provision of free healthcare services, short-term safety nets for food security in times of crisis, and ensuring that those eligible for social protection programmes

* In contrast to, for example, short-term emergency cash transfers provided by international aid agencies.

have access to them – through, for example, systematic birth registration. To be effective, social protection needs to be complemented by wider policy reforms and actions that help address structural causes of poverty and promote social equity and inclusion.

Cash transfer programmes vary substantially in their objectives, target population and design. These programmes include transfers to poor households, non-contributory (social) pensions, and child-focused transfers.

Over the past decade, an increasing number of developing country governments, working with donors and NGOs, have been implementing cash transfers as pilots or as national-scale programmes. A number of programmes are well-established in Latin America. Cash transfer programmes are also emerging in sub-Saharan Africa and South Asia.

While transfers in Latin America have emphasised achieving human development objectives related to health, education and child labour, programmes in sub-Saharan Africa have typically had a stronger focus on addressing chronic poverty and food insecurity. Programmes also differ in whether they have implemented conditional cash transfers – which require certain actions from recipients, such as ensuring children's school attendance or participation in ante-natal care – or unconditional transfers without requirements attached. There are also differences in other design features, such as the value of the transfer or whether a programme is implemented in tandem with other types of support. See Appendix 1 for a summary of key features of these programmes.

Despite these differences, the programmes are united by a common set of core assumptions. The first is that income poverty is a key driver of other poverty outcomes, such as poor health and nutrition. The second assumption is that cash empowers poor individuals and households to make their own decisions in improving their lives.

Increasing political commitment to social protection

As a children's rights organisation, Save the Children UK views social protection as a fundamental right and an essential service. Children's rights to social protection are elaborated in the UN Convention on the Rights of the Child and in the Universal Declaration of Human Rights, and are supported in other human rights documents.

There is increasing political commitment to expanding social protection. In January 2009 African heads of State agreed policy recommendations for social protection that called on their governments to progressively implement "a minimum package of essential social protection [that] should cover: essential health care, and benefits for children, informal workers, the unemployed, older persons and persons with disabilities."[2] The Communiqué of the London G20 Summit in 2009 committed members of the G20 to make funding available for social protection in the poorest countries. G20 countries have clearly recognised the importance of social protection in mitigating the impacts of the current financial crisis and in ensuring a fair global economy.[3]

Structure of the report and selection of evidence

This report has six chapters. Chapter 1 discusses progress on MDG 4 and the limitations of responses that only address the supply of services that help tackle child mortality, without addressing the factors that restrict demand for these services. Chapter 2 examines the evidence on the impact of cash transfers on the determinants of child mortality. Chapter 3 explores the economic benefits of investing in cash transfers. Chapters 4 and 5 examine the cost and affordability of cash transfers in developing countries. This is followed by our conclusions and recommendations.

This report draws mainly on evidence from government programmes that administer regular cash transfers. Where relevant, it occasionally draws on evidence from emergency cash transfers and NGO-run pilots.

The selection of quantitative evidence for chapters 3 and 4 prioritised studies that applied quasi-experimental methodologies – using a 'treatment' group that received cash transfers and a 'control' group that did not – in order to ensure data isolated the impacts that were due to the programmes, rather than to broader changes.* Where we use evidence from these studies, we specify a comparison group or refer to 'percentage point' differences, which indicate how much *more* change was seen among programme participants compared to similar households who did not participate in the programme. Qualitative evidence was not restricted to meeting this requirement.

Statements on 'cash transfers' refer to both unconditional and conditional transfer programmes. Most of the evidence from Latin America is on conditional transfers (with the exception of Ecuador), while all of the evidence presented from Africa is on unconditional transfers.

Given the focus of the report, we do not look at the full range of impacts resulting from cash transfers – for example, on education or child protection. Nor does the report tackle the issue of social protection and cash transfers in fragile states. Although child mortality is almost two-and-a-half times higher in fragile states than in other low-income countries,[4] the dearth of evidence and the complexity of issues in relation to delivery of regular cash transfers in fragile states made it unfeasible to do justice to this issue in this report. Further research on implementation and impacts, involving donor and NGO support, is required in order to understand the potential of cash programmes in fragile states.

* A few of the studies also apply 'dosage' models, which estimate differences in outcomes due to differences in total amount and/or duration of cash received.

1 Child survival, poverty and inequity

Millennium Development Goal 4

In 2000, global leaders agreed the 'Millennium Development Goals' (MDGs), a set of eight goals for poverty reduction and development. MDG 4 sets a goal of reducing under-five child mortality by two-thirds from the 1990 level by 2015. Some progress has been made – child mortality has fallen overall by nearly 25% since 1990. However, at the half-way point to 2015, 9.2 million children still died before reaching the age of five. Thirty-five countries are improving but making insufficient progress towards MDG 4. In 27 countries, levels of child mortality are not declining, or are actually increasing.[5] The greatest challenges are in countries in sub-Saharan Africa and South Asia.

Focusing solely on changes at the national level risks masking an even bigger challenge: ensuring that the poorest are not left behind. In a review of data from 56 developing countries,[6] under fives in the poorest 20% of households were 1.8 times more likely to die than children in the richest 20% of households.

Across 68 developing countries, children in the wealthiest households are 1.9 times more likely to access essential healthcare services than children in the poorest households (see Table 1).[7] There is even greater inequality in those countries deemed the best performers on MDG4, such as Peru, Indonesia and Bolivia. It is essential that efforts to improve newborn and child survival do not simply focus on those countries that are performing poorly on MDG4, but that they also examine the situation of the poorest children in better performing countries.

Reducing mortality: the current package of interventions

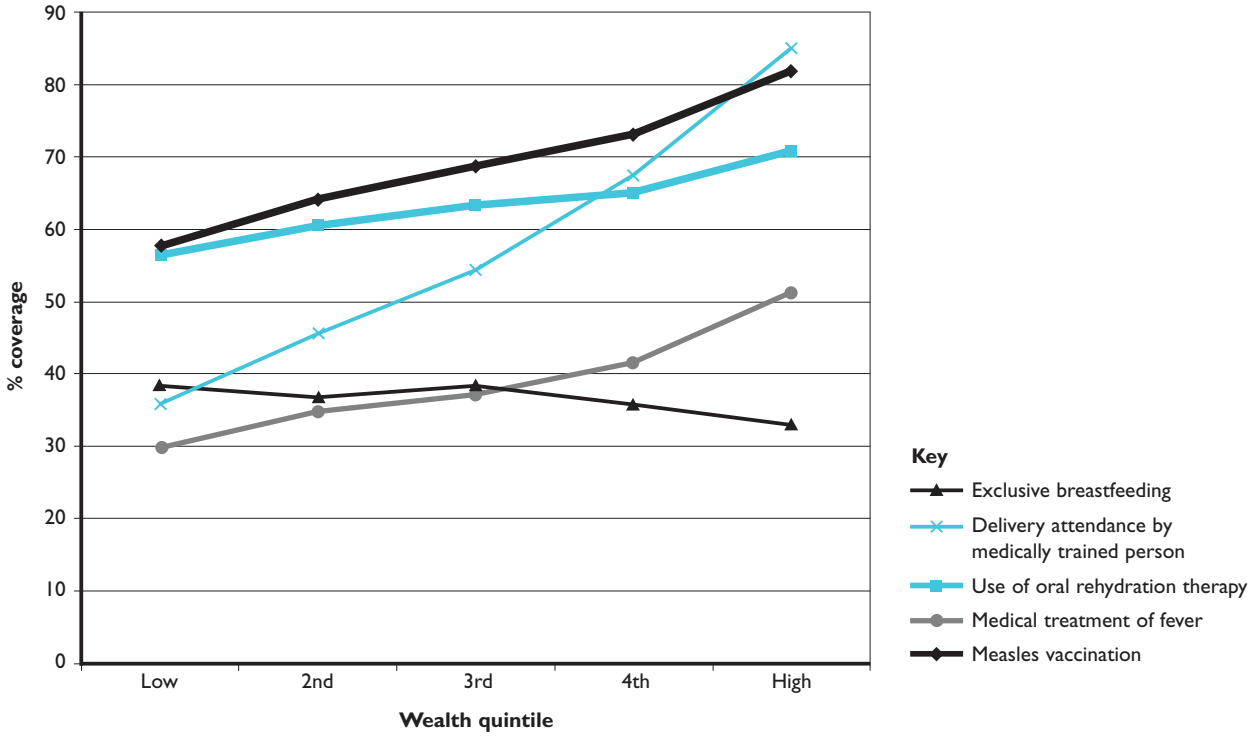
There is a growing consensus regarding the package of interventions required to increase child survival. This package of interventions was originally set out in the Lancet Series on Child Survival.[8] It has since been built upon and tracked through the 'Countdown to 2015' initiative,[9] which looks at the performance of the 68 countries that collectively account for 97% of child deaths in the world.

Table 1: Inequity in healthcare access and progress against MDG4

Country progress against MDG4	Healthcare coverage gap ratio, poorest:wealthiest
On track (n = 16)	2.2
Insufficient (n = 26)	1.9
No progress (n = 26)	1.8

Source: derived from PMNCH, 2008

Figure 1: Coverage of key child survival interventions by wealth quintiles



Source: Gwatkin et al (2007)

The recommended package of interventions, if implemented at scale, would reduce child mortality by 63%.[10] The package of interventions focuses on:

- supplying healthcare services (eg, vaccinations, treatment of diarrhoea, malaria and pneumonia, antenatal services and obstetric care) or materials for preventing illness (eg, improving water and sanitation facilities)
- increasing demand for services and bringing about changes in behaviour (eg, counselling and information provision to promote exclusive breastfeeding and good complementary feeding practices).

Although children living in poverty require the same treatments as other children, their families are less able to access healthcare services and less able to prevent diseases. Figure 1 above illustrates how coverage of a subset of five of the 23 key child survival interventions* varies from the poorest to the wealthiest quintiles of population. The data shows that other than for exclusive breastfeeding, coverage of interventions increases significantly with wealth. Ensuring high levels of coverage of these interventions across all wealth groups requires a mix of supply-side and demand-side interventions – ie, making sure that healthcare facilities are available where the poor live, and making sure that social, cultural and economic barriers to access are addressed.

Supply-side and demand-side solutions to inequity

While there is growing recognition of inequality in newborn and child survival outcomes, and of the need to tackle them,[11] there is still a long way to go before inclusion of the poorest children is mainstreamed.† Among those who recognise

* These interventions together could reduce child mortality by 40% if full coverage was achieved (Jones et al, 2003).

† Fenn et al (2007), for example, reported that they "failed to identify a single study specifically looking at inequities in coverage of interventions for neonatal survival".

inequalities, there is a tendency to focus heavily on adapting the targeting and delivery of the package of interventions.[12] This approaches the problem as one of taking services to the poor, for example, by targeting geographical areas poorly serviced by health services, and looking at the greater use of alternative delivery mechanisms, such as community health workers for outreach.[13]

It is clear that, in many countries, child survival inequalities cannot be addressed without tackling these types of 'supply-side' problems. Of the 68 Countdown countries, 54 (79%) have less than 2.5 health workers per 1,000 people, which is the minimum standard for the delivery of essential maternal, newborn and child health services. More than half of the countries (35) have a health worker density of less than one per 1,000 people. Increasing the supply of quality healthcare in such contexts is essential. Targeting the delivery of healthcare to areas with high levels of poverty and lacking health service infrastructure is also important in tackling inequality.

However, addressing the supply of health services on its own will usually be inadequate to remedy child survival inequalities. Nearly all of the interventions in the package identified to reduce child mortality can be made inaccessible to the poor by economic barriers. In particular, access to healthcare services can be limited by either or both of the two following demand-side factors:

- economic costs associated with healthcare services: these include direct costs, such as user fees or costs of drugs; indirect costs, such as transport; and 'opportunity costs', such as income foregone due to time seeking healthcare;
- economic costs of individual and household practices that play a vital role in preventing disease and malnutrition: for example, buying the diverse diet necessary for good complementary feeding, or paying for an insecticide-treated mosquito net.

The issue of the direct costs of healthcare has been the subject of a great amount of policy debate, particularly around user fees, and the role of 'out-of-pocket' expenses in leading to inequity in health outcomes. User fees are seen by some governments and donors as a key mechanism for health financing. However, evidence indicates that the contribution of user fees to overall resource generation is limited, and that they represent an important barrier to access, especially for the poorest.[14] There is now a growing consensus regarding the need for free maternal and under-five healthcare services (see Appendix 2).

There is less discussion and agreement on how to address indirect and opportunity costs. Economic constraints also hinder households from applying practices necessary for ensuring child health and nutrition. For example, Save the Children UK's 'Cost of a Diet' work has demonstrated that the cost of purchasing the diverse range of nutritious foods that children need to grow and develop well is beyond the reach of poor households in countries such as Bangladesh, Tanzania, Ethiopia and Myanmar (Burma).[15]

Too often, plans to address child survival fail to include interventions to overcome economic barriers. Efforts to address newborn and child survival must ensure that healthcare services are affordable to the poor. Save the Children UK believes that cash transfers can play a key role in addressing these economic barriers. This will be demonstrated in the next section.

2 The impact of cash transfers on child mortality

Social protection has the potential to play a crucial role in cutting child mortality rates, particularly among the poorest children. Cash transfers have demonstrated impressive impacts on factors that lead to unnecessary child deaths. And in many cases, these impacts are greatest among the poorest children.

While evaluations of existing cash transfer programmes have looked at a variety of outcomes, there is, unfortunately, very little research that looks at direct effects of cash transfers on child mortality. The only direct evidence of impacts on mortality is from two separate studies, which found that Mexico's PROGRESA conditional cash transfer programme led to declines in infant mortality of up to 11% in participating households.[16] Given the limited direct evidence on the impact of cash transfers on child mortality rates, the approach adopted in this chapter is to review the available evidence on how transfers affect the immediate, intermediate and structural causes of child mortality.

How we understand the determinants of child mortality

The factors that lead to child mortality are illustrated in Figure 2 on page 9.

Immediate determinants

As has been stated, the direct cause of most preventable child deaths in poor countries is illness. Often, there is a vicious cycle of poor nutrition and illness, where malnourished children are more susceptible to diseases. Illness, in turn, decreases the ability of children to take in and absorb the necessary nutrients.*

Intermediate determinants

A number of intermediate causes lead to illness and malnutrition in young children:

- **Poor or inadequate access to good-quality healthcare.** Not all families are able to use existing services, for reasons such as the direct and indirect costs of care and drugs, or discrimination experienced at clinics.
- **Inability to access the right quantity and quality of food.**
- **An unhealthy or inadequate physical environment**: Is there access to clean water and enough soap? Is the home sturdy enough to withstand the monsoon?
- **Inability of households to care for children and women**: Mothers' long-term nutritional status before and during pregnancy is a key determinant of their babies' weight at birth; babies with a low birthweight are at higher risk of neonatal and infant mortality. If these babies survive, they are more likely to be malnourished and susceptible to disease as children.[17]

These factors may seem obvious. However, they begin to point to the fact that technical responses will only be a part of addressing child mortality.

* 35% of all child deaths are attributable to malnutrition.

Structural determinants

Digging to the root of the problem, it quickly becomes clear that the determinants of *which* children survive are closely tied to economic, social and political factors. Household poverty is a key driver of child mortality. Families' level of income and wealth will affect children's health through many of the channels mentioned above – how much food they are able to purchase or produce, whether they can afford transport to the clinic, and whether women can afford to work less while their children are of breastfeeding age.[18]

Women's empowerment and gender dynamics also have a profound effect on child survival. One of the most powerful indicators of this is the relationship between child mortality and women's education. Children whose mothers have no education are twice as likely to die as those whose mothers have at least a secondary education.[19] A number of factors linked to girls' and women's education influence child mortality: women's education and knowledge about caring for children; women's increased earning potential; and women's greater bargaining power within the household. It is also important to note the role of older women carers. Particularly in places with high rates of HIV and AIDS and of migration, grandmothers and other female relatives often take on significant responsibilities for caring for children.[20] Women's control over resources has positive effects for children, because in most cultures women are more likely to dedicate a greater proportion of these resources to children's needs.

The rest of this chapter discusses the evidence on the impact of cash transfers on causes of child mortality. At the same time, it is acknowledged that, for some determinants of child mortality, transfers will have a limited effect, if any. Key among these determinants is the quality and supply of healthcare, given that healthcare systems in many developing countries are under-resourced financially and in terms of human resources, especially in places where poorer people live. Likewise, cash transfers are unlikely to impact on supply of water and sanitation,* or on attitudes and knowledge. This points to the need for transfers to be implemented in tandem with other measures, in order to maximise reductions in child mortality.

The impact of cash transfers on the immediate causes of child mortality

Illness

The World Bank recently concluded that, although conditional cash transfers have led to positive effects in the use of preventive healthcare services, and have reduced disparities in access to health between the poor and better off, the evidence of impact on final outcomes, such as illness,† is more mixed.[21] This is to be expected given that other factors that cause illness may not be addressed by cash transfers, and that the presence of complementary interventions, the quality of services and the design of the transfer programme can make a difference. However, the evidence from studies both of conditional and unconditional transfers with regard to children does include successes from which lessons can be learned.

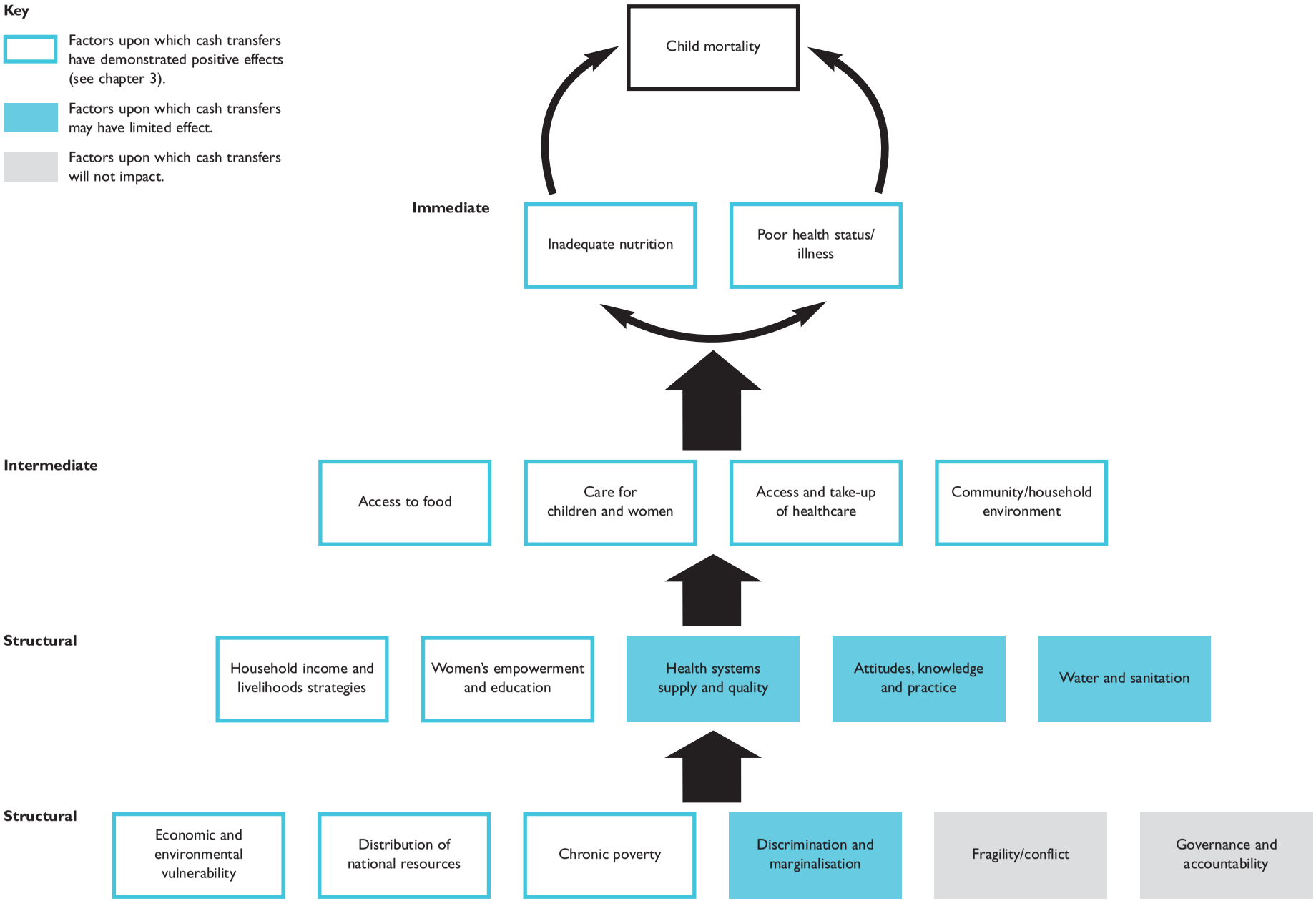
Cash transfer programmes have proven effective in reducing the overall incidence of illness among children in a number of countries, such as Mexico, Colombia and Malawi. With the exception of the PATH conditional cash transfer programme in Jamaica, in cash transfer programmes for which there is data, the overall incidence of illness decreased among children following the introduction of the programme, particularly among younger children.

In Mexico, children aged 0–2 years who were enrolled in the PROGRESA conditional cash transfer programme had 4.7 percentage points less incidence of illness than children in comparable families who were not enrolled.[22] Similarly in Malawi, between 2007 and 2008, illness reduced by 23% among

* Cash transfers may have an impact on water and sanitation, by helping households to afford clean water and better sanitation, although this has rarely been measured.

† The World Bank considered impacts on illness in adolescents, adults and the elderly, in addition to young children.

Figure 2: The determinants of child mortality – immediate, intermediate and structural[23]



children participating in the Mchinji unconditional cash transfer programme, versus 12.5% among non-participants.[24]

Evidence on specific illnesses is less consistent. In rural areas of Colombia, for example, children under 24 months old participating in the *Familias en Acción* conditional cash transfer programme had 10.5 percentage points lower occurrence of diarrhoea than similar children not enrolled.[25] However the same evidence shows that the effect on older children and children in urban areas was not significant, nor was the effect on respiratory infections.

Although subjective, households' perceptions of health are also telling. In Malawi, participating and non-participating families rated children's health similarly prior to the start of the Mchinji programme. After two years, 31% of children in families receiving cash were reported to be in excellent health, compared with 13% in households that were not in the programme.[26]

Nutrition

> "Before the scheme started, three-quarters of the malnourished children that were coming to Chipumi Health Center were coming from Kalulu area. I was busy following up such malnutrition cases. These days, it has changed; there are few malnourished children from this area."
>
> **Health worker, Malawi**[27]

Many cash transfer programmes have demonstrated strong positive impacts on children's nutritional status. Stunting or chronic malnutrition is estimated to lead to nearly 1.5 million children's deaths each year,[28] and is a strong indicator of a broad number of the factors leading to child mortality. Out of ten cash transfer programmes that report on stunting, seven show positive and sizeable impacts. For example, in Nicaragua, where the average stunting prevalence nationally was 41.5%, the *Red de Protección Social* (RPS) conditional cash transfer programme led within two years to a reduction in malnutrition among children in families receiving cash that was 1.7 times greater than the national trend, with even greater impacts among poorer families.[29] In South Africa, children in families receiving a pension have on average 5cm greater growth than children in families without a pension.[30] Appendix 1 consolidates the evidence on nutritional impacts from ten different cash transfer programmes.

Transfer programmes produce different levels of impact on malnutrition, and these differences indicate some important lessons on how best to maximise their impact. The first is that the duration of the transfers matters. Studies on the South African child support grant and Mexico's PROGRESA programme both find greater impacts on stunting in households that had participated in the programme for longer periods of time.[31] In South Africa, maximum gains in height-for-age in children were found in those whose families had received the child support grant for two-thirds of the period when children were aged 0–36 months.[32]

Another finding is that reaching children at a very young age is key, given the importance of the window between 0–24 months of age (as well as during pregnancy) in order to prevent irreversible effects of malnutrition. All of the programmes that report age-disaggregated data had larger impacts among younger children.[33]

Lastly, the amount of the transfer matters. Although even small amounts of cash can have positive effects, the size of the transfer must be sufficient to make a substantial contribution to household income in order to have a measurable impact on nutrition.[34]

Evidence from those cash transfer programmes that did not find positive impacts on nutrition also seem to confirm the importance of these three design features. Children in Ecuador's *Bono de Desarrollo Humano* programme evaluation did not begin the programme until at least 18 months, and the weak effects found on nutrition may be because children were not reached early enough.[35] In the case of Honduras's conditional cash transfer programme, lack of impact on nutrition is attributed to a combination of factors, but the small size of the transfers (about 4% of monthly household expenditure) and the fact they were not distributed consistently are likely contributing factors.[36]

The impact of cash transfers on the intermediate causes of child mortality

Access to healthcare

> "[My grandchildren] now take porridge each morning and they are in good health as you can seem them, unlike in the past. To me [the transfer programme] has helped me a lot because I use the money for ARV drugs."
>
> **65-year-old woman living with AIDS and caring for two grandchildren, Malawi**[37]

Cash transfers help to break down the direct and indirect financial barriers that prevent families from getting the necessary healthcare they need for their children. Households receiving transfers have been found to increase their use of a range of preventative healthcare measures, including routine check-ups for children, pre- and post-natal care, and regular visits to a health clinic to monitor children's growth, though the evidence is mixed on the effects on immunisation coverage.[38] Monthly health clinic visits for children under two in Nicaragua were 11 percentage points higher among children participating in the RPS compared to similar children not enrolled in the programme, and the effects were largest in poorer households.[39] Similarly in Colombia, clinic visits for under twos were higher by 22.8 percentage points.[40]

Several of the programmes led to improvements in immunisation rates. Before the introduction of the PROGRESA programme in Mexico, overall immunisation rates were already high, but progress among more marginalised households was more difficult.[41] Within 12 months of the start of the programme, children up to age three in households receiving transfers caught up in terms of rates of immunisation with children in households not enrolled in the programme, who had previously had higher rates. In Peru's *Juntos* programme, within one year there was a 30% increase in immunisations of children under one year of age.[42] However, in Colombia's *Programa Familias en Acción*, there was no significant effect on immunisation.[43]

It is important to recognise that these achievements in Latin America may not be easily replicated in other regions. Many of the Latin American programmes were explicitly trying to improve preventative healthcare outcomes through awareness-raising sessions, under the conditions of the programmes, and through investments in strengthening health systems in poor and rural areas. Nonetheless, a counter-example from Honduras is illuminating. The Honduras *Programa de Asignación Familiar II* (Family Assistance Programme II) had extremely weak or non-existent supply-side interventions, which is likely to be similar to many African or Asian low-income contexts. Yet the Honduras programme saw improvements in antenatal care and routine child check-ups by 18–20% in areas that had only received cash vouchers, indicating that the transfers alone made a large difference.[44]

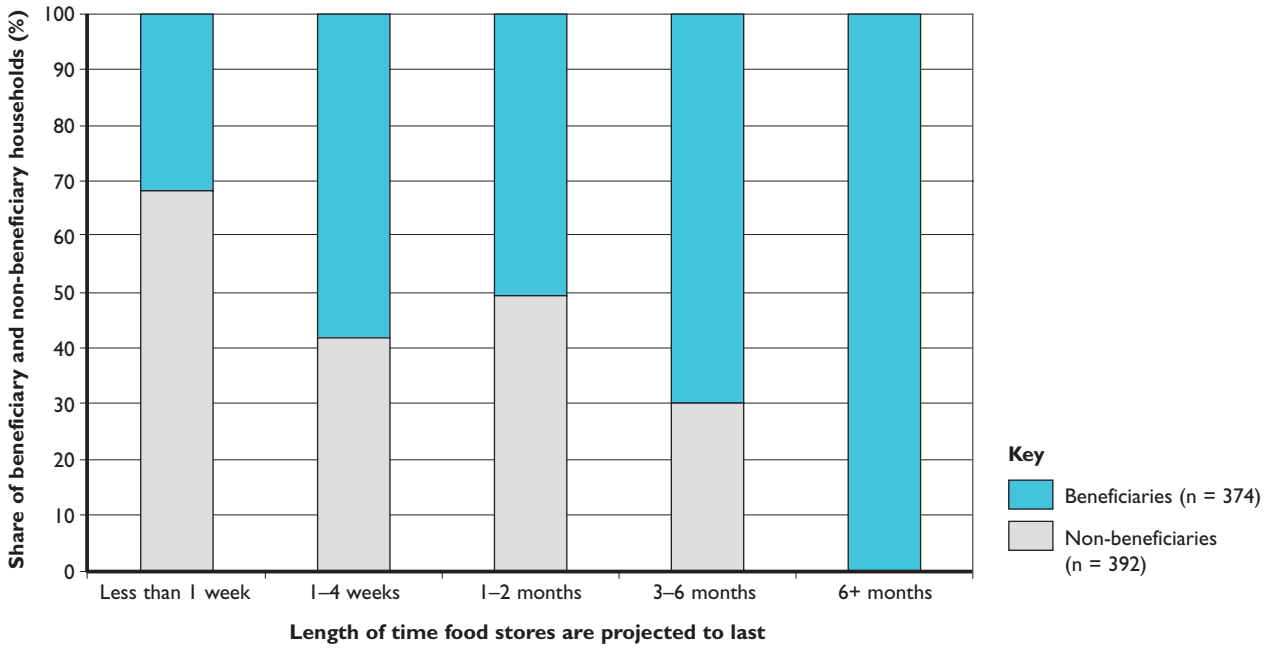
The limited evidence on health access from unconditional cash transfer programmes in African contexts does suggest positive impacts on access to healthcare. For example, the Mchinji cash transfer programme in Malawi reportedly enabled significantly more participating families to afford healthcare when children were ill, compared with non-participating households.[45] Households receiving pensions in South Africa and Namibia spent 40% and 14% respectively on healthcare and medicines,[46] and cash transfers in Kenya were used to increase ARV treatment for children and adults.[47]

Access to food

Evidence from a wide variety of cash transfer programmes in Latin America and sub-Saharan Africa shows beneficial effects of the programmes on households' access to food. Measured against a range of indicators – including calorie consumption, average number of meals and budget expenditure – families use cash to increase their food intake.

Crucially for child survival, participants in cash transfer programmes improve the diversity of their diets, increasing their intake of animal protein, fats, fruits and vegetables. Families receiving unconditional cash transfers in Save the Children

Figure 3: Cash transfers and food security in Mchinji, Malawi – beneficiaries and non-beneficiaries



Source: Miller et al 2008

UK's Meket programme in Ethiopia spent 75% of the cash on food, increasing purchases of pulses, animal products, oil and sugar.[48] In Malawi, households participating in the Mchinji unconditional cash transfer programme ate meat or fish with their meals on 2.1 days per week, in contrast with 0.3 days per week in similar households that did not receive transfers.[49]

A review of the impacts of three cash transfer programmes in Central America on food consumption found that total calorie intake per person particularly improved among the poorest third of eligible households – by 5.8% in Mexico, 6.9% in Honduras and 12.7% in Nicaragua. Although less pronounced, improvements in dietary quality also tended to be stronger in poorer households.[50]

Cash transfers have also been found to smooth food consumption during difficult periods, as transfers can protect savings and food stores for future need. Figure 3 presents evidence from Malawi on the differences in food stores between participant and non-participant households in the Mchinji unconditional Social Cash Transfer programme. In Zambia's Kalomo unconditional cash transfer programme, participants were similarly able to save maize for later consumption, representing a positive change from the usual pattern of being forced to sell their crop post-harvest at a low price when the supply on the market is high, and buying maize back later at a higher cost.[51]

Care for children and women

Changes in household care for children and women carers are clearly influenced by a broad set of social and cultural factors. Cash transfers, though, can play an important role here. By increasing income and potentially allowing households to spend time differently, transfers can support better care.

The most noticeable contribution is in relation to maternal health and nutrition, with clear links to reducing the risk of infant deaths. In Peru, the conditional cash transfer programme has reduced the number of women giving birth at home – an important contribution to improving maternal and child health in programme areas that had very high levels of maternal mortality.[52] In Mexico, maternal mortality reduced by 11% among women participating in *Oportunidades*, and impacts were

strongest in more marginalised communities.[53] Newborn babies born to mothers participating in the Colombian *Familias en Acción* in urban areas increased in average weight by 0.58kg, a change that is attributed to improved maternal nutrition.[54]

At the same time, design of cash transfer programmes must pay attention to impacts on caring for children within the household. For example, Save the Children's experience working with the Productive Safety Net Programme (PSNP) in Ethiopia suggests that the work requirements of the PSNP made it difficult for women to exclusively breastfeed their children and to transition their children to complementary foods, both critical in ensuring infants' health and nutrition. Save the Children UK worked with the Ethiopian government and donors to translate this evidence into policy, and the PSNP now provides cash to women for ten months after birth without imposing work requirements.

Household environment and hygiene

Receipt of cash transfers has also been associated with cleaner and safer household environments. In terms of hygiene, pensions in South Africa increase the likelihood that the household has a flush toilet and piped water; the longer someone in the household has been receiving the pension, the stronger this relationship.[55] Households in the Mchinji Social Cash Transfer programme were more likely than comparison households to report that their children bathed daily (92% vs 67%), when there were no differences prior to the start of the programme.[56] Families' expenditure on items that support children's health, such as soap, warm clothing and footwear, increased in programmes in Zambia, Ethiopia and Colombia.[57]

The impact of cash transfers on structural causes of child mortality

Household poverty and livelihoods

The economic effects of cash transfers are addressed in more detail in the next chapter, but it is important here to underscore their impact on poverty and livelihoods strategies. Programmes in Ethiopia, Nicaragua, Mexico and Malawi all find increases in income and assets among beneficiaries. Some transfer programmes have had impacts on lifting people above the poverty line, but – crucially – they can also have impacts on the depth of poverty. In Brazil, for example, it is estimated that cash transfers have reduced the poverty rate by 5%, and reduced the severity of poverty by 19%.[58]

Cash transfers have also been found to decrease the extent to which families, during difficult periods, are forced into harmful coping strategies that can affect short-term consumption and have long-term knock-on effects on children's health and nutrition.[59] In the context of the current global economic downturn, this effect of cash transfers is particularly important. In Nicaragua, for example, households that were not enrolled in the RPS programme decreased annual expenditure between 2000 and 2001 due to the effects of a severe drought and a sharp drop in coffee prices. In contrast, households participating in the programme were protected from the shock, and actually increased expenditure, primarily on food. Differences between the two groups were most pronounced among extremely poor households.[60]

Women's empowerment and education

Although not well-researched, cash transfers appear to have a number of positive effects on women's status, which has been shown to be closely linked to child and maternal mortality.[61]

Many of the programmes in Latin America and Africa have transferred cash to women recipients, and evidence suggests that they retain control over the money, although there are exceptions. In Mexico, Peru and Ecuador, the programmes seem to have small but positive impacts on increasing women's bargaining power and decision-making within the family. In some cases, women report greater self-confidence in areas such as expenditure decisions, knowledge about taking care of their children, and using financial services. Women also feel that there is greater acknowledgment by men, and by the community in general, of the importance of their role in the family.[62]

The limited evidence of impact on intra-household relations paints a mixed picture. In Peru, for instance, women and men reported increased involvement of men in traditionally female responsibilities. This programme included an explicit goal of transforming gender relations, for example, through awareness-raising with both men and women.[63] Evidence from Mexico, Lesotho, Peru and Malawi on increasing or decreasing intra-household tensions is varied, suggesting that context is important.[64]

Also of concern are the implications of cash transfer programmes for women's work burden and the reinforcement of traditional gender roles, particularly in conditional cash transfer programmes. Women in conditional cash transfer programmes report that requirements such as taking children to clinics or participating in meetings increased their workload. On a deeper level, cash transfer programmes run the danger of viewing women simply as instrumental to achieving human development goals for children. When asked what type of government support they wanted, women participating in Mexico's Progresa consistently mentioned jobs, and literacy and numeracy skills. They also suggested that men, as well as women, should participate in the education programmes on topics such as domestic violence and family planning.[65] These responses imply that opportunities to shift gender relations and involve women in broader poverty reduction were underused.

Cash transfers are consistently found to have positive effects on girls' education, suggesting that transfers can contribute to women's empowerment over the long term. Programmes have positive effects on increased education expenditure, enrolment and retention – in Bangladesh, Mexico, Nicaragua,[66] Colombia, Malawi, Zambia and Brazil.[67] In some cases, effects were measurably stronger for girls. In Mexico, for example, secondary school enrolment of girls increased by 11–14%, compared with 5–8% for boys.[68]

Health system supply and quality

Cash transfers in isolation will not contribute to improvements on the supply side. Nonetheless, it is important to stress the complementarity of interventions. The majority of Latin American programmes combined transfers with efforts to improve health services, particularly in rural and marginalised communities. The substantial success of these programmes in improving child health and well-being are likely due to the combination of interventions.[69]

Cash transfers should not be implemented to the neglect of investing in quality healthcare. Without this investment, there is a danger of overwhelming the health system and, in fact, decreasing the quality of healthcare. Given the challenges of addressing the supply-side constraints in some of the Latin American programmes, these issues need to be carefully thought through in poorer countries with weaker infrastructure.[70]

Summary

The available evidence indicates that cash transfers can help reduce illness, improve nutritional status, increase access to healthcare and to food, and improve maternal welfare, particularly among the poorest. All of these point to the importance of considering transfers among the package of interventions for improving child survival and addressing inequality in outcomes.

The evidence also, however, has limitations. We know less about the relative impacts of – and relationships between – a range of variables: the size, duration and regularity of transfers; the role of conditionality; and the existing supply-side conditions.

The monitoring of some transfer programmes has been limited in its scope, with information on health outcomes particularly lacking for sub-Saharan African programmes. The evidence gaps and differences in programme design and context require caution about general policy prescriptions on the design of transfer programmes in new contexts where they have not been tried to date. Nevertheless, the available evidence makes a strong case for greater use of transfers to help reduce child mortality.

3 The economic benefits of investing in cash transfers

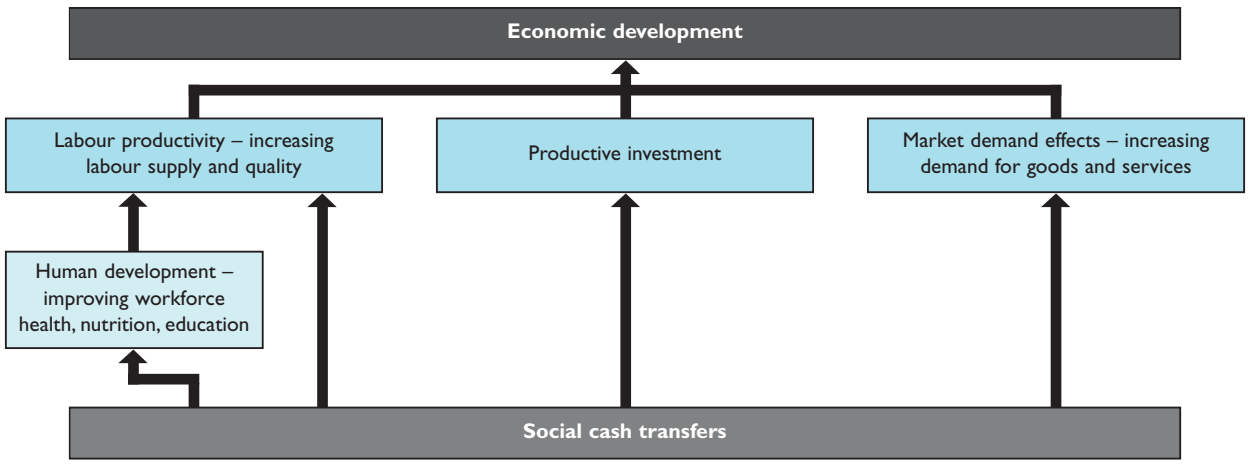
As chapter 2 shows, a strong case for cash transfers in reducing child mortality is emerging. Nevertheless, implementing social protection programmes presents real practical challenges for developing countries. The 'catch 22' is that those countries that are arguably most in need of strong social protection programmes are also those with the least capacity to implement them, in terms of human, administrative and financial capacity.[71] In environments where pressing priorities compete for limited resources – as is particularly the case in the current global economic crisis – it is crucial to look at the returns and costs of investing in social protection. In this chapter, we examine the broader benefits of cash transfers and the potential economic returns of investing in social protection.

Investment in social protection has sometimes been viewed as an expenditure drain on a country's economy. However, there is growing support for the argument that cash transfers may in fact play an important role in supporting the building blocks of inclusive growth in economies caught in self-reinforcing poverty traps. There are a number of channels through which cash transfers can have positive impacts on economic development:

- the long-term or intergenerational effects on labour productivity due to the improved education, health and nutritional status of children
- the immediate effects on productivity of adults
- increasing productive investment
- increasing market demand.

Figure 4 provides a basic illustration of these channels, which are elaborated below with the existing evidence.

Figure 4: Cash transfers and channels for economic development



Intergenerational effects of children's development

To some, transfers are viewed simply as a form of welfare to support current consumption. However, the positive impacts of cash transfers on children can also have long-term effects on productivity. For example, malnutrition in early childhood has permanent and irreversible effects on physical and cognitive development, educational achievement, and adult height.[72] These effects, in turn, have been proven to have negative impacts on productivity in adult life, including physical productivity, hours worked and adult earnings.[73] Increased longevity through positive effects on health and nutrition also increases total lifetime earnings, due to the greater number of years that individuals are able to work.[74] For example, in India the losses of foregone adult wage employment due to malnutrition in childhood are estimated to be $2.3 billion annually, or 0.4% of GDP.[75]

A recent study estimates that children receiving the South African child support grant (CSG) during the critical development window* will on average earn 5–7% higher monthly wages throughout adulthood due to improvements in childhood nutrition.[76] The evaluation of PROGRESA in Mexico estimated that participating children will see 8% higher earnings due to additional years of schooling.[77] Although the impacts of transfers and returns in relation to earnings are different across countries, the economic gains of even modest impacts from cash transfers would likely be substantial when compounded over time and cohorts of children.

Cash transfers are also of value in protecting children against the impact of short-term shocks, which can have devastating consequences for them as individuals and for the society as a whole. Negative impacts of transient but serious economic shocks on young children have been shown to yield long-term losses in terms of education, labour supply and income.[78] In the current global context of climate change, fluctuating food prices, and global economic downturn, the probability of poor families in developing countries facing short-term shocks is high, with potentially significant long-term impacts. This makes the case for cash transfers even more urgent.

Work, labour productivity and dependency

Cash transfers are sometimes argued to have negative impacts on labour productivity, and to create dependency, particularly by enabling recipients to work less. However, evidence so far from developing countries contradicts this argument.

Cash transfers can actually increase the participation of poor households in work, through reducing days of work lost due to ill health, lessening the burden of childcare responsibilities, and covering the costs of job-seeking. In South Africa, labour force participation was 13–17% higher in households with a pension, compared with similar households not receiving benefits.[79] Receipt of pensions by women in particular has been found to have a positive effect on labour, as grandmothers were able to take care of grandchildren, thus allowing other adults to migrate for work.[80] In Brazil, 3% more adults in households benefiting from the *Bolsa Familia* programme participated in the labour market, compared with similar households not in the programme. The effects were even higher for women.[81]

Transfers may also indirectly increase the work available for poor people in rural areas. In Zambia and Malawi, programme beneficiaries who were not able to work themselves employed others to work in their fields. There is also some evidence from India, Niger and Ethiopia that cash transfer programmes have given labourers stronger bargaining positions with employers, and improved their ability to negotiate better wages.[82] While the overall market effects of this finding warrant further investigation, this may have important outcomes in terms of poverty reduction.

* Children who receive the CSG for at least two-thirds of their first three years, and who begin participation before the age of one (Aguero, Carter and Woolard 2007).

In particular cases, transfers may lead to reduced levels of work, but in positive ways. In households affected by HIV and AIDS, chronic illness, older age or high dependency ratios, poverty may lead members of these families to work even though it is detrimental to their welfare – cash transfers can reduce their work burden. Some transfer programmes that have been specifically designed to decrease child labour have demonstrated positive outcomes. However, the overall evidence of the impact of transfer programmes on child labour is mixed, particularly as programmes that require participants to work in return for benefits, or those which increase agricultural productivity, can unintentionally lead to children taking on more work.[83]

Productive investment

Studies from Latin America and Africa suggest that, while households spend the majority of cash benefits on basic consumption, health and education expenses, they also use a portion to invest in economic assets and activities. The extent of investment appears to depend on size, duration and predictability of transfers, as well as initial levels of poverty.

In Mexico, research found that households participating in *Oportunidades* had increased rates of investment, and that these increases rose in relation to the cumulative amount received. The study estimates that almost 12% of each peso transferred is invested in agriculture and micro-enterprises, and that this investment generates a 17.5% return in terms of income.[84] Rate of micro-enterprise investment in female-dominated activities by participants compared to non-beneficiaries was even higher than the overall rate, supporting the evidence that cash transfers can help to improve women's economic position.[85]

In a very different setting, evidence from Save the Children UK cash transfer projects in Ethiopia echoes these findings, albeit on a smaller scale. Investment in assets and livelihoods occurred where the amount of the transfer was larger and/or over a longer period of time. Transfers enabled poor farmers to farm their own land, and to negotiate better terms on agricultural contracts and loans with better-off families.[86] Similar patterns of modest investment in petty trading, small productive animals, and agricultural assets and inputs have been found in other African cash transfer programmes, from the Lesotho pension, to cash transfer pilots in Zambia and Malawi.[87]

Cash transfers can also facilitate productive investment in indirect ways. Regular income can facilitate access to credit for productive investment, as has been found to be the case with a pension for informal workers in Brazil.[88] Transfers can also play a risk protection function, allowing households to invest in riskier but higher returns activities.[89] In Maharashtra state in India, the Employment Guarantee Scheme plays an insurance function by ensuring employment, and farmers have planted higher-yielding and less drought-resistant crops than those in neighbouring states.[90]

Multiplier effects and strengthening local markets

At sufficient scale, cash transfers could produce economic multiplier effects, through increasing demand for goods in local markets and stimulating trade and production. Because this is not a primary objective of most cash transfer programmes, there has been little investigation in this area.[91]

However, two studies attempt to quantify these economic effects at the community level. The first study from Mexico found that in communities where PROGRESA had been introduced, after one year, even those families not receiving transfers saw an increase in consumption of 12% more than comparison communities where the programme had yet to be introduced. These community members also saw an increase in assets, particularly those with low initial levels. The authors suggest that this may be explained by higher consumption in beneficiary households being met by increased

production by other households, which did not receive transfers, in these communities.[92]

The second study examines the multiplier effects of the Dowa emergency cash transfer programme in Malawi. The authors calculate that for the £230,000 (MK 66,883,330) that was transferred to 10,161 households through the five-month programme, at least another £464,600 was generated through increased production and added value to products – a multiplier effect in the range of 2.02 and 2.79.[93]

Further micro-level evidence supports these findings of positive effects on local economies. In Zambia, most maize bought using cash transfers was purchased in the local economy.[94] In Ethiopia, grain inflows to local markets increased in response to cash transfers, and traders reported an increase in total volume of trade and the number of traders.[95] Programme evaluations from emergency cash transfer programmes also indicate that traders experience an increase in business.[96] What remains unclear is the long-term effects of these demand and supply responses, and who will benefit.

Cash transfer programmes have also been shown to have positive counter-cyclical effects on markets. The role of transfers in smoothing consumption has important aggregate effects beyond the household, particularly by increasing demand during lean periods. For example, in Malawi "businesses repeatedly indicated that they were grateful to the [transfer] programme for helping to maintain a stream of business income at a time of the year which is often difficult".[97]

In relation to market effects, a potential concern is inflation due to injections of cash into communities. To date, most studies find little evidence of price inflation, even in places where there have been cash injections on a large scale, such as Mexico.[98] Nonetheless, some evidence in Ethiopia points to price rises of basic goods,[99] which may suggest more inflationary pressures where connections to markets are weak. This is an issue that should continue to be monitored.

Summary

The findings on the economic impacts of cash transfers challenge commonly held assumptions that transfers detract from economic productivity. Instead, the existing micro-level evidence suggests cash transfers can encourage and strengthen labour productivity in the immediate and long term, increase productive investment, and increase market demand. These issues require further investigation to better understand the long-term market outcomes and the scale of these effects.

4 What are the costs of cash transfers for children?

The previous chapters have shown the crucial role that cash transfers can play in improving child survival outcomes, and the potential broader economic benefits. Regardless of these positive impacts, however, the reality is that developing country governments face financial resource constraints. These include lower levels of GDP; challenges in expanding the tax base; and fluctuating revenues, which make it difficult to plan for recurrent expenditure.[100] As a result, social protection is often assumed to be unaffordable in developing countries.

Nonetheless, a growing number of middle- and low-income countries are calling this assumption into question by implementing cash transfer programmes on a large scale. What is useful to examine, therefore, is not *if* cash transfer programmes are affordable, but *how*. Transfer programme design choices offer national governments a range of options with different cost implications. In addition, affordability will be affected by economic growth and consequent domestic financing capacity over time, and by the role of foreign aid in complementing domestic resources.

Decisions about the design and allocation of national resources to cash transfers are political choices, as well as financial ones. The feasibility of establishing or expanding cash transfers will be shaped, in part, by national political processes, the way in which transfer programmes are institutionalised, and administrative capacity.

While it is beyond the scope of the report to determine what is optimal for each country given country-specific factors, this chapter provides policy-makers with additional evidence to help evaluate how cash transfers can be affordable. Drawing on evidence from countries that have implemented cash transfers at scale, we summarise what can be learned about key factors that affect cost and affordability – coverage and targeting, level of transfer, phasing of the programme, conditionality and financing.

Programme design options that impact cost

How do we define affordable?

Before examining the factors that affect cost, it is useful to look at existing programmes to get a sense of what level of expenditure on cash transfers is feasible at a national level. Examples of large-scale programmes can be found in Latin America, Africa, China and India. Appendix 1 (on page 33) summarises some of the features of a selection of these programmes.

In terms of overall cost, existing conditional cash transfer programmes in Latin America cost less than 1% of GDP.* Recent reviews suggest that an allocation of 1–2% of GDP is a reasonable rule of thumb for the level required to finance basic social assistance programmes in developing

* Note that this figure does not include other social assistance spending, such as pensions or disability benefits.

countries. Country specificities related to revenue sources and collection will affect what a country can afford, while levels of economic growth influence changes in affordability over time. For low-income countries, the current envelope of affordability may be closer to 1% of GDP,[101] particularly given low rates of revenue collection.

Coverage and targeting

One of the key factors that will affect costs is the selection of beneficiaries – both which populations are selected for the programme (coverage), and the actual process for selection of beneficiaries (targeting). Decisions about the desired coverage level and targeting methods involve trade-offs between cost, administrative burden and the accuracy of targeting in terms of including those in need, and excluding those not in need. The box below describes common types of targeting.

In a review of targeting of transfers using various methods across 48 countries, the World Bank and International Food Policy Research Institute found that, although in many cases targeting increased the percentage of resources reaching the poor, in 25% of programmes the effects of targeting were actually regressive, meaning that the better-off were more likely to benefit. Targeting performance improved as national income and inequality increased, suggesting that where poverty is more widespread, it may be more difficult to differentiate among households.[102] This is particularly concerning in terms of the potential to exclude households who should be

Types of targeting

Means-tested targeting identifies beneficiaries based on level of income or consumption. Means testing usually requires strong data collection systems.

Proxy means-tested targeting identifies beneficiaries using household characteristics that indicate poverty levels, rather than directly measuring income. The characteristics used include type of housing or number of productive assets. This can provide a more multi-dimensional measurement of poverty, and can be more straightforward to collect than income data – but this still requires significant data collection.

Categorical targeting is based on particular individual characteristics, such as age or physical status (eg, pensions, child benefits, disability benefits). Verification of status can be a challenge – for example, if birth registration is limited.

Geographical targeting selects beneficiaries by location. Where poverty is concentrated or higher in particular areas, geographical targeting can be useful. It requires sufficient data to identify poverty levels in different places. Geographical targeting can be politically charged where particular areas have been historically marginalised or dominant, or where poverty coincides closely with specific ethnic, religious or political groupings.

Community targeting relies on members of the community to identify those most in need – eg, as defined by an agreed set of criteria, such as labour-constrained or elderly headed households. Potential weaknesses of community targeting include the manipulation of selection by local elites or prejudice against marginalised groups, and potential community tensions.

benefiting. The authors point out that there is considerable variation in effectiveness within different targeting methods, indicating that implementation capacity and accountability played as much of a role as the choice of method.

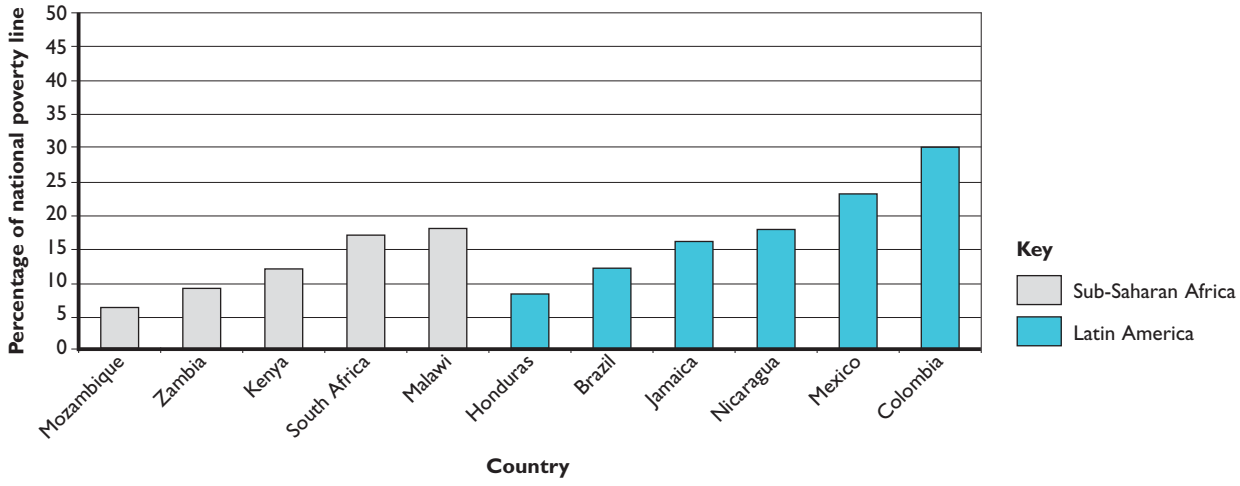
Most of the conditional cash transfer programmes in Latin America were designed to benefit households below a certain level of wealth, and with particular household characteristics, and adopted some form of proxy means-tested targeting. In part, this was made possible by the existence of relatively strong existing data collection at the household level. However, both RPS in Nicaragua and *Red Solidaria* in El Salvador used a combination of targeting based on geography and categories of individuals. *Red Solidaria* identified the poorest 100 municipalities in the country, and all households in these municipalities with pregnant women and children under 15 are eligible. The 100 municipalities are being phased in over a period of four years, beginning with those ranked with the highest level of poverty. Household-level targeting was evaluated to be not worth the administrative costs, given the high levels of poverty in these areas and the potential to create community tensions.[103] El Salvador is one of the poorer countries in Latin America, and this experience may hold lessons for other low-income countries with less capacity.

Existing transfer programmes in sub-Saharan Africa have used a wide range of approaches. A few, mostly pensions, have used a simple categorical approach – for example, focusing on a specific age group. Some have used a combination of categorical and means-tested targeting (eg, people of a specified age who are also below the poverty line), such as South Africa's child support grant. Given weak data collection systems, traditional means testing is unlikely to be a viable or affordable option for most African countries. Many pilot programmes in African countries target using a set of poverty and vulnerability criteria or proxies agreed at the community level. The feasibility and effectiveness of this community-based targeting approach at scale needs further examination.

Level of transfer

A second factor affecting the total cost of programmes is the level of transfer. In Latin America, the level of transfers ranges from 8–23% of the national poverty line, or 10–30% of average household consumption. Transfer levels in sub-Saharan Africa cover a similar range, from 5–30% of the national poverty line. There are obvious trade-offs in setting the level of transfer. A lower level of transfer will enable the programme to reach more people and/or to lower total cost. On the other

Figure 5: Value of transfer as percentage of poverty line



Source: Blank and Handa 2009

hand, transfers have to be of sufficient size in order to have significant impacts on children's nutrition and health, or on economic productivity. The value of the transfer to the household can be a fixed amount per family, linked to the number of eligible people in the household (eg, per child), or capped at a maximum level (eg, up to four children). For transfers to make a substantial impact, it is suggested that they should be equivalent to 20–30% of the per capita poverty line.[104]

Phasing of programme roll-out

Third, the pace of phasing in a programme will affect affordability. Even where national coverage was the goal from the outset, almost all of these programmes started with a subsection of the eventual coverage, gradually expanding the programme to national scale. This approach allows countries to increase budget allocation gradually, to strengthen institutional capacity over time, and to build political support. Most frequently, expansion of coverage was geographic, but in some cases also by age. The Lesotho social pension, for instance, originally targeted individuals over 70, but the government is in discussion on lowering the age of eligibility to 65.

Conditional or unconditional transfers?

Another dimension affecting cost is whether or not transfers are conditional. Conditionality – eg, making transfers conditional on regularly visiting a health clinic or on children's attendance at school – is a hotly debated issue. Proponents of conditionality argue that conditional transfers provide incentives for positive behaviour change, encourage long-term investment in children, help to 'crowd-in' service supply, and increase the accountability of service-providers to beneficiaries. Opponents raise questions about their value in contexts of limited or low-quality service, the burden they place on administrative capacity, the cost of ensuring compliance – both administratively and for beneficiaries – and their moral acceptability.[105] Further evidence is needed to help resolve debates on the added benefit and appropriateness of conditionality in different contexts.

For the purposes of this report, we will focus on the cost and feasibility of conditionality. Information on costs is limited, but suggests they may be high. For PROGRESA, it is estimated that monitoring adherence to conditionality amounts to 26% of the programme cost (ie, excluding cost of the transfers themselves). When one-time fixed costs – such as initial design and external evaluation costs – are excluded, it is estimated that conditionality accounts for more than 20% of the implementation costs of conditional programmes.[106] This percentage may be higher in countries with more limited administrative infrastructure, as there is less existing capacity on which to build.

Supply-side issues are a key issue when considering the feasibility of conditions. For example, if payment of the transfer is conditional upon attending a health centre or clinic, there must be an adequate number of clinics within a feasible and affordable travelling distance for families.[107] Making transfers conditional on attending clinics may risk further marginalising the poorest or most remote, who are likely to be less able to comply with the conditions. If the intention is to improve children's health, nutrition or education, there may be options other than conditions for reinforcing those outcomes, such as providing complementary services[108] and working with communities to bring about broader changes in social attitudes or relations.

Financing cash transfers

As well as the design issues just discussed, the affordability of a cash transfer programme will also depend on the source of domestic financing, and whether foreign aid supplements domestic resources. Options for domestic funding must be considered on a country-by-country basis. This includes national budget analysis to determine the possibilities of switching resources between sectors and spending priorities, of consolidating and reformulating existing social protection programmes, and of reallocating from regressive or poorly performing programmes. However, in poorer countries these options are likely to be limited.[109] Based on modelling the projected costs of basic

social protection in comparison with governments' current social protection budgets, the International Labour Organization (ILO) estimates that the external funding needed to finance a basic benefits package would range from 73% of the total cost in Burkina Faso, to 4% in Tanzania, assuming no reallocation of current national expenditure.[110]

The majority of transfer programmes in Latin America and pilot programmes in Africa have received external donor support. However, there are differences in the extent to which national governments initiated these programmes and the percentage of domestic funding. There is some evidence that government ownership, including domestic financing, plays a crucial role in the effectiveness and sustainability of these programmes.[111] Aid predictability is also important. A survey of African governments found that many were highly sceptical that donors would provide the regular and reliable funding needed to establish effective social protection programmes. They were sensitive to the risk of funding being diverted or frozen as donor priorities changed, while also recognising the importance of transfers being dependable.[112]

5 Child benefits: an affordable transfer for child survival

Building on the previous evidence on design features, costs and impacts, this chapter models the costs of providing a specific type of cash transfer: child and maternal benefits. While different types of cash transfers can have positive impacts for children, Save the Children believes that child benefits are an under-explored option from the perspective of both social protection and child survival. For the purposes of this report, we define child benefits as:

> The transfer of predictable, regular sums of adequate amounts of cash…
> … for an extended timeframe…
> … by national governments…
> … to meet children's survival and development needs.

We investigate different options for providing child and maternal benefits, with the objective of maximising the impact on child survival. Within the context of increasing recognition of child benefits as part of a minimum social protection package, this is an important stepping stone along the gradual realisation of children's right to social security. Costs are calculated in those countries that account for the greatest share of global child mortality* for a single year at current population and poverty levels.

Existing evidence on the costs of child benefits

There are a small number of existing studies that include modelling of the costs of child benefits for low-income countries. A well-cited publication by the ILO estimates costs up to the year 2034 of three different social protection packages that include basic healthcare and education, and cash benefits. Initial estimated costs in 2005 for a universal child benefit in a number of African countries of US$0.25 (purchasing power parity) per day for children aged 0–14 range from 1.8% to 5.9% of GDP.† This level of cost is unlikely to be affordable, particularly if countries also want to implement other types of transfers, such as pensions.[113]

Looking at 15 sub-Saharan countries, a study by the International Poverty Centre assesses the options for conditional cash transfers for children aged 5–16. The study finds that transfers at 20%, 30% and 40% of the average national poverty line would have a significant impact on child poverty, but the costs in terms of GDP rise from a minimum of 5.09% to a maximum of 16.41%. The authors also find that the high administrative costs of targeting in relation to the limited added benefit may not be cost-effective, given high overall rates of child poverty, and the difficulties of approximating perfect targeting. However, in most countries geographical targeting of rural children does improve pro-poor results.[114]

* This is not to imply that child benefits should not be pursued in other countries.

† By 2034, costs are lower in terms of GDP, but still range from 0.9% (Guinea and Cameroon) to 2.4% of GDP (Ethiopia).

Child benefits for child survival: options costed

Age group

Most existing modelling exercises for child benefits examine the costs of providing benefits to school-age children. In relation to child survival and to MDG 4, however, improving outcomes for children under 5 is key. And improving outcomes for children under 2 is particularly crucial, as long-term nutritional deficiencies are largely irreversible after this age. We therefore model the cost to reach these two age groups. We also illustrate the cost to reach all under-18s, as policy-makers may want to include older children to help achieve other goals, such as universal access to education. While we acknowledge that transfers are desirable for a longer period, where it is necessary to prioritise by age we believe that it is important to focus on younger groups.

Given the close link between maternal and child health and nutrition and child survival, we also calculate the cost of providing a cash transfer to mothers in the second and third trimester of pregnancy. This particular period of pregnancy was chosen because of the practical challenges involved in identifying and reaching women during earlier stages of pregnancy.

Size of transfer

In our estimates, we assume a transfer value per person sufficient to fill the gap between current income* and the $1.25 a day poverty indicator in MDG 1. In most cases this level of benefit per child is sufficient to translate into the target range of 20–30% of household income. Where we model benefits for children under 2, however, most households are likely to have only one, or possibly two, eligible children, which often means a total household transfer below the desired range.

Targeting mechanism

We consider the options of targeting based on specific age ranges (or pregnancy), and of targeting only those within the age range who fall below the poverty line. This affects the numbers of children eligible and the administrative cost. Based on existing literature, we assume administrative costs of 15% for age-based targeting, and 33% for means-tested targeting. We have also considered the cost of only targeting the poorest 10% of children. However, where poverty rates are significantly higher than 10%, this approach will clearly be limited in the impact it can have at national level.

Due to the limited information on costs of administering conditionality, we have not modelled different scenarios for conditional and unconditional transfers. The modelling is based on unconditional transfers.

Child benefits for child survival: what are the costs?†

At the global level, for the 57 developing countries for which the necessary data is available, the total current cost of providing different types of transfers ranges from US$5.6 billion – for a highly targeted programme focusing only on under 2s below the poverty line – to US$117.5bn to reach all under-18s (see Table 2 on page 26).

The basics of our findings are not surprising. Overall, the costs of a universal benefit to under-18s would be unaffordable in all but a handful of middle-income countries such as Brazil, Egypt and China. The most narrowly targeted child option of a benefit targeted to under 2s below the poverty line is the least expensive. However, it is desirable to reach a broader group, such as under 5s, which would provide a greater transfer value for longer for most households, and thus have a greater impact on mortality.

*We use the average income level for those households below the poverty line, not the average income for the total population.

† Full details of data and methods are available on the Save the Children UK website.

Table 2: The cost of providing different types of transfers in 57 countries

Type of transfer	Universal under 18	Universal under 5	Universal under 2	Under 18, below poverty line	Under 5, below poverty line	Under 2, below poverty line	Poorest 10%	Maternity benefit	Maternity benefit, below poverty line
Average cost* – % of GDP	6.26%	2.08%	0.83%	3.88%	1.28%	0.51%	0.63%	0.21%	0.13%
Total costs for 57 countries – $US millions	117,533	34,865	13,946	46,183	14,230	5,692	11,753	5,523	1,911

* Average cost is for 54 countries – Burundi, Liberia and Democratic Republic of Congo are treated as outliers.
See data online for averages for all 57 countries.

Looking behind the averages to explore what broader coverage options are affordable, there are interesting differences between countries and regions. For low-income countries in Africa, a universal transfer for children under 5 covering the whole country is unaffordable without external assistance in most cases. Liberia, for example, would need approximately 90–95% donor funding, while Tanzania would need approximately 70–85% donor funding. Countries such as Sierra Leone, Niger or

Figure 6: Child benefit costs – selected Asian countries

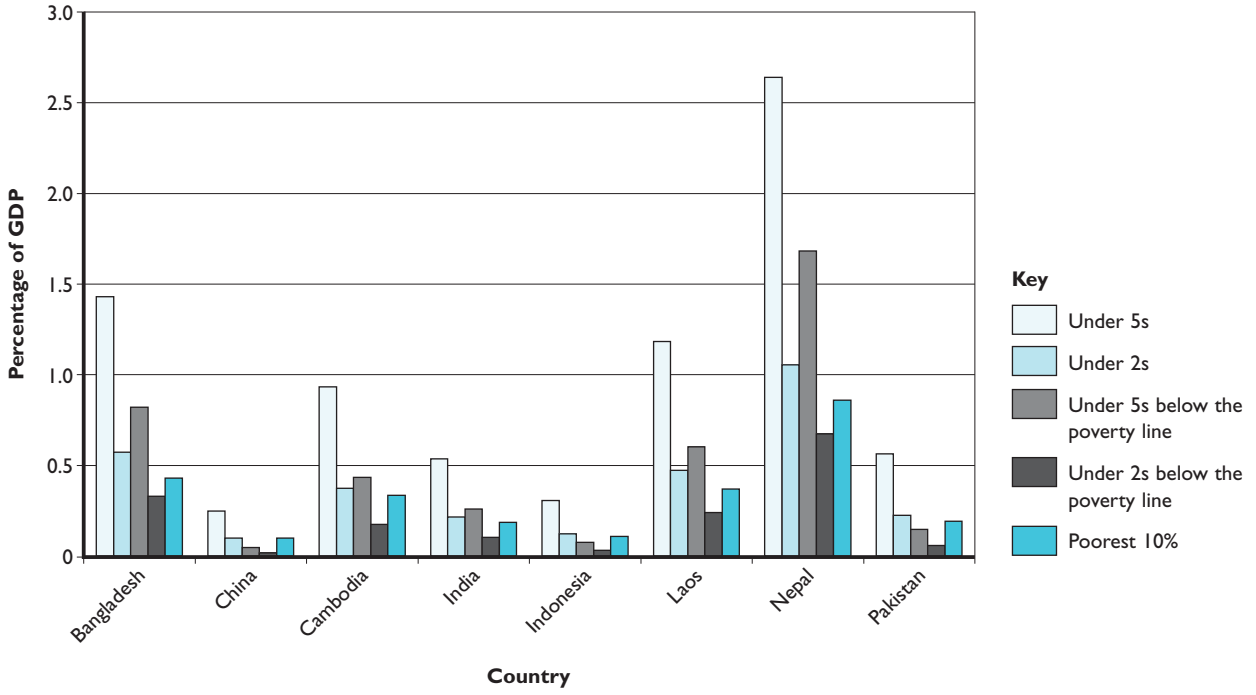
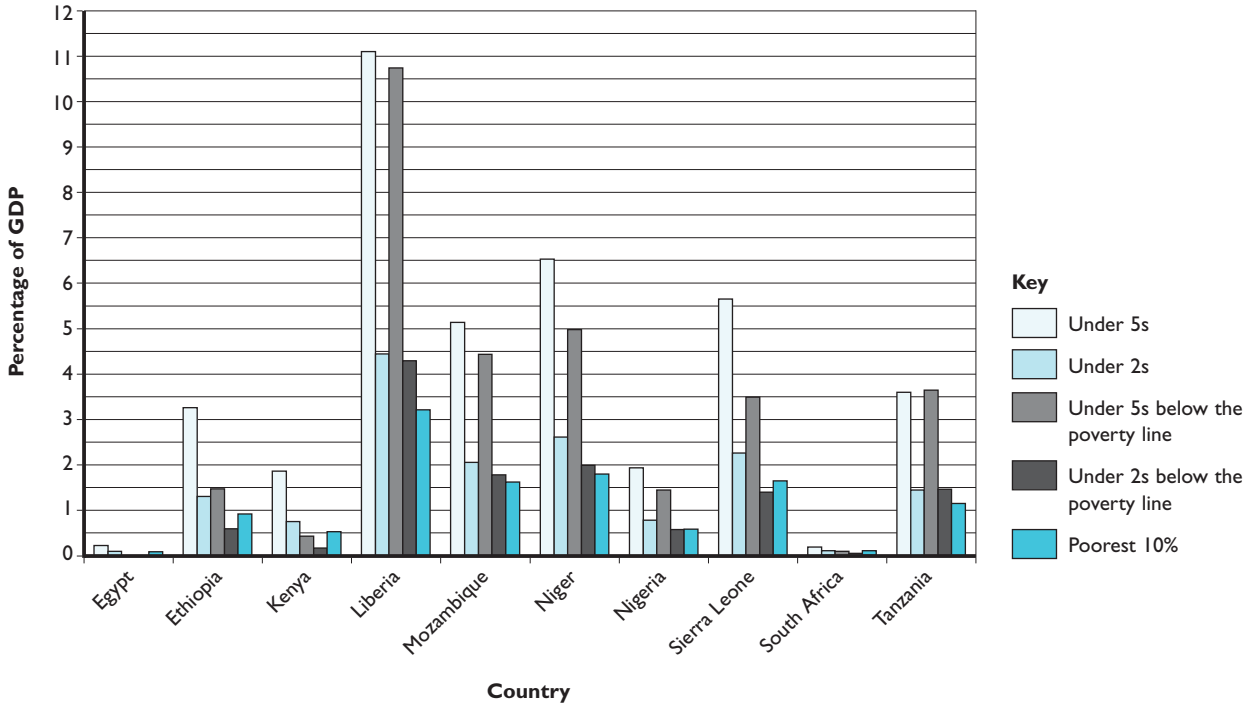


Figure 7: Child benefit costs – selected African countries



Mozambique currently could not afford even the more narrowly targeted options at national scale out of domestic resources. However, these countries could start with a smaller geographical area. For the stronger economies in the region, such as South Africa, Nigeria and Kenya, a range of poverty and categorical targeting options are possible. Similarly, any of the options for children under 5 are in the range of affordability in most Asian countries.

In countries where poverty is widespread, such as Liberia, Congo and Rwanda, the difference in costs between transfers targeted based on both age and poverty and those targeted only by age are significant, but not as large as one might expect. In Tanzania, poverty is so widespread that the additional cost of targeting would actually make a means-tested transfer as expensive, or even more expensive, than universal coverage for under 2s and under 5s.

It is striking to note that the cost of providing cash transfers to pregnant women is the least expensive option, and should be widely affordable. However, while the transfer value assumed should be sufficient to ensure good nutrition, visits for antenatal care and uncomplicated delivery at a health clinic, it should be noted that emergency obstetric care can often be extremely expensive and would still not be affordable to women with this level of transfer. This links to the earlier discussion on the importance of equitable access to health services.

Summary

The evidence suggests that a child benefit can be affordable for the countries accounting for the greatest share of global child mortality, particularly if complemented with predictable foreign aid. The precise design of a child benefit needs to be tailored to each country context, but countries and donors should aim to support transfers to under 5s that would provide at least 20% of household income. For middle-income countries, maternity benefits and universal child benefits for under 5s are likely to be a feasible option. In countries with high overall poverty rates, priority should be given to rolling out a universal programme geographically in areas with the highest poverty rates. Gradual expansion by age or geography will help to keep costs manageable, and allow time for building the systems and capacity necessary to deliver programmes at scale.

6 Conclusion and recommendations

Progress is being made against MDG 4, but not enough. As we approach 2015, we need to ensure that the solutions for reducing newborn and child mortality that we know will work are reaching more children and families. But we also need to be willing to answer the challenge in new ways.

Cash transfers do just that. They offer a new tool for reducing child mortality in developing countries. Child mortality is not simply a biomedical phenomenon, but also a deeply social one linked to poverty and inequality. Cash transfers address part of this social injustice by tackling chronic poverty, and by improving access to health, nutrition and education.

As discussed in this report, many cash transfer programmes have demonstrated positive impacts on a variety of determinants of child mortality, most immediately by increasing access to healthcare and reducing malnutrition. Across a number of countries, particularly in Latin America and Africa, transfers have increased access to food and healthcare, improved care for women and children, and supported improvements in household environment. There is substantial evidence of the positive effects on household poverty and livelihoods, and some evidence of the potential of cash transfers to improve women's status.

In addition to addressing factors driving child mortality, cash transfers have the potential for broader benefits for the economy. In the short term, cash transfers can increase labour participation, encourage productive investment, and have positive market effects. Contrary to common assumptions, cash transfers can also be an investment in medium- and long-term growth. The improvements due to transfers in children's health, nutrition and education have long-term impacts on productivity and earnings. It is a false economy to save money by compromising the potential of future generations.

Positive impacts from transfer programmes are not automatic, however. The evidence from both high-impact and low-impact programmes provides lessons about design factors and complementary interventions that maximise the likely impact of providing cash. These lessons must be taken into account and applied to each country context when establishing a new cash transfer programme.

The experience of an increasing number of developing countries in implementing large-scale cash transfers begins to provide evidence on how social cash transfers can be an affordable option. Central to affordability are a number of programme design choices. While lower levels of transfers will decrease costs, evidence suggests that in order to be effective in achieving health and nutrition outcomes or poverty reduction, the transfer should be equivalent to 20–30% of household consumption. Another way to control costs is by using a phased roll-out, which also helps governments to build up capacity to deliver programmes at scale. The choice of unconditional or conditional transfers will also have an impact on affordability.

Based on these findings, Save the Children UK makes the following recommendations:

1. National governments in countries with high rates of maternal and child mortality should invest in maternity and child benefits as an integral part of child survival efforts. National governments should set targets for expanding coverage of benefits over time, at pace with national budget and administrative capacity.

Child and maternity benefits are possible on a large scale, even in developing countries. In middle-income countries and many countries in Asia, universal benefits for children under 5 are likely to be possible. A universal under 5 benefit would cost 0.25%, 0.54% and 0.93% of GDP in China, India and Cambodia respectively. For low-income countries, the appropriate mixture of age-based and geographical targeting should be determined based on national child poverty profiles. Nigeria, for example, could afford a benefit for all children under 2 and a maternity benefit for 0.92% of GDP. Gradual scale-up by age and geography should keep pace with building administrative and financial capacity. In Tanzania, benefits for all children under 2 would cost an estimated 1.44% of GDP; the roll-out would therefore be likely to require geographical prioritisation.

In order to be sustainable, adoption of national programmes needs to be led by national governments as part of a broader national social protection framework, developed in consultation with their citizens and civil society. In 2008, African governments specifically stated that "long-term funding for social protection should be guaranteed through national resources with specific and transparent budget lines".[115] Financing of child and maternity benefits will require examination of existing budgets, including current social protection spending.

In fragile states, new operational research on cash transfer programmes, involving donor and NGO support, are required to understand the potential of these types of programmes to build capacity for long-term systems.

In order to be effective in reducing child mortality, cash transfers need to incorporate a number of key features:

- Cash transfer programmes should prioritise children under 5 and pregnant women, expanding to older ages as possible. It is critical to reach children at an early age.
- In most contexts transfers should be made to women carers, but potential gendered impacts – positive and negative – must be incorporated into the design and monitoring. Opportunities for increasing positive impacts on women's empowerment should be maximised.
- The size of transfer must be sufficient to allow families to invest beyond their immediate consumption needs. Experience thus far suggests that the amount should be in the range of 20–30% of household consumption.
- Further evidence is needed on the added value of conditionality, particularly in settings where the supply of services, available funding and administrative capacity are weaker. Where programmes choose conditional transfers, failure to adhere to conditions should prompt additional case management support rather than punitive actions.
- Programme design should seek ways to maximise human development outcomes – for example, through coordinating with existing health services, and providing early childcare centres and educational classes. Where there are real challenges to meeting micronutrient requirements, even with a transfer, programmes should include nutritional supplements distributed via health systems, for pregnant and lactating women and for children under 2.

2. National governments, supported by donors, should invest in complementary actions that maximise the impacts of cash transfers. Cash transfers are an important tool for reducing child mortality and supporting economic development, but need to be implemented in combination with other policies and programmes in order to produce mutually reinforcing outcomes.

Investment in health and education services should not be neglected in favour of cash transfers. Strengthening investment in health systems, and addressing quality issues and inequities in provision and access, are crucial for reducing child mortality. Broader social protection policy should include healthcare that is free at the point of service, including removal of user fees for essential healthcare services.

Birth registration is limited in many low-income countries, and can be an obstacle to children and their carers accessing a wide range of services, including transfers targeted on the basis of age. Maternity and child benefit programmes should be used as an opportunity to increase birth registration.

In order to maximise the potential economic benefits of cash transfers, broader inclusive economic development policy is necessary. Particular attention should be given to strengthening demand for low-skilled labour in rural areas.

3. National governments and donors should introduce equity targets within the existing MDG framework and into future development commitments, so that the poorest and most marginalised people are not left behind. Countries should routinely report these statistics disaggregated by wealth groups, gender, age, disability and – where appropriate – ethnic or religious group.

4. The Partnership for Maternal and Newborn Child Health should include child and maternal benefits in the package of interventions for reducing child mortality, particularly among the poorest, in Countdown-to-2015 countries.

Further progress on reducing the number of preventable child deaths requires addressing inequality and the economic drivers of child mortality. Cash transfers are a key demand-side intervention in tackling child mortality and must be integrated into national and regional plans to tackle newborn and child survival, and not simply come under entirely separate poverty reduction strategies.

A review of interventions for maternal and child undernutrition and child survival identified conditional cash transfers as an effective intervention for reducing stunting and child deaths.[116] Existing evidence on unconditional cash transfers has also demonstrated positive impacts on the determinants of child mortality. A recent editorial in *The Lancet* underlines the findings from the Joint Learning Initiative on Children and HIV/AIDS that the impact of cash transfers is "now established beyond a doubt and no further pilot studies are needed".[117] While it is important to continue examining evidence as it emerges, enough is known about the successes and challenges of cash transfers to move forward in their implementation as part of the package for reducing child mortality.

5. Donors should commit to increase their investment in social protection programmes, particularly in countries with high maternal and child mortality, and they need to set aside predictable, multi-year funding to finance cash transfers.

Social protection, including cash transfers, should be viewed as a fourth basic service alongside health, education, and water and sanitation. The current

global financial crisis is placing greater demands on aid budgets and government resources, at a time when the need for cash transfer schemes is rising. As a result, there are likely to be funding gaps in countries most in need of cash transfers in order to improve child survival rates. Donor support in the medium term is therefore necessary. The cost of cash transfer schemes amounts to a small fraction of the spending being committed to support the financial systems in developed countries.

While the UK Department for International Development, the ILO and the World Bank have shown considerable leadership in supporting social protection, broader donor financing and technical assistance is needed. To achieve these goals, bilateral and multilateral donors should set targets for social protection spending and report on progress against these targets.

All donors should support identified national and regional priorities. It is critical, for example, that the international community supports the African Union to implement its 2009 Social Policy Framework. Given the high percentage of recurrent costs and the importance of predictability for cash recipients, predictable multi-year financing is necessary. Donors should particularly focus on technical and financial support to high initial start-up costs in ensuring quality design, implementation and delivery capacity, and evaluation. Where appropriate, this should be in the form of budget support, in order to back national leadership.

Appendix 1 Selected cash transfer programmes and key features

Country/ programme	Total cost* (year)	Percentage of GDP	Number of beneficiaries	Amount of monthly transfer	Targeting	Conditional/ unconditional	Administrative costs	Funding source	Source (see page 36)
Mexico – Progresa/ Oportunidades	US$2.8 billion (2004)	0.66%	5 million	19.5% of mean consumption of poor households in non-Progresa areas	Geographical; proxy means-testing	Conditional – health, education	9%	Domestic – national budget; Inter-American Development Bank (IDB) funding for urban expansion	a, b, c, d
Brazil – Bolsa Familia	US$2.1bn (2004)	0.3% for BF and BPC – Medeiros et al 2008	8m	Average of $28.50 per household; 12% of poverty line	Means-tested, using national register system	Conditional – health, education		Initially domestic; later loans from IDB and World Bank (WB)	a, c
Nicaragua – Red de Protección Social	US$6.37m (2004)	0.1%	21,619 families (131,054 individuals)	Food security transfer – 18% per capita expenditure; plus school transfer	Geographical	Conditional – health, education	25% (includes design and evaluation); 21% without	IDB	a, b
Colombia – Programa Familias en Acción	US$125m (2004)	0.11%	400,000 families	Average US$50; 30% of household consumption	Geographical; proxy means-testing	Conditional – health, education		IDB, WB, national government	a, b

* Important to note that cost figures may include total programme costs including supply-side support.

continued overleaf

Country/ programme	Total cost* (year)	Percentage of GDP	Number of beneficiaries	Amount of monthly transfer	Targeting	Conditional/ unconditional	Administrative costs	Funding source	Source (see page 36)
Honduras – PRAF II	US$25m (2005)	0.25%	411,000 households	Average US$17; 8% of poverty line; 10% of household consumption	Geographical	Conditional – health, education		IDB (US$45.2m) and government (US$5.1m)	a, b
El Salvador – Red Solidario	US$50m (2005)	0.14%	24,106 households (2006); goal of reaching 100,000 households by 2009	US$15–20 per month; 37–50% of rural poverty line	Geographical and categorical	Conditional – health, education		National budget for transfers (EU, Luxembourg and Spanish funding for project management and infrastructure. Supported by World Bank and IDB technically	l
Ecuador – Bono Solidario	US$200m	1%	1.2m households	Average of 15% of household expenditure, $15/month	Loosely means-tested; categorical	Unconditional	4%	National budget	a, b
Starting in 2003, Bono de Desarrollo Humano replaced Bono Solidario		0.7%			Proxy means-tested	Intended to be conditional but not implemented	6.8% (not including fixed and evaluation costs)	Domestic and World Bank	a
South Africa – Child Support Grant	$1bn (2005/6)	0.7%	3.6m children	R180/month/ child under 14; average 15–20% household monthly income	Categorical and means-tested	Unconditional		National budget	b, e, f
South Africa – Old Age Pension	US$1.88bn (R13.2bn)	1.4%	1.9–2.1m beneficiaries (2007)	R740 (approximately £61)	Categorical and means-tested	Unconditional		National budget	g, h

continued opposite

Country/ programme	Total cost* (year)	Percentage of GDP	Number of beneficiaries	Amount of monthly transfer	Targeting	Conditional/ unconditional	Administrative costs	Funding source	Source (see page 36)
Lesotho Pension	US$19.81m (M126m) (70+) (2005)	1.4%	69,046 people (2005)	M150 (US$25) per month; rose to M200 (US$29) in 2007	Categorical	Unconditional	10%	National budget	f, g, k
Ethiopia	US$230m (2008)	Approx 1.1%	1.64m households; 8m people (2006)	Average US$17 per capita/year plus food – total value can vary substantially	Community targeting	Unconditional; Programme includes cash/ food for work and direct support components		Donor funded	n, p
Kenya			25,000 households, 75,000 OVCs; target of 100,000 households by 2012	US$19.50	Community targeting and verification	Testing conditional and unconditional		Donor and national government US$8.59 million (2008/9) national budget; US$150 million donor commitment over next 10 years	o, p
Malawi	US$3m (2008)	Approx 0.08%	13, 045 households	US$4–13m depending on HH size	Community targeting	Unconditional		Donor and national government	o, p
Mozambique	US$7.3m (2007)	0.09%	172,000 households	US$4 plus US$2 for each dependant	Community targeting	Unconditional		National budget	p
India – National Rural Employment Guarantee Scheme	US$2.5bn (2006–7)	0.3%	Target of 40 million	Set according to state agricultural minimum wage	Self-selection	Unconditional; Guarantees minimum number days of work		National and state budgets	i

continued overleaf

Country/ programme	Total cost* (year)	Percentage of GDP	Number of beneficiaries	Amount of monthly transfer	Targeting	Conditional/ unconditional	Administrative costs	Funding source	Source (see below)
China – Minimum Living Standards Scheme			22m (2006)	Set according to local minimum standard of living assistance line. National average of 14% of average wage	Means-tested	Unconditional		National budget	j, m

Sources
a) Handa and Davis 2006
b) Srindhar and Duffield 2007
c) Kakwani et al. 2005
d) Skoufias 2001
e) Barrientos and DeJong
f) Save the Children/HAI/IDS
g) Pelham 2007
h) HelpAge International 2003
i) Sjoblom and Farrington 2008
j) Barrientos and Hulme 2008b
k) Ellis, Devereux and White 2009
l) Britto 2007
m) Gao, Garfinkel and Zhai 2007
n) Adato and Bassett 2008
o) Blank and Handa 2008
p) Save the Children UK research

Appendix 2 Key effective child survival interventions and their elements of supply, behaviour change and financial demand

Intervention	Supply of services	Behaviour change	Financial element
Prevention			
Exclusive breastfeeding	Yes – counselling	Yes – home behaviour	Yes – opportunity cost of time required
Insecticide-treated nets	Yes – via health centres (or private sector)	Yes – home behaviour	Only if sold
Complementary feeding	Yes – counselling	Yes – home behaviour	Yes – buying foods
Zinc	Yes – via health centres	No (service provision)	Yes – healthcare costs
Clean delivery	Yes – via health centres	No (service provision) Yes – health-seeking	Yes – healthcare costs
HiB vaccine	Yes – via health centres	Yes – health-seeking	Yes – healthcare costs
Water, sanitation, hygiene	Yes – construction of facilities	Yes – home behaviour	Yes – healthcare costs
Antenatal steroids	Yes – via health centres	No (service provision)	Yes – healthcare costs
Newborn temperature management	Yes – via health centres	No (service provision) Yes – home behaviour if home birth	Yes – healthcare costs No, if home birth
Vitamin A	Yes – via health centres	Yes – health-seeking	Yes – healthcare costs
Tetanus toxoid	Yes – via health centres	Yes – health-seeking	Yes – healthcare costs

continued overleaf

Intervention	Supply of services	Behaviour change	Financial element
Prevention *continued*			
Nevirapine and replacement feeding	Yes – via health centres	Yes – health-seeking and home behaviour	Yes – healthcare costs
Antibiotics for premature rupture of membranes	Yes – via health centres	No (service provision)	Yes – healthcare costs
Measles vaccine	Yes – via health centres	Yes – health-seeking	Yes – healthcare costs
Antimalarial intermittent preventive treatment in pregnancy	Yes – via health centres	Yes – health-seeking	Yes – healthcare and drugs costs
Treatment			
Oral rehydration therapy	Yes, if clinic; No, if homemade solution	Yes – home behaviour	Minor – sugar, salt
Antibiotics for sepsis	Yes – via health centres	Yes – health-seeking	Yes – healthcare costs
Antibiotics for pneumonia	Yes – via health centres	Yes – health-seeking	Yes – healthcare costs
Antimalarials	Yes – via health centres	Yes – health-seeking	Yes – healthcare costs
Zinc	Yes – via health centres	Yes – health-seeking	Yes – healthcare costs
Newborn resuscitation	Yes – via health centres	No	Yes – healthcare costs
Antibiotics for dysentery	Yes – via health centres	Yes – health-seeking	Yes – healthcare costs
Vitamin A	Yes – via health centres	Yes – health-seeking	Yes – healthcare costs

Appendix 3 Key findings on health and nutrition outcomes of cash transfers

Programme	Health	Nutrition	Source	Control group/ differential treatment
Mexico PROGRESA/ Oportunidades	Children participating PROGRESA aged 0–2 have 12% lower incidence of illness than children in comparison households, and children aged 3–5 have 11% lower No association with haemoglobin concentration		Gertler (2000)	Yes
		Among urban beneficiaries, impact not significant for 2–24 months. However, children less than 6 months at baseline grew 1.5 cm more or 0.41 height-for-age (HAZ) score. Also significant for children in poorest tertile – 0.9 cm or 0.27 HAZ	Leroy et al. (2008)	Yes
		Children aged 6–36 months grew, on average, 1cm more than the control group children. Effects were larger in poorer households with better-educated fathers	Srindhar and Duffield (2006)	Yes
	No association with increased cash exposure (among beneficiaries) and number of sick days in previous 4 weeks Children 12–36 months (Oct–Dec 1999) 25% less likely to be anaemic	Doubling of cash exposure (among beneficiaries) associated with increase in HAZ (0.2) and lower prevalence of stunting (-0.1) Lower prevalence of being overweight (-0.08) (which is an issue in Mexico)	Fernald, Gertler and Neufeld (2008)	Yes

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Programme	Health	Nutrition	Source	Control group/ differential treatment
Ecuador Bono de Desarrollo Humano	Positive but not significant overall, except for poorest quartile – 39% S.D.	Incidences of stunting but not significant. However, children sampled were aged 3–7 and programme didn't begin until children were at least 18 months	Paxson and Schady (2007)	Yes
Nicaragua Red de Protección Social (RPS)	Despite effects on % mothers receiving iron supplement, no impact on anaemia and average haemoglobin Programme data indicate serious shortages in supply of supplements, so difficult to tell if getting complete treatments; alternatively, could be deficient in other micronutrients	Net effect of RPS reduced stunting 5.3 percentage points among children 6–59 months compared to control; and 1.7 times more than national trend of 1.5 per year 6.0 percentage point difference in WAZ scores 4.9% decrease in underweight among beneficiaries	Maluccio and Flores (2004)	Yes
		Improvement of HAZ score by 0.17 due to programme. Sample size not large enough to be significant by decile, but indication that effects larger among extreme poor and poor	NCHS/WHO (1995)	Yes
Colombia Familias en Acción	In rural areas, decreased occurrence of diarrhoea from 32.6% to 22% for children less than 24 months, and from 21.3% to 10.4% for 24–48 months	12-month-old boys grew 0.44 cm more than without the programme in context of 21% of children 0–7 being chronically malnourished	Attanasio et al. (2005)	Yes
		Average increase of 0.58 kg for newborns in urban areas – attributed to better nutrition during pregnancy	Lagarde et al. (2007)	Yes
		Mean height-for-age of children aged 0–24 months increased by approximately 0.2. No effect on stunting was seen in older age groups, but this was thought to be due to the existence of a successful nursery programme in which the older children take part, which masked the effects of the programme	Srindhar and Duffield (2006)	Yes
Malawi Mchinji Social Cash Transfer Pilot	Intervention children experienced fewer sicknesses in the past month versus comparison children (42% vs. 55%). Over one year, there was a 23.4% reduction in the percentage of intervention children experiencing illnesses in the past month versus 12.5% reduction in comparison children. The health of 31% of children in intervention households was rated as excellent vs. 13% of children in comparison households. Intervention households reported that the health of 81% of intervention children improved (vs. 15% of comparison children)	Between March 2007 and April 2008, reduction in underweight children by 10.5 percentage points, and reduction in stunting among children by 4.2 percentage points	Miller (2008)	Yes

continued opposite

Programme	Health	Nutrition	Source	Control group/ differential treatment
Kalomo pilot scheme, Zambia	Incidence of illnesses decreased at evaluation when compared to baseline. During the month preceding the baseline 43% reported to have been sick, reducing to 35% the year afterwards. Considerable decreases have also taken place in the group of under 5s and in the group of productive age from 19–64, which is probably a result of improved nutrition and hygiene		MCDSS/PWAS/ GTZ (2005)	No
		According to a small sample of children's growth monitoring cards, the percentage of underweight children aged 0–5 years decreased from 41% to 33%. Although supported by qualitative data on household diets, the quantitative findings should be viewed with caution due to a number of data collection problems	Srindhar and Duffield 2008	No
Brazil Bolsa Alimentação		Impact of Bolsa Alimentação in four municipalities in north-east Brazil was associated with lower weight gain and lower average height for weight scores among participants in comparison group not enrolled in the programme (little if any difference prior to enrolment), despite evidence of increase in nutritious foods in the household. However, this is attributed to perceptions among beneficiaries that they would be removed from the programme if children were not underweight.	Morris et al. 2004	Yes
Honduras Programa de Asignación Familiar (PRAF II)		Interventions had no significant impact on height-for-age of children	Srindhar and Duffield 2008	Yes
South Africa Pension		Programme impact was to increase height for girls 0.093 cm or 0.026 SD/month (2.23 cm or 0.62 SD over 2 years) relative to non-eligible children. Positive but smaller results for boys of 0.037 cm or 0.013 SD/month. Effects strongest where woman recipient	Duflo 2000a, Duflo 2000b	Yes

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Programme	Health	Nutrition	Source	Control group/ differential treatment
South Africa Pension *continued*		A later study finds that the presence of a pensioner is associated with a 5cm increase in height for age – approximately half a year's growth for Black and Coloured children, controlling for a number of household and child characteristics. Slightly higher than Duflo estimates, but Duflo sample included data from before pension was fully operational	Case 2001	Yes
South Africa Child Support Grant		Benefiting from programme for less than 20% of the nutrition window (first 36 months), there are no nutritional gains. At coverage for two-thirds of window, child has 0.25 HAZ more than child covered for 1% of window (aggregate regardless starting age). Maximum gain of 0.45 HAZ when treatment begins before one year of age	Aguero, Carter and Woolard 2007	Yes

Appendix 4 Methodological notes on costing child benefits

Full data and calculations are available at www.savethechildren.org.uk

The 68 countries selected for analysis constitute the 'Countdown to 2015' list of countries that globally account for 97% of all child mortality (see http://www.childinfo.org/files/Countdown2015Publication.pdf).

Population estimates for 2008 were taken from the US Census Bureau's International Database (http://www.census.gov/ipc/www/idb/). Original data in five-year age ranges (0–4, 5–9, 10–14, 15–19) were adjusted on a simple pro rata basis to provide estimates for 'under 2s' and 'under 18s'.

Information on the poverty gap and poverty headcount for each country was sourced from the World Bank's PovcalNet tool (http://iresearch.worldbank.org/PovcalNet/povcalSvy.html), as of November 2008. Poverty data was available only for 57 of the 68 Countdown countries, and the most recent survey year varied from country to country. The international poverty line used by the World Bank for this data is US$1.25 per person per day (pppd), expressed in purchasing power parity terms. This line refers to the minimum amount of income or consumption necessary to meet basic food and non-food needs, and is the mean of the national poverty lines for the 10–20 poorest countries of the world. 'Poverty headcount' refers to the percentage of total population with income or consumption levels of less than US$1.25 pppd. 'Poverty gap' refers to the average gap between current income/consumption and the poverty line across the entire population (using a value of zero for those with income above the poverty line), expressed as a percentage of US$1.25.

For our purposes, we needed to exclude the zero values for those above the poverty line from the poverty gap figure to get the average poverty gap only for that portion of the population with income/consumption below the poverty line. Manipulating the World Bank Poverty Gap formula accordingly gives a formula for the average gap only for the poor of (Total population × Poverty gap) / Population below the poverty line:

$$PG_{population} = \frac{\sum_{i=1}^{n = \text{total population}} PL - I}{\text{Total population}}$$

$$PG_{BPL\ population} = \frac{\sum_{i=1}^{n = \text{total population}} PL - I}{\text{BPL population}}$$

$$= \frac{\sum_{i=1}^{n = \text{total population}} PL - I}{\text{Total population}} \times \frac{\text{Total population}}{\text{BPL population}}$$

where *PL* is the $1.25/day poverty line, *I* is household income, and a zero value is given for all households above the poverty line.

This new gap was then converted into a monetary value for each country to give the basic daily cash transfer value per recipient. To get the actual cost of the transfer per person, we added 15%

administrative costs when the transfer was targeted based on age criteria only; and 33% administrative costs when the transfer was targeted only to those below the poor and thus would require means-testing or proxy means-testing. These values were selected from within the range of cost estimates for various similar programmes available from Coady, Grosh and Hodinott (2004), and used in Behrendt (2008).

We applied the poverty headcount figure to the age-specific population estimates to estimate the number of children per country below the poverty line (BPL) for the three age groups (under 2s, under 5s and under 18s). While we recognise that studies typically show that there are proportionately greater numbers of children in BPL families than in the population as a whole, and therefore that our approach is likely to underestimate the numbers of poor children, we found no reliable basis for adjusting to get accurate numbers of children in poverty across the entire dataset. We estimated the number for the 'poorest 10% of children' simply by dividing the number of under 18s by 10.

On maternity benefit, stunting at birth reflects maternal undernutrition throughout pregnancy, while wasting is thought to result from undernutrition that occurs late in pregnancy. Wasted intrauterine growth retardation infants exhibit greater postnatal catch-up growth and less severe cognitive deficits than their stunted counterparts (Tanner and Whitehouse 1973; Kramer et al. 1990). Therefore, interventions should aim to reduce stunting in newborns. Studies have shown that maternal supplementation during 2nd trimester onwards shows greatest pregnancy outcomes in terms of weight gain and increasing birth weight (Ceesay 1997; Prentice et al. 1987). Ideally, pregnant women should be enrolled in cash transfer programmes as soon as they are reported pregnant. However, in order to reduce administrative cost and targeting error, we recommend and have costed benefits starting in the 2nd trimester.

Finally we multiplied the appropriate daily transfer cost by the relevant population figure and by 365 days per year to give an annual cost per country, which was summed to give a total figure for the 57 countries.

Data on GDP in purchasing power parity terms for the most recent available year per country was taken from the World Bank's World Development Indicators database (http://ddp-ext.worldbank.org/ext/DDPQQ/member.do?method=getMembers&userid=1&queryId=135; accessed January 2009), and was used for the estimate of child benefits cost as a percentage of GDP.

It is important to stress that this is a static analysis of the likely current cost of child benefits. Cost estimates will change over time according to the particular combination of changes in each country arising from:

- population growth
- changes in poverty headcount
- changes in average poverty gap
- economic growth
- potential changes in administrative costs over time.

Bibliography

Adams, L and Kebede, E (2005) *Breaking the Poverty Cycle: A case study of cash interventions in Ethiopia*, Humanitarian Policy Group Background Paper, London, ODI

Adato, M and Bassett, L (2008) *What is the Potential of Cash Transfers to Strengthen Families Affected by HIV and AIDS? A review of the evidence on impacts and key policy debates*, Joint Learning Initiative on Children and HIV/AIDS, http://www.jlica.org/resources/publications.php

Adato, M et al (2000) *The Impact of Progresa on Women's Status and Intrahousehold Relations*, Washington DC, IFPRI

Aguero, J, with Carter, M and Woolard, I (2007) *The Impact of Unconditional Cash Transfers on Nutrition: The South African Child Support Grant*, Working Paper 39, Brasilia, International Poverty Centre

Alderman, H and Hoddinott, J (2007) *Growth-Promoting Social Safety Nets*, 2020 Focus Brief on the World's Poor and Hungry People, Washington DC, IFPRI

Alderman, H, with Hoddinott, J and Kinsey, B (2003) *Long-term Consequences of Early Childhood Malnutrition*, FCND Discussion Paper 168, Washington DC, IFPRI

Attanasio, O et al (2005) *How Effective are Conditional Cash Transfers? Evidence from Colombia*, IFS Briefing Note 54, London, The Institute for Fiscal Studies

Barham, T (2007) *Providing a Healthier Start to Life: The impact of conditional cash transfer programs on infant mortality*, Discussion Paper No. 06-02 Department of Economics, University of Colorado Boulder

Barham, T, Logan Brenzel, and Maluccio, J (2007) *Beyond 80%: Are there new ways of increasing vaccination coverage? Evaluation of CCT Programs in Mexico and Nicaragua*, Health, Nutrition and Population Discussion Paper Series, The World Bank.

Barrientos, A (2008 A) *Social Transfers and Growth: A review*, Manchester, Brooks World Poverty Institute

Barrientos, A (2008 B) 'Financing Social Protection', in *Social Protection for the Poor and Poorest: Concepts, policies and politics*, Basingstoke, Palgrave Macmillan

Barrientos, A and Hulme, D (2008 A) *Social Protection for the Poor and Poorest in Developing Countries: Reflections on a quiet revolution*, BWPI Working Paper 30, Manchester, Brooks World Poverty Institute

Barrientos, A and Hulme, D (2008 B) 'Social Protection for the Poor and Poorest: An Introduction', in *Social Protection for the Poor and Poorest: Concepts, policies and politics*, Basingstoke, Palgrave Macmillan

Barrientos, A and Sabates-Wheeler, R (2006) *Local Economy Effects of Social Transfers*, Brighton, IDS

Behrman, J, with Alderman, H and Hoddinott, J (2004) *Copenhagen Consensus – Challenges and Opportunities: Hunger and malnutrition*, Copenhagen Consensus Challenge Papers

Behrman, J and Hoddinott, J 'Programme evaluation with unobserved heterogeneity and selective implementation: the Mexican PROGRESA impact on child nutrition', *Oxford Bulletin of Economics and Statistics*, **67**, 4, 2005, pp 547–69

Berton, H (2009) *How Cash Transfers can Improve the Nutrition of the Poorest Children: An evaluation of a pilot safety nets projects in Southern Niger*, London, Save the Children UK

Bhutta et al 'What works? Interventions for maternal and child undernutrition and survival', *The Lancet*, **371**, 9610, 2008, pp 417–40

Black et al 'Maternal and child undernutrition: global and regional exposures and health consequences', *The Lancet*, **371**, 2008, pp 243–60

Blank, L and Handa, S (2008) *Social Protection in Eastern and Southern Africa: A framework and strategy for UNICEF*, Nairobi, UNICEF

Blas et al 'Addressing social determinants of health inequities: what can the state and civil society do?', *The Lancet*, **372**, 9650, 2008, pp 1684–1689

Britto, T (2007) *The Challenges of El Salvador's Conditional Cash Transfer Programme, Red Solidaria*, International Poverty Centre Country Study number 9, Brasilia, IPC

Case, A (2001) *Does Money Protect Health Status? Evidence from South African pensions*, NBER Working Paper 8495, Cambridge, MA

Case, A and Deaton, A (1996) *Large Cash Transfers to the Elderly in South Africa*, NBER Working Paper 5572, Cambridge, USA, National Bureau of Economic Research

Ceesay, SM et al 'Effects on birth weight and perinatal mortality of maternal dietary supplements in rural Gambia: 5 year randomised controlled trial', *British Medical Journal*, **315**, 7111, 1997, pp 786–90

Chapman, K (2006) 'Using social transfer to scale up equitable access to education and health services', Background Paper prepared for DFID

Chastre, C et al (2007) *The Minimum Cost of a Health Diet: Findings from piloting a new methodology in four study locations*, London, Save the Children UK

Chen, Y and Zhou, L 'The long-term health and economic consequences of the 1959–1961 famine in China', *Journal of Health Economics*, **26**, 2007, pp 659–681

Coady, D, with Grosh, M and Hoddinott, J (2004) *Targeting of Transfers in Developing Countries: Review of lessons and experience*, Washington DC, World Bank and IFPRI

Coady, D and Parker, S (2002) *A Cost-effectiveness Analysis of Demand- and Supply-side Education Interventions: The case of Progresa in Mexico*, IFPRI

Cook, S, with Heintz, J and Kabeer, N 'Economic growth, social protection and 'real' labour markets: linking theory and policy', *IDS Bulletin*, **39**, 2, 2008, pp 1–10

Davies, S and Davey, J 'A regional multiplier approach to estimating the impact of cash transfers on the market: the case of cash transfers in rural Malawi', *Development Policy Review*, **26**, 1, 2008, pp 91–111

Deaton, A (2003) *Health, Income, and Inequality*, NBER Reporter, www.nber.org

Devereux, S (2002) *Social Protection for the Poor: Lessons from recent international experience*, IDS Working Paper 232, Sussex, IDS

Devereux, S and Sabates-Wheeler, R (2004) *Transformative Social Protection*, IDS Working Paper Series 232, Brighton, IDS

Devereux, S et al (2007) *An Evaluation of Concern Worldwide's Dowa Emergency Cash Transfer*

Project (DECT) in Malawi, 2006/07, Lilongwe, Concern Worldwide

Devereux, S, with Sabates-Wheeler, R, Tefera, M, and Taye, H (2006) *Ethiopia's Productive Safety Net Programme (PSNP): Trends in PSNP transfers within targeted households*, Brighton, UK, and Addis Ababa, Ethiopia, Institute of Development Studies and Indak International Pvt. L. C

Devereux, S et al (2008) *Linking Social Protection and Support to Small Farmer Development*, FAO, http://www.fao.org/ES/ESA/pdf/workshop_0108_social_protection.pdf

DFID (2005 A) 'Can low-income countries in Africa afford social transfers?' *Social Protection Briefing Note*, Series Number 2, London, DFID

DFID (2005 B) *Why We Need to Work More Effectively in Fragile States*, London, DFID

DFID (2006) 'Social protection and economic growth in poor countries', *Social Protection Briefing Note*, Series Number 4, London, DFID

Duflo, E 'Child Health and Household Resources in South Africa: Evidence from the Old Age Pension Program', *The American Economic Review*, **90**, 2, 2000 (A), pp 393–398

Duflo, E (2000 B) *Grandmothers and Granddaughters: Old-age pensions and intrahousehold allocation in South Africa*, MIT Department of Economics Working Paper 00 05, Cambridge, USA, MIT

Economic Policy Research Institute (2004) *Final Report: The social and economic impact of South Africa's social security system*, EPRI Research Paper 37, Cape Town, EPRI, South Africa Department of Social Development

Ellis, F (2007) 'Old Age Pension, Lesotho', *REBA Case Study Brief* 3, Johannesburg, Regional Hunger and Vulnerability Programme

Farmer, P (2005) *Pathologies of Power: Health, human rights, and the new war of the poor*, Berkley, University of California Press

Farrington, J, with Harvey, P and Slater, R (2005) *Cash Transfers in the Context of Pro-poor Growth*, London, ODI

Fenn, Bridget et al 'Inequities in Neonatal Survival Interventions: Evidence from National Surveys', *Archives of Disease in Childhood – Fetal and Neonatal Edition*, **92**, 2007, pp 361–366

Fernald, L, with Gertler, P and Neufeld, L 'Role of cash in conditional cash transfer programmes for child health, growth, and development: an analysis of Mexico's *Oportunidades*', *The Lancet*, **371**, 2008, pp 828–37

Fiszbein, A and Schady, N (2009) *Conditional Cash Transfers: Reducing present and future poverty*, Washington DC, World Bank

Gao, Q, Garfinkel, I and Zhai F (2007) 'How effective is the Minimum Living Standard Assistance Policy in Urban China' Paper presented at IARIW-NBS International Conference on Experiences and Challenges in Measuring National Income and Wealth in Transition Economies, 18–21 September 2007, Beijing China

Gassman, F and Behrendt, C (2006) *Cash Benefits in Low-income Countries: Simulating the effect on poverty reduction for Senegal and Tanzania*, Issues in Social Protection Discussion Paper 15, Geneva, ILO

Gertler, P (2000) 'Final Report: The impact of Progresa on health', Washington DC, IFPRI

Gertler, P 'Do conditional cash transfers improve child health? Evidence from PROGRESA's Controlled randomized experiment', *American Economic Review*, **94**, 2, 2004, pp 331–336

Gertler, P, with Martinez, S and Rubio-Codina, M (2006) *Investing Cash Transfers to Raise Long-Term Living Standards*, World Bank Policy Research Working Paper 3994, World Bank

Grantham-McGregor, SM, with Cheung, YB, Cueto, S, Glewwe, P, Richter, L, Strupp, B and the International Child Development Steering Group 'Developmental potential in the first 5 years for

children in developing countries', *The Lancet*, **369**, 2007, pp 60–70

Guhan, S 'Social security options for developing countries', *International Labour Review*, **133**, 1, 1994, pp 35–53

Gwatkin et al (2007) *Socio-Economic Differences in Health, Nutrition and Population within Developing Countries – An Overview*, Washington DC, The World Bank

Gwatkin, Davidson, et al (2005) *Reaching the Poor with Health, Nutrition and Population Services*, Washington DC, The World Bank

Handa, S and Davis B (2006) *The Experience of Conditional Cash Transfers in Latin America and the Caribbean*, ESA Working Paper No. 06-07, Rome, FAO

Handa, S, with Huerta, M, Perez, R and Straffon, B (2000) *Poverty, Inequality and Spill-over in Mexico's Education, Health and Nutrition Program*, Washington DC, IFPRI

Handa, S, with Koch, S and Ng, S (2008) 'Child mortality in Eastern and Southern Africa', unpublished mimeo, Carolina Population Center, UNC, Chapel Hill

Harvey, P (2005) 'Cash and vouchers in emergencies', *Humanitarian Policy Group Discussion Paper*, London ODI

HelpAge International (2003) *Non-contributory Pensions and Poverty Prevention: A comparative study of Brazil and South Africa*, London, DFID

Hernández, B., D. Ramírez, H. Moreno, and N. Laird (2004) 'Evaluación del impacto de Oportunidades en la mortalidad materna e infantile', in *Resultados de la Evaluación Externa del Programa de Desarrollo Humano Oportunidades*, Instituto Nacional de Salud Publica/ Oportunidades/CIESAS

Hill, K 'Frameworks for studying the determinants of child survival', *Bulletin of the World Health Organization*, **81**, 2, 2003, pp 138–139

Hoddinott, J, with Maluccio, J, Behrman, J, Flores, R and Martorell, R 'Effect of a nutrition intervention during early childhood on economic productivity in Guatemalan adults', *The Lancet*, **371**, 2008, pp 411–416

Hoddinott, J and Wiesmann, D (2008) *The Impact of Conditional Cash Transfer Programs on Food Consumption in Honduras, Mexico, and Nicaragua*, SSRN http://ssrn.com/abstract=1269417

Holzmann, R and Jorgensen, S (2000) *Social Risk Management: A new conceptual framework for social protection, and beyond*, Social Protection Discussion Paper 6, Washington DC, World Bank

Inter-Agency Task Team (IATT) on Children and HIV and AIDS: Working Group on Social Protection (2008) 'Expanding Social Protection for Vulnerable Children and Families: Learning from an Institutional Perspective' http://www.unicef.org/aids/files/ Expanding_Social_Protection.MTemin.May2008.pdf

ILO (2001) *Social Security: A new consensus*, Geneva, ILO

ILO (2007) *Growth, Employment and Social Protection: A strategy for balanced growth in a global market economy*, Geneva, ILO

International Health Partnership, http://www.internationalhealthpartnership.net/ ihp_plus_countries.html

JLICA (2009) 'Home Truths: Facing the facts on children, AIDS and poverty', http://www.jlica.org/ resources/publications.php

Jones et al 'How many child deaths can we prevent this year?', *The Lancet*, **362**, 2003, pp 65–71

Jones, N, with Vargas, R and Villar, E 'Cash transfers to tackle childhood poverty and vulnerability: an analysis of Peru's Juntos programme', *Environment and Urbanization*, **20**, 1, 2008, pp 255–273

Kabeer, N, Sharma, A and Upendranadh, C 'Social Security in South Asia: Issues and perspectives', http://www.ids.ac.uk

Kakwani, N, Soares, F and Son, H.(2005) *Conditional Cash Transfers in African Countries*, International Poverty Centre Working Paper 9, Brasilia, IPC

Kakwani, N and Subbarao, K (2005) *Ageing and Poverty in Africa and the Role of Social Pensions*, International Poverty Centre Working Paper 8, Brasilia, IPC

Kramer, MS et al 'Impact of intrauterine growth retardation and body proportionality on fetal and neonatal outcome', *Paediatrics*, **86**, 5, pp 707–13

Kukrety, N (2007) *Investing in the Future*, Save the Children UK position paper on the role of cash transfers in reducing child malnutrition, Save the Children UK

LaGarde, M, with Haines, A and Palmer, N 'Conditional cash transfers for improving uptake of health interventions in low- and middle-incomes countries: a systematic review', *JAMA*, **298**, 16, 2007, pp 1900–10

Lagarde, M and Palmer, N 'The impact of user fees on health service utilization in low and middle-income countries: how strong is the evidence?', *Bulletin of the World Health Organization*, **86**, 11, 2008, pp 839–848

Lancet (2009) 'Editorial: A new agenda for children affected by HIV/AIDS', *The Lancet*, **373**, 517

Leroy, J, with García-Guerra, A, García, R, Dominguez, C, Rivera, J and Neufeld, L 'The Oportunidades Program increases the linear growth of children enrolled at young ages in urban Mexico', *Journal of Nutrition*, **138**, 2008, pp 793–798

Lundberg, O et al 'The role of welfare state principles and generosity in social policy programmes for public health: an international comparative study', *The Lancet*, **372**, 9650, 2008, pp 1633–40

Maluccio, J and Flores, R (2004), *Impact Evaluation of a Conditional Cash Transfer Program: The Nicaraguan Red de Protección Social*, FCND Discussion Paper 184, Washington DC, International Food Policy Research Institute

MCDSS/PWAS/GTZ (2005) 'External monitoring and evaluation report of the Pilot Social Cash Transfer Scheme, Kalomo District, Zambia', Lusaka, MCDSS/GTZ

Medeiros, M, Britto, T and Soares, FV (2008) *Targeted Cash Transfer Programmes in Brazil: BPC and the Bolsa Familia*, Working Paper 46, Brasilia, International Poverty Centre

Miller, C, with Tsoka, M and Reichert, K (2008) 'Impact Evaluation Report: External evaluation of the Mchinji Social Cash Transfer Pilot, Boston', Boston University School of Public Health and the Centre for Social Research, University of Malawi

Mizunoya, S et al (2006) *Costing of Basic Social Protection Benefits for Selected Asian Countries: First results of a modelling exercise*, Issues in Social Protection Discussion Paper 17, Geneva, ILO

Molyneux, M 'Mothers at the service of the New Poverty Agenda: Progresa/Oportunidades, Mexico's Conditional Transfer Programme', *Social Policy & Administration*, **40**, 4, 2006, pp 425–449

Morris, S et al 'Monetary incentives in primary health care and effects on use and coverage of preventive health care interventions in rural Honduras: cluster randomized trial', *The Lancet*, **364**, 2004 A, pp 2030–37

Morris, S, with Olinto, P, Flores, R, Nilson, E and Figueiró, A 'Conditional cash transfers are associated with a small reduction in the rate of weight gain of preschool children in northeast Brazil', *Journal of Nutrition*, **134**, 9, 2004 B, pp 2336–42

Mosley, WH and Chen, L 'An analytical framework for the study of child survival in developing countries', *Bulletin of the World Health Organization* 2003, **81**, 2, 1983, pp 140–145

Mvula, P (2007) 'The Dowa Emergency Cash Transfer (DECT) Project: A study of the social impacts, regional hunger and vulnerability project', http://www.wahenga.net/index.php/evidence/

Osorio et al (2008) *Conditional Cash Transfers in Education: Design features, peer and sibling effects; evidence from a randomized experiment in Columbia*, Policy Research Working Paper 4580, Washington, World Bank

Pal, K et al (2005) *Can Low Income Countries Afford Basic Social Protection? First results of a modeling exercise*, Issues in Social Protection Discussion Paper 13, Geneva, ILO

Pan American Health Organization (2008) *Social Protection in Health Schemes for Mother, Newborn and Child Populations: Lessons learned from the Latin American region*, Washington DC, PAHO

Paxson, C and Schady, N (2007) *Does Money Matter? The effects of cash transfers on child health and development in rural Ecuador*, World Bank Policy Research Working Paper 4226, Washington, World Bank

Pelham, L (2007) *The Politics behind the Non-contributory Old Age Social Pensions in Lesotho, Namibia and South Africa*, CPRC Working Paper 83, CPRC

Prentice, AM et al 'Increased birthweight after prenatal dietary supplementation of rural African women', *American Journal of Clinical Nutrition*, **46**, 6, 1987, pp 912–25

Ramirez, A, with Ranis, G and Stewart, F (1997), *Economic Growth and Human Development*, Economic Growth Center Discussion Paper 787, New Haven, Yale University

Rivera, J, with Sotres-Alvarez, D, Habicht, J-P et al 'Impact of Mexican Program for Education, Health and Nutrition (Progresa) on rates of growth and anemia in infants and young children: A randomized effectiveness study', *JAMA*, **291**, 21, 2004, pp 2563–70

Sadoulet, E, with De Janvry, A and Davis, B 'Cash transfer programs with income multipliers: PROCAMPO in Mexico', *World Development*, **29**, 6, 2001, pp 1043–56

Save the Children UK, with HelpAge International and IDS (2005) *Making Cash Count: Lessons from cash transfer scheme in east and southern Africa for supporting the most vulnerable children and households*, London, SCUK/HAI/IDS

Save the Children UK (2008 A) *Saving Children's Lives: Why equity matters*, London, SCUK

Save the Children UK (2008 B) *Helping Children Survive: Supporting poor families to overcome barriers to maternal, newborn and child health services*, London, SCUK

Schubert, B and Slater, R 'Social cash transfers in low-income African countries: conditional or unconditional?' *Development Policy Review*, **24**, 5, 2006, pp 571–78

Schultz, TP (2005) *Productive Benefits of Health: Evidence from low-income countries*, Economic Growth Center Discussion Paper 903, New Haven, Yale University, www.econ.yale.edu/~egcenter/research.htm

Sjoblom, D and Farrington, J (2008) 'The Indian National Rural Employment Guarantee Act: Will it reduce poverty and boost the economy?', *ODI Project Briefing* 7, London, ODI

Skoufias, E (2001) *PROGRESA and its impacts on human capital and welfare of households in rural Mexico: A synthesis of the results of an evaluation by IFPRI*, Washington, IFPRI

Slater, R and Mphale, M (2008) 'Cash transfers, gender and generational relations: evidence from a pilot project in Lesotho' *Humanitarian Policy Group report*, London, ODI, World Vision

Smith, L et al (2003) *The Importance of Women's Status for Child Nutrition in Developing Countries*, Washington DC, IFPRI

Soares, F and Britto, T (2007) *Confronting Capacity Constraints on Conditional Cash Transfer in Latin America: The cases of El Salvador and Paraguay*, Working Paper 38, Brasilia, IPC

Soares, F, with Soares, S, Medeiros, M and Osório, R (2006) *Cash Transfer Programmes in Brazil: Impacts on inequality and poverty*, Brasilia, IPC

Srindhar, D and Duffield, A (2006) *A Review of the Impact of Cash Transfer Programmes on Child Nutritional Status and some Implications for Save the Children UK Programmes*, London, Save the Children UK

Strauss, J and Thomas, D 'Health, nutrition, and economic development', *Journal of Economic Literature*, **36**, 2, 1998, pp 766–817

Tanner, JM and Whitehouse, RH 'Height and weight charts from birth to 5 years allowing for length of gestation. For use in infant welfare clinics', *Archives of Disease in Childhood*, **48**, 10, 1973, pp 786–9

Townshend, P (2007) *The Right to Social Security and National Development: Lessons from OECD experience for low-income countries*, Issues in Social Protection Discussion Paper 18, Geneva, ILO

Townshend, P (2008) 'The abolition of child poverty and the right to social security: a possible UN model for child benefit? A report to the ILO, GTZ and DfID', London, LSE

UNICEF (2007 A) *Progress for Children: A world fit for children – statistical review*, New York, UNICEF

UNICEF (2007 B) *The Impact of Social Cash Transfers on Children Affected by HIV and AIDS: Evidence from Zambia, Malawi and South Africa*, Nairobi, UNICEF, East and Southern Africa Regional Office

UNICEF (2008) *Countdown to 2015: Tracking progress in maternal, newborn and child survival: The 2008 report*, New York, UNICEF

Victora, C et al 'Applying an equity lens to child health and mortality: more of the same is not enough', *The Lancet*, **362**, 2003, pp 233–241

Victora, C et al (2008) 'Maternal and child undernutrition: consequences for adult health and human capital', *The Lancet*, **371**, pp 340–57

Wagstaff, A 'Poverty and health sector inequalities', *Bulletin of the World Health Organization*, **80**, 2, 2002 pp 97–105

Wagstaff, A and Watanabe, N (2000) *Socioeconomic Inequalities in Child Malnutrition in the Developing World*, World Bank Policy Research Working Paper 2434, Washington DC, World Bank

WHO (2001) *Macroeconomics and Health: Investing in health for economic development*, Geneva, WHO

World Bank (2006) *Repositioning Nutrition as Central to Development: A strategy for large-scale action*, Washington DC, World Bank

World Bank (2009) 'Swimming against the tide: How developing countries are coping with the global crisis', background paper prepared by World Bank staff for the G20 Finance Ministers and Central Bank Governors Meeting, 13–14 March 2009 Horsham, UK, http://siteresources.worldbank.org/NEWS/Resources/swimmingagainstthetide-march2009.pdf

Yablonski, J (2007) *Children and Social Protection: Towards a package that works*, London, Save the Children UK

Yablonski, J and Woldehanna, T (2008) *Impacts of Social Protection Programmes in Ethiopia on Child Work and Education*, Young Lives Policy Brief 6, Oxford, Young Lives

Zepedo, E (2006) *Do CCTs Reduce Poverty?*, IPC One pager 21, Brasilia, IPC

Endnotes

Introduction

[1] World Bank, 'Swimming against the tide: How developing countries are coping with the global crisis', background paper prepared by World Bank staff for the G20 Finance Ministers and Central Bank Governors Meeting, 13–14 March 2009, Horsham UK, http://siteresources.worldbank.org/NEWS/Resources/swimmingagainstthetide-march2009.pdf

[2] African Union Social Policy Framework 2009 ref CAMSD/EXP/4/(1), pg 17

[3] G20, The Global Plan for Recovery and Reform, 2 April 2009

[4] DFID (2005b)

1 Child survival, poverty and inequity

[5] UNICEF, *Progress for Children: A world fit for children statistical review*, New York, UNICEF, 2007 (A)

[6] Gwatkin et al, *Socio-Economic Differences in Health, Nutrition and Population within Developing Countries: An overview*, Washington DC, The World Bank, 2007

[7] UNICEF, *Countdown to 2015: Tracking progress in maternal, newborn and child survival: The 2008 report*, New York, UNICEF, 2008

[8] Jones et al, 'How many child deaths can we prevent this year?', *The Lancet*, **362**, 2003, pp 65–71

[9] UNICEF (2008), see note 7

[10] Jones et al (2003), see note 8

[11] See for example UNICEF (2008), see note 7; Fenn, Bridget et al, 'Inequities in neonatal survival interventions: evidence from national surveys', *Archives of Disease in Childhood – Fetal and Neonatal Edition*, **92**, 2007, pp 361–366; Gwatkin, Davidson, et al, *Reaching the Poor with Health, Nutrition and Population Services*, Washington DC, The World Bank, 2005; IHP+ Country Stock Taking Reports. See the website of the International Health Partnership: http://www.internationalhealthpartnership.net/ihp_plus_countries.html

[12] Gwatkin, Wagstaff and Yazbeck; *State of the World's Children 2008*

[13] As described, for example, in Gwatkin, Wagstaff and Yazbeck 2007

[14] M Lagarde and N Palmer, 'The impact of user fees on health service utilization in low- and middle-income countries: how strong is the evidence?', *Bulletin of the World Health Organization*, **86**, 11, 2008, pp 839–848

[15] C Chastre et al, *The Minimum Cost of a Health Diet: Findings from piloting a new methodology in four study locations*, London, Save the Children UK, 2007

2 The impact of cash transfers on child mortality

[16] Barham (2005); Hernández et al (2004), in M Adato and L Bassett, *What is the Potential of Cash Transfers to Strengthen Families Affected by HIV and AIDS? A review of the evidence on impacts and key policy debates*. Joint Learning Initiative on Children and HIV/AIDS, 2008, http://www.jlica.org/resources/publications.php

[17] P Gertler, 'Final report: the impact of Progresa on health', Washington DC, IFPRI, 2000

[18] C Victora et al, 'Applying an equity lens to child health and mortality: more of the same is not enough', *The Lancet*, **362**, 2003, pp 233–241; A Wagstaff, 'Poverty and health sector inequalities', *Bulletin of the World Health Organization*, **80**, 2, 2002, pp 97–105

[19] Save the Children UK 2008

[20] Save the Children UK, with Help Age International and IDS, *Making Cash Count: Lessons from cash transfer scheme in east and southern Africa for supporting the most vulnerable children and households*, London, SCUK/HAI/IDS, 2005; N Kakwani and K Subbarao, *Ageing and Poverty in Africa and the Role of Social Pensions*, International Poverty Centre Working Paper 8, Brasilia, IPC, 2005

[21] A Fiszbein and N Schady (2009) *Conditional Cash Transfers: Reducing present and future poverty*, Washington DC: The World Bank

[22] P Gertler (2000), see note 17

[23] Determinants causal framework developed by Save the Children UK, based on UNICEF Malnutrition Framework; WH Mosley and L Chen, (1984) 'An analytical framework for the study of child survival in developing countries', *Bulletin of the World Health Organization* 2003, **81**, 2, 1983, pp 140–145; Black et al, 'Maternal and child undernutrition: global and regional exposures and health consequences', *The Lancet*, **371**, 2008, pp 243–60; K Hill, 'Frameworks for studying the determinants of child survival', *Bulletin of the World Health Organization*, **81**, 2, 2003, pp 138–139; A Wagstaff (2002), see note 18; Victora et al (2003), see note 18

[24] C Miller, with M Tsoka and K Reichert, *Impact Evaluation Report: External evaluation of the Mchinji Social Cash Transfer Pilot. Boston*, Boston University School of Public Health and the Centre for Social Research, University of Malawi, 2008

[25] O Attanasio et al, *How Effective are Conditional Cash Transfers? Evidence from Colombia*, IFS Briefing Note 54, London, The Institute for Fiscal Studies, 2005

[26] P Gertler (2000), see note 17

[27] Miller et al (2008), see note 24, p 36

[28] Black et al (2008), see note 23

[29] J Maluccio and R Flores, *Impact Evaluation of a Conditional Cash Transfer Program: The Nicaraguan Red de Protección Social*, FCND Discussion Paper 184, Washington DC, International Food Policy Research Institute, 2004

[30] A Case, *Does Money Protect Health Status? Evidence from South African pensions*, NBER Working Paper 8495, Cambridge MA, 2001

[31] L Fernald, with P Gertler and L Neufeld, 'Role of cash in conditional cash transfer programmes for child health, growth, and development: an analysis of Mexico's Oportunidades', *The Lancet*, **371**, 2008, pp 828–37

[32] J Aguero, with M Carter and I Woolard, *The Impact of Unconditional Cash Transfers on Nutrition: The South African Child Support Grant*, Working Paper 39, Brasilia, International Poverty Centre, 2007

[33] Aguero, Carter and Woolard (2007), see note 32; Attanasio et al (2005), see note 25; Gertler (2000), see note 17; J Leroy, with A García-Guerra, R García, C Dominguez, J Rivera and L Neufeld, 'The Oportunidades Program increases the linear growth of children enrolled at young ages in urban Mexico', *Journal of Nutrition*, **138**, 2008, pp 793–798

[34] D Srindhar and A Duffield, *A Review of the Impact of Cash Transfer Programmes on Child Nutritional Status and Some Implications for Save the Children UK Programmes*, London, Save the Children UK, 2006

[35] C Paxson and N Schady, *Does Money Matter? The effects of cash transfers on child health and development in rural Ecuador*, World Bank Policy Research Working Paper 4226, Washington, World Bank, 2007

[36] Srindhar and Duffield (2006), see note 34

[37] Miller et al (2008), see note 24, p 28

[38] P Gertler, 'Do conditional cash transfers improve child health? Evidence from PROGRESA's controlled randomized experiment', *American Economic Review*, **94**, 2, 2004, pp 331–336; N Jones, with R Vargas and E Villar, 'Cash transfers to tackle childhood poverty and vulnerability: an analysis of Peru's Juntos programme', *Environment and Urbanization*, **20**, 1, 2008, pp 255–273; Morris et al. (2004)

[39] Maluccio and Flores (2004), see note 29

[40] Attanasio et al (2005), see note 25

[41] Gertler (2000), see note 17; Barham (2005)

[42] Jones et al (2008), see note 38

[43] Attanasio et al (2005), see note 25

[44] Morris et al, 'Monetary incentives in primary healthcare and effects on use and coverage of preventive healthcare interventions in rural Honduras: cluster randomized trial', *The Lancet*, **364**, 2004, pp 2030–37

[45] Miller et al (2008), see note 24

[46] Adato and Bassett (2008), see note 16; K Chapman, *Using Social Transfer to Scale Up Equitable Access to Education and Health Services*, Background Paper prepared for DFID, 2006

[47] Acacia Consultants (2007), cited in Adato and Bassett (2008), see note 16

[48] N Kukrety, *Investing in the Future*, Save the Children UK position paper on the role of cash transfers in reducing child malnutrition, Save the Children UK, 2007

[49] Miller et al (2008), see note 24

[50] J Hoddinott and D Wiesmann, *The Impact of Conditional Cash Transfer Programs on Food Consumption in Honduras, Mexico, and Nicaragua*, SSRN, 2008, http://ssrn.com/abstract=1269417

[51] MCDSS/PWAS/GTZ, External monitoring and evaluation report of the Pilot Social Cash Transfer Scheme, Kalomo District, Zambia, Lusaka, MOCDSS/GTZ, 2005

[52] Jones et al (2008), see note 38

[53] Hernandez et al (2004), in Adato and Bassett (2008), see note 16

[54] Lagarde et al, 'Conditional cash transfers for improving uptake of health interventions in low- and middle-income countries: a systematic review', *JAMA*, **298**, 16, pp 1900–10

[55] Case (2001), see note 29; Samson (2004), in Adato and Bassett (2008), see note 16

[56] Miller et al (2008), see note 24, p 29

[57] Attanasio et al (2005), see note 24; S Devereux, with R Sabates-Wheeler, M Tefera and H Taye, *Ethiopia's Productive Safety Net Programme (PSNP): Trends in PSNP transfers within targeted households*, Brighton, UK and Addis Ababa, Ethiopia, Institute of Development Studies and Indak International Pvt. L. C, 2006; MCDSS/PWAS/GTZ (2005), see note 51

[58] E Zepedo, *Do CCTs Reduce Poverty?*, IPC One pager 21, Brasilia, IPC, 2006

[59] S Davies and J Davey, 'A regional multiplier approach to estimating the impact of cash transfers on the market: the case of cash transfers in rural Malawi', *Development Policy Review*, **26**, 1, 2008, pp 91–111; D Sjoblom and J Farrington, *The Indian National Rural Employment Guarantee Act: Will it reduce poverty and boost the economy?*, ODI Project Briefing 7, London, ODI, 2008; de Janvry et al. 2006

[60] Maluccio and Flores (2004), see note 29

[61] L Smith et al, *The Importance of Women's Status for Child Nutrition in Developing Countries*, Washington DC, IFPRI, 2003. See study results, as well as review of existing empirical research

[62] M Adato et al, *The Impact of Progresa on Women's Status and Intrahousehold Relations*, Washington DC, IFPRI, 2000; E Skoufias, *PROGRESA and its Impacts on Human Capital and Welfare of Households in Rural Mexico: A synthesis of the results of an evaluation by IFPRI*, Washington, IFPRI, 2001; Jones et al (2008), see note 38; Devereux et al (2006), see note 57; Paxson and Schady (2007), see note 35

[63] Jones et al (2008), see note 38

[64] Adato et al (2000), see note 62; Devereux et al (2006), see note 57; Jones et al (2008), see note 38; R Slater and M Mphale, *Cash Transfers, Gender and Generational Relations: Evidence from a*

pilot project in Lesotho, Humanitarian Policy Group Report, London, ODI, World Vision, 2008

[65] Adato et al (2000), see note 62; M Molyneux, 'Mothers at the service of the New Poverty Agenda: Progresa/Oportunidades, Mexico's Conditional Transfer Programme', *Social Policy & Administration*, **40**, 4, 2006, pp 425–449

[66] Maluccio and Flores (2004), see note 29

[67] Chapman (2006), see note 46; Miller et al (2008), see note 24

[68] Skoufias (2001), see note 62

[69] Leroy et al (2008), see note 33; Srindhar and Duffield (2006), see note 34

[70] Morris et al (2004), see note 44; Adato and Bassett (2008), see note 16; M LaGarde, with A Haines and N Palmer, 'Conditional cash transfers for improving uptake of health interventions in low- and middle-incomes countries: a systematic review', *JAMA*, **298**, 16, 2007, pp 1900–10

3 The economic benefits of investing in social transfers

[71] S Devereux, *Social Protection for the Poor: Lessons from recent international experience*, IDS Working Paper 232, Sussex, IDS, 2002

[72] SM Grantham-McGregor, with YB Cheung, S Cueto, P Glewwe, L Richter, B Strupp and the International Child Development Steering Group, 'Developmental potential in the first 5 years for children in developing countries', *The Lancet*, **369**, 2007, pp 60–70; C Victora et al, 'Maternal and child undernutrition: consequences for adult health and human capital', *The Lancet*, **371**, pp 340–57

[73] J Strauss and D Thomas, 'Health, nutrition, and economic development', *Journal of Economic Literature*, **36**, 2, 1998, pp 766–817

[74] WHO, *Macroeconomics and Health: Investing in health for economic development*, Geneva, WHO, 2001

[75] World Bank, *Repositioning Nutrition as Central to Development: A strategy for large-scale action*, Washington DC, World Bank, 2006

[76] Aguero, Carter and Woolard (2007), see note 32

[77] Skoufias (2001), see note 62

[78] Y Chen and L Zhou, 'The long-term health and economic consequences of the 1959–1961 famine in China', *Journal of Health Economics*, **26**, 2007, pp 659–681; H Alderman, with J Hoddinott and B Kinsey, *Long-term Consequences of Early Childhood Malnutrition*, FCND Discussion Paper 168, Washington DC, IFPRI, 2003

[79] Economic Policy Research Institute, *Final Report: The social and economic impact of South Africa's social security system*, EPRI Research Paper 37, Cape Town, EPRI, South Africa Department of Social Development, 2004

[80] Barrientos, A. 2008

[81] M Medeiros, T Britto and FV Soares, *Targeted Cash Transfer Programmes in Brazil: BPC and the Bolsa Familia*, Working Paper 46, Brasilia, International Poverty Centre, 2008

[82] Sjoblom and Farrington (2008), see note 59; L Adams and E Kebede, *Breaking the Poverty Cycle: A case study of cash interventions in Ethiopia*, Humanitarian Policy Group Background Paper, London, ODI, 2005; H Berton, *How Cash Transfers can Improve the Nutrition of the Poorest Children: An evaluation of a pilot safety nets projects in southern Niger*, London, Save the Children UK, 2009

[83] Barrientos (2008); J Yablonski and T Woldehanna, *Impacts of Social Protection Programmes in Ethiopia on Child Work and Education*, Young Lives Policy Brief 6, Oxford, Young Lives, 2008

[84] P Gertler, with S Martinez and M Rubio-Codina, *Investing Cash Transfers to Raise Long-Term Living Standards*, World Bank Policy Research Working Paper 3994, World Bank, 2006

[85] see note 84

[86] Adams and Kebede (2005), see note 82. Save the Children UK has found similar trends in Niger, where cash transfers shifted socio-economic relations between the poorest and richest by strengthening economic independence and, therefore, increasing the bargaining power of the poorest – Berton (2009), see note 82

[87] Save the Children UK, with Help Age International and IDS (2005), see note 20

[88] Barrientos (2008)

[89] H Alderman and J Hoddinott, *Growth-Promoting Social Safety Nets*, 2020 Focus Brief on the World's Poor and Hungry People, Washington DC, IFPRI, 2007

[90] DFID, *Social Protection and Economic Growth in Poor Countries*, Social Protection Briefing Note Series Number 4, London, DFID, 2006

[91] Barrientos (2008)

[92] A Barrientos and R Sabates-Wheeler, *Local Economy Effects of Social Transfers*, Brighton, IDS, 2006

[93] Davies and Davey (2008), see note 59; Devereux et al (2007)

[94] MCDSS/PWAS/GTZ (2005), see note 49

[95] Adams and Kebede (2005), see note 80

[96] P Harvey, 'Cash and Vouchers in Emergencies', *Humanitarian Policy Group Discussion Paper*, London ODI, 2005

[97] Davis and Davey (2008), p 102, see note 59

[98] S Handa, with M Huerta, R Perez and B Straffon, *Poverty, Inequality and Spill-over in Mexico's Education, Health and Nutrition Program*, Washington DC, IFPRI, 2000; Gertler et al (2006), see note 84; Hoddinott and Skoufias (2004); Adams and Kebede (2005), see note 82; F Ellis, *Old Age Pension, Lesotho*, REBA Case Study Brief 3, Johannesburg, Regional Hunger and Vulnerability Programme, 2007

[99] Devereux et al, *Linking Social Protection and Support to Small Farmer Development*, FAO, 2008, http://www.fao.org/ES/ESA/pdf/workshop_0108_social_protection.pdf

4 What are the costs of social cash transfers for children?

[100] Barrientos (2008), cited in Barrientos and Hulme (2008)

[101] N Kakwani, F Soares and H Son, *Conditional Cash Transfers in African Countries*, International Poverty Centre Working Paper 9, Brasilia, IPC, 2005; A Barrientos and D Hulme, *Social Protection for the Poor and Poorest in Developing Countries: Reflections on a quiet revolution*, BWPI Working Paper 30, Manchester, Brooks World Poverty Institute, 2008 (A); A Barrientos and D Hulme, 'Social protection for the poor and poorest: an introduction', in *Social*

Protection for the Poor and Poorest: Concepts, policies and politics, Basingstoke, Palgrave Macmillan, 2008 (B); L Blank and S Handa, *Social Protection in Eastern and Southern Africa: A framework and strategy for UNICEF*, Nairobi, UNICEF, 2008

[102] D Coady, with M Grosh and J Hoddinott, *Targeting of Transfers in Developing Countries: Review of lessons and experience*, Washington DC, World Bank and IFPRI, 2004

[103] F Soares and T Britto, *Confronting Capacity Constraints on Conditional Cash Transfer in Latin America: The cases of El Salvador and Paraguay*, Working Paper 38, Brasilia, IPC, 2007; T Britto, *The Challenges of El Salvador's Conditional Cash Transfer Programme, Red Solidaria*, International Poverty Centre Country Study number 9, Brasilia, IPC, 2007; Srindhar and Duffield (2007), see note 33

[104] S Handa and B Davis B, *The Experience of Conditional Cash Transfers in Latin America and the Caribbean*, ESA Working Paper No. 06-07, Rome, FAO, 2006; Blank and Handa (2008), see note 101

[105] Adato and Basset (2008), see note 16; Blank and Handa (2008), see note 99; A Fiszbein and N Schady, *Conditional Cash Transfers: Reducing present and future poverty*, Washington DC, World Bank, 2009; Kukrety (2007), see note 48; B Schubert and R Slater, 'Social cash transfers in low-income African countries: conditional or unconditional?', *Development Policy Review*, **24**, 5, 2006, pp 571–78

[106] Skoufias (2001), see note 62; Handa and Davis (2006), see note 104

[107] Save the Children UK, *Helping Children Survive: Supporting poor families to overcome barriers to maternal, newborn and child health services*, London, Save the Children, 2008

[108] Handa and Davis (2006), see note 104

[109] Barrientos & Hulme (2008)

[110] Behrendt 2008

[111] Blank and Handa (2008), see note 99; Inter-Agency Task Team (IATT) on Children and HIV and AIDS: Working Group on Social Protection, 'Expanding social protection for vulnerable children and families: learning from an institutional perspective', 2008, http://www.unicef.org/aids/files/Expanding_Social_Protection.MTemin.May2008.pdf; Medeiros et al (2008), see note 79; Srindhar and Duffield (2006), see note 33

[112] Beales and German 2005

5 Child benefits: an affordable transfer for child survival

[113] K Pal et al, *Can Low Income Countries Afford Basic Social Protection? First results of a modeling exercise*, Issues in Social Protection Discussion Paper 13, Geneva, ILO, 2005; Behrendt (2008)

[114] Kakwani et al (2005), see note 101

6 Conclusion and recommendations

[115] African Union Social Policy Framework 2009, pg 18

[116] Bhutta et al, 'What works? Interventions for maternal and child undernutrition and survival', *The Lancet*, **371**, 9610, 2008, pp 417–40

[117] The Lancet, 'Editorial: A new agenda for children affected by HIV/AIDS', *The Lancet*, **373**, 517, 2009

Save the Children
UK

Lasting Benefits

The role of cash transfers in tackling child mortality

Over the past decade, an increasing number of developing country governments, working with donors and NGOs, have been implementing cash transfer programmes – regular transfers of cash to individuals or households. These programmes are united by common assumptions: that income poverty has a highly damaging impact on people's health and nutrition, and that cash empowers poor individuals and households to make their own decisions on how to improve their lives.

This report examines three key questions:

- What contribution can cash transfers make to reducing child mortality?
- What are the broader economic benefits of investing in cash transfers?
- How can child-focused cash transfers be affordable in developing countries?

Lasting Benefits argues that cash transfers have a critical role to play in accelerating reductions in child mortality, as well as bringing broader economic benefits. It estimates the costs of child and maternity benefits and finds that they are affordable on a large scale, even in low-income countries. This report will be of particular interest to policy-makers and advisers in developing countries and donor governments.

"This timely report highlights the growing role of transfer programmes in tackling child poverty and vulnerability in developing countries. The report skilfully gathers the available evidence from a range of programmes in low- and middle-income countries, and sets out a challenging agenda for national policy-makers. The report will be required reading for policy-makers concerned with the plight of children in developing countries."

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