



Joint Learning Initiative on Children and HIV/AIDS JLICA

Learning Group 1 – Strengthening Families

Co-Chairs: Linda Richter and Lorraine Sherr

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

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Michelle Adato & Lucy Bassett

*Food Consumption and Nutrition Division,
International Food Policy Research Institute, Washington, DC*

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Preface - Learning Group 1: Strengthening Families

The work conducted in Learning Group 1 was based on the fact that families, in all their many forms, are everywhere the primary providers of protection, support and socialization of children and youth, and families exert a very strong influence on children's survival, health, adjustment and educational achievement. This influence tends to be greater under conditions of severe strain, such as is caused by HIV and AIDS, particularly in the context of poverty.

In general, functional families love, rear and protect children and buffer them from negative effects. Functional families are those that have sufficient material and social resources to care for children, the motivation to ensure that children are nurtured and protected, and are part of a community of people who provide one another with mutual assistance. Family environments are especially important for young children. It is well established that multiple risks affect the cognitive, motor and social-emotional development of children and that the quality of parenting, assisted by intervention when needed, can ameliorate such impacts.

From the start of the epidemic, families have absorbed, in better or worse ways, children and other dependents left vulnerable by AIDS-induced deaths, illness, household and livelihood changes, and migration. Similarly, families have contributed, more or less successfully, to the protection of young people from HIV infection. Under the devastating effects of the epidemic, families need to be strengthened – economically, socially and with improved access to services – to enable them to continue, and to improve, their protection and support of children and youth. Families that neglect and abuse children need to be identified and social welfare services must be provided to them.

Families, extended kin, clan and near community are the mainstay of children's protection in the face of the AIDS epidemic - as they have been in poor countries under other severely debilitating social conditions, including war, famine and natural disaster. Only a very small proportion of AIDS-affected children are currently reached by any assistance additional to support they receive from kith and kin. The most scalable strategy for children is to strengthen the capacity of families to provide better care for more children.

The co-chairs, secretariat, lead authors and stakeholders of Learning Group 1 were guided in the work undertaken in the Learning Group by the following key questions. By and large, these are the critical research, policy and programme questions currently being debated in the field.

1. On which children and families should we focus?
2. What evidence is available on which children are vulnerable and what can be done to help them, and how good is the research?
3. What aspects of the HIV/AIDS epidemic impact on children, how and why?
4. How are families changing as a result of adult illness and death associated with HIV and AIDS?
5. In what ways are children's health, education and development affected by the HIV/AIDS epidemic?
6. What does knowledge and experience of other crises teach us about the AIDS response for children and families?
7. What can we learn from carefully evaluated family strengthening efforts in fields other than HIV and AIDS that can be usefully applied in hard hit countries in southern Africa?
8. What programmatic experience has been gained in strengthening families in the HIV/AIDS field?
9. What promising directions are there for the future and what do they suggest?
10. What mistakes have been made and what now needs to be done?

These questions form the structure of the integrated report. As indicated in the Preface, detailed data and references are to be found in the respective LG1 papers.

Twelve detailed review papers constitute the primary evidence base for the conclusions drawn and the recommendations made by Learning Group 1. The papers, their authors in alphabetical order, and their affiliations are listed below.

List of authors, affiliations and paper titles

Authors	Affiliation	Title
Adato, M Bassett, L	International Food Policy Research Institute (IFPRI) – United States of America	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
Belsey, M	Consultant – United States of America	The family as the locus of action to protect and support children affected by or vulnerable to the effects of HIV/AIDS: A conundrum at many levels
Chandan, U Richter, L	Human Sciences Research Council (HSRC) – South Africa	Programmes to strengthen families: Reviewing the evidence from high income countries
Desmond, C	Human Sciences Research Council (HSRC) – South Africa	The costs of inaction
Drimie, S Casale, M	International Food Policy Research Institute (IFPRI), Regional Network on AIDS, Food Security and Livelihoods (RENEWAL), Health Economics and AIDS Research Division (HEARD – South Africa	Families' efforts to secure the future of their children in the context of multiple stresses, including HIV and AIDS

Haour-Knipe, M	Consultant – Switzerland	Dreams and disappointments: Migration and families in the context of HIV and AIDS
Hosegood, V	London School of Hygiene and Tropical Medicine (LSHTM), Human Sciences Research Council (HSRC) – South Africa	Demographic evidence of family and household changes in response to the effects of HIV/AIDS in southern Africa: Implications for efforts to strengthen families
Kimou, J Kouakou, C Assi, P	Ivorian Centre for Economic and Social Research (CIRES), Family Health International (FHI) - Côte d'Ivoire	A review of the socioeconomic impact of antiretroviral therapy on family wellbeing
Madhavan, S DeRose, L	University of Maryland – United States of America	Families and crisis in the developing world: Implications for responding to children affected by HIV/AIDS
Mathambo, V Gibbs, A	Human Sciences Research Council (HSRC) – South Africa	Qualitative accounts of family and household changes in response to the effects of HIV and AIDS: A review with pointers to action
Sherr, L	Royal Free and University College Medical School – United Kingdom	Strengthening families through HIV/AIDS prevention, treatment, care and support
Wakhweya, A Dirks, R Yeboah, K	Family Health International (FHI) – United States of America	Children thrive in families: Family-centred models of care and support for orphans and other vulnerable children affected by HIV and AIDS

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1. Introduction¹

The international trend toward investing in social protection in poor countries has reached Sub-Saharan Africa, taking on a new urgency as HIV and AIDS interact with other drivers of poverty to simultaneously destabilize livelihoods systems and family and community safety nets. A new focus on the vulnerability of families, and threats to the human capital of children with lifelong and intergenerational consequences, has accelerated international, regional, and national commitments to social protection programmes in heavily AIDS-affected countries. Social protection in the form of cash transfers—which provides support for food purchases, transportation, education, health care, and other expenses—is receiving increasing recognition as an important part of a comprehensive AIDS response. The urgency of cash assistance for food purchases is underscored by emerging evidence on the effect of good nutrition to slowing the progression of AIDS, and to the effectiveness of antiretroviral therapy, with consequences not only for people living with HIV but also their children, broader families, and communities.

More commonly a feature of social policy in wealthier countries, social protection has emerged as a political possibility for poor countries, with an increasing number experimenting with programme options. Social protection enables individuals, families, and communities to reduce risk and vulnerability, mitigate the impacts of stresses and shocks, and to support people who suffer from chronic incapacities to secure basic livelihoods due to, for example, age, illness, disabilities, discrimination, or their position within the social and economic structure of their society. If designed to do so, social protection can enable people to move structurally out of poverty by building assets, and by altering social relations.

¹ The authors would like to thank the many program implementers and researchers who assisted us in accessing documents—there are too many people to name, but all are greatly appreciated.

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Among different forms of social protection, a momentum is gathering around cash transfers, now found from El Salvador to Kenya to Bangladesh to Cambodia. In Sub-Saharan Africa, some countries already have cash transfers reaching tens of thousands to millions of people, and in other countries in the region governments, donors, multilateral agencies, and international and national nongovernmental organizations (NGOs) are cooperating to pilot and roll out programmes intended to reach hundreds of thousands of people within a few years. More than a dozen countries in southern and East Africa currently have cash transfers programmes, most at early stages, and more countries are planning or considering them. Questions are raised, however, with respect to their effectiveness in mitigating the impacts of HIV and AIDS, reducing poverty, and protecting human capital, and their affordability, sustainability, political support, targeting, and design.

This paper examines how social protection can be used to protect children and families affected by HIV and AIDS, and specifically, the potential of cash transfers to secure basic subsistence and reduce poverty, while also strengthening the human capital of children—specifically, their education, health, and nutrition. The paper reviews evidence to date on the impacts of programmes under different designs, and reviews key policy debates that accompany decisions on programme designs, and how to make them to be responsive to the context of HIV and AIDS. In particular, it examines systems, experiences and dilemmas of targeting, and the debate on conditionality, i.e., whether cash transfers should be conditioned on beneficiaries' participation in services such as education and health care.

Cash transfer programmes can take many forms. They can be given to households as a unit because they meet poverty or vulnerability criteria, to an individual such as an elderly or disabled person, or to families based on the presence of individuals such as children, girls, or fostered orphans. Cash transfers can be unconditional—given without obligations—or conditional—tied to obligations of recipients to participate in work, training, education, health, nutrition, or other services or activities—or they can be linked to these activities but not obligatory. Cash transfers provide for current basic needs of adults and children such as food and clothing. They can also contribute to development processes, by enabling or encouraging investment in assets that increase people's chances of breaking out of poverty in the long term. Cash transfer programmes—depending on their design and people's

ability to take advantage of that design—can also have additional benefits such as increasing women’s autonomy and capacities, or strengthening capacities of local organizations.

Globally, the vast majority of cash transfer programmes have been designed and rolled out in contexts where AIDS was either not a dominating factor requiring different attention in social protection policy, or was not taken specifically into account. Under any circumstances, determining whether and which type of programme should be undertaken requires policymakers to consider a web of issues related to the causes of poverty, the indicators most in need of improvement, the constraints on those improvements, administrative, technical, and financial capacities, demographics, the structure of employment, political economy, as well as natural disasters, political conflict, and epidemics. In addition to the global challenges of growing the economy, creating jobs, and improving living standards, countries in Sub-Saharan Africa face the added challenge of dramatic escalations in the number of adults and children whose livelihoods are threatened by HIV and AIDS. In 2006, AIDS killed almost 3 million people globally while nearly 4.3 million became infected, bringing to 39.5 million the number of people living with the virus. Almost 25 million of these live in Sub-Saharan Africa (UNAIDS 2006). Furthermore, there is growing evidence that HIV/AIDS is significantly intertwined with other sources of vulnerability, including a two-directional relationship with food insecurity and malnutrition (Gillespie and Kadiyala 2005). Articulations of the epidemic with forms of chronic poverty have made social protection a moral and economic imperative.

Behind these cases of infection and illness are tens of millions of additional people who are affected by AIDS, most of them children. As of 2006, an estimated 15.2 million children under age 18 had lost at least one parent to AIDS, about 80% of whom live in Sub-Saharan Africa (UNAIDS/UNICEF/WHO 2007). Most of these children are being taken care of by extended families and communities, but many of these families were already very poor, and are now in even greater need of external support. In addition to orphaned children, millions more children are also affected by HIV and AIDS, as illness in families and communities undermine livelihoods systems, human capital, and physical and psychological well-being. While preserving basic levels of comfort and human dignity among the sick, social protection interventions may also be the only means of preventing

destitution of entire households, and irreversible health, nutrition, and education deprivation among children—with lifelong consequences. These programmes thus have the potential to reduce trade-offs between short-term household needs and the long-term well-being of individuals and the wider society (Adato and Gillespie 2006).

The rest of this paper is organized in the following manner. Section 2 presents a social protection-assets framework for understanding the objectives that different types of interventions can achieve, and explains why the paper focuses on cash transfers, and on human capital. Section 3 describes the research methods used in the paper, and the programmes reviewed. Section 4 discusses the key issues and dilemmas inherent in targeting, and discusses targeting systems and experiences with targeting in AIDS-affected contexts. Section 5 turns to the question of conditioning cash benefits on participation in services, exploring the many facets of this debate. Sections 6 through 10 examine evidence to date on the impacts of unconditional and conditional cash transfers on poverty, education, health, food consumption, and nutrition, and consider complementary activities that can be implemented in conjunction with cash transfers to increase their impacts. Section 11 draws conclusions on the evidence to date on cash transfer performance, the debates raised, and the implications for the potential of cash transfers to strengthen families affected by HIV and AIDS.

2. Social protection in the context of HIV and AIDS: Preventing destitution and strengthening assets

New possibilities for social protection in poor countries began to emerge in the 1980s, as strategies for reducing poverty through growth, as well as through targeted direct development programmes, were not proving to be sufficient to provide even a basic level of protection against deprivation. Growing attention to the role of risk and vulnerability in casting people into poverty, or preventing people from investing such that they could move out of poverty, was underscored by new forms of vulnerability brought on by structural adjustment policies, and contributed to a new role for social assistance as a legitimate component of development policy (Guhan 1994). By the early 1990s social safety nets had become a component of the World Bank's strategy for poverty alleviation, seen as contributing to growth through reducing risk (World Bank 1990). Over time, the safety net approach came to be criticized as "residualist and paternalistic" and more sophisticated possibilities began to emerge (Devereux and Sabates-Wheeler 2004). Ideas around social protection gained momentum and became mainstreamed in development discourse throughout the 1990s, as multilateral agencies, nongovernmental organizations, and researchers focused substantial attention on how to operationalize it, even if governments that would need to undertake social protection policies were much slower to respond (Devereux and Sabates-Wheeler 2004).

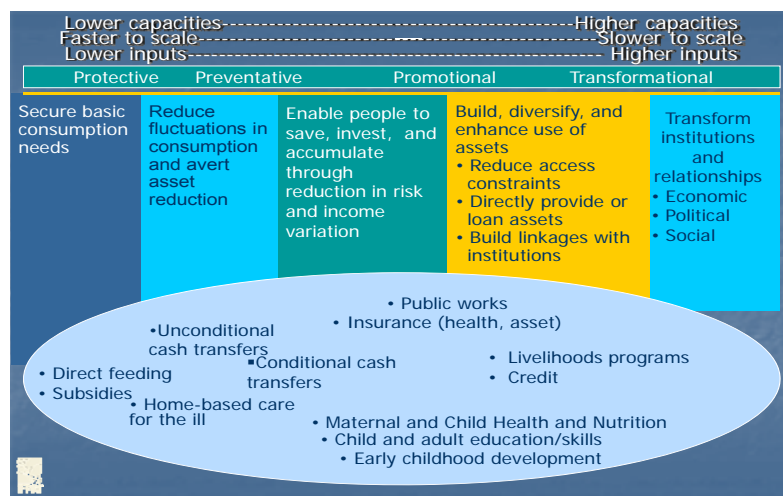
Social protection includes safety net-type protective features, but can also contribute to development processes in a more systematic, dependable, and integrated way. It is often advocated as a right rather than a reactive form of relief (Adato, Ahmed, & Lund 2004). There are many different perspectives on social protection, reflecting different positions on scope, timeframes, targeting, and the role of the state, as well as on poverty, vulnerability, development, and human rights.

2.1 Social protection and assets: A conceptual framework

Figure 2.1 presents an asset-based social protection conceptual framework for understanding what social protection can achieve, and how different types of interventions fit within these objectives. In constructing this framework we draw on the conceptual

categories devised by Guhan (1994:38)² in an effort to develop an “operational notion of social security within a comprehensive antipoverty approach.” These categories reflect different types of objectives: promotional measures to improve endowments, income, and consumption; preventative measures to avert deprivation; and protective measures that even more directly avert deprivation (often associated with safety nets). We also add the transformational category developed by Devereux and Sabates-Wheeler (2004), who are concerned with adding a transformative dimension that confronts the power imbalances that create and sustain vulnerabilities.³ The framework further draws on a continuum of “goals and means” around which people organize their livelihood strategies (Kabeer 2002, 593). Finally, we integrate an assets framework that uses the sustainable livelihoods framework’s categories of financial, physical, natural, social, political, and human capital assets (Ashley and Carney 1999). Social protection can pursue the five types of objectives in Figure 1 for each of these types of assets.

Figure 2.1. An asset-based social protection framework



In Figure 2.1, the different uses of social protection are seen as one moves from left to right: (1) securing basic consumption needs; (2) reducing fluctuations in consumption in

² These categories were adopted in the ILO framework for social protection.

³ Devereux and Sabates-Wheeler (2004, 9) come up with the following useful “working definition”: “Social protection is the set of all initiatives, both formal and informal, that provide: social assistance to extremely poor individuals and households; social services to groups who need special care of would otherwise to denied access to basic services; social insurance to protect people against the risks and consequences of livelihood shocks; and social equity to protect people against social risks such as discrimination or abuse.”

order to avert the reduction of assets; (3) enabling people to save, invest in, and accumulate assets through reduction in risk and income variation; (4) building, diversifying, and enhancing use of assets, by reducing access constraints, directly providing or loaning assets, or building links with institutions; and (5) transforming institutions and economic, social, or political relationships. The programmes in the oval represent a range of interventions that provide forms of social protection. They are loosely placed under the objectives with which they are most normally associated. For example, a direct feeding scheme is usually used to secure a basic level of subsistence; health or asset insurance is often used to reduce risk and enable investment; a livelihoods programme is most often used to build assets; a credit programme giving women cash and skills can transform social relations inside her household. The programmes are arranged loosely, however, to make a point: although programmes have tendencies to be used to achieve particular objectives, each can be used to achieve any of these five objectives. Whether they can depends on first, how they are designed (and, important, the ability to implement the design as planned); and second, the capacities that people have to take advantage of these design features. So, for example, depending on their design, a public works programme may be used to (1) pay people to dig ditches, so that they can earn wages that keep them from going hungry when a drought has damaged their crops; or where chronic high unemployment robs them of alternatives; (2) keep people from selling off their livestock; (3) build roads to help poor farmers get crops to market, or clinics in poor, underserved areas; (4) transform capacities of community organizations, where projects are managed by or in partnership with these organizations. In the same way, a cash transfer programme can assist AIDS-affected families by, for example, (1) securing their basic subsistence when illness prevents them from working to secure a livelihood; (2) keeping children from leaving school because of an inability to pay fees or because labour is needed at home; (3) enabling people to invest in a small income generating activity; and (4) increasing the agency of communities where local organizations participate in targeting, monitoring, or service delivery.

2.2 Why a focus on cash transfers?

Figure 2.1 also illustrates another point that speaks to the question of why this paper focuses on cash transfers, and not livelihoods interventions, microcredit, or public works, in considering how to best support families affected by HIV and AIDS. Despite the

potential of different programme designs to achieve the range of objectives above, there are reasons why some programmes are most often used to, and more likely to, achieve certain objectives than others. These reasons are illustrated at the top of Figure 2.1, related to capacities, ease and speed of scalability, and quantity and quality of inputs required.⁴ At one end of the spectrum, interventions intended to secure basic consumption, such as cash transfers designed with simple objectives to provide cash for food and other basic needs, and avert the sale of assets, require less capacities on the part of beneficiaries (e.g., less education or physical strength), as well as on the part of programme administrators (e.g., technical or financial capacities). Cash transfers will also be easier to scale up relatively quickly (even if not very quickly), and require lower inputs (e.g., cash and an administrative and delivery system). Interventions intended to build physical and financial assets, such as livelihoods activities and microcredit (the latter normally intended to invest in the former), demand more capacities on the part of both beneficiaries and programme implementers, are more complicated and take longer to scale up, and are more demanding with respect to inputs and institutions (materials, training, markets). They cannot reach as many people, as quickly, as can cash transfers, and tend to benefit those who are better off because they are more able to participate and succeed.⁵ Microcredit programmes have been used successfully by many poor people, but tend not to do as well in benefiting the extremely poor (Hulme and Mosley 1997; Hashemi 1997; Halder and Hussain 1999; Rahman and Hossain 1995 cited in Kabeer 2002), although some have managed to be better targeted (Sharma et al. 2000). Microcredit programmes in highly AIDS-affected areas also involve high risks to borrowers and lenders. Families affected by AIDS are not just poor, they are also struggling with poverty and severe illness, and are labour constrained, often headed by the elderly, the sick, or even children.⁶ Furthermore, many countries with high levels of AIDS-affected populations have low administrative and technical capacities. It is unlikely that they would be able to scale up livelihoods interventions for a reasonable fraction of people who need them.

⁴ Note that this is a continuum and not a dichotomy, with ways to design programs with varying degrees of complexity.

⁵ Although programs involving graduated steps into microcredit, such as the Vulnerable Group Development Programme in Bangladesh, have been much more successful at reaching poorer and offer valuable models, they still are more demanding than cash transfers.

⁶ Parker, Singh, and Hattel (2000) argue that there is a tension between scale of microcredit and the extent of services, and that those who most need them are also those most likely to default. Barnes et al. (2001) found that HIV-affected households in Zimbabwe who started microenterprises had a decline in profits as compared with non-affected households.

This is not to argue that livelihood interventions or microcredit should not be undertaken for people affected by HIV and AIDS. They should. There are countless NGOs and community-based organizations (CBOs), as well as some government programmes, doing excellent work with these types programmes, and they should be supported to scale these up at the pace that they can. This is not a question of either/or—different types of interventions should exist simultaneously. There are cases of microcredit programmes that have been adapted to reduce risk in AIDS-affected contexts (further explained in Section 10): for example, through mandatory loan default and death benefit insurance, legal services, and education trusts for children (Barnes et al. 2001; IMAGE 2002 cited in Gillespie and Kadiyala 2005). But these measures will remain small-scale relative to need, and do not resolve all the capacity constraints. Those AIDS-affected families with members who can take advantage of microcredit and livelihoods programmes will benefit. The United Nations Capital Development Fund/Special Unit for Microfinance (UNCDF/SUM 2003) recommends that microfinance services be targeted to clients who are HIV-positive but still productive, family members of HIV-positive individuals, and surviving family members. But credit and livelihoods programmes will reach fewer families, and are more likely to miss the most destitute and in need. In a country such as Zambia where the cash transfer is limited to the poorest 10% of the population, the next decile or so might be more likely to take advantage of a livelihoods programme. If they are successful, they may benefit more than those receiving a cash transfer. However, the capacities, scalability challenges, and inputs required explain why these interventions, creative and empowering as they can be when they work well, tend to be “boutique” projects, ad-hoc and scattered, supported by NGOs and donors, or by local churches, organizations, or volunteers (Subbarao and Coury 2004), rather than systematic and ensuring broad coverage.

There are several other types of programmes that have been used to reach AIDS-affected families. One category is public works. Public works fall somewhere in the middle of the capacity/scalability/inputs continuum—exactly where depends on their design, which can vary widely, from conventional food or cash for physical labour, to the Productive Safety Nets programme in Ethiopia that combines transfers with access to agricultural technologies, extension, and other services; to the ambitious but smaller Community-Based Public Works Programme in South Africa that required community-based

organizations to participate in project implementation; to the Expanded Public Works Programme that provides training for caregiving activities (see Section 10.6). If conventionally designed as labour-intensive infrastructure or environmental projects, public works do not offer a good solution for helping labour-constrained, severely AIDS-affected families. Creative ideas have been developed to adapt to AIDS-affected contexts, however, from reducing the labour demands to providing needed services. Some are closer to livelihoods or food transfer programmes than public works, but may be undertaken as a subcomponent of a public works programme. Innovations include the use of household contracts with flexible family labour arrangements so that well members can substitute for weak or ill members as needed; home-based activities such as small food gardens; free distribution of food or agricultural inputs for people unable to work; and programmes of training and work in home-based care for the ill (HBC) and early childhood development (ECD)⁷ (see more on these in Section 10.6). These are also potentially important interventions that should be piloted and scaled up at the pace possible. However, public works, especially those involving more ambitious plans for skills certification in service provision, will not necessarily be the best solution for providing income support to the very poorest, most severely affected by AIDS (although they will benefit from the services).

The remaining intervention that needs to be considered seriously is that of food and nutrition transfers.⁸ These transfers have the same strengths as cash with respect to where they fall on the household capacity continuum. They do better on the scalability and inputs continuum in comparison with livelihood approaches, but involve complexities in these dimensions. Food and cash have relative advantages and disadvantages in different contexts related to factors such as infrastructure, food markets, seasonality, logistical and administrative capacities, politics, gender relations, and the target group and the nature and urgency of their needs (Gentilini 2007).⁹ These are factors that apply to food and cash comparisons in all contexts, not specifically that of HIV and AIDS. How these factors look

⁷ Although these provide services rather than income for AIDS-affected families, they can strengthen their human capital through ECD services, and through HBC that frees up older children to go to school.

⁸ “Nutrition transfer” refers here to a food-based transfer or supplement that has the specific objective of improving nutritional status. These may include different types of nutritional supplements or biofortified food.

⁹ Interviews carried out on beneficiary preferences for cash vs. food in four African countries found beneficiary preferences for cash, mainly because of the choice it offered them in meeting a wider range of needs (Devereux et al. 2005). Interviews in Malawi revealed similar preferences, although results were mixed, and the market had food shortages (Savage and Umar 2006). A cash/food comparison from a survey in Bangladesh also found beneficiary preferences for cash, and that cash and food transfers performed similarly with respect to targeting and school enrollment; however, food consumption was only increased by the food transfers (Ahmed 2005).

through an “HIV/AIDS lens”¹⁰ is an important area for research. Food-based interventions may be better than cash for specific groups of AIDS-affected adults and children under specific conditions, and these conditions need to be better understood. However, there are issues of logistics, economics, and political-economy at the international and national levels that make it unlikely that food transfers would be scaled up as a national strategy of social protection. Cash has been gaining momentum in recent years in countries looking at national social protection systems for children affected by AIDS. Furthermore, many food transfer programmes operate in conjunction with other livelihoods, health, nutrition, and education programmes. While some like school feeding may compete for resources with a cash transfer programme, others, such as those that operate as part of livelihoods programmes, maternal health, or nutritional rehabilitation programmes, should not have to.

Despite these reasons for our focus on cash transfers, an argument for scaling them up ultimately depends on how they perform—the impacts they have on poverty and human capital. This paper explores the evidence that currently exists to answer these questions.

2.3 Why a focus on human capital?

This paper focuses on human capital in two ways: first, we look at the impact of cash transfers on education, health, and nutrition, as well as how they could be designed to increase these impacts. Second, we consider conditional cash transfers (CCTs), programmes that, in addition to reducing short-term poverty, have increasing education, health, and nutrition as their primary objectives. CCTs make cash benefits conditional on household members’ participation in education, health, and nutrition services. We give this attention to CCTs for two reasons. The first is that the vast majority of the global evidence to date on impacts of cash transfer programmes comes from evaluations of CCTs. This is because these programmes have been undertaken in a large number of Latin American and other countries, where complex impact evaluations, often involving experimental designs and large panel surveys, have been mandated by governments or donor agencies. The impacts, particularly with respect to human capital, are the strongest

¹⁰ The “HIV/AIDS” lens is a conceptual tool for reviewing situations and actions in the light of HIV/AIDS, and how they may increase or reduce risks (Loevinsohn and Gillespie 2003).

found in terms of magnitude, underscored by the rigor of the research and analytic methodologies. CCTs thus show us what can be achieved through cash transfer programmes. The second reason we consider these conditional programmes is that, given their demonstrated impacts, there is at least the possibility that they could have significant impacts on protecting and strengthening the human capital of children in AIDS-affected families. We do not know this yet—we do not know whether conditions would make a difference, or whether they would work at all. Evaluations comparing conditional and unconditional programmes are currently underway in a few African countries. There are many arguments that support and caution against conditionality in cash transfer programmes, and many contextual considerations in this debate, and there are reasons why conditionality may not be appropriate for the most severely AIDS-affected families, who need immediate unconditional assistance. One of the main concerns is the quantity and quality of education and health services available. The options for improving services, in or out of the context of a cash transfer programme, deserve attention, as does the possibility that conditional cash transfer programmes might provide impetus for increasing the availability and quality of services. All of these issues are discussed further in Section 5.

Whether through conditional or unconditional programmes, the need to achieve impacts on human capital is paramount, and cannot be put off. Of course food security always will be a priority, as without this education and health will be sacrificed regardless. But the human capital of children must be a simultaneous priority, because any sacrifice now has lifelong and intergenerational consequences. There is extensive evidence on the interactions between early childhood nutrition, health, and education, as well as between human capital and long-term earning ability. During pregnancy and in the first two years of life, known as the “window of opportunity” for nutrition interventions, nutritional losses take their greatest toll, causing damage that is largely irreversible.¹¹ Children under two years of age are growing at a rapid pace, and have high nutritional requirements. However, the typical foods provided to complement breast milk in low-income countries provide insufficient energy and nutrient content for optimal growth. Additionally, with weak immune systems and living in conditions of poor hygiene and sanitation, young

¹¹ Martorell, Khan, and Schroeder (1994) note that growth lost in early years can only partially be regained during later childhood and adolescence when children remain in poor environments.

children are highly susceptible to infection, which can exacerbate malnutrition. Approximately half of all under-five deaths in developing countries result from the interaction between common infections, such as diarrhea, respiratory infection, and measles, and malnutrition (Behrman 2000, 7). Inadequate food supply and quality, poor hygiene and sanitation, and low levels of maternal education are all associated with child illness and poor nutritional status.

These nutritional impacts interact with education. Poor and malnourished children are likely to start school later and complete fewer years of schooling compared to wealthier and healthier children. Cross-sectional studies in Zambia and Uganda showed poor children to be four and ten times, respectively, more likely than the richest children to enter school late (Grantham McGregor et al. 2007, 64). Malnourished children were shown to enrol later than healthy children in Nepal, Ghana, Philippines, and Tanzania (Behrman 2000, 9; Grantham-McGregor et al. 2007, 63). In Tanzania, stunted children were also less likely than healthy children to be enrolled in school at all (Grantham-McGregor et al. 2007, 63). Glewwe, Jacoby, and King (2001) find that better-nourished Filipino children start school earlier and repeat fewer grades. The authors conclude that a 0.6 standard deviation increase in the height of malnourished children would increase completed schooling by nearly one year (Glewwe, Jacoby, & King 2001, 362-363). Alderman et al. (2001) find that malnutrition decreases the probability of ever attending school, particularly for girls. An improvement of 0.5 Z-scores in height-for-age for preschoolers would increase school initiation by 4% for boys, and 18% for girls, closing the gender gap in enrolment by 20% (Alderman et al. 2001, 198). Tracking a cohort of Zimbabwean children over two decades, Alderman, Hoddinott, and Kinsey (2003) find evidence of delayed school initiation and fewer grades completed for individuals who were malnourished as children. The authors conclude that a median preschooler in the sample could have started school 7 months earlier, completed 0.7 additional grades, and grown 4.6 centimeters taller, if s/he would have attained median height in a developed country (Alderman, Hoddinott, & Kinsey 2003, as cited in Behrman, Alderman, & Hoddinott 2004, 373). Behrman et al. (2003) find that Guatemalan children age 6-24 months receiving a nutritional supplement experienced significantly higher probability of attending school and of passing first grade (Behrman et al. 2003 as cited in Behrman, Alderman, & Hoddinott 2004, 373).

Additional evidence comes from a study of 79 countries with data on education and stunting, which found that every 10-percent increase in stunting was associated with a reduction of 7.9% in the proportion of children reaching the final grade of primary school. A similar study including 64 countries found that every 10-percent increase in the prevalence of poverty reduced by 6.4% the likelihood that children would enter the final grade of primary school (Grantham-McGregor et al. 2007, 63). A study in the Philippines found that a one standard deviation increase in the stature of malnourished children would increase completed schooling by nearly 18 months and reduce the probability of repeating first grade by around 9% (Glewwe, Jacoby, & King 2001).

Beyond delayed entry and reduced school completion, malnourished children often experience a reduced capacity to learn. Stunted children have been found to be more likely than healthy children to have lower achievement levels and poorer grades (in Nepal, China, Jamaica, India, Philippines, Malaysia, Vietnam, Brazil, and Turkey, and boys in Guatemala).

Stunting was also associated with lower scores on cognitive tests in Guatemala, the Philippines, and Ecuador (Pollitt et al. 1995; Martorell 1995, 1999, cited in Berman, Alderman, & Hoddinott 2004, 368; Grantham-McGregor et al. 2007). Stunted children were more likely to have lower achievement scores and poorer cognitive ability in Kenya, Indonesia, Guatemala, Ethiopia, Peru, India, Chile, and Vietnam. Stunting at 24 months was associated with lower cognition at age 9 in Peru and with lower IQ at 8 and 11 years of age in the Philippines (Grantham-McGregor et al. 2007, 63). In Guatemala, children exposed to a high-energy, high-protein nutritional supplement performed better on tests of knowledge, reading and vocabulary, numeracy, and information processing (Pollitt et al. 1995, 1116S).

Furthermore, according to studies from Barbados (Galler et al. 1983; Galler 1984), Guatemala (Pollitt, Gorman, & Metallinos-Katasaras 1991), and Jamaica (Richardson, Birch, & Ragbeer 1975), individuals who were severely malnourished as young children were less well-liked by their peers and were unhappier than classmates who had been well-nourished as children. Previously severely malnourished children exhibited more frequent immature behaviour, had poorer relationships with classmates and teachers (in Barbados

and Jamaica), and acted more withdrawn, solitary, or unsociable than their classmates (Behrman 2000, 9).

These human capital deficits in turn have long-term impacts on earnings, completing the cycle that transmits poverty through generations of families. One route is through a link between poor nutrition and physical productivity. Stunting at 36 months among Guatemalan children led to reduced body size and strength among adults (Behrman 2000, 13). Work capacity, defined as maximal oxygen consumption (or VO₂ max), was significantly higher among males who had received an energy- and protein-rich supplement as children, compared to those who had received a low-energy, low-protein supplement, albeit fortified with vitamins and minerals. The effect on productivity for females was weak (Martorell 1995, 1134S). More recent research comparing these same groups years later found that exposure to the more nutritious supplement before age 3—but not after—was associated (when the children had become adults) with a 46-percent increase in average wages, although for men only (Hoddinott et al. 2008).

Fewer years of education, poor cognitive development, and smaller stature in childhood reduce adult earning potential. Studies from 51 countries show that each year of schooling increases wages by 9.7%, on average (Grantham-McGregor et al. 2007).¹² Examining the relationship between cognitive skills and earning for male workers in rural Pakistan, Alderman et al. (1996) find that a 1% increase in cognitive skills increases earnings by 0.233% (Behrman 2000, 18). Similarly, low adult height, resulting from childhood stunting, is associated with reduced adult earnings in 55 countries (Grantham-McGregor et al. 2007, 67). In Brazil, a 1% increase in height was found to lead to a 2.4% increase in adult male earning (Thomas and Strauss 1997 cited in Behrman 2000, 18). If each year of schooling increases adult yearly income by 9%, the loss in adult income from being stunted but not poor is roughly 22.2%, the loss from being poor but not stunted is 5.9%, and from being both stunted and poor is 30.1% (Grantham-McGregor et al. 2007, 67).

¹² Although some of the studies had methodological weaknesses, this average matches another more rigorous study, which reported that each year of schooling in Indonesia increased wages by 7–11% (Grantham-McGregor et al. 2007, 66).

2.4 Poverty, food security, human capital, and HIV/AIDS

The dynamics between human capital and long-term poverty are likely to be intensified in the context of AIDS. Many studies have demonstrated AIDS-related impacts on food security, including those showing reductions in subsistence agriculture, income, and expenditures on food. Gillespie and Kadiyala (2005) review over 150 studies examining linkages between HIV/AIDS and food and nutrition security. For example, studies in Kenya, Zimbabwe, and Swaziland have documented strong associations between AIDS and substantial reductions in crop production (Yamano and Jayne 2004; Kwaramba 1997; Muwanga 2002). A nationally representative survey using recall data in Mozambique found that households experiencing deaths had lower levels of cash, cattle, assets, and income (Mather et al. 2004). Other studies in South Africa and Zambia found AIDS-related impacts on income (Booyesen and Bachmann 2002; Oni et al. 2002; Nampanya-Serpell 2000). Of course, findings are contingent on economic and social variables at the individual, household, community, and country level, to which policy responses must be attentive (Gillespie and Kadiyala 2005).

Poverty and food and nutrition security are also critical concerns in HIV-prevalent areas because of their powerful and mutually reinforcing relationship with HIV. In a vicious cycle, food and nutrition insecurity increase susceptibility to HIV exposure and infection, and lowers resiliency to AIDS impacts, while HIV/AIDS intensifies vulnerability to food and nutrition insecurity. Poverty and food and nutrition insecurity can accelerate the spread of HIV by increasing exposure to the virus and heightening risk of infection if exposure occurs. There are several reasons for increased exposure. The economic and educational disadvantages that often accompany food and nutrition insecurity can limit people's access to information about the disease and make it more difficult for them to act on information they do obtain. Poverty and food insecurity leads people to migrate to find work (increasing risk of exposure to infection), and some, primarily women and adolescent girls, may resort to transactional sex to earn income for food. A recent review of the literature (Gillespie, Kadiyala, & Greener 2007) finds evidence to support this relationship between poverty and risk-increasing behaviour, although with contextual caveats. Several studies have shown that migration is associated with risky behaviours and increased HIV transmission in Senegal, Guinea-Bissau, Tanzania, Zimbabwe, and Malawi, and cities in

Kenya, Zambia, Benin, and Cameroon (Bloom et al. 2002; Lagarde et al. 2003; Boerma et al. 2003; Auvert et al. 2001 as cited in Gillespie and Kadiyala 2005, 14-15).

Another hypothesized although less researched causal pathway is where malnourished people are more likely to suffer weakened immune systems, which may increase risk of HIV transmission in an unprotected sexual encounter (Gillespie, Kadiyala, & Greener 2007). Poor maternal nutritional status can increase the risk of vertical transmission of HIV from mother to infant (during pregnancy, delivery, or via breastfeeding). HIV can suppress the immune system and increase oxidative stress, which lead to nutritional deficiencies, which allow for increased HIV replication and accelerated disease progression (Haddad and Gillespie 2001). HIV can lead to insufficient dietary intake, altered metabolism, and malabsorption of nutrients—opportunistic infections associated with HIV, which cause diarrhea, vomiting, and damaged intestinal cells, among other effects, can inhibit the absorption of nutrients that are consumed—accelerating the onset of AIDS (Semba and Tang 1999 as cited in Gillespie and Kadiyala, 2005, 24). Weight loss resulting from the deleterious interactions between HIV and food intake and absorption has been shown to be a strong predictor of morbidity and mortality for HIV-positive individuals. Compared to people with no weight loss, losing 5 to 10% of one's body weight increases the risk of infection by 61 to 176%, and losing more than 10% of one's body weight is associated with more than double the likelihood of death (Tabi and Vogel, 2006).

All of these processes severely affect children, from their own risks of infection (e.g., from mother to child transmission, or risk-taking by adolescents), to the interactions of malnutrition with infection, to the economic and psychosocial impacts of parental and other relatives' illness and death. Children, before and following the death of parents, suffer from trauma, new workloads and responsibilities, abandonment, migration, fear, and stigma (Adato et al., 2005). Children living with ill parents may be more food insecure, or their foster families may not be able to afford, or may not prioritize, spending on them. There is evidence from some countries that orphans are more food-insecure, malnourished, are less healthy (Lundberg and Over, 2000; Ainsworth and Semali, 2000; Gilborn et al., 2001; Deininger, Garcia, & Subbarao, 2003; Rivers, Silvestre, & Mason, 2004), and have lower school enrolment and attendance rates (Case, Paxson, & Ableidinger, 2003; Case and Ardington, 2006; Evans and Miguel, 2007). But there is also

evidence that orphans do the same or occasionally better on these indicators, and are not always living with poorer families than non-orphans, as wealthier families may be better positioned to take them in (Ainsworth and Filmer 2006). The relationship between child and caregivers, economic status, household structure, and especially wealth can have more bearing on these indicators than orphan status alone (see Stewart 2007 on nutrition; Ainsworth and Filmer 2006; Case, Paxson, & Ableidinger 2003 on education). We review this literature and debate further in Section 4, in discussing how best to target benefits—i.e., how to reach people affected by AIDS while remaining fair to others with similar needs. The vicious cycles involving poverty and AIDS, AIDS and human capital, and poverty and human capital are discussed here to illustrate the urgency of action. The potential contribution of cash transfers to breaking these cycles is the concern of this paper.

3. Research methods and data, including programme and evaluation overviews

3.1 Research methods

The first stage of this paper involved identification of the key focal issues: first the decision to focus on cash transfers, then a selection of which issues pertaining to cash transfers. There are a vast number of issues related to cash transfers that potentially could be reviewed—including impacts, technical aspects of programme design, administrative and institutional issues, political economy, costs, and others—not all of which could be included in one paper. Prioritization was based on prior knowledge of, and a preliminary review of, the literature on social protection in general and in the context of HIV and AIDS, followed by consultation with stakeholders, including a presentation of the proposal to the Joint Learning Initiative on Children and AIDS (JLICA) Learning Group on Strengthening Families, discussion at a meeting of the U.N. Inter-Agency Task Team on Children and HIV and AIDS Working Group on Social Protection, and further discussions between members of JLICA and other stakeholders. These discussions took into account the focus of other papers, and the significance of the questions to the broader objectives of JLICA and its stakeholders.

The second stage involved a search of databases for peer-reviewed literature. The databases searched included the following: *Agora-Cab 1; Agricola; CAB Direct; Directory of Open Access Journals; Econlit; Eldis; PubMed; Highwire Press; Ingentaconnect.com; OAlster; PAIS International; Political Science: A Sage full-text collection; Scelio: Scientific Electronic Library Online; Scirus; Sociological Abstracts; Sociology: A Sage full-text collection; Worldwide Political Science Abstracts*. The publications selected from these searches were then entered into the programme Reference Manager.

The third stage involved a broader literature search and review—the main research method used in the paper—including published and grey literature. This included review of peer-reviewed journal articles, qualitative and quantitative programme evaluations, programme design documents and manuals of operation, published and unpublished working papers, and reports. Documents reviewed led us to more relevant documents, which we found on

the web, through literature databases, or through e-mail or telephone requests to authors or organizations that commissioned the studies. The grey literature was particularly important to this paper because most of the research done on cash transfer programmes in Africa is in this form, with little yet published in journals (this does not apply to the Latin America literature, for which we used both original project reports and subsequent journal articles. In total, over 300 documents were reviewed for this report.

The fourth stage involved analysis of the literature. This process began with a review of different types of cash transfer programmes implemented in different contexts, and ways in which they are or can be responsive to the needs of AIDS-affected families. A subset of programmes was selected for in-depth review, including all those for which some evaluation or impact research had taken place, where some data were available on education, health, nutrition, or poverty impacts. We did not include (1) programme without impact data; (2) programmes such as disability grants with very narrow targeting criteria; and (3) programmes that included work requirements.¹³ A total of 20 cash transfer programmes were analyzed in the paper, 10 unconditional programmes in east and southern Africa¹⁴ and 10 conditional programmes (from Latin America, the Caribbean, and Asia). Table 3.1 shows the unconditional cash transfer programmes reviewed in this study, plus others that were extensions of earlier programmes or current expansions, or otherwise mentioned in the paper. We also include poverty impact results from empirical studies of six existing cash transfer programmes (two unconditional in South Africa and four conditional in Latin America) and simulation models for 18 African countries. A table with the main evaluations from which data were drawn is included in the Appendix.

The analysis continued with a careful review of each document, collecting and summarizing each finding that provided information relevant on a wide range of issues (wider than those reported in this paper). A large database was constructed in Microsoft Access, with approximately 65 variables (including descriptive characteristics and others related to issues of primary and secondary interest to the paper). Data on these variables from the documents were entered into the database for all programmes to the extent that

¹³ The one exception was the Productive Safety Nets Programme (PSNP) in Ethiopia, which had components with and without work requirements, because of the large scale of this program and quality of the evaluation, with outcomes of direct relevance to the foci of this review.

¹⁴ Again the exception is the Ethiopia PSNP, which is partly conditioned on work.

the data were available on each issue. The table created a “case-ordered meta-matrix,” organizing data by case (each country-based cash transfer programme) on one axis and variables on the other (representing the key research themes and questions).

The next stage of the analysis focused on a narrower set of crosscutting themes, comparing them across all programmes where data were available. The central crosscutting themes of the paper are (1) targeting, (2) conditionality, (3) impacts on poverty, (4) impacts on education, (5) impacts on health, and (6) impacts on nutrition. Gender is also brought out as a crosscutting subtheme within each broader theme.

Findings on impacts come mostly from quantitative data to the extent available. Findings on targeting and conditionality draw on quantitative and qualitative research. Where quantitative studies were conducted in such a way as to report on statistical significance (e.g., in all of the CCT evaluations), we only report significant findings.¹⁵ It is important to note that there is a wide variation across the studies in research design, research and analytic methods, control groups, sample sizes, time frames, etc. The studies on conditional cash transfer programmes used the most rigorous methods from the discipline of economics, whereas quantitative methods in some of the unconditional cash transfer programme evaluations vary substantially with respect to rigor (Appendix A explains these variations). It is also important to note that at the time that this paper was written, more rigorous impact evaluations of cash transfer programmes were underway in several African countries, but results were not available before this paper was finalized.

3.2 Cash transfer programme overviews

Table 3.1 provides information on the design of the unconditional cash transfer programmes reviewed or mentioned in this study. It also includes information on the newer planned programme expansions.

¹⁵ In the tables where we report impact findings, blank cells normally mean that the indicator was not evaluated.

Table 3.1. Unconditional cash transfer programmes (with evaluation impacts reviewed in this paper)^a

Country	Programme	Date initiated (or expansion plan)	Conditional Yes/No	Geographic coverage	Main target group	Transfer size	Number of beneficiaries	Administering agency	Implementing partner
Ethiopia	Productive Safety Net Programme	Jan 2005-Dec 2006 (phase 1) Jan 2007-(expansion)	Yes/no (some public works requirements)	262 woredas	Chronically food insecure households	\$17 ^b per capita/year (2005) + food (cereals)	8 million (2006)	Government of Ethiopia	DFID, World Bank
Kenya	Cash Transfer Programme for Orphans and Vulnerable Children	Dec 2004 (pre-pilot)	No	3 districts	Orphans and other vulnerable children	\$6.50/month	500 households	Government of Kenya	UNICEF
Kenya	Cash Transfer Programme for OVC	2007-2008 (expansion)	Yes/no	17 districts	Orphans and other vulnerable children	\$13/month	30,000-50,000 households	Government of Kenya	UNICEF, SIDA, DFID, and the World Bank
Kenya	Cash Transfer Programme for OVC	2009-2015 (full-scale)	Yes/no	74 districts	Orphans and other vulnerable children	\$22.50/month ^c	2009-2015: 300,000 households	Government of Kenya	UNICEF, SIDA, DFID, and the World Bank
Lesotho	Old age pension (universal)	2004	No	National	Elderly over 70 years	\$25/month	72,000 beneficiaries	Ministry of Finance and Development Planning	
Malawi	Mchinji Social Cash Transfer Scheme	2006 (pilot)	No	Mchinji district	Ultra poor, labour constrained households	\$13/month	3,094 households	Government of Malawi	UNICEF
Malawi	Social Cash Transfer Scheme	2007-2008 2009-2012 (expansion)	No	4 districts	Ultra poor, labour constrained households	\$13/month	25,000 households 260,000 households	Government of Malawi	UNICEF
Malawi	DECT	Dec 2006 (ended April 2007)	No	Dowa district	Poor households in affected area	Sufficient to purchase Missing Food Entitlement	11,000 households	Concern Worldwide	Concern Worldwide
Malawi	FACT	Jan 2006 (ended April 2006)	No	3 districts	Poor households in affected area	Cash + food (equivalent to 25% of household food needs)	5,050 households	Concern Worldwide	Concern Worldwide
Mozambique	GAPVU	1990-1996	No	Provincial capital cities	Elderly, disabled, chronically ill (not including those living with HIV/AIDS), malnourished pregnant women	\$3-6/household depending on household size	30,000 (1997)	Ministry of Finance	UNICEF and SDA/GTZ ^d

Country	Programme	Date initiated (or expansion plan)	Conditional Yes/No	Geographic coverage	Main target group	Transfer size	Number of beneficiaries	Administering agency	Implementing partner
Mozambique	INAS	1997	No	National (provincial capital cities selected districts, expanding to rural areas)	Same	\$3-6/household depending on household size	69,095 (2005) 101,800 (March 2007)	Ministry for Women and Social Action (MMAS)	
Namibia	Social Pension (universal)	1965 ^e	No	National	Elderly over 60	\$24.40/month	96,767 (2001)	Government of Namibia	
Namibia	National Pension Fund (universal)	1992	No		Elderly over 60	\$30.50/month	96,767 (2001)		
South Africa	Child Support Grant	1998	No	National	Poor children 14 or under (15 in 2009)	\$27/month	7 million (March 2006)	South African Social Security Agency SASSA	N/A
South Africa	Foster Care Grant		No	National	Children under 18 (21 if still in school) determined by court to be in need of care.	\$84/child/month	300,000 children (March 2006)	South African Social Security Agency SASSA	N/A
South Africa	Old-Age Pension	1944 ^t	No	National	Poor men over 65 and women over 60	\$111/month	1.9 million (2002)	South African Social Security Agency SASSA	N/A
Uganda	Cash Transfer Pilot Programme	2007-2010 (pilot)	Yes/no	6 districts	Children, elderly and persons living with chronic illnesses and disabilities	\$10 plus \$1 supplementary transfer (per child & elderly person meeting conditions)	2007-2010: 9,000 households ⁹	Ministry of Gender, Labour and Social Development	DFID, UNICEF, World Bank, HelpAge International
Zambia	Social Cash Transfer Scheme	Nov 2003-April 2004 (test phase)	No	Kalomo Central agricultural block	Destitute, incapacitated households	\$5/month	169 households	Ministry of Community Development and Social Services	GTZ
Zambia	Social Cash Transfer Scheme	May 2004 (pilot)	No	Kalomo district: 2 agricultural blocks (Kalomo Central and Kanchele)	Destitute, incapacitated households	\$7.50/month, (increased to \$10/month in April 2005) plus \$2.50 (child bonus)	1,027 households	Ministry of Community Development and Social Services	GTZ
Zambia	Social Cash Transfer Scheme	2007-2008 (expansion)	No	5 districts (possible scale-up to 72 districts by 2012)	Destitute, incapacitated households	Same, but adjusted 5% for inflation	9,600 households	Ministry of Community Development and Social Services	GTZ/CARE

(continued)

Sources: Campbell et al. 2007; Croome 2006; Devereux et al. 2006; Ellis 2007; <http://www.helppage.org/Home> 2007; International Poverty Center 2007; Low, Garrett, and Ginja 1999; MCDSS/GTZ 2005; MCDSS/GTZ 2006; MCDSS/GTZ 2007; MGLSD 2007; OVPMA 2006; Ortiz 2007; Palacios and Sluchynsky 2006; RHVP 2007; Samson et al. 2004; SASSA website 2007; Devereux et al. 2005; Schubert 2004a, 2004b, 2005; 2007; Schubert et al. 2007; Schubert and Huijbregts 2006; World Bank 2007c.

^a Some numbers of beneficiaries and districts listed in this table are approximate because of conflicting sources based on changing targets and timelines for programme implementation.

^b Valued at November 2007 exchange rate: 1 birr - .011 USD.

^c Valued at November 2007 exchange rate: 1 KES = 0.015 USD.

^d SDA is the Social Dimensions of Adjustment programme, of which GAPVU was a part (Low, Garrett, & Ginja 1999, 5, 12).

^e Black Namibians only became eligible in 1973 (Palacios and Sluchynsky 2006).

^f All South Africans by law, but de facto expansion to different races occurred over time.

^g Roll out had not yet started as of April 2008, as the programme awaits cabinet approval.

4. Targeting of families and children affected by HIV and AIDS: Key issues, dilemmas, methods, and experience

Targeting, where resources are directed toward a particular group based on socioeconomic or demographic characteristics, has long been a feature of social assistance programmes, from cash assistance to public works to certain forms of public subsidies. Whether and how programmes are targeted are driven by global and national political economy, including revenues and access to grants and loans, political climate, ideology, and mobilization, by social characteristics of communities, as well as by technical knowledge and capacities. In the 1980s and 1990s, targeting gained new prominence against a global backdrop of economic downturns, a growing neoliberal orthodoxy preoccupied with efficiency of government expenditures and leading to dramatic reductions in poverty alleviation budgets, and a growing body of evidence that universal programmes such as general food subsidies were benefiting middle classes more than the poor. Social programmes were reexamined for how to best allocate resources among a smaller group of beneficiaries, and the “extreme poor” became a new subset of “the poor.” In Mexico in the 1990s, for example, targeted programmes were directed to the 20% of the population living in “extreme poverty,” although government recognized a 40-percent poverty rate, leaving the other half uncovered (Yaschine 1999). In the early 1990s, Besley and Kanbur (1993) observed that targeting had come to be seen as a panacea in poverty alleviation, where policymakers thought that improved targeting meant they could alleviate poverty with less expenditure.

Poverty targeting is based on an efficiency argument and an equity argument: for a fixed amount of resources, if the objective is to reduce poverty, then a greater proportion of these resources should be directed at the more poor. Targeting is mainly justified on two economic principles: first, that the social returns for a given level of transfers are higher for households at the lower end of the income distribution than the higher end, thus maximizing the welfare impact for a given population means targeting the poorest; and second, that targeting saves budgetary resources, giving more of these resources to the poorest who need it most, and avoiding more taxation (Subbarao et al. 1997). These economic, political economy, social, and technical issues are all relevant to cash transfer programmes for AIDS-affected families. However, in AIDS-affected contexts, these issues

articulate with others specific to AIDS, to introduce new issues, dilemmas, and design considerations.

4.1 Options for targeting

Targeting normally takes one of four main forms, although in practice these are usually used in combination: categorical, self-targeting, geographic, and individual/household assessment. Categorical targeting does not require a means test, instead directing benefits toward a group that is relatively easily identifiable, e.g., women, the elderly, children, the disabled, the landless. Targeting resources toward people affected by HIV and AIDS would be a form of categorical targeting, although this is a harder group to delineate and identify and involves other problems (discussed later in this section). Categorical targeting is often closely related to poverty targeting, in that demographic or other socioeconomic groups are often targeted to lift them out of poverty or keep them from falling into, or further into, poverty (e.g., the landless, the elderly, families or children affected by HIV and AIDS). Not all in these groups will be poor, however; for example, there are many wealthy households affected by AIDS, but cash transfers would not be directed to them.

A second form, self-targeting, refers to a method whereby anyone may participate, but the programme is designed with features that discourage the participation of people with better alternatives. A common example is a public works programme with wages set at or below market wages, where (at least in theory) the poorest people who are willing to work for these wages (because they are less likely to get work in the better-paying private labour market) self-select into the programme. Another form of self-targeting is used with subsidies, where, for example, subsidies are put on types of food disproportionately consumed by the poor.

A third form is geographic targeting where a region is selected, because of its poverty, demographic, or other characteristics, e.g., where there is a very high proportion of people who are very poor, or people affected by AIDS, or both. Complex processes of geographic

targeting can develop indexes based on sets of variables.¹⁶ While geographic targeting can mean that everyone in that geographic region is included, it is often followed by individual or household assessment, where individuals—but more commonly households—within that region are differentiated by some criteria and only those meeting the criteria are included. There are several methods for individual or household assessment. In the case of many Latin American conditional cash transfer programmes (e.g., rural Mexico, Nicaragua), a proxy means test through a detailed household survey is filled out in a visit to the household. Another variation is an application-based process (e.g., South Africa, Turkey, urban Mexico), where people go to centralized locations and fill out an application form that collects proxy means information. Programme implementers sometimes then do a random or systematic verification of information at the household. Application methods have tended to be used in urban areas where both household survey visits and community-based processes are not easy to implement well.

The household visit and application processes both use a proxy means test collecting data on variables that are proxies for poverty, vulnerability, or other targeted objectives. Proxies can be developed to capture variables signifying AIDS-affected households, such as dependency ratios (although these are not always correlated with poverty), illnesses, or presence/absence of able-bodied working age adults. For poverty/vulnerability targeting, quantitative data are collected on a set of observable characteristics, such as housing, durable goods, demographic structure of the household, education, types of work, expenditures, or reported income. Following the data collection, a statistical analysis is used to weigh variables and calculate a score. In Mexico's *PROGRESA*, for example, survey data were used to construct per capita income, and then compared to the Standard Food Basket, equivalent to an average aggregate income of approximately two minimum wages. A statistical technique was then used, separately for each geographic region, to identify the characteristics that best discriminated between poor and nonpoor households, and these variables used to compute an index that represented the differences between poor and nonpoor households (Skoufias, Davis, & de la Vega 2001; *PROGRESA* 1997). Some countries follow this process up with a community assembly that reviews and comments on the list, raising errors of exclusion (people who should be included but were not) and

¹⁶ In Mexico's CCT, e.g., these indicators related to share of illiterate population aged 15 or more; dwellings without running water, drainage, or electricity, dwellings with earth floors; average occupants per room; and percent of labour force in agriculture.

errors of inclusion (people who should not be included but are). There is variation with respect to centralization of the targeting process (e.g., in Mexico's CCT) and decentralization (such as in Brazil's CCT, which has a large role for municipalities).

A final method of individual/household assessment is community-based targeting, where selection decisions are made locally. This often involves a community-based committee or general assembly, although they may also include local government officials, traditional leaders, or other elites, international NGOs, and local CBOs. Beneficiaries are selected based on some set of criteria, determined by another community-based process or by programme implementers. These have been used in Latin America, Africa, and Asia. This is the method used in most of the new cash transfers programmes emerging in southern and East Africa, and will be reviewed below.

The trend toward more data intensive systems has been motivated by first, a history of political clientelism interfering in the distribution of resources and efforts to make this distribution fair and nonpoliticized; and second, evidence that antipoverty programmes have often not done well in reaching the poorest people. According to a review of 122 targeted programmes by Coady, Grosh, and Hoddinott (2004), on average a quarter more resources go to those considered poor than would random allocations, but over 25% of the programmes had regressive outcomes. Methods that tended to perform best with respect to reaching the poor were self-targeting through work requirements, followed by means testing, categorical targeting based on age, and community-based methods (other forms of categorical and self-selection did worse). There was less variation between these categories than within them, indicating that the way in which the systems are implemented is more important in determining performance than choice of the method itself (Coady, Grosh, & Hoddinott 2004).

Proxy-means test methods have been evaluated as largely successful in many of the Latin American CCT programmes in which they have been used, although with qualifications. In Nicaragua's CCT, *Red de Protección Social*, in locations using geographic targeting, quantitative analysis found inclusion errors at 14% and exclusion errors at 3%. Where household targeting was used, inclusion errors dropped to 6%, while exclusion errors rose to about 10% (Maluccio forthcoming). In Mexico, Skoufias, Davis, and de la Vega (2001)

found that *PROGRESA*'s household targeting method outperformed alternative simulated methods in reducing the depth and severity of poverty gap (not headcount), even accounting for cost. Once it had covered the extreme poor, however, it had a harder time distinguishing among localities and households in the middle. The reduction in higher order measures of poverty accomplished by household over geographical targeting was relatively small, and the authors concluded that whether using household vs. geographic targeting was worthwhile depended on the noneconomic costs (Skoufias, Davis, & de la Vega 2001, 1781), which were found in qualitative studies to be significant (Adato 2000).

Proxy-means test methods have accuracy advantages, due to the use of large quantities of data applied in a model. They also have several drawbacks. First, they can be costly, although these costs fall over time. In Honduras' CCT, the cost of targeting as a percentage of total programme costs was about 23% (although this also included beneficiary incorporation costs). In Mexico's CCT, the cost of targeting as a percentage of programme costs started out at a high of 61% in 1997 then fell to 47% in 1998, 26% in 1999, and to 3% in 2000. In Nicaragua's CCT, targeting costs similarly fell from 20% in 2000 to 2% in 2002. This drop-off represents the fact that most of the targeting activities go on early in the programme, followed by incorporation of those beneficiaries and then delivery of transfers (Caldés, Coady, & Maluccio 2006, 828). In this sense the first year's high costs can be seen as representative of the targeting process, but this can be averaged over a number of years, assuming beneficiaries mostly remain in the programme.

Second, administration of a proxy-means test with the accuracy found in the Latin American cases requires a high level of technical and administrative capacity, beyond what is likely to be available in many poor parts of the world. The formulation of a proxy means test model as normally used also requires the availability of a representative household survey data set (at national or regional level, depending on the geographic focus of the programme) with a comprehensive set of variables (indicators of household welfare) that are highly correlated with household income or total consumption expenditures. However, depending on its objective, a proxy means test and its analysis can range from very complicated to very simple, where a small survey uses a set of indicators chosen to be good proxies for poverty (or for AIDS-affected). The simpler end of the spectrum is often what is carried out by committees in a community-based targeting process (see below).

A third issue is that proxy-means tests often use a generic measure of poverty based on an index from the field of economics. This method is considered state-of-the-art and usually results in good targeting performance based on the indicators chosen. The problem is that these indicators and the formulas used for weighing them may yield results that differ significantly from local perceptions of relative need. Community-based targeting processes on the other hand draw on local people's knowledge of local norms and individual circumstances, and reflects local priorities and perceptions of fairness, need, and entitlement, which can differ widely from what is captured through statistical measures (Adato and Haddad 2002; MCDSS/GTZ 2006). In Nicaragua's CCT, for example, the quantitative evaluation of the proxy means test found "acceptably low" errors of exclusion (see figures above), but in the qualitative evaluation, 81 out of 125 households believed there were errors of exclusion in their communities, based on their perceptions of relative poverty and fairness (Adato and Roopnaraine 2004). Both proxy means and community-based methods are likely to involve errors of inclusion and exclusion, and can generate social tensions between neighbors and individual stress, particularly where criteria and processes are not transparent. These problems are compounded where there is no reliable appeals process (Adato 2000; Adato and Roopnaraine 2004). Any externally implemented method needs a reliable process for appeals and complaints, so that individual cases are reviewed and errors caught (see e.g., *Oportunidades* 2006a).

Community-based methods have also produced tensions, and are subject to the elite-influence that the survey-based approaches have been successful at avoiding. Where strong systems of patronage exist, or the target group has little representation, a categorical approach might be better (DFID 2005). Community-based systems can be designed with reviews built-in that strengthen transparency and accountability. In practice, targeting methods are most often used in combination, where, for example, data-driven geographic targeting is followed by a community-based process, involving some kind of household-level data collection.

In all of the methods above, there are risks of missing certain kinds of households and individuals: remote households living in difficult terrain, migrants, child-headed

households,¹⁷ or street children. While community-based methods tend to be better at identifying some of these groups, they may still exclude others, such as people who self-exclude or face discrimination by other community members due to race, ethnicity, case, severe disability, or other factors. Ways to reach these groups, through eligibility criteria and targeting methods, must be carefully designed into the process.

4.2 Targeting poverty and vulnerability or AIDS-affected families? Conceptual dilemmas, evidence, and arguments

A number of global initiatives and forums have coalesced around the issues facing orphans and other vulnerable children affected by HIV/AIDS. These include, among others, UNGASS/AIDS' Declaration of Commitment (2001)¹⁸; The U.S. President's Emergency Plan for AIDS Relief (PEPFAR)'s Orphans and Other Vulnerable Children Category; The U.S. Assistance for Orphans and Other Vulnerable Children in Developing Countries Act of 2005¹⁹; The Global Partners Forum on Children Affected by HIV and AIDS²⁰; the Inter-Agency Task Team on Children and HIV/AIDS²¹; the Joint Learning Initiative on Children

¹⁷ DHS data from 2000-2004 show that under 1% of households were headed by children (UNICEF 2006); still, these households are likely to be among those most in need.

¹⁸ The UNGASS Declaration of Commitment commits to "Urge the international community, particularly donor countries, civil society, as well as the private sector to complement effectively national programmes to support programmes for children orphaned or made vulnerable by HIV/AIDS in affected regions, in countries at high risk and to direct special assistance to Sub-Saharan Africa" (UNGASS 2001).

¹⁹ The Assistance for Orphans and Other Vulnerable Children in Developing Countries Act of 2005 amends the Foreign Assistance Act of 1961 to authorize the U.S. President to provide assistance, including through nongovernmental or international organizations, for basic care for orphans and other vulnerable children in developing countries, including assistance for (1) community-based care, (2) school food programs, (3) education and employment training, (4) psychosocial support, (5) protection of inheritance rights, and (6) HIV/AIDS care.

²⁰ In 2004 UNICEF and the World Bank jointly convened the Second Global Partners' Forum for Orphans and Vulnerable Children Living in a World with HIV and AIDS. In 2006 this forum was hosted by UNICEF and the U.K. Department for International Development (DFID) and supported by UNAIDS, and brought together senior representatives from 90 international nongovernmental organizations and governments (World Bank 2004a; UNICEF 2007c).

²¹ Created in March 2001, this task force was first called the Inter-Agency Task Team (IATT) on Orphans and other Vulnerable Children. In 2004, to better reflect the challenges facing orphans and non-orphaned children made vulnerable by the AIDS epidemic, the name was changed to the Inter-Agency Task Team on Children and HIV and AIDS. The IATT, comprised of representatives from UNAIDS co-sponsors, NGOs, donors, and other organizations involved in the international response to children affected by HIV and AIDS, promotes coordination and harmonization of programs and policies, encourages the development and sharing of technical and programmatic information, advocates for timely implementation of evidence-based interventions, and supports networking and collaboration among partners (UNICEF 2007d).

and AIDS.²² There are also regional forums such as the National Plans of Action for Orphans and Vulnerable Children (NPAs),²³ and the South Asian Association for Regional Cooperation (SAARC) Draft Framework for the Protection, Care and Support of Children Affected by HIV/AIDS,²⁴ among others. Apart and collectively these have provided powerful opportunities for mobilizing strategies, resources, and action on behalf of children affected by HIV and AIDS. Although all allow room for “other vulnerable children,” they vary with respect to their focus on HIV/AIDS verses children vulnerable from other causes, and the extent to which they are grappling with issues surrounding this focal dilemma.

This central targeting dilemma—to target AIDS-affected families and children or to target the most extreme poor households—involves (1) questions of equity and justice—where non-AIDS-affected families and children may be just as adversely affected by chronic poverty, illness and death from other causes, war, or other forms of shocks or discrimination; (2) questions about accuracy—whether AIDS-affected households or orphans are always the worst off and thus whether targeting them will reach those most in need; and (3) concerns about stigma—the effects of identifying “AIDS-affected” or “AIDS-orphans.” Questions about equity and accuracy are closely intertwined, both requiring evidence on whether AIDS-affected families and children are worse off than those who are not.

²²The Joint Learning Initiative on Children and HIV/AIDS (JLICA), launched in 2006 and continuing through 2008, draws on interdisciplinary collaboration among policymakers, practitioners, and scholars to address the needs of children affected by HIV/AIDS. JLICA aims to mobilize and generate evidence on operational, political, and public policy issues as well as programmatic experience, and produce actionable recommendations for policy and practice. Furthermore, JLICA facilitates linkages among groups engaged in issues of children and HIV/AIDS (JLICA 2007).

²³ Many southern and East African countries have recently drafted National Plans of Action for Orphans and Other Vulnerable Children, which prioritize a range of services for OVC including childcare, psychosocial support, child protection, access to basic health and education services, improved sanitation, birth registration, and social safety nets. Some NPAs also include advocacy and institutional capacity building, as well as legislative reform to protect orphans and vulnerable children. By late 2006, at least 20 countries had drawn up NPAs and others were nearing completion (Sabates-Wheeler and Pelham 2005; UNAIDS/UNICEF/WHO 2007).

²⁴ The SAARC Strategic Framework for the Protection, Care and Support of Children Affected by HIV/AIDS provides guidance to the eight member states on the protection, care, and support of children affected by HIV/AIDS. The Regional Framework establishes a regionally consistent response to meeting children’s medical, nutritional, educational, legal, and psychosocial needs in an age- and gender-sensitive manner, within the context of the UN Convention on the Rights of the Child, which all Member States have ratified (South Asian Association for Regional Cooperation (SAARC) 2007).

The relationship between poverty and AIDS is not one of a clear, positive correlation. A recent review of the literature found that because HIV has different drivers across socioeconomic groups, poorer groups are not necessarily more at-risk to HIV exposure than wealthier groups. What is clear, however, is that poor families are likely to be hit harder by the downstream impacts of AIDS. They are less able to cope, and HIV and AIDS are very likely to make them poorer. There are many reasons for this. Vicious downward spirals involve reduction and fluctuations in on-farm and off-farm income due to labour constraints from ill or deceased breadwinners; reductions in purchase and application of agricultural inputs and access to extension; increased expenditure on health care, transportation, funerals, expenses for fostered children, and food to replace that formerly accessed through subsistence agriculture; reduction in savings and selling of assets; reduced access to credit and/or increases in debt at unfavorable terms. This is compounded by and compounds other impacts on natural, physical, human, and social capital (Gillespie, Haddad, & Jackson 2001; Harvey 2004; Stokes 2002, cited in Gillespie and Kadiyala 2005);

Gillespie and Kadiyala (2005) review over 150 studies examining linkages between HIV/AIDS and food and nutrition security. Many studies have demonstrated AIDS-related impacts on subsistence agriculture, income, and expenditures on food. A panel study of 1,422 households in Kenya found the death of a prime-age adult male household head associated with a 68% reduction in the value of per capita household crop production. It also found that the initial asset base helped to cushion this impact, another poverty-related determinant (Yamano and Jayne (2004). Other studies found crop output declines of 37 to 61% in Zimbabwe (Kwaramba 1997) and 54% in Swaziland (Muwanga 2002); labour reductions of 60 to 80% in Rwanda (Donovan et al. 2003), and labour shortages in 70% of households in Malawi (Shah et al. 2001). A nationally representative survey using recall data in Mozambique found that households experiencing deaths had lower levels of cash, cattle, assets and income (Mather et al. 2004). Several smaller studies in South Africa and Zambia demonstrated large AIDS-related impacts on incomes, including Booyesen and Bachmann (2002) in Free State Province; Oni et al. (2002) in Limpopo; and Nampanya-Serpell (2000) in Zambia. As always, findings are contingent on various economic and social variables at the individual, household, community, and country level.

The evidence is thus strong that targeting AIDS-affected families is likely to reach families that are poor and in need of social protection. The problem remains, however, that first, many affected by AIDS are not poor, and second, many people are extremely poor due to other causes. Recent work, e.g., has highlighted the importance of assets in explaining persistent, structural poverty (Carter and Barrett, 2006). In a study based on data from six southern African countries, Caldwell (2005) found household asset ownership to be a better predictor of food security than chronic illness, presence of orphans, and gender of the household head. Targeting on multiple criteria capturing poverty and vulnerability, including but not limited to indicators associated with AIDS, can capture AIDS-affected families but not exclude others.

Another case for targeting poverty rather than AIDS-affected households can be made based on evidence that AIDS not only contributes to impoverishment, but that poverty also is a driver of HIV infection. Poverty and food insecurity can lead women and older children into transactional sex, or prevent economically dependent women from refusing unsafe sex. A recent review of the evidence (Gillespie, Kadiyala, & Greener 2007) finds a number of qualitative and quantitative studies that support this relationship between poverty and risky behaviour (Bryceson and Fonseca 2006; Tladi 2006; Brook et al. 2006; Kaufman et al. 2004), although there are also contextual caveats and specificities (Kimuna and Djamba 2005; Weiser et al. 2007; Nii-Amoo Dodoo, Zulu, & Ezeh 2007). Another hypothesized although less researched causal pathway is where malnourished people are more likely to suffer weakened immune systems, which may increase risk of HIV transmission in an unprotected sexual encounter. Gillespie, Kadiyala, and Greener's (2007) review of the evidence concludes that this directional relationship between poverty and AIDS is not straightforward, in part because research on the association between socioeconomic status and the spread of HIV is still in a rudimentary stage, and because of the complexity and context-specificity of pathways, including the influence of factors such as location, gender, age, mobility, and the social ecology of HIV transmission. Although the conclusion is that poor people are not necessarily more likely than wealthier people to be exposed to HIV, as there are different processes at work in both cases, the fact remains that poverty increases risk, and that the poor are less resilient. In this light, interventions that target poverty can also reduce new cases of HIV and in turn reduce poverty.

The question of whether orphans are more disadvantaged than non-orphans is the subject of a large body of research, but the answer is also far from straightforward. Research shows that orphans are more vulnerable and disadvantaged, and other research shows that they are not. This is not necessarily contradictory, but rather contingent on variables such as the relationship between child and caregivers, poverty status, and household demographics and structure. Ainsworth and Filmer's (2006) review of 102 data sets from 51 countries found mixed-results on whether fostering households were poorer or better-off than households without orphans. In about two-thirds of the studies, paternal orphans were more likely to be in relatively poorer households, while maternal orphans were in poorer households in only about one-third of the countries.²⁵ Results varied even more for double orphans—in 10 studies they were in poorer households, while in 22 studies they were in relatively richer households. This latter result probably reflects the fact that some deceased parents were from better-off families, and because richer households may be better able to care for orphans and thus end up taking more in.

With respect to nutrition effects, orphans might be expected to be more malnourished than non-orphans because they came from households with very ill parents caught in the downward economic spiral described above, or because their fostering households may discriminate against them. A number of studies have found orphans to be more food-insecure, malnourished, and less healthy than non-orphans (Lundberg and Over 2000; Ainsworth and Semali 2000; Gilborn et al. 2001; Deininger, Garcia, & Subbarao 2003; Rivers, Silvestre, & Mason 2004). To illustrate, a study in Tanzania interviewing 718 children in the early 1990s and again in 2004 found that children who lost their mother before age 15 suffer a deficit of around 2 centimeters in final attained height and 1 year of final attained schooling, and that the effect is causal. Another study of 1,190 children under 6 in Western Kenya (Lindblade et al. 2003), 7.9% of which had lost one or both parents, found no difference in key health and nutrition indicators, except in weight-for-height Z-scores, particularly among paternal orphans and those orphaned more than one year. Mason, Musgrove, and Habicht (2003) found that drought in six southern African countries interacted with HIV/AIDS, contributing to a rapid reduction in children's nutritional status. The Community and Household Surveillance (CHS) system from six

²⁵ Paternal, maternal, and double orphans refer to children whose fathers, mothers, or both are deceased, respectively.

southern African countries (C-SAFE/WFP, cited in Greenblott and Greenaway 2007) found that households with orphans were not more food-secure than those without orphans, although this did not take into account how many orphans were in the household. An earlier review by Rivers, Silvestre, and Mason (2004) found evidence that households caring for one orphan were less food-insecure than households without orphans, but that 40% of households with more than one orphan were food-insecure, with child hunger. Several other data sets collected by international NGOs also found that households with multiple orphans, or those with orphans and other HIV and AIDS-affected children, were more food-insecure than households without orphans (Greenblott and Greenaway 2007). Hallman (2004) shows that controlling for wealth and other factors, orphanhood confers added risk for unsafe sexual behaviours.

New evidence based on analysis of DHS data from five countries (Stewart 2007), using sample sizes up to seven times larger than previous studies, found that orphans do not necessarily have poorer nutritional outcomes than non-orphans, when controlling for age, sex, household wealth, and household demographics. The main factor consistently and significantly affecting nutrition is wealth, and in some cases relationship of orphans to household head. The study did not find any pattern that orphans were overrepresented in poorer households, but evidence is again mixed. Within the poorest two quintiles, there is evidence of orphan disadvantage in Zambia and Tanzania, where orphans in blended households (those with orphans and non-orphans, where discrimination would be more expected) had greater evidence of stunting than non-orphans. In Kenya those in blended households had lower weight-for-age scores where they lived in grandparent-headed households, consistent with findings elsewhere that discrimination is affected by distance in kinship ties, where the de facto household heads may be aunts or uncles. Other findings further complicate the picture: non-orphans in blended households were better off than non-orphans in non-blended households, providing further evidence that fostering households may have greater capacity to care for children than households that do not take in children. These results are all for younger children that may be more easily assimilated than older children. Stewart (2007) notes that the probability of being an orphan and of suffering nutritional deficits that translate into anthropometric indices increase with age.

If children are more easily assimilated at earlier ages, then one might expect more evidence of discrimination with respect to education, especially since school expenses may be high, older children are needed to work or care for the ill, and education may seem more expendable than food. The question of whether orphans are disadvantaged with regard to schooling has received considerable research attention, but again the answer is not straightforward. Ainsworth and Filmer (2006) review 102 nationally representative data sets from 51 countries in Africa, Latin America, the Caribbean, and Asia, examining the relation between parental survival, poverty, gender, and school enrolment. Compared to non-orphans, and controlling for enrolment differentials associated with economic status, statistically significant deficits in enrolment were found in 38% and 46% of the surveys for paternal and maternal orphans, respectively, climbing to 58% for double orphans. Associations between enrolment and the interaction of economic and orphan status find similarly varying results. There is a strong systematic association, however, between enrolment and economic status, i.e., wealth status is a much stronger predictor of enrolment than orphan status, for paternal, maternal, and double orphans in most countries, although in fewer countries in the case of double orphans. Girls tend to be disadvantaged compared to boys, but not significantly different from girl non-orphans. The overall picture is one of a great deal of variation across countries, implying the importance of context-specific policy interventions. A UNICEF analysis of DHS and MICS data for 24 countries compared school attendance of orphans and non-orphans and also found wide variation across countries (UNAIDS/UNICEF/WHO, 2007). With respect to the question of targeting, the implication is that it makes more sense to work harder at reaching orphans in some contexts than others. Countries with overall low enrolment rates among the poor can focus on the overall group and catch orphans in the process. In countries with overall high enrolment rates but large gaps among orphans, orphan-focused policies are more defensible, although these may require means other than an unconditional cash transfer, or other than cash transfers entirely.

Case, Paxson, and Ableidinger (2003) find a different outcome than Ainsworth and Filmer, particularly with respect to the importance of economic status, with somewhat different policy implications. Using 19 DHS surveys from 10 countries between 1992 and 2000, they find that paternal, maternal, and double orphans have significantly lower enrolment rates, in 8, 8, and 13 of the surveys, respectively. They also compare enrolment rates for orphans

with that of non-orphans living in the same households, finding significantly lower enrolment rates for paternal, maternal, and double orphans in 9, 7, and 17 of the 19 surveys, respectively. Orphans tended to be poorer, on average, than non-orphans, but their enrolment rates were not explained by poverty, nor by gender differences, as orphaned girls were not disadvantaged compared to orphaned boys. Schooling outcomes were affected instead by the “closeness of biological ties”—enrolment outcomes depend on the degree of relatedness of the orphan to the household head. Children living in households headed by non-parental relatives were systematically worse off than those in households headed by parental relatives, and those living with nonrelatives fared even worse. Where intrahousehold discrimination exists, Case et al. recommend targeting orphans, as income support to families may not benefit them.

Data from Kenya, Tanzania, and Zimbabwe show that orphans 11-14 years of age are significantly more likely to be at a low grade for age, and, in Ghana and Nigeria, young paternal and double orphans are at lower grade for age, as are older paternal orphans (Bicego, Rutstein, & Johnson 2003). School and student surveys in Botswana, Malawi, and Uganda found mixed results, with orphans and non-orphans faring better, worse, or the same with respect to different measures (Bennel 2005). Country-level studies present more insights, with gender implications: using longitudinal data from the KwaZulu-Natal, South Africa DSA, Case and Ardington (2006) find that maternal orphans are significantly less likely to be enrolled, have completed fewer years of school, and those enrolled have less money spent on their education, compared to children whose mothers are alive. These results hold for younger and older orphans, but there were no differences between outcomes for boys and girls. These disadvantages were not found for paternal orphans. Using a five-year panel study of 20,000 children in Kenya, Evans and Miguel (2007) found a substantial and highly significant drop in primary school participation following the death of a parent, and a smaller drop just before death. Impacts are over twice as large following maternal deaths over paternal deaths. Effects are largest for children whose mothers have died, as well as for those with lower baseline educational performance. Panel data on 1,300 households analyzed by Deininger, Garcia, and Subbarao (2003) in Uganda showed orphans to be disadvantaged in primary and secondary education, but this effect was reversed after the introduction of universal primary education, demonstrating the impacts of universal as opposed to targeted policies. New results from a panel survey

conducted in Malawi in 2000 and 2004 found that maternal and double orphans tend to face higher mortality risks and lower schooling outcomes than paternal and non-orphans, especially in the case of boys. As in Uganda, the effect on young orphans who enrolled following the introduction of free primary education in 1994 was less than that on adolescent orphans (Ueyama 2007). These studies show that programmes reducing costs of education can mitigate the effects of parental death.

While many studies focus on orphans, these do not capture the experiences of children before they become orphans, which may be as bad or worse with respect to impacts on education and other areas. In a study in Uganda, Gilborn et al. (2001) found that older children (ages 13-17) living with an ill parent had lower school attendance rates compared with double orphans, and that the former group had declines in school attendance due to parental illness, while the latter reported increased attendance following parental death. Adato et al. (2005) use qualitative research to focus on children before and after the death of parents, noting that orphaning in the context of HIV/AIDS is a process that begins long before the death of a parent. This involves the trauma and fear of imminent and—absent anti-retroviral drugs (ARVs)—inevitable death, and often new workloads and responsibilities, withdrawal from school, abandonment, migration, fear, family dissolution, and stigma, the last of which may prevent parents and children from accessing resources that can strengthen capacities of children to deal with these challenges. Another unique aspect of HIV/AIDS is multiple and serial deaths within households. All of this can contribute to impacts on children, including their physical and mental health, and consequently schooling attendance and performance. These unique disadvantages should be explicitly addressed, and cash transfers on their own will be an insufficient response. A focus on poverty status rather than orphan status does not necessarily need to apply to all interventions, such as, for example, mental health interventions that target children who are caring for or have lost parents, or suffer from stigma. Haddad and Gillespie (2001), citing Parker, Singh, and Hattel (2000), suggest targeting for poverty, but modifying interventions to meet the needs of HIV/AIDS survivors.

It may never be possible to completely unravel this picture of relative disadvantage, mapping out all permutations. Even if we accept that orphans or children living with ill parents face unique challenges, and may be worse off in some cases, the evidence of their

disadvantage with respect to poverty, health, nutrition, and education is not strong enough to justify assisting only orphans, from an evidence and equity standpoint. There is also the consideration of stigma—negative effects that can come from the government or other institution publicly labeling a child as an “orphan.” Meintjes and Giese (2006) found that in South Africa, local notions of vulnerability and orphanhood correspond poorly with international definitions. Local notions have negative connotations, derived in part from local translations of the term, associated with abandonment and destitution. These local terms are “steeped in stigma” and the authors argue that labeling a child as an orphan is stigmatizing for the child and an insult to those providing care and support to the child.

Furthermore, given the evidence that orphans’ disadvantage varies with factors such as poverty, demographic characteristics, household structure, and orphan-caretaker relations, targeting explicitly to respond to these variations would be operationally and ethically infeasible at a community level. This research can help us contemplate, however, how AIDS-related specificities, articulated with other social and contextual specificities (based on region, gender dynamics or household structure, for example), can inform the development of proxies, perhaps applied at a wider geographic level. These findings could also inform complementary programming.

In light of these concerns around accuracy, equity, and stigma, a consensus is building among researchers and programme implementers around targeting cash transfers based on poverty and multiple vulnerability criteria, with attention to the context of AIDS, rather than on AIDS-affected or orphan status alone (see, for example: Subbarao, Mattimore, & Plangemann 2001; Slater 2004; Harvey 2004; Greenblott 2007; Schubert et al. 2007; Devereux et al. 2005). This is not a complete consensus (see, e.g., Evans and Miguel 2007), which is not necessarily problematic, in that it leaves room for caveats and context where needed. Organizations implementing food- and nutrition-based interventions see a more mixed picture, suggesting that school feeding and take-home rations be universal for all children (in poor communities) but that interventions such as Prevention of Mother to Child Transmission (PMTCT), home-based care, growth monitoring, and nutritional rehabilitation services, as well as pediatric hospices and foster care programmes, be used to improve targeting of vulnerable children (Greenblott and Greenaway 2007; see, also, more below on food transfers in the context of clinical treatment). Furthermore, a consensus

among researchers and programme implementers may take time to permeate into international and regional institutions and policy forums where “orphans” is still a key operational category and political rallying point.

Returning to questions of stigma and equity, lessons from food transfer programmes are useful. Responding to evidence on interactions between HIV/AIDS, food security, and nutrition, including research suggesting that anti-retroviral therapy (ART) is more effective for people who are well-nourished, because of increased caloric intake as well as decreased side effects that may reduce adherence (Paton et al. 2006; Zachariah et al. 2006), clinical care and treatment programmes are teaming up with food aid programmes.²⁶ A study in Kenya comparing 2,200 people receiving food aid and ARVs, with people on ARVs alone, found that the benefits of the food were substantial with respect to improved health, strength, and other measures of well-being.²⁷ There were also several problems identified, one of which was stigma, as the programme potentially rendered visible this singled-out group, although stigma was reported to have reduced over time. Many beneficiaries were keeping the food collection a secret from family and friends, because of fear of revealing their HIV-positive status and facing discrimination. One problem was the visibility of the food distribution points, and gossip that occurred as a result. Another was the fact that some food packets were labeled with AIDS awareness messages, something that beneficiaries requested be changed (Byron, Gillespie, & Nangami 2006).

These findings have two potentially contradictory implications for targeting. On the one hand, they demonstrate the importance of these food transfers for ART patients. On the other hand, they illustrate the stigma problem, and raise the equity question—how can this group alone receive food if their HIV-negative neighbors are also hungry? The answer is that the lives of symptomatic people may depend on these transfers. Given the importance of adequate nutrition for people on ART, it is difficult to argue against programmes providing them with food assistance, equity and stigma considerations notwithstanding.

²⁶ A recognition of the importance of integrating food and nutritional support into HIV/AIDS programming is reflected in policy declarations by several organizations, including the World Health Assembly, UNGASS, and the Africa Forum 2006 (see Byron, Gillespie, and Nangami 2006).

²⁷ Those on food had self-reported health outcomes such as weight gain, recovery of strength, and resumption of labour activities, as well as greater adherence to treatment, fewer side effects, ability to satisfy increased appetites, increased dietary diversity, and increased emotional well-being. Problems included stigma, transportation costs to distribution points, seasonal vulnerability to food insecurity, and transitions off of the supplement (Byron, Gillespie, and Nangami 2006).

Schubert et al. (2007), in arguing for poverty targeting rather than AIDS-specific targeting of cash transfers, suggest a possible exception for people on ART. While cash assistance for those on ART should also be explored, it may be that this is a better role for food transfers, particularly as the money must be spent on food for it to be effective, and food can be fortified with micronutrients whereas food purchased in the market is less likely to be. This might be akin to an emergency assistance programme, where it is less likely that cash transfers would be used when people are at immediate risk of starvation.²⁸ Still, in light of equity and stigma concerns, targeting cash and food transfers only to those on ARVs might be difficult to sustain in the long run (despite the fact that cash can be better hidden than food, family and neighbors are likely to learn about their neighbors regular new cash infusions). Furthermore, a poverty-targeted programme could improve the nutrition of HIV-positive people who are asymptomatic, possibly delaying their need for ARVs.²⁹ If well implemented, poverty targeting would reach those on ARVs who need the assistance, since not everyone on ARVs is poor. In fact, the very poorest may be less likely to access ARVs, so other targeting means would be needed to reach them. The ideal combination might be a food transfer for the patient, and a cash transfer for their family, where the family is selected based on the poverty-targeting criteria.

The identification of a family or child as “AIDS affected” not only risks stigma in the form of shame and social exclusion, but also potentially a form of disempowerment, as this public and self-identification reinforces people’s victim status and undermines agency. While the reality of illness, poverty, and the death of breadwinners and loved ones is arguably disempowering enough, one can see how public stigma and self-identification would compound the problem.

²⁸ At the other end of the spectrum, food transfers are sometimes used in conjunction with livelihoods activities implemented by NGOs and CBOs, where AIDS-affected households may or may not be able to take advantage of them. As noted earlier, these tend to be smaller in scale and found in pockets. These should not be at odds with cash transfer programs, although until cash transfers are operating at a large scale, the interventions should probably be coordinated, so that some areas do not have multiple interventions while others have none.

²⁹ Current research is also looking into whether better nutritional status for asymptomatic HIV-positive individuals may delay the need to start ARVs (Byron, Gillespie, and Nangami 2006, 2).

4.3 Targeting approaches in AIDS-affected contexts: Experience with community-based, categorical, and application-based methods

Community-based targeting in Eastern and Southern Africa

Most of the new cash transfer schemes in eastern and southern Africa have used community-based targeting. Some of these systems have evolved from others used in earlier programmes of implementing partners. As noted above, community-based processes are perceived to have a number of advantages with respect to accuracy, transparency, administration, and local acceptance, and they also are prone to a number of problems. Several variations on community-based targeting systems for cash transfer programmes are described and evaluated in this section. Pilot programmes in Zambia and Malawi used a very similar design, while Kenya's bears some similarities and some differences. Concern Worldwide's two programmes in Malawi use a different community-based process altogether. Several key points are of interest in the descriptions below: the structure of the community forums; the system for data generation; the criteria used as proxies for poverty, vulnerability, and "AIDS-affected"; and the nature of checks and balances on community processes.

Zambia's SCTS states the following rationale for use of a community-based method: geographic areas are too large, remote, and sparsely populated to enable a reliable survey method; rural poverty levels are not sufficiently different to be detected in a survey; and finally, Zambia already had a public assistance scheme that used voluntary, community-based processes for beneficiary identification. The targeting process works as follows (MCDSS/GTZ 2006; World Bank 2007c³⁰): The community is briefed about the programme at the outset, including the targeting system and criteria, so that people understand the basis of the selection. A volunteer Community Welfare Assistance Committee (CWAC) makes a list of all eligible households based on the following criteria: (1) extremely needy (hunger, malnourishment, begging); (2) incapacitated (bread winners are sick or have died; no able-bodied person in the working age; a dependency ratio of 3 or higher); (3) no valuable assets (e.g., no cattle or functioning TV); (4) no regular and

³⁰ This description reflects both the pre-2006 pilot and the new program underway, which contain only a few differences.

substantial source of income (business in town, renting out houses, regular support from relatives).

CWAC representatives visit each listed household and fill out an application form with questions about external support, livelihoods, assets, and household problems. This information is verified by the village headman. The CWAC reviews the information and selects the neediest 10%, a cap derived from a study indicating that about 10% of Zambians are destitute and incapacitated. Those ranked just outside of the 10% can enter if others are deleted or leave from the programme at some stage. The ranking is presented to the community, which can propose additions or subtractions and a consensus is reached. In order to avoid the nepotism to which this system could be prone, and otherwise check for errors, a system of checks and balances has been instituted: the final list is reviewed by an Area Welfare Committee, District Social Welfare Officer, and District Welfare Assistance Committee official for final approval. Questionable cases are investigated. A reassessment process takes place every two years, graduating those who have new productive members, and allowing other households to be included in their place (MCDSS/GTZ 2006; World Bank 2007c). Malawi's Mchinji Pilot Social Cash Transfer Scheme used a very similar process to that used in Zambia, and similar targeting criteria (Schubert 2006; Schubert and Huijbregts 2006).

Kenya's pilot Cash Transfer Scheme for Orphans and Vulnerable Children in three districts started with a community-based listing process, using community-developed criteria based on broad guidelines from UNICEF. These included poverty, vulnerable children in households, caretakers chronically ill, and other factors, including lack of able-bodied adults. A detailed questionnaire was filled out for each household, entered into an MIS system, and ranked according to criteria including orphans; not attending school, under 15 years old; households with only income of under KES2,000; and no other support from an organization. A community discussion followed to finalize the selection (UNICEF/Kenya 2007b; Acacia Consultants 2007; Pearson et al. undated). The new phase of Kenya's scaled-up cash transfer programme (see Table 3.1) targets households based on poverty, presence of orphans and other vulnerable children (defined as double or single orphans) living without adults (child-headed households), or with a disabled person, defined as someone with a "physical or mental disability that prohibits the individual from carrying

out normal daily activities and requires the individual to depend on others.” The household also cannot be receiving any other programme benefits. Location OVC Committees (LOCs) meet with village elders and community leaders to collect information on households that may be eligible based on these criteria. A preliminary form is filled out on the household and entered into a computerized MIS system. Enumerators visit the households and fill out a detailed questionnaire, and this new information is entered into the MIS, which ranks the households. Households are classified into high, medium, and low vulnerability depending on whether they have 1-3 of the following characteristics: (1) at least one orphan below 18; (2) a household head below 18; (3) at least one child, parent, or guardian is chronically ill (easily identifiable illness, e.g., AIDS). The ranking is reviewed in a public meeting and questionable cases sent for review by the LOC, supported by the DOSC (OVPMHA 2006).

Malawi’s FACT and DECT programmes used a method different from those above. A “community triangulation” method divided communities into three groups and asked each to make a list of the neediest households. Criteria were defined by each community, although Concern field staff and committees gave some guidance. Although FACT was supposed to respond mainly to the food crisis, some of the criteria steered communities toward people affected by AIDS: households with chronically ill members; households headed by orphans, elderly, or disabilities; households involved in Concern’s Outpatient Therapeutic Programme; households receiving Concern agricultural input loans; households facing severe hunger (one meal per day) and those not receiving food aid from another source. The three groups’ lists were compared in a public forum and those appearing on all three lists were included, while those appearing on one or two lists were discussed and a consensus reached. This had the advantage of avoiding the nepotism and favoritism that may accompany selection by a powerful individual or elite group, such as a village committee (Devereux, Mvula, & Solomon 2006).

Findings on community-based targeting processes

Interesting qualitative studies of the community-based targeting processes were carried out for the FACT and DECT programmes (Devereux, Mvula, & Solomon 2006; Devereux et al. 2007). In the Malawi FACT process, the community triangulation method was found to

be a good system where it was used as planned, but there were many problems in implementation. First, the methodology was not strictly applied in some areas, where Concern staff influenced the choice of criteria. In one area, for example, 75% of households were selected because of their caring for orphans or the elderly, a disability, or their health status. This might be considered successful as a method for targeting families affected by AIDS, but this was not the intention of the programme, which was aimed at responding to a weather-based food emergency. Second, some areas received the message that Concern livelihoods programme participants were to be included so they repay their loans, and these were not the most needy households. Third, in some places quotas were imposed by headquarters, requiring cuts in the list, which contradicted the self-assessed need principle. Fourth, the most vulnerable households may not have participated in the selection process because they do not have the time, or might be out of the village, looking for work or in the hospital. Fifth, influential elites, such as village headmen or their wives, managed to find their way into the programme. Sixth, poor coordination within the programme and across programmes meant that some families got double benefits, while some got none.

In the programme evaluation, Devereux, Mvula, and Solomon (2006) recommended that the community triangulation method be used as intended, emphasizing the importance of using the community's own criteria of vulnerability and need, and that all community members are encouraged to actively participate in the process. They make the controversial but wise recommendation that errors of exclusion are taken as a bigger problem than errors of inclusion, with a margin of about 10% given for errors of inclusion, allowing the inclusion of some non-needy or politically influential people; they argue that this is a small price to pay in order to ensure that desperate people are not left out. The FACT evaluation also suggests giving the benefits to women rather than men (women sometimes asked Concern staff for this change), to minimize risk of irresponsible spending (although there was little evidence of irresponsible spending by men); to avoid disadvantaging women in polygamous households, and to use female-headed households as a proxy for vulnerability. While they raise the possibility that this might generate intrahousehold tensions, given that men tend to control cash resources, on balance they recommend this approach (Devereux, Mvula, & Solomon 2006). Evidence from CCTs in Mexico and Nicaragua found that while there were some tensions arising from designating

women as beneficiaries, on balance women and men alike favored giving the benefits to women, because they both believed women make better spending decisions, and because the programme became to be seen as a women's and children's programme, so that it was less threatening to men's identity as the breadwinner (Adato and Mindek 2000; Adato and Roopnaraine 2004). A study of the Child Support Grant (CSG) in South Africa, which looked at intrahousehold dynamics and the role of women as the primary caregivers and thus cash recipients, found that while there were some tensions with male partners over the CSG, for the most part it was accepted without problems (Hunter and Adato 2007a).

Responding to problems in FACT, Concern dedicated more staff resources to the community triangulation process, improving accuracy but also increasing costs. The DECT baseline survey found that over 90% of 509 beneficiary households were poor and food insecure, using a range of proxies (Brewin 2006, cited in Devereux et al. 2007). Several problems were also identified. First, the community-based wealth ranking identified the neediest within a community, but not across them, such that the "middle groups" would be included in some. This had equity implications across communities. Second, because of a rush before the hungry season, some beneficiaries were asked to select others, leading to biases toward family members and debtors. The reduced transparency and inclusiveness of the process led to resentments between families. Third, wealth indicators were sometimes applied that were not appropriate, e.g., roofing material excluded some, but this material may have been acquired long ago and the households have been destitute since the male household head died. Third, some households were deleted when they did not show up at the targeting or registration process, although they might have been absent because of illness. Fourth, although Concern guidelines specify that each wife in a polygamous family should be registered separately, this often did not occur and wives were left out, receiving inadequate or no transfers.

Oxfam's cash transfer programme in Malawi also used a community-based process with committees that had responsibility for targeting decisions, but without formal checks and balances, and a number of additional risks were discovered with these methods. First, communities could decide whether to use existing committees or form new ones, and it appears that some committees were cementing inequalities, leading to elite capture and inclusion errors. Second, there was confusion over concepts of vulnerability, and some

relatively wealthy households who had taken in orphans or had ill members were using these criteria to justify their inclusion. Some areas were excluding people who did not have National Registration Cards, whereas the elderly, migrants, or people designated to pick up benefits on behalf of someone else might not have them. Greater monitoring by Oxfam, and more clarity and transparency with respect to resources available and numbers of people who could be included, would have reduced targeting errors (Harvey and Marongwe 2006).

Assessing targeting systems' effectiveness in reaching AIDS-affected families is difficult because data will normally not indicate whether a household has someone living with AIDS, or whether an orphan is orphaned by AIDS. Schubert et al. (2007) take up this challenge, assessing how well the Malawi Mchinji and Zambia SCTS community-based systems performed in targeting AIDS-affected households. In Malawi, profiles of households in the scheme were compared to those in the national Integrated Household Survey (IHH) for 2004, finding the following shares of households in the programme vs. those in the IHH, respectively: elderly households—65 vs. 12%; female-headed households—65 vs. 12%; children—69 vs. 56%; orphans (single and double) —85 vs. 12%. Using a number of assumptions (as empirical verifications were not available) as to the extent to which the categories above (such as elderly-headed) are related to AIDS, the analysis estimates that 53% of the households have someone who died due to AIDS, and of those 47% remaining, 34% have absorbed children orphaned by AIDS. This adds another 16% to the total of AIDS-affected households, meaning that about 70% of the households were AIDS-affected, plus some additional number were likely to be living with AIDS. Another survey of 382 households with a control group similarly concludes that 75% of households in the programme were AIDS-affected. Because extreme poverty is also a criterion, it is assumed that the programme also captured the worst off and most vulnerable people. (Schubert et al. 2007, 21-22).

A similar method was used to assess the targeting performance of the pilot programme in Zambia. Data from the programme baseline were again compared to a national 2004 Living Conditions Monitoring Survey or LCMS (although it was harder to compare the rural programme households with the LCMS data that averages rural and urban). The proportion of programme households headed by someone 55 or above was 79% vs. 19% in

the LCMS. Among these, two-thirds were female-headed, of those under 55 over half were female-headed, and 63% widowed. From there, a calculation using assumptions about the extent to which deaths were due to AIDS, and about children orphaned by AIDS, led to an estimate that a total of approximately 68% of participants were AIDS-affected, plus an additional number who were living with AIDS (Schubert et al. 2007, 13-15). Based on the Zambia and Malawi experiences, Schubert et al. (2007) conclude that cash transfer programmes can be most effective in reaching AIDS-affected households if they focus on households that are poor and labour-constrained, and use targeting criteria with exclusion errors under 20%.

Still, the Technical Working Group on Social Assistance, which developed the implementation framework for the expanding cash transfer programme in Zambia, did not find the evidence on effectiveness of the targeting system to be conclusive. Quantitative data found that the dependency ratio criterion was not applied for all households, calling into question its fairness and adequacy. In response, the programme proposed to test a universal pension system, improve the training of the committees, standardize the application form, but include more questions identifying destitution, and request committees to comment on whether household assets reported are still functional (MCDSS/TWG 2007a). Furthermore, some have questioned whether community-based targeting on a national scale is the most effective means of reaching the most vulnerable, defined as female-headed, elderly-headed, and caring for orphans and other vulnerable children. There are also questions about costs—although proxy-means tests are expensive, community-based processes can be as well.

The targeting system is currently being evaluated to model the outcomes of alternatives, and explore the institutional capacities needed to implement them (CARE Zambia 2007). Other proposed improvements to the process include refining the current eligibility criteria, and developing an index to provide additional information about the relative position of eligible households, deepening information on the type and quantity of assets owned, the sources and types of income earned by household members, dependency ratios, and access to public services (World Bank 2007c). Uganda's planned cash transfer programme also proposed to combine a community-based process, followed by a means

test based on census data to determine which families identified by the community process meet the criteria (International Poverty Center 2007).

Means tests and categorical targeting in southern Africa

South Africa's targeting system for its cash transfers, including the Old Age Pension (OAP), Child Support Grant (CSG), Foster Care Grant (FCG), and others, use an application-based means test. The OAP has been found to be well-targeted to poor households, and to households caring for children, with three-generation households and skip generation households (where grandparents are caring for children) accounting for almost three-quarters of pension-receiving households (Case and Deaton 1998, 1341). Although it is means tested, it is closer in effect to a categorical approach, nearly universal with respect to poor black South Africans (Palacios and Sluchynsky 2006, 20). Old age pensions in Namibia and Lesotho are also categorical (universal for the elderly) programmes. Old age pensions tend to be well targeted toward AIDS-affected children, as the AIDS epidemic shifts the responsibility of caring for orphaned children onto elderly-headed households. Over 60% of orphaned children in Namibia, South Africa, and Zimbabwe are living with their grandparents and over 50% in Botswana, Malawi, and Tanzania. In Namibia, the overall percentage of orphans living with their grandparents increased from 44% in 1992 to 61% in 2000 (Gorman 2004, 18; UNICEF 2003).

While pension recipients in Namibia are slightly less well off compared to the general population, most live above the poverty line—however, this is due to the pension, on which most households are highly dependent: 81% of household income is pension income (Palacios and Sluchynsky 2006, 24). The Lesotho old age pension is still relatively new, but thus far has reported errors of inclusion and exclusion, due to elderly people's lack of required documentation, and areas that are difficult to reach because of poor infrastructure and weather. Nevertheless, for those who receive it, the pension does seem to be benefitting children: there are data indicating that 50% of pensioners in Lesotho spend some of their pension on education and associated costs and 20% of their pension on caring for dependent orphans (Croome 2006).

The South African CSG is found to be well targeted in terms of those who have it, i.e., there are low inclusion errors. With respect to exclusion errors, the CSG programme did poorly in early years but has improved sharply. One study finds that exclusion errors dropped from 91% in 2000 (two years after its introduction) down to 45% in 2004 (Samson, MacQuene, & van Niekerk 2006). In 2007 the Department of Social Development put exclusion errors at just 10% (Budlender 2007).³¹ Streak (2008) calculates the take up rate in 2008 at 80%, or 20% exclusion errors. A challenge then remains in learning why this last 10-20% is so difficult to reach, and how to overcome these obstacles. Two studies have found that the poorest families are those who are the least likely to access the CSG (Rosa, Leatt, & Hall 2005; Goudge et al. 2007). The Goudge et al. (2007) study, involving 280 households, found that among households eligible for the child support grant, 57% of children in the poorest quintile were eligible for the CSG but not receiving it. The percent not receiving declined steadily with each better-off quintile, such that 39% were not receiving in quintile 4, though this climbs back to 48% in quintile 5.

The CSG is not rationed in the sense that there are no caps (such as the 10% limit in Zambia), although the overall budget restrictions in effect create a cap.³² A primary caregiver is eligible for the CSG if s/he has children age 14 or under (to be extended to 15 in early 2009) and her/his income plus that of the spouse comes to under R13,200 per year, or R9,600 if they live in an urban area and live in a formal dwelling. The eligibility criteria are subject to some criticism: that the poverty thresholds have not kept pace with inflation resulting in exclusions (Budlender, Rosa, & Hall 2005, 8-9), that the poverty line used may not be reasonable, especially as such a line is a complicated concept, that is, it does not take into account household size, discriminating against families with many dependents—including families fostering orphans. Finally, the cutoff age of 14 excludes coverage of children at a vulnerable age. For those who apply, only about half of one percent of applications are rejected, suggesting that the means test criteria are not prohibitive (Haarman 1998; Rosa, Leatt, & Hall 2005).

³¹ Streak (2008) explains that take-up rates for the CSG are hard to estimate, due to outdated national household income and expenditure data (from 2005/6), and the difficulty of applying a means test designed for the primary caregiver and spouse to household-level income and expenditure data.

³² Given the remaining gap in take-up for eligible households, this budget-related “cap” does not currently have that much significance. Where it does have more effect is with respect to the age cutoff for eligible children, currently at 14 and expanding to 15 in 2009, while many argue that it should be extended up to age 18.

Errors of exclusion instead have had more to do with gaps in take-up among eligible households, based initially on lack of knowledge about the grant, and requirements with respect to documents and procedures. The earlier problem has been greatly reduced—people generally know about the grant. The problems with the requirements still remain, although increased uptake figures imply that people have been navigating the process more easily than at earlier stages in the programme. The KwaZulu-Natal Income Dynamics Study in 2004 found that the main reason why people do not apply for the grant is the difficulty of obtaining documents, including the cost, time, complications, and difficulties accessing documents needed to obtain other documents (Woolard, Carter, & Agüero 2005; Hunter and Adato 2007b). For example, birth certificates are required to access the CSG, but there are various reasons why births are not registered, exacerbated by an AIDS-related context of extreme poverty, maternal illness and death, and increased mobility of children (Giese and Smith 2007). A review of studies of birth registration in South Africa found considerable provincial and local variability, with an inverse correlation between poverty and birth registration (Giese and Smith 2007). Another problem with the South African application method as currently implemented and staffed is that the administration is too burdensome on the welfare offices (Rosa, Leatt, & Hall 2005). As noted earlier, Coady, Grosh, and Hoddinott (2004) found that globally, targeting performance is less the result of the system type than its implementation. However, some in South Africa argue that the high costs, monetized and not, on administrators and beneficiaries, underscored by the fact of undercoverage of the poor in at least substantial part due to these burdens, make a case for eliminating the means test (Rosa, Leatt, & Hall 2005).

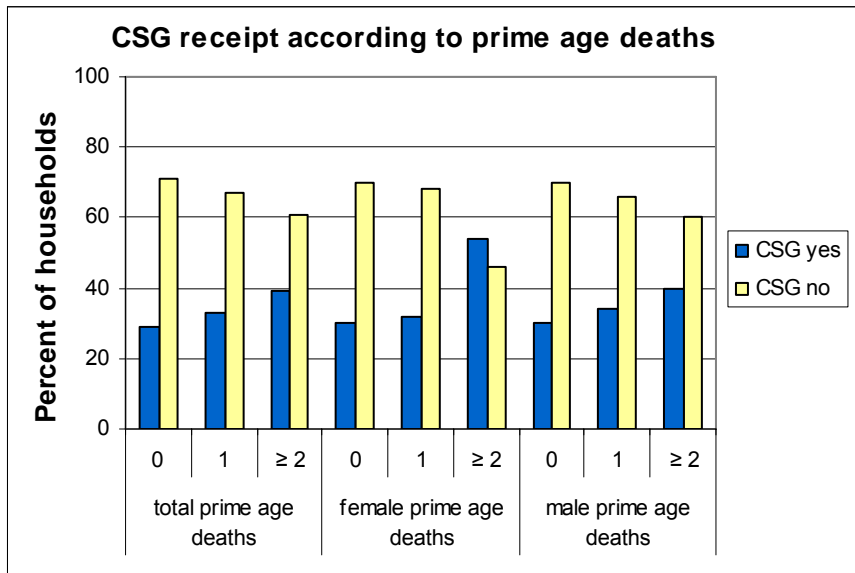
Add to this the likelihood that many of those not taking up the grant are AIDS-affected, and a stronger case could be made for simplifying the application process. Most studies that attempt to surmise the effectiveness of social grants in reaching AIDS-affected households use evidence on the impact of grants on children in high-prevalence regions, or on the impact of pensions on children (see Sections 7-9 on education, health, food consumption and nutrition), and assumptions as to the covariance of AIDS and poverty, and of AIDS-affected and fostering households. For example, Case, Hosegood, and Lund's (2005) study in the one region in KwaZulu-Natal found mixed results, based largely on low take up: only one-third of all age-eligible resident children had the grant accessed on their

behalf; among the poorest households, only 50% were receiving the grant. Among those with the grant, however, it appears to be well-targeted: recipient households were likely to have less educated and less employed parents and live in households with fewer assets and luxury items. This may be a self-targeting process, where better-off households for whom the grant would make up a smaller proportion of their household income find the time costs of applying and picking up the grant not worth the benefits. Children with deceased fathers were more likely to receive the grant, but the opposite was true for mothers—children living without mothers for all reasons were particularly at risk of not receiving the grant: 41% of children living with mothers received the grant vs. 29% with nonresident mothers, 23% with deceased mothers, and 19% with mothers of unknown status (Case, Hosegood, & Lund 2005, 472-480). This points to an important targeting challenge: how to reach out to children living in households without mothers.

Additional insight into how well the CSG and OAP reach AIDS-affected households is provided by data from 1,428 households in the 2004 KwaZulu-Natal Income Dynamics Survey (KIDS).³³ Using prime-age adult mortality between 1998 and 2004 as a proxy for AIDS-affected households, we look at cash grant receipts in those households. Figure 4.1 illustrates the trend in CSG receipt by number of household prime age deaths (note that for two or more deaths, the total numbers are small). As the number of prime age deaths per household increases, the percentage of households receiving the CSG increases. This effect is slightly larger among households that lose prime age women, compared to those that lose prime age men. This trend suggests that, among those who receive it, the CSG may be fairly well targeted to AIDS-affected households. However, Figure 4.1 also shows that many households, even those with two or more prime age deaths, do not receive the CSG—more than half in most cases, except among a small group of households with two or more prime-age female deaths. This is consistent with findings reported above from South Africa, suggesting undercoverage of poor, eligible, households. While the sample includes some households that do not meet the eligibility requirements for the CSG, because these data come from one of the poorest provinces in the country, we assume that far more of these households should be receiving the grant.

³³ We thank Futoshi Yamauchi for assistance with analyzing the KIDS data.

Figure 4.1. CSG targeting of AIDS-affected households

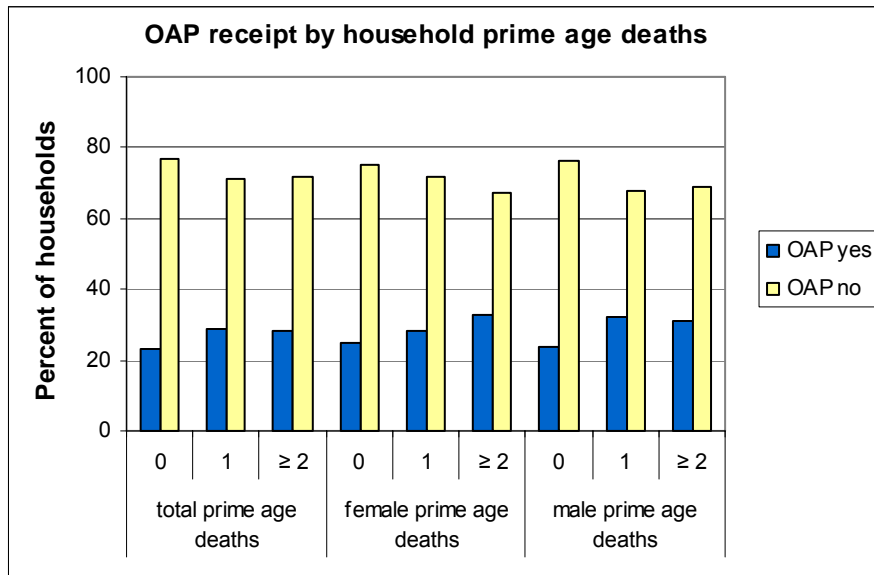


Source: KIDS data from 2004.

Figure 4.2 shows a similar trend for receipt of the OAP. Again, the trend shows a slight increase in coverage as the number of household prime age deaths increases, although weaker, and only consistently upward for prime-age female deaths. Like the CSG, the percentage of households *not* receiving the OAP is always greater than the percentage receiving the OAP. The meaning of this is less certain as we do not calculate how many of these households do not have elderly members.

We also tried another proxy for AIDS-affected households, the presence of fostered orphans, and found that only 30% of households fostering orphans were receiving the CSG. Despite the small overall sample size of 207 fostering households, this suggests that the CSG is not yet reaching this important category of AIDS-affected households. We do not know whether this finding to any extent represents better-off households (those not eligible for or choosing not to access the CSG) disproportionately fostering orphans.

Figure 4.2. OAP targeting of AIDS-affected households



Source: KIDS data from 2004.

Booyesen's (2004a) study in Free State Province in South Africa is able to directly assess targeting of AIDS-affected households because this sample is of households identified as experiencing morbidity or mortality due to AIDS. For 296 of these households, the OAP is accessed by over 80% (in two periods by as much as 90%), but the CSG by just between over 15 to over 35% of households, over a 19-month period. The Foster Care and Disability Grants reached fewer households. This is only at best representative of the two communities, but does suggest that the OAP is an effective means of reaching AIDS-affected households. Since it is likely that most of these households would be CSG-eligible, these communities appear to suffer from uptake problems as found elsewhere (Booyesen 2004a).

The South African grants that could arguably be most directly suited for AIDS-affected households are the Disability Grant and the Foster Care Grant, although they were not intended for this. The Disability Grant can be obtained by adults who are HIV-positive when their CD4 count falls below 200. The take-up rate was about 36% in 2000, but while higher take up would both reduce poverty (Samson et al. 2004) and help families with a very ill member, its potential reach for AIDS-affected families is very limited. The Foster Care Grant is a means tested grant for children determined to be "in need of care" regardless of whether their biological parents are alive (devised as part of the child

protection system), but orphans fall into this eligibility category. It is a much higher payment (about three times) than the CSG and much more complicated to obtain and monitor, involving court orders and referrals to social workers. It has increasingly been used to support families fostering children orphaned through AIDS, although take-up by eligible households is far more limited than the CSG. Among households who have accessed the grant, it appears to be well-targeted toward AIDS-affected families. Schubert et al. (2007) estimate that among FCG recipients about 50% are AIDS-affected. The FCG has been given considerable attention in social assistance policy with respect to children affected by HIV/AIDS. The national Minister of Social Development, in a 2002 address to the national Department of Education's HIV/AIDS conference, said that "The Department of Social Development is encouraging relatives to take care of orphaned children under the foster care package," and reaffirmed this in October 2004 in a DSD document stating that one of the Department's priorities was the "intensification of . . . registration of orphans for the Foster Care Grant" (South Africa 2004).

The higher grant provides much better support for households, and many have advocated for an aggressive expansion in response to the orphans crisis. A strong case has also been made, however, for why it is an inappropriate response (Meintjes et al. 2003). Aside from issues of prohibitive application burdens on beneficiaries (indicated by the low take-up) as well as burden on administrators and social workers (much greater than the CSG), it is argued that the FCG is fundamentally inequitable. The concern is that many children living with biological parents are just as impoverished and at risk, especially since many are living with ill parents, as children living with other relatives, and that there is no basis to give the latter a grant that is so much higher (the FCG) than the grant for the former (the CSG). The funds could instead go to raising the CSG or expanding it to children up to age 18. The FCG perhaps best illustrates the equity dilemma, and the constraints of political economy: while it is one of the few grants large enough to provide adequately for the needs of orphans and their fostering families, many (although not all) advocates for child welfare do not see it as a viable option.

5. To condition or not to condition: Key considerations and policy options

A major debate is occurring over whether or not cash transfers should be “conditional,” i.e., whether programmes should involve obligations on the part of beneficiaries, for example, to participate in preventative health-care services and keep their children in school. There is little research to date that directly compares conditional cash transfers (CCTs) and unconditional cash transfers (UCTs) in a given setting. The debate over conditionality is sometimes passionate and ideological, without enough evidence in support of either position, although there is some evidence supporting both. Below are five broad sets of issues to take into account when considering whether and under what circumstances to condition, evidence available to date, and a discussion of key concerns.

5.1 Appropriate design

As CCT programmes have been adopted in new countries across the world, they look very much alike. This is largely because the earlier programmes were widely considered to be very successful, e.g., those in Mexico, Brazil, and Nicaragua, and other countries have hoped to replicate results. Furthermore, many of the early programme adopters in Latin America had similar human capital deficits, reasons for these deficits, and objectives, and many countries around the world indeed share similar problems—e.g., discrimination against girls in schooling decisions. However, different countries have different levels of achievement and different failings with respect to human capital and other objectives, and different factors contributing to poverty. As reported in Section 7, the reason that CCT programmes in several countries had very low impact on primary school enrolment is that enrolment was already very high before the programme. Primary school enrolment does not need to be a condition of a CCT as often as it is. There are often regional variations, where, for example, primary enrolment is high nationally but very low in some parts of the country, as is the case in Turkey, which had a CCT for primary (as well as secondary) school nationally. Variations may also occur within countries across groups defined by sex, ethnicity, age, or other variables. CCTs can be designed to respond to these differences.

Relevant differences may also lie in the nature of shocks—HIV and AIDS being one important example—that can be reflected in programme design. In Tanzania and South

Africa, CCTs are being planned or considered that condition on STI testing; AIDS tests would be offered but not required (Richter et al. 2006; World Bank 2007a). In India a small programme conditions benefits on delaying marriage to age 18, and completing school (Chaudhury 2007). In Malawi, a new study will try to determine the effectiveness of a conditional cash transfer on promoting schooling and reducing risky sexual behaviour and HIV/AIDS risk among young girls (Ozler, Baird, & McIntosh 2007). There is growing interest in developing conditional programmes with Early Childhood Development services (World Bank 2006a, 36). Conditioning cash in some form has been used to create incentives for behaviour change in the area of sexual and reproductive health in Bangladesh, India and the U.S., and small studies have experimented with incentives for participation in HIV/STD prevention counselling and steps related to treatment goals (Mauldon 2003; Kamb et al. 1998; Petry et al. 2001; cited in Medlin and de Walque 2008). More recently a small CCT programme has been used to encourage use of Voluntary Counselling and Testing (VCT) services for HIV in a small study in Malawi (Thorton 2006; cited in Medlin and de Walque 2008). Given some successes in this area, it is a concept worth pursuing. However, these are areas that must always be approached very carefully. Depending on the outcomes pursued and indicators needed to determine these, there will be particular complications with respect to feasibility and ethics introduced where HIV prevention is the objective (Medlin and de Walque 2008).

There are two broad questions to ask in considering and designing a CCT: first, what are the priority problems that the programme should target? For example, is there an urgent need to provide basic subsistence to ensure survival or protect against destitution? This may be the case among families the hardest hit by AIDS. If so, then an unconditional transfer, of cash or food, is the most appropriate response. Or is the main objective to increase investment in children's health or education? For girls and/or boys, and at which ages? Are there particular micronutrient deficiencies to target?

Second, what are the *reasons* for these gaps? Is it people's lack of knowledge about, or an undervaluing of, prenatal health care or girls education? Or is it lack of access to nearby facilities? Or is it a cost issue, either the cost of transportation to the clinic, school fees, or the opportunity cost of child labour? Is child labour even a problem in the region? In Turkey, Adato et al. (2007) found that while cost was a major constraint on children's

schooling and thus a cash transfer responded to the problem, in some regions, other concerns were as or more important to schooling decisions: inadequate supply of nearby schools, inadequate transportation, unsafe schools, lack of perceived value of education (value to work for boys; value to marriage for girls); and other gender issues revolving around sexuality and threats to family reputation and honour. With respect to conditioning in the context of AIDS, other questions should be asked: does HIV and AIDS affect families' behaviour and constraints in particular ways, such that the conditions may not work, or may deny benefits to those who most need them? Are children in households with ill parents affected in particular ways? Is this related to care responsibilities, stigma, or emotional/psychological problems? What are the main influences on adolescent behaviour and choices? Do fostering families discriminate against orphans? Conditioning is a concept used to create incentives for change—the object of that change and ways to achieve it will vary widely from one context or another. Conditions, if used at all, should be developed flexibly and creatively to achieve carefully thought-through objectives.

5.2 Human capital impacts

Once the nature of the problems to be tackled, their underlying causes, and programme objectives are defined, the next issue to face is whether conditionality is necessary for achieving these objectives. What difference does it make? There is no reason to expect that UCTs would necessarily be less effective than CCTs with respect to short-term poverty reduction. There is more reason to believe that they might be less effective in increasing school enrolment and attendance, and use of health services, since with UCTs such participation would be optional rather than mandatory, and because supply-side interventions—such as building schools or contracting NGOs to deliver health series—sometimes accompany the CCTs. However, a UCT could also provide the cash needed for school fees or transportation, or to compensate for child labour, increasing school attendance without the conditionality. While we know that cash transfers can have an impact on human capital (see Sections 7-9), we do not know the relative importance of the different mechanisms through which either CCTs or UCTs work. Even rigorous CCT evaluations have presented results as a “black box,” studying the combined effects of all components on a given outcome, without assessing which components are responsible for which outcomes (Burtless 1995; Heckman and Smith 1995, cited in de Brauw and

Hoddinott 2008). Conditionality is one of those components—we know little about whether, to what extent, and under what conditions, conditionality would be responsible for increasing a particular outcome.

Evidence is beginning to emerge, however, and new research is being designed to answer this question. Simulating the impact on school enrolment of the conditional cash transfer *Bolsa Escola* in Brazil, and that of an unconditional transfer, Bourguignon, Ferreira, and Leite (2003) conclude that the main enrolment impact is due to the conditionality: among 10-15 year-olds not in school, about 60% enrol in response to the programme, whereas an unconditional cash transfer has no effect. Using a model for Mexico's CCT PROGRESA, Todd and Wolpin (2003, cited in de Janvry and Sadoulet 2006) attribute 80% of programme impact on enrolment to the conditionality, and 20% due to the income effect. Using data from Mexico, De Janvry et al. (2006, cited in de Janvry and Sadoulet 2006) also reach a similar conclusion on conditionality, finding that one dollar of CCT income is about eight times more effective at inducing enrolment than a dollar of UCT income, at mean income of the poor.

Two other studies take advantage of “accidental experiments” to assess conditionality. Data reflecting widespread implementation errors, such that transfers were not conditioned or people thought they were not, were used to construct a group on “unconditional” transfers to compare with a group on conditional transfers. The first study, by de Brauw and Hoddinott (2008), takes advantage of the fact that in Mexico's *PROGRESA*, some beneficiaries did not receive the forms needed to monitor school attendance. If the form was not received, attendance could not be monitored. In order to control for the fact that some households without the form might still have thought that attendance was required, this group was further divided into those who listed (on the evaluation survey) school attendance as a condition, and those who did not. A number of statistical techniques were used to ensure that results were not due to unobserved difference between the “conditioned” and “unconditioned” groups at the household or community level. The analysis found statistically significant impacts of conditionality: for all age groups who had completed grades 3-8, the “unconditioned” group enrolment rate was 5.4 percentage points lower than the “conditioned” group. This varied substantially at the grade level, however: the biggest impact was for children who had completed grade 6,

about to make the transition from primary to enrolling in lower secondary school, when many children are most likely to drop out. For this grade cohort, children in the “unconditioned” group (those who did not receive the enrolment form) were 18 to 20 percentage points less likely to enrol in school, whether or not the parents knew of the conditionality. For other grade levels, the differences were smaller and not always statistically significant, or the unconditioned groups were slightly more likely to enrol. Adding all parental, household, and community controls had little effect on the overall outcome, although there was some evidence suggesting that the impact of conditionality was greater when the household head was not literate. In the smaller sample of households that did not receive the enrolment forms and did not know the conditions, the overall enrolment rate was 9.1% lower, or 7% with all controls applied. These outcomes of conditionality are quite large compared with other education outcomes in the *PROGRESA* study (although the results are not directly comparable): for example, the enrolment impact of being in *PROGRESA* (as compared to not being in the programme) for children who completed grade 6 was only 8.3 percentage points (Schultz 2004), compared to the 18-20 percentage point increase in the conditionality impact analysis.

The second study of the programme *Bono de Desarrollo Humano* (BDH) in Ecuador (Schady and Araujo 2006) provides evidence that conditionality is important in increasing enrolment effects, although this evidence could be interpreted in different ways. The results of the impact evaluation found that the effect of the programme on school enrolment was an increase of between 9.8 and 12.8 percentage points. BDH was different from most CCTs in that school enrolment was not enforced; however, programme officials and television ads stressed the importance of enrolment, so that many households believed it was a requirement. The study thus tested a “conditionality impact” by splitting the beneficiary households into those who stated that there was an enrolment requirement, and those who did not, also using statistical techniques to control for other (observable) differences between the households (although not unobservables). It found that the programme effects on enrolment for “conditioned” households was 7.3 to 13 percentage points, while the effect on enrolment for “unconditioned” households was 1.4 to 2.1 percentage points. Significant programme effects were only found for those who believed there was an enrolment requirement.

Whether such results would be found in different African contexts is unknown. There are some reasons to believe they would not, or would not be as strong, discussed below. However, the magnitude of impacts found in Latin America and Asia, and the importance of strengthening human capital, make it worth exploring carefully. Research comparing UCTs with CCTs is currently underway or planned in Kenya, Zambia, Uganda, and South Africa (OVPMHA 2006; World Bank 2007c; MGLSD 2007; Richter, Streak, & Aber 2006).³⁴

5.3 Choice, autonomy, and power

One of the debates around CCTs revolves around the social implications of state-imposed behavioural change. Whether a CCT involves state imposition can itself be debated, since people can opt out. In this sense CCTs can be seen as a form of “self-targeting,” in the same way that public works are—in the latter people choose whether to work, weighing the costs vs. benefits. The state is not forcing behaviour change, but rather changing the “price” of decisions; with CCTs they are compensating parents for the loss of child labour so that the “price” of schooling becomes cheaper. A price subsidy could be seen in the same way—not forcing people to buy a certain item, but changing the price to influence choice. If, on the other hand, the policy decision is between an unconditional and conditional cash transfer, then comparatively there is a state imposition in the latter.

The imposition of conditionality is seen in the conditionality debate as both a problem and a strength, depending on one’s perspective. The problem lies in loss of autonomy implied by the imposition. Schubert and Slater (2006) argue that a conditionality cost-benefit analysis should take in account “the dimensions of human dignity, self-esteem and autonomyImposing conditions on people may smack of top-down attitudes of ‘we know better’ and ‘the poor cannot be trusted’” to make good decisions. While CCTs do have this flavor of paternalism, but it is not really an autonomous ‘decision’ either when parents take children out of school because they cannot afford fees and supplies, or

³⁴ Zambia had planned to test a “hard” conditionality and a “soft conditionality,” i.e., not enforced, but due to administrative costs it will only apply a soft conditionality of school attendance and an under-five health card. (MCDSS/TWG 2007b). This will reveal useful information on the added value of a soft conditionality, but will not reveal the impact of a hard conditionality. There is some question as to the extent to which hard conditions where adopted will be applied in other country programs, a point to look out for in assessing results.

because children are needed to work in the fields. In this sense, by decreasing the “cost” of a schooling decision, a CCT can be seen to increase parents’ real choices about whether to educate their children. On the other hand, a UCT would give them even greater choice. In laying out the pros and cons of conditionality, Samson raises the concern that conditions “deprive the poor of freedom to choose appropriate services—and to freely make decisions to improve household welfare” (Samson 2006). The fact that people choose to participate even without conditions is an indication that they do not necessarily need the state to impose them (although the question of the extent to which they will make these decisions with an unconditional rather than conditional transfer is not known). More controversially, reversing the autonomy argument, conditionality has also been advocated as a means of promoting citizenship, involving families as active agents in their own integrated development process (*Oportunidades* 2003, 58).³⁵

There is also a concern that CCTs are used to impose consumption of items preferred by the funder and curtail “undesirable spending” (Schubert and Slater 2006, 572). CCT programmes do usually involve communication to beneficiaries, normally during orientations, that cash should be spent on children, and spent by the woman, and food purchase is encouraged. However, beneficiaries are not required to spend the money in any particular way, i.e., this is not a conditionality. In Nicaragua, some of the community *promotoras*, the beneficiaries elected by the others to serve as their liaison with the programme, were checking shop receipts, creating the impression that spending on food was a requirement. But this was not a practice that the programme promoted or even approved of (Adato and Roopnaraine 2004). *Oportunidades* in Mexico actually sees the fact that beneficiaries decide how to spend the money according to their own priorities as part of the programme’s promotion of families as autonomous agents (*Oportunidades*

³⁵ *Oportunidades*’ policy strategy (*Oportunidades* 2003, 58) states [translation from Spanish] that it “considers of highest importance the strengthening of ‘co-responsibility’ of families through concrete actions to themselves improve and elevate their level of well-being The participation of families allows them to take on a role as active subjects in their own development. For them co-responsibility implies the challenge of acting as autonomous agents, capable of setting goals that conform to their aspirations and to work to realize them.”

2003).³⁶ A risk is that conditionality is prone to misinterpretations as in the Nicaragua case above, to rumor as people try to figure out how not to lose benefits, and to perverse incentives. Another example from Nicaragua is where people believed that an initial condition—requiring children to gain weight—was still in place, even though it had been dropped. In response, some mothers were stuffing their children with food and water on the growth monitoring days (Adato and Roopnaraine 2004). Another case of a possible perverse incentive was in the nutrition CCT in Brazil, *Bolsa Alimentação*, where an early evaluation found that child height-for-age had decreased by a small amount among participating households. A hypothesis based on anecdotal information (no research was conducted to investigate this) was that parents were withholding food from children because of a mistaken belief that growth improvements would lead to their being dropped from the programme. This had been the case with a previous programme providing milk powder for children, although it was not the case for the CCT (Morris et al. 2004). In Mexico and Nicaragua, there was a fair amount of stress generated by fears over losing the benefit, although this had more to do with the lack of understanding of the targeting system than to the conditionality (Adato and Roopnaraine 2004; Adato 2000). All of these examples point to the need for conditions to be carefully designed, and monitored to catch unanticipated consequences. They also point to the importance of effective and continuous communications with beneficiaries. In the CCT in Turkey, weakness in communications reduced programme impacts (Ahmed et al. 2007; Adato et al. 2007).

From an economics perspective, state influence on people's decisions can potentially be a strength for the broader society. If society places a value on certain outcomes, for example, a literate, educated female population, or children who are vaccinated against contagious diseases, then it may decide that the social benefits to imposing certain requirements outweigh the social costs to households that come from imposing a conditionality. Referred to by economists as "externalities," people sometimes make investment decisions that are not optimal from a societal standpoint. The most common example in the context of CCTs would be where parents choose not to continue their daughters' education. An

³⁶ *Oportunidades* strategic planning document states [translation from Spanish]: "To promote this co-responsibility, the benefits are given in a manner that respects social specificities of families, expanding their options and opportunities within a framework of taking decisions that are informed and responsible. Families best know their most pressing needs and decide how to spend their benefits. The program strengthens their knowledge about actions that contribute to improving their conditions through information provided through the health and nutrition workshops (*Oportunidades* 2003, 58).

example in the context of families affected by AIDS is where families fostering orphans may choose not to invest in the fostered children's health or education. Where society perceives a net benefit from altering household decisions, a CCT that changes the incentives to influence those decisions is a good thing.

There are a number of reasons why parents make decisions that are perceived by others as "suboptimal." In the case of education, they may not perceive a sufficient value in education because of the structure of the local economy and their position within it. There may be no jobs to employ graduates, or parents and children may not be aware of job opportunities from technological change or migration. Strengthening the economy and creating jobs could thus serve as a better incentive for educating children than a CCT. The need for the economy to be able to absorb new school graduates created by CCTs has been recognized as a major challenge in Mexico and Turkey.³⁷ There are also social bases for parents' schooling decisions. In parts of Turkey, some parents were reluctant to invest in their daughter's education where the benefits would be reaped by their in-laws when the girls marry; for others, too much education was seen as counterproductive to marriage (Adato et al. 2007). In these cases, people's choices may be the best ones for them given local economic or sociocultural realities. There are also reasons why poverty, culture, and historical processes of social exclusion and discrimination may prevent people from participating in activities regardless of the benefits. In these cases, it can be the very people most in need of cash transfers who are excluded.

The example of parents' decisions not to educate girls or fostered children speaks to another issue in this debate, that of power relations within the household. Households are not a homogenous entity with one will, which would exhibit one unified expression of autonomy. Rather, they are fraught with unequal power relations, where the will of more powerful members are imposed on the less powerful, the most common example being decisions against educating girls. For some families in Van province in Turkey, the conditionality provided state legitimation for decisions that ran counter to powerful biases against girls schooling, allowing women to make the case to their husbands that they must send their daughters to school (Adato et al. 2007). As in other cases of policies that enforce

³⁷ This point was made with respect to Mexico by Santiago Levy in a seminar at The Brookings Institution in 2007. The findings in Turkey are from Adato et al. 2007.

women's rights or protect them from violence through legislation or education campaigns, the state can be a force for positive (if not in everyone's eyes) social change.

5.4 Political economy

An argument in support of conditionality is that it is important for maintaining political support. This has two main dimensions. One relates to social attitudes toward the poor. Where poverty is seen as related to a lack of effort or responsibility (as Handa and Davis [2006] explain to be the case in Latin America) then setting reciprocal obligations makes programmes more palatable to policymakers and taxpayers, and can increase budget size and sustainability (de Janvry and Sadoulet 2006).³⁸ Schubert and Slater (2006) reply that socio-cultural, ethnic, and political attitudes toward the poor may be different in Africa and that this must be determined before assuming that conditioning benefits is necessary. The other dimension of a political economy perspective has to do with political interests, where politicians and policymakers may be evaluated by performance indicators such as changes in school enrolment or use of health clinics. CCTs provide a clear and measurable means of improving, monitoring and measuring these impacts. Conditionality has also increased the credibility of programmes where historically the public has been suspicious of antipoverty efforts that were deemed ineffectual (Adato and Hoddinott 2007).

5.5 Service availability and quality, costs, and administrative constraints

Probably the most important issue in considering conditionality is that of availability of the services on which to condition, and the administrative capacity to implement the system. The principle objection raised to conditionality for African cash transfer programmes is that there will not be sufficient quantity and quality of schools and clinics, within a reasonable distance or with adequate transportation, with reliable and sufficient staffing, skills, and supplies. Schubert and Mwiinga (2005), citing findings by Care International in Chipata in Eastern Province, Zambia, report that primary schools were turning away applicants because they had no space for them. They estimated an excess demand of about

³⁸ de Janvry and Sadoulet (2006) argue that this support will only come where the program involves a condition that the public sees as not met without the condition, e.g., it cannot be a primary school condition if attendance is already 95%. This seems contradictory, however, in that if families have achieved such a high attendance rate, then they might seem particularly "deserving."

20% beyond capacity. Leatt and Budlender (2006, 4) explain how in South Africa, eligibility for the Child Support Grant originally required proof of child immunizations—a condition dropped when it became clear that it discriminated against those without access to health services—and required participation in development programmes—dropped because they did not exist. One of the main problems with the grant was slow take up; once these requirements were dropped, take up advanced rapidly. On the other hand, demand-side interventions have made a difference in many countries, as seen in the many evaluations of CCT programmes, as well as the CCT vs. UCT comparisons cited above. Probably demand plus supply interventions will be the most effective: In Bangladesh, for example, a study compared a supply-side grants-to-schools intervention with one that combined these grants with an educational allowance for students. It found that the supply-side intervention alone had no significant impact, but that the combined intervention had a large impact on school enrolment (Ahmed 2006. See Section 7.2 for more details).

The idea of conditioning on a nonexistent service is unlikely, so the supply-side concern is sometimes overstated. Where it becomes problematic is with respect to capacity, distance, transportation, supplies, and quality, where “access” becomes more subjective. The other problem concerns geographic targeting: if only regions with service access become part of the CCT, then people who are already most disadvantaged, living in the poorest, least served areas, who are also most likely to need the cash transfer, will not get the programme. Programme designs can adapt in other ways to supply constraints, however. In the proposed pilot CCT in Uganda, the conditionality does not apply to the elderly, disabled, others with mobility problems, or those with long distances to schools or clinics (MGLSD 2007).

There is, however, another side of the supply argument. Precisely because CCTs require adequate services, they can serve as a strong impetus for increasing quantity and quality of services, putting pressure on governments, and respective departments, to increase supply. CCTs are often joint undertakings by ministries of social development or welfare, education, and health, requiring intersectoral collaboration—in fact the ability to achieve this is another prerequisite for a CCT. Farrington and Slater (2006) argue that conditionality may not promote increased supply because health and education services

remain largely in the public domain, which is less responsive to demand. While this may often be true, ministries of health and education are participating in CCTs in many countries. In Nicaragua, *Red de Protección Social* (RPS) “forced” important supply-side improvements (Maluccio, Murphy, & Regalia 2006). Honduras’ CCT programme, *Programa de Asignación Familiar (PRAF)*, consisted of two “packages,” a demand-side package of conditional transfers to families, and a second package called “supply-side incentives” consisting of cash transfers to the Healthcare Provision Units (UPS)—conditioned on their undertaking quality improvements—and to the schools. Teachers also participated in a continuous training programme to improve their math and Spanish teaching (IFPRI 2003b). Nicaragua’s supply-side component was successful; Honduras’ was not, which was in part responsible for the latter country’s low impacts. In Nicaragua, where the government health services could not meet new demand, NGOs were contracted to supply health services and monitor participation. Because of the large NGO presence in the health sector already in Africa, they are likely to play a large role in a CCT programme. To what extent African governments will step up to the supply-side task, either themselves or through contracting NGOs, is another open question. Their new involvement in cash transfer schemes, conditional and unconditional, indicates some will as a starting point.

Another major consideration is that of capacity to administer the conditionality. In the African context, Schubert and Slater (2006) point to limited administrative skills, low salaries, lack of guidance, lack of supervision, little experience with results-oriented management, need for behaviour change, and weak ministries, particularly in social welfare. They argue that transfer schemes should thus be kept as uncomplicated as possible. These problems will apply to unconditional transfers as well, but monitoring and enforcing conditions does introduce significant additional burdens. In South Africa, Leatt and Budlender (2006) cite too few school inspectors and no database to verify attendance. These are serious concerns to confront if considering a CCT. Lack of current capacity does not mean that building the capacity is impossible, however. Many much poorer countries (e.g., Bangladesh and Nicaragua) monitor attendance (via teachers) and presumably this is a goal that South Africa should set apart from the question of CCTs. Whether teachers will report absences and deprive families of resources in the context of communities suffering extreme poverty and illness, with so many vulnerable children, is another question. This question can only be answered empirically.

Finally, an important dimension of capacity is that of the cost of conditionality, for service delivery as well as setting, monitoring, and enforcing conditions, which are data and management-intensive processes. Any analysis of benefits vs. costs of conditionality should bear in mind that neither the economic benefits nor even costs are easy to quantify (although the costs are easier to quantify than the benefits), much less the social benefits and costs. In the case of *PROGRESA* in Mexico, conditionality represented approximately 18% of programme costs, on average, between 1997 and 2000. In Honduras' *PRAF*, conditionality costs averaged about 9% over three years, and in Nicaragua the cost averaged about 3% over two years (Caldés, Coady, & Maluccio 2006). Funds otherwise used to implement conditionality could instead be used to distribute more benefits (Campbell et al. 2007), although this brings us back to the overall cost-benefit analysis.

Whether it is supply-side components or administrative capacity for delivery or monitoring conditions, each must be adapted to local circumstances. For many reasons—from selecting objectives that make sense, to designing a feasible programme—CCT programmes should not be blueprints of each other, but rather be adapted to local circumstances so that they are relevant to the problem at hand and can work. Where families are affected by AIDS, incentives can be structured to meet appropriate, priority objectives. Poorer countries with less capacity can adopt simpler designs, with fewer conditions, or “soft conditions” that are not enforced. Beneficiaries can sign a paper or consent by oral agreement to meet conditions, with no sanction carried out if they do not. Exemptions can be made for people who cannot meet the conditions. Another approach is to link cash transfer programmes to complementary but not required activities, e.g., service delivery, information or training (discussed further in Sections 7-10).

6. Poverty impacts of cash transfer programmes

Cash transfer programmes are increasingly used as a component of poverty reduction strategies. The degree to which these programmes affect poverty on a broad level varies by country and programme, and is affected by the poverty rate in each country, the size of the target population, and the size of the transfer, among other factors. Poverty reduction can be evaluated using three different measures, known as the Foster, Greer, and Thorbecke class of poverty measures (Foster, Greer, & Thorbecke 1984). The poverty headcount measure represents the share of the population that is poor, i.e., the proportion of the population for which income or consumption falls below the poverty line. The poverty gap measure describes the depth of poverty in a given population. Defined as the mean distance separating the poor from the poverty line (the nonpoor having a mean distance of zero), the poverty gap corresponds to the amount of resources that would be needed to pull the poor up to the poverty line. The severity of poverty measure, or the squared poverty gap, takes inequality of the poor into account by weighing the extreme poor, who fall far below the poverty line, more heavily than the less poor, who may hover just below the poverty line (Coudel, Hentschel, & Wodon 2002, 405-407).

These measures are best used in combination because they provide different kinds of information about poverty. Using the headcount measure, a policy that benefits those just below the poverty line would appear as effective as a policy that brought the extreme poor closer to the poverty line. Adding the poverty gap and severity of poverty measures to a poverty analysis captures the effect of a poverty intervention on all poor households no matter where they fall below the poverty line, thereby providing a more complete picture of potential programme impacts.

For each of these measures, a poverty line, or minimum income or expenditure necessary to keep a household out of poverty, must be defined. Poverty lines vary according to different assumptions and methodologies. For example, adjustments of consumption based on age or gender or assumptions of economies of scale can affect a household-level poverty line. Poverty lines can be constructed based on income or expenditure measures. Expenditure is generally preferred because, compared to income, it is a more direct measure of consumption. When households experience economic hardship, they are likely

to smooth their consumption by borrowing or using household savings. Therefore, expenditure, rather than income, is likely to be a more dependable indicator of household welfare. And, in many developing countries, income is much harder to capture, because many people work in the informal sector and because self-reported income is frequently inaccurate (Samson et al. 2004, 22).

6.1 Impacts of unconditional cash transfer programmes on poverty

Estimates of the poverty impacts of unconditional cash transfers (see Table 6.1) come primarily from South Africa, and mostly from the Old-Age Pension. Case and Deaton (1998) estimated that the national poverty headcount (using a \$1/day poverty line) would have been five percentage points higher without the Old-Age Pension (40% without the pension compared to 35% with the pension). The authors asserted that this result was independent of the choice of poverty line (Case and Deaton 1998, 1342). Comparing total household income to income minus pension income, Barrientos (2004) found that the pension resulted in impacts of slightly smaller magnitude on headcount poverty rates (2 percentage points, from 43 to 41%), and a 10.4% reduction in the average poverty gap (Barrientos 2004, 17). Jensen (2003) found a much larger poverty impact of the Old-Age Pension in the Venda region: a 26-percentage-point reduction in the poverty rate among elderly households, taking into account crowding out associated with pension receipt (Jensen 2003, 110).

Booyesen (2004b) estimated the impact of four social grants on HIV-affected households, both urban and rural, in Free State Province, using a purposive sample of 351 HIV-affected households. Each household included at least one person known to be HIV-positive or known to have died from AIDS in the past 6 months (Booyesen 2004b, 5). The Child Support Grant reduced the incidence of poverty among HIV-affected households by 8%, the poverty gap by 15%, and the severity of poverty by 20%. The Foster Care Grant (three times as large as the CSG) and the Old-Age Pension (more than four times as large as the CSG) had an even larger impact on poverty reduction among HIV-affected households, reducing the headcount poverty by 6%, the poverty gap by 20%, and the severity of poverty by 33%. The OAP reduced headcount poverty by 48%, the poverty gap by 61%, and the severity of poverty by 75% (Booyesen 2004b, 16). While the sampling design and sample

size mean that this household impact study cannot be generalized across South Africa, the results suggest that social grants have had an important impact on HIV-affected households.

With an average transfer of \$1.14 per person per month,³⁹ representing 12.7% of mean gross consumption expenditure, the GAPVU cash transfer programme in Mozambique was estimated to have contributed to a reduction in headcount poverty of 6 percentage points and, more significantly, to reductions in the poverty gap and poverty severity of 27% and 44%, respectively. Cash benefits were fairly constant across income deciles, but represented a much larger share of income for poorer deciles, helping to reduce the poverty gap and severity of poverty (Datt et al. 1997, 46-47, 51). This study focused exclusively on rural areas and had no control group, so results cannot be generalized to a broader population and do not establish causality.

Table 6.1. Summary of impacts of unconditional cash transfers on poverty

Country/Programme	Headcount Poverty	Poverty Gap	Poverty Severity
South Africa all grants	-7.2%	-22%	
South Africa OAP	-5% pts -2.8% pts (-2.3 % pts indigence headcount) -48% (HIV-affected households)	-81% (-20% indigence poverty gap) -61% (HIV-affected households)	-75% (HIV-affected households)
South Africa CSG	-8% (HIV-affected households)	-15% (HIV-affected households)	-20% (HIV-affected households)
South Africa FCG	-6% (HIV-affected households)	-20% (HIV-affected households)	-33% (HIV-affected households)
Mozambique GAPVU	-6 % pts	-27%	-44%
Uganda (projected)	No impact	-15%	

Sources: Barrientos, 2003; Booysen, 2004b; Case and Deaton, 1998; Datt et al., 1997; Samson et al., 2004.

6.2 Simulated impacts of unconditional cash transfer programmes on poverty

While there is growing documentation of poverty reduction impacts from conditional cash transfer programmes in Latin America (discussed below), in Africa empirical evidence remains limited. Given this lacuna, several authors have conducted simulations of the poverty impacts of social transfers in Sub-Saharan Africa, using different transfer sizes,

³⁹ Transfer was Mt 10,353, converted to dollars at the May-August 1995 exchange rate (IMF 1996, cited in Datt et al. 1997, 45) of US\$1 = Mt 9,045 (Datt et al. 1997, 45).

targeting mechanisms, and poverty measures to predict the range of impacts that can be expected.

Samson et al. (2004) analyzed the role of three of the country's six social grants—the State Old Age Pension (OAP), the Child Support Grant (CSG), and the Disability Grant (DG)—in reducing poverty at the national level. The study utilized a micro-simulation model developed by the Economic Policy Research Institute (EPRI) to assess the three grants, both in their current form and under different scenarios with variations in take-up and transfer size.

Samson et al. used an absolute poverty line that was created based on the cost of basic needs method, employing cost data from South Africa's Household Subsistence Level (HSL) survey on the cost, in urban areas, of food, housing, transport, clothing, and necessary household items. Notably, education costs were excluded, even though school expenses comprised part of basic needs for many South African families. The HSL accounts for variation in consumption requirements by age and gender and regional food price variation (Samson et al. 2004, 18). Using this data, EPRI constructed an absolute poverty line specific to each province in South Africa, utilizing several poverty lines, including scaled (adjusted for economies of scale and adult equivalency⁴⁰) and unscaled poverty lines (Samson et al. 2004, 24-25, 31).⁴¹

To estimate the impact of existing social grants on poverty, Samson et al. simulated a scenario of no social assistance by calculating the income of all grant-receiving households exclusive of grants and estimating the resulting headcount and poverty gap measures based on income with and without grants. Results showed that at the national level, social grants would reduce headcount poverty by 7.2% and the average poverty gap by more than 22%.⁴² This masks considerable variation across provinces, from the highest rate of

⁴⁰ The convention in literature on poverty lines in South Africa has been to give children under 18 the weight of half an adult equivalent and to account for economies of scale with an exponential scale of 0.9. However, these numbers are not based on empirical studies for South African household economies (Samson et al. 2004, 23).

⁴¹ The poverty lines are HSL poverty line based on expenditure data from HSL survey (311 rand/person); Committee of Inquiry poverty lines based on terms of reference of the Taylor Committee of Inquiry (394 rand/adult equivalent) (variations: scaled and unscaled; based on both income and expenditure); Destitution poverty line, the lowest 20% of households in the income distribution (scaled) (R180/person/month); Relative poverty line, the lowest 40% of households (based on expenditure and scaled).

⁴² These numbers vary by poverty line used.

household poverty headcount reduction in Western Cape at 21.9% and the lowest rate in the Free State at 3.9%. Nationally, social grants would reduce the poverty gap ratio by 14.6 percentage points (based on mean income) and 13.6 percentage points (based on median income) and the rand poverty gap by 29%, or about 12.8 billion dollars. This amount represents what it would take to eliminate poverty in South Africa.

Overall, Samson's results illustrate that South Africa's social grants have contributed to poverty reduction, but impacts vary depending on the choice of poverty line and methodology for quantifying impact. Similarly, there is notable variation in the potential poverty impacts of each type of grant (see Table 6.2). With respect to expanding take-up, the OAP with full take-up would have small impacts on all poverty measures because coverage is already quite high and most of the elderly who would be eligible are less poor. However, extension of the CSG is likely to have significant poverty reduction impact, particularly if age-eligibility is raised from the current level of age 14 to age 18 and transfer value is adjusted to current day value.

Table 6.2. Summary of impacts of South African social grants (assuming full take-up)

Programme	Poverty headcount	Poverty gap
Old Age Pension	-1.5% to -4.5%	-3.8% to -6.2%
Child Support Grant (to age 18)	-12.4% to -35.6%	-29.9% to -58.7%
All social security grants	-15.2% to -45.4%	-33.5% to -58.6%

Source: Samson et al. 2004.

Notes: Range reflects different poverty lines. Poverty headcount is measured for individuals and poverty gap is the aggregate national poverty gap.

Gassmann and Behrendt (2006) simulate the impact of several types of social transfers in Tanzania and Senegal including an old-age and disability pension, a universal child transfer, and a targeted transfer for vulnerable households. Data from both countries come from nationally representative household budget surveys. The micro-simulations are based on household consumption measured by expenditures and utilize a food poverty line and a basic poverty line.⁴³ Both poverty lines are calculated per adult equivalent. The study assesses the impact of several types of transfers. The basic old-age and disability pension entitles all individuals 60 or older (and those 15-59 who are disabled only in Senegal), regardless of income or other social assistance benefits, to a transfer representing

⁴³ For both countries, the food poverty line is based on the cost of a food basket covering specified daily calorie requirements (2,400 kcal per adult equivalent in Senegal and 2,200 in Tanzania). The basic poverty line is adjusted to account for the need for nonfood goods and services (Gassmann and Behrendt, 2006).

70% of the food poverty line per person. In Tanzania this represents about \$10 PPP⁴⁴ and for Senegal about \$30 PPP, considered sufficient to lift the elderly out of poverty in each country. The universal child benefit covers all school-age children (7-14) and orphans below age 7 only in Tanzania, and provides 35% of the food poverty line per eligible child, representing just under \$5 PPP in Tanzania and \$15 in Senegal. The targeted cash transfer provides the equivalent value of the old-age pension to vulnerable households, defined as those without able-bodied household member (members under age 20 or over age 59 or are sick, injured, or handicapped) (Gassmann and Behrendt 2006, 19).

Table 6.3 below shows the range of headcount poverty impacts of an old-age pension in Senegal and Tanzania. Impacts are greater in Senegal because pension coverage is higher (in part due to the modeling of a benefit for disabled individuals). However, results from both countries show that noncontributory old-age pensions reduce poverty, not only among the elderly who are direct beneficiaries, but also for households with children and without able-bodied members. In each country, the poverty gap is reduced by about 1 percentage point, representing a 20% reduction in Senegal and an 18% reduction in Tanzania.

Table 6.3. Impact of old-age pension on headcount poverty

	Senegal	Tanzania
Overall	-3% pts; -15%	-2% pts; -9%
Children (0-14 years)	Girls: -2.7% pts; -13% Boys: -3% pts; -14%	Girls: -1.7% pts; -7% Boys: -1.7% pts; -7%
Households with children (0-14)	-3% pts; -15%	-1.9% pt; -8%
Households without able-bodied member	-3.9% pts; -51%	-2.5% pts; -13%

Source: Gassmann and Behrendt, 2006.

The targeted cash transfer demonstrates a powerful impact on headcount poverty of the target group (households without an able-bodied member), particularly in Tanzania (see Tables 6.4 and 6.5 below). Although the transfer would not have a large impact on overall headcount poverty, especially in Senegal, it would reduce the poverty gap in both countries, very significantly for the target group.

⁴⁴ PPP=Purchasing Power Parity.

Table 6.4. Impact of targeted transfer on headcount poverty

	Senegal	Tanzania
Overall	-2.2% pts; -1%	-1.4% pts; -6%
Children (0-14 years)	Girls: -1.1% pts; -0.5% Boys: -2.2% pts; -0.5%	Girls: -1.8% pts; -7% Boys: -1.5% pts; -6%
Households with children (0-14)	-0.2% pts; -1%	-1.5% pts; -6%
Households w/o able-bodied member	-3.9% pts; -51%	-8.4% pts; -43%

Table 6.5. Impact of targeted transfer on poverty gap

	Senegal	Tanzania
Overall	-6%	-15%
Children (0-14 years)		
Households w/o able-bodied member	0.8% pts; -50%	-4.9% pts; -93%

Source: Gassmann and Behrendt, 2006.

Looking beyond these country examples, a set of simulations by Kakwani, Soares, and Son (2005) and Kakwani and Subbarao (2005) examines the poverty impacts of cash transfers and social pensions in 15 countries in Sub-Saharan Africa. The countries were chosen based on data availability, but also because they are broadly representative of the whole of Sub-Saharan Africa, with representation from East and West Africa as well as high and low HIV/AIDS prevalence (Kakwani, Soares, & Son 2005, 16, 2). Both studies use unit-record household data sets from the 15 countries, which have been standardized (all use a systematic set of variables) by the World Bank for the purpose of comparing welfare across countries (Kakwani, Soares, & Son 2006, 555).

The first simulation is an ex-ante assessment of the impact of a cash transfer on national poverty using several cash transfer scenarios.⁴⁵ First, the authors designate a transfer budget based on a specific share of the country's GDP. The authors select 0.5% because they assume that African countries would need larger programmes than those provided by existing CCTs in richer Latin America, which represent between 0.1 and 0.2% of gross national income (Kakwani, Soares, & Son 2005: 18). Under the 0.5% of GDP budget allocation, there are three scenarios: universal targeting (transfer for every child 5-16), poverty and geographical targeting (transfer for poor children and children in rural areas), and progressive targeting (after a common base transfer, the transfer value rises by 5% according to the child's age). Finally, the authors simulate a transfer not as a percentage of

⁴⁵ Estimates use the national poverty line for each country, which the authors have adjusted for equivalence and household economies of scale. For years in which there was no poverty line available, the authors used the consumer price index to adjust poverty lines to correspond to survey years (Kakwani, Soares, & Son 2005, 16; Kakwani, Soares, & Son 2006, 555).

GDP, but instead as a proportion of the national poverty line (20, 30, or 40%). Simulations assume that transfers provided to children are pooled within families and allocated such that each family member enjoys the same level of welfare (Kakwani, Soares, & Son 2005, 17, 33).

A transfer representing 0.5% of GDP to all school-aged children brings about little impact on the headcount ratio, but much greater impacts on the poverty gap and severity of poverty indices. Although 0.5% of GDP is insufficient to bring about significant poverty reduction (particularly when measured by headcount) in the short term, the impact would likely be higher if the transfers were made over a longer time period, if accompanied by positive economic growth. Additional results show that the impact on poverty is higher when transfers are made to rural children rather than all children and that there is little difference in impact between a progressive transfer and a fixed value transfer across age groups (Kakwani, Soares, & Son 2005, 35, 38).

A transfer proportional to the poverty line has a much greater impact than one equivalent to 0.5% of GDP. Table 6.6 shows the poverty impacts of a transfer given to all children 5-16 representing 30% of the average poverty line. Here, even headcount poverty is affected.

Table 6.6. Percent change in poverty from a transfer of 30% of the average poverty line

Country	Headcount ratio	Poverty gap ratio	Severity of poverty
Burundi	14.1	28.5	38.9
Burkina Faso	18.6	33.1	42.7
Cote d'Ivoire	23	34.9	43
Cameroon	15.5	29.3	39.9
Ethiopia	24.7	40	49.1
Ghana	16	30.1	40.5
Guinea	17.4	34	45.6
Gambia	11.1	26.6	37.7
Kenya	15.9	33.7	45.4
Madagascar	8.2	23.9	35.5
Mozambique	8.6	25.9	37.6
Malawi	10.3	24.5	35
Nigeria	10.6	24.7	36.3
Uganda	18.2	33.3	43.8
Zambia	8.1	20.6	30.4

Source: Kakwani, Soares, & Son 2005.

Note: Transfer to all children 5-16 years.

A transfer equivalent to 30% of the poverty line is slightly larger than the value of Kenya's cash transfer and smaller than those provided in Zambia and Malawi. Kenya's Cash

Transfers for Orphan and Vulnerable Children Programme (providing about \$20 per OVC per month) is, on average, equivalent to 12% of the poverty line and 24% of the ultra poverty line (OVPMHA; UNICEF/Kenya 2007a).⁴⁶ In Zambia, the Social Cash Transfer Scheme transfer (\$10 per household per month, plus an additional \$2.50 if the household has children) represents 55% of the 2003 national basic poverty line (calculation based on MCDSS/GTZ 2007, 8; Demombynes 2005).⁴⁷ In Malawi, the average transfer of \$12/month represents more than 100% of the 2005 national poverty line (calculation based on Schubert and Huijbregts 2006; Malawi/World Bank 2005, 4).⁴⁸

The second study by Kakwani and Subbarao (2005) focuses on the poverty impact of social pensions in the same 15 African countries. The methodology is similar to the study described above in that scenarios are defined in terms of a fixed budget (0.5% of GDP in local currency) and a fixed benefit level (equal to 35 and 70%⁴⁹ of the national poverty threshold expenditure level). Impacts on headcount ratio and poverty gap ratio are measured under several targeting alternatives: perfect targeting,⁵⁰ universal targeting, and targeting different household types (all elderly regardless of income, elderly living with children but no prime age adults, poor elderly, and households headed by elderly) (Kakwani and Subbarao, 2005, 6, 17).

The simulations suggest that targeting a social pension of 0.5% of GDP to elderly-headed households, elderly living with children, and poor elderly would bring about greater poverty reduction (both headcount and poverty gap) gains than a universal elderly pension. Overall, targeting a pension to the poor elderly over age 65 (rather than to all elderly) would produce the best results in all of the 15 countries (Kakwani and Subbarao 2005, 20, 23).

⁴⁶ These figures refer to the rural poverty line of 2,228 ksh and assume an average family size of 5.5 people. Ultra poverty is half the poverty line (UNICEF/Kenya 2007a).

⁴⁷ According to Demombynes (2005), the national poverty line in 2003 was 73,394 kwacha.

⁴⁸ The national poverty line is MK16,165/person/year and the ultra poverty line is MK10,029/person/year. The average transfer per year is MK20,400, or \$144 (Schubert and Huijbregts 2006 and The Ministry of Economic Planning and Development, National Statistical Office and The World Bank, 4).

⁴⁹ The authors choose this value due to the significant poverty gap that characterizes some vulnerable groups, such as the elderly with children (Kakwani and Subbarao 2005, 19).

⁵⁰ This is defined as “filling the poverty gap,” i.e., bringing everyone up to the poverty line (Kakwani and Subbarao, 2005).

Kakwani and Subbarao (2005) summarize the expected impact on poverty headcount in each of the 15 countries if a social pension of 35% of the average poverty line were transferred to poor elderly: headcount poverty would fall by just under 1% to 2.3%. If 70% of the average poverty line was transferred, the headcount poverty would fall by 1.5 to 4.6%.

According to calculations by the Ministry of Gender, Labour and Social Development (MGLSD) in Uganda, the currently proposed basic household transfer of \$10⁵¹ provided to all poor households would be insufficient to lift these households up to the poverty line, so would have no effect on the poverty headcount. However, this transfer was predicted to reduce the poverty gap by 15% (from 8.7 to 7.4%). Adding supplementary transfers of \$1.14⁵² for each child 0-17, elderly person above 60, and person with a disability in the household (up to a limit of five supplementary transfers per household) would bring about a 20% reduction in the national poverty gap (driving the poverty gap down to 6.8%) (MGLSD 2007, 22-23).

6.3 Impacts of conditional cash transfer programmes on poverty

In addition to promoting investment in human capital for long-run poverty reduction, CCTs aim to alleviate current poverty among programme beneficiaries. Table 6.7 outlines the impacts of four CCT programmes on headcount poverty, the poverty gap, and poverty severity. Below is more detail on each programme's poverty impacts.

⁵¹ The basic household transfer is Sh 18,000 (MGLSD, 2007, 22).

⁵² The supplementary transfer is Sh 2,000 (MGLSD, 2007, 22).

Table 6.7. Impacts of CCT programmes on poverty

Country/Programme	Headcount Poverty	Poverty Gap	Poverty Severity
Nicaragua RPS	Poverty: -10% pts (2001), -5% pts (2002) Extreme poverty: -21% pts (2001), -15% pts (2002)		
Mexico PROGRESA	Simulation: -10% Census and surveys: -17%	Simulation: -30% Census and surveys: -36%	Simulation: -45% Census and surveys: -46%
Brazil Bolsa Escola	-1% pt; -3.2%	-1.1% pt; -8.1% ^a	-1% pt; -12.3%*
Colombia Familias en Acción	Poverty: -1.3% pts (not statistically significant) Severe poverty: -5.9% pts (rural); -5.8% pts (urban)	-3.7% pts (rural and urban)	

Sources: Atanasio and Gomez, 2004; Bourguignon, Ferreira, & Leite, 2003; Maluccio and Flores, 2005; Skoufias, 2005.

^a Author's calculations.

Nicaragua's RPS provided an average monetary transfer of \$272/year to beneficiary families, representing 18% of average monthly household expenditure for poor households and 30% for extremely poor households⁵³ (Maluccio and Flores, 2005, 29). In the first year of the evaluation (2001), when expenditures fell for the control group due to a general economic downturn in RPS areas, resulting from a drought and plummeting international coffee prices, RPS transfers protected beneficiary households from losing income during the economic slump. The double-difference⁵⁴ estimate of RPS programme impact on annual total household expenditures for 2001 was \$322 and for 2002 was \$219. In per capita terms, the estimated average effect of RPS on annual total household expenditures was \$77 in 2001 and \$53 in 2002. For poor households, this translated into a large change in expenditures, leading to a reduction in headcount poverty of 10 percentage points in 2001 and 5 percentage points in 2002. Extreme poverty fell by even more: 22 percentage points in 2001 and 16 percentage points in 2002 (Maluccio and Flores, 2005, 27-29). Considering that income per capita was essentially unchanged over the evaluation period (World Bank, 2004b, as cited in Maluccio and Flores, 2005, 26), this is a large effect. According to additional analysis by the World Bank, RPS reduced headcount poverty by 10 percentage points in 2001 and 6.7 percentage points in 2002; the poverty gap by 13.3 percentage points in 2001 and 9.8 percentage points in 2002, and the severity of poverty

⁵³ In 2000, when the baseline data were collected for the RPS impact evaluation in Nicaragua, 36–61% of the rural population in RPS municipalities were extremely poor and 78–90% were extremely poor or poor; in the *comarcas* selected for the RPS evaluation, 42% were extremely poor and 80% were extremely poor or poor.

⁵⁴ This refers to the comparison of control and treatment groups at baseline and evaluation interval, so that differences between these groups at baseline, and changes in both groups not attributable to the program, are subtracted from reported impacts, in order to identify program impacts. This is further explained in Section 7.

by 11.3 percentage points in 2001 and 8.7 percentage points in 2002 (Schady and Fiszbein, 2007).

Between 2002 and 2004, Colombia's CCT, *Familias en Acción*, which provided an average monetary benefit of \$20/family/month (Handa and Davis, 2006), had a significant impact on the proportion of households living in extreme poverty, with a reduction of 5.9 percentage points in rural areas and 5.8 percentage points in urban areas. The impact on the proportion of people living in poverty was small in rural areas (1.2 percentage points) and inconsequential in urban areas (0.19 percentage points) (neither impact is statistically significant) (Attanasio and Gomez, 2004, 118). Overall, the programme reduced the poverty headcount by 1.3 percentage points and the poverty gap by 3.7 percentage points. The Gini coefficient fell by 1.2 percentage points, suggesting that national-level inequality fell slightly. In sum, the programme seems to have had a greater impact on poverty for the poorest among the poor and those living in rural areas. Furthermore, the programme contributed to reductions in current poverty, but not chronic poverty. This is to be expected since programme impact was only measured in the short-to-medium term and human capital investments thought to contribute to reducing long-term poverty take longer to take effect (Attanasio and Gomez, 2004, 120-121).

According to an ex-ante evaluation of Brazil's *Bolsa Escola*, which simulated programme impact using micro-econometrically estimated models, the programme has only a moderate impact on poverty and inequality. An average monthly transfer of R15 (or \$6.60)/child/month⁵⁵ would imply a 1-percentage point reduction in headcount poverty, or a 3.2% reduction. The poverty gap would fall proportionately more (from 13.5 to 12.4%, representing a reduction of 8.1%) and the poverty severity by even more (from 8.1 to 7.1%, representing a reduction of 12.3%) (Bourguignon, Ferreira, & Leite, 2003, 20). Doubling the transfer amount would reduce the headcount only slightly (by another 1.3 percentage points, or 7.5%), but would imply more significant reductions in the poverty gap (2.3 percentage points, or 17%) and the severity of poverty (1.9 percentage points, or 23%) (Bourguignon, Ferreira, & Leite, 2003, 31). The authors note that their results are significantly lower than arithmetic simulations by Camargo and Ferreira (2001), which suggest that a similar, but broader programme with much larger transfers, would reduce

⁵⁵ Based on exchange rate of 1 real = \$0.44.

the incidence of poverty (using the same poverty line and sample) by two-thirds, from 30.5 to 9.9% (Bourguignon, Ferreira, & Leite, 2003, 21).

Mexico's *PROGRESA* provided an average monetary benefit of \$13/family/month, equivalent to 20% of mean household consumption (Schady, 2006; Skoufias, 2005). Skoufias (2005) describes methods used to assess the poverty impact of *PROGRESA*. One approach involved a simulation based on the predicted consumption of each household in the 1997 evaluation sample, adding the cash transfer for eligible households and assuming full compliance with conditions. The other approach used reported household income and consumption from census and evaluation surveys (spanning 1997-1999). The two methods produced quite similar results, both using the 50th percentile of per capita value of consumption as a poverty line (Skoufias 2005, 79). The simulation suggested that *PROGRESA* would reduce headcount poverty by 10%, the poverty gap by 30%, and the severity of poverty by 45%. The empirical double-difference impact using programme data indicates that *PROGRESA* reduced headcount poverty by 17% (11.7 percentage points), the poverty gap by 36% (12.9 percentage points), and the severity of poverty by 46% (11.5 percentage points) (Skoufias, 2005, 37). A recent World Bank analysis indicates slightly lower impacts for October 1999, with a reduction in poverty headcount of 2 percentage points, poverty gap of 7.9 percentage points, and severity of poverty of 9.4 percentage points (Schady and Fiszbein, 2007). Despite their slight variation, all of these calculations suggest that programme impact is concentrated among the poorest.

A study analyzing the poverty impact of *Oportunidades* classified beneficiary families as poor or not poor in an initial and follow-up survey (conducted in 1997 and 2002, respectively) and divided into the following four groups: P-P (poor before, poor after), P-NP (poor before, not poor after), NP-P (not poor before, poor after), and NP-NP (not poor before and after). After one year, there was a 37.4% increase in household income for households classified as NP-NP, a 17.8% increase in household income for households classified as P-NP. Income per capita grew at a similar rate: 42% for NP-NP, 44.3% for P-NP, 27.7% for P-P, and 10.1% for NP-P (Cruz, de la Torre, & Velásquez, 2006).

Although there is no calculation of the poverty impact of Honduras' *PRAF* in impact evaluation reports, a recent analysis by the World Bank indicates that *PRAF* had no

statistically significant impact on headcount poverty or the poverty gap, but reduced poverty severity by 2 percentage points (Schady and Fiszbein, 2007). This could be because the transfer size was so small. The average monetary benefit was only \$4/family/month (Handa and Davis, 2006), representing only 4% of mean household consumption (Schady, 2006).

Another measure of poverty, seen in Table 6.8, is the change in household consumption.

Table 6.8. Impacts of CCTs on consumption

Country/Programme	Consumption
Honduras <i>PRAF</i>	No impact on per capita household consumption (in demand, supply or demand + supply groups)
Nicaragua <i>RPS</i>	2002: +13% in initial per capita household expenditure (40% for extreme poor) +20% in per capita annual household expenditure (net average impact)
Mexico <i>PROGRESA</i>	+14.5% in average level of consumption
Mexico <i>Oportunidades</i>	+22% total consumption (rural) +14-18% total consumption (urban)
Colombia <i>Familias en Acción</i>	15% increase in total consumption

Sources: Angelucci, Attanasio, & Shaw, 2004; Attanasio and Mesnard, 2006; Cruz, de la Torre, & Velásquez, 2006; Gertler, Martínez, & Rubio, 2005; IFPRI, 2003b; Maluccio and Flores, 2005; Schady and Fiszbein, 2007; Skoufias, 2005.

7. Cash transfers and education

Interest in the impact of cash transfers on education derives from the body of evidence demonstrating the role that children's educational status plays in explaining the intergeneration transmission of or escape from poverty (see Section 2). Cash transfers have the potential to increase children's education by several means: first, the cash can be spent on school fees, uniforms, supplies, and other school-related expenses. Second, the transfers can compensate for lost income from child labour, such that parents are more likely to enrol children, and they will miss fewer school days. Third, cash can contribute to food budgets so that children are better fed and can concentrate and perform better in school. These effects can potentially take place through conditional and unconditional cash transfers.

Cash transfers may have particular advantages for girls in the context of HIV and AIDS. Girls are at risk from being withdrawn from school because they are often the ones who bear the burden of care for children and ill adults in HIV-affected households (Soul City et al., undated as cited in van Dijk, 2007; Subbarao, Mattimore, & Plangemann, 2001, 4). Staying in school may have benefits for girls aside from education. In Malawi, an evaluation is underway to examine the impact of a randomized conditional cash transfer intervention that provides a cash transfer and school fees to young girls who have recently dropped out of school. Girls are targeted because the incidence and prevalence of HIV is higher among young adult females than among males of the same age, and some observational studies have shown that girls who are enrolled in school are less likely to engage in risky behaviour. This evaluation will look specifically at impacts of the cash transfer on schooling, sexual behaviour (number of partners/relationships, protected sex, marriage, and pregnancy), and HIV and STD status (Ozler, Baird, & McIntosh, 2007).

7.1 Impact of unconditional cash transfers on education

Effects of UCT on school enrolment and attendance

Table 7.1 summarizes the results on impacts of unconditional cash transfers in South Africa, Zambia, and Malawi. In South Africa, some evidence on the effect of an

unconditional cash transfer on enrolment comes from a study of the Child Support Grant (CSG) in the Umkhanyakude District of KwaZulu-Natal Province (Case, Hosegood, & Lund, 2005), a district that is very poor and hard hit by illness and deaths due to AIDS. The study used data from a survey of over 11,000 African households, just under about a third of which received the CSG. Children for whom households received the CSG were compared to their older siblings who did not receive the grant because it was not available when they were 6 or younger (about one-third of the CSG households had a sibling that could be compared). Although not a strict control group, the older siblings offer a reasonable counterfactual: what was likely to have occurred for the younger siblings in the absence of the CSG. This approach at least removes the possibility that enrolment is a result of characteristics of parents. Primary school enrolment was already high in the study area (as in the rest of South Africa), although slightly lower among 6- and 7-year-olds (85 and 95%, respectively), such that there was some room for improvement, especially among 6-year-olds. Controlling for many variables, Case, Hosegood, and Lund (2005, 479) found that receipt of the CSG in 2002 was associated with an 8.1 percentage point increase in enrolment among 6-year-olds, and a 1.8 point increase for 7-year-olds. Since CSG households were poorer than the average, these enrolment increases are particularly meaningful. Although it is not possible to know why the CSG had this impact for 6-year-olds, the authors suggest that it could be by improving their health and nutrition and thus their school readiness.

More evidence from South Africa comes from Samson et al. (2004) using national-level data from the 2000 Income and Expenditure Survey and the September 2000 Labour Force Survey, building a model of income and other variables to evaluate the impact of the CSG and the Old Age Pension (OAP) on children's school attendance. The attendance rate in the full sample averages 94%. The model establishes that household receipt of an OAP is associated with a 20 to 25% reduction in the school nonattendance gap, and receipt of a CSG associated with a 25% reduction in the nonattendance gap (receipt of a Disability Grant has no impact). Of importance, the OAP results are strongly affected by the gender of the recipient: receipt by a female is associated with about a one-third reduction in the nonattendance gap, but receipt by a male has no significant impact. The most significant of other socioeconomic variables positively affecting attendance is the number of years of education of the household head—one year of education is equivalent to twice the impact

of the OAP. This suggests that cash grants can have very long-term impacts—if they succeed in increasing schooling now, results will be even higher for the next generation. Household income is also significantly and positively correlated with attendance, but interestingly cash grant income has a greater impact than non-grant income. Samson et al. (2004, 62-63) hypothesize that grant recipients have different spending patterns, prioritizing school attendance more than non-grant recipients. Poverty has a significant negative impact on attendance. Attendance is also more likely in female-headed households and where there are resident elderly members (controlling for pension receipt). These results hold across provinces and the rural-urban divide.

Some similar results are found in national-level October Household Survey data, also analyzed by Samson et al. (2004), with respect to the importance of poverty and education of household head. Controlling for demographic, geographic, and other variables, and using several models with different specifications, pension receipt has significant positive effects on school attendance in poor households. Disaggregating gender differences for households in the poorest quartile (measured by expenditure), receipt of an OAP increases the likelihood of boys full-time school attendance by 3% and girls attendance by 7%. A 500-rand increase in OAP receipt to a household of five increases boys' school attendance by 2% and girls school attendance by 5%. Household size has no bearing on effects on boys, but it has a significant negative impact on girls, consistent with findings from many countries that under conditions of limited resources, girls education is likely to suffer first, and thus cash transfers can have a greater impact on girls than boys (see also CCT results below).

Other evidence of impacts of unconditional cash transfers on education comes from an evaluation of the Social Cash Transfer Scheme (SCTS) started in 2004 in two agricultural blocks in the Kalomo District in Zambia. The evaluation used a survey of approximately 300 households (considered representative of the 1,000 households in the SCTS), focus groups, and key informant interviews. The survey and focus groups were conducted at baseline and one year later. The study did not have a control group, thus the results are not definitive because the influence of environmental factors, institutions, and economic conditions could not be determined; in particular, a severe drought probably had a significant effect (MCDSS/GTZ 2006, 9-12). For almost all age groups, households in the

SCTS at baseline had lower enrolment rates than the provincial average. Between baseline and programme evaluation, school enrolment for children ages 7-18 increased by 3 percentage points, from 76.1 to 79.3%. This occurred for almost all age groups, except 16-18, suggesting that the grant was least able to affect schooling choices for this age group (this was also the one age group that had a baseline average almost 9 points higher than the provincial average). The largest increase, however, was for 14-15-year-olds (8 percentage points), as well as 5-6-year-olds (10.4 percentage points) (MCDSS/GTZ 2006, 36). Like Case, Hosegood, and Lund (2005) in the South Africa study, the Kalomo study authors hypothesize that children were starting school earlier and staying in primary school longer due to improved nutrition, as well as ability to pay school fees.

The study also found significant gender differences. For girls, enrolment stayed the same or went down slightly for almost all age groups, whereas for boys it went up substantially for almost all age groups. For 7-13-year-olds enrolment went down by 1 percentage point for girls, and up by 7.1 points for boys. For ages 14-18, it was unchanged for girls but went up by 7.7 points for boys. The exception to the gender pattern was the 5-6-year-olds, which showed a huge increase for both (10.9 points for girls and 9.5 for boys), and the 16-18 age group. Some households appear to have decided to send some and not other children to school, with the percentage of households not sending at least one child (7-18) dropping from 41.4% to 33.8% (MCDSS/GTZ 2006, 36-37). With a very small cash grant, parents may feel able to let one or more children go to school while keeping the others at home (see reasons for absenteeism below).

The authors attribute the lack of a greater impact on the already high enrolment rates, and small amount of the grant. However, there was substantial room for improvement in enrolment rates, and this also does not explain the gender differences. The study sample at baseline had substantially higher enrolment rates for older girls 15-18, but not for the younger ones. The difference could also be due to parents' choices to prioritize boys' education over girls' under conditions of scarce resources. The notion of conditioning a cash transfer to respond to gender biases—where grants are higher for girls than boys, and higher for secondary than primary school attendance—might be effective in this context. The conclusion that the grant (about US\$10/month for households with children) was too small to affect the desired impact for all children is an important operational lesson. This

is felt most at the secondary level, where school is not free and often involves boarding costs, although primary education also involves costs for transportation, and school-related associations and activities.

The evaluation also measured the impact on absenteeism, finding that longer periods (10 days or more) increased, whereas shorter periods of absenteeism (1-9 days) decreased, for boys and girls. Substantially more cases of absenteeism involved the short periods, such that the authors' hypothesize that the programme could have contributed to mitigating effects of the drought (this could not be tested due to neither a control group nor information on distract averages of absenteeism). Rises in absenteeism are seen as possibly resulting from the major drought, where increased food insecurity could have led to more illnesses, and the need for children to miss school to work. The main reasons given for absenteeism included illness, unpaid fees, and children needed in the household. These reasons support the conclusion that the amount of the cash transfer was not sufficient to overcome these problems (MCDSS/GTZ, 2006, 38).

Results from the evaluation of the scaling-up Mchinji Cash Transfer programme, which began in 2007, showed some impact on school enrolment and attendance for children 6-18 over the approximately one year period between the baseline and final follow-up survey. From March to September 2007, the study looked at school enrolment and retention among 721 children under 11 years old, and 459 children 11 to 14 years old. The programme appears to have served a protective function, keeping some children from leaving school. For intervention households receiving the transfers, there was less than a 1 percentage point increase in school enrolment; however, among children in households not receiving the transfers (the comparison group⁵⁶), the enrolment figure dropped by 4 percentage points for the under-11-year-olds, and about 2 percentage points for 11-to-14-year-olds (Miller et al., 2007). From March 2007 to March/April 2008, the percentage of children newly enrolled in school was more than twice as high in intervention households (8.3%) compared to comparison households (3.4%). Over this same period, a total of 96% of children from intervention households were enrolled in school compared to 84% of

⁵⁶ This group is referred to as a "comparison" group rather than a "control group" because the intervention and comparison households were not demographically identical at baseline, as children appear to have been prioritized in the intervention areas, whereas elderly households appear to have been prioritized in the comparison areas. However, the authors of the study point out that the households were the same in terms of monthly expenditures, food insecurity, and asset ownership (Miller et al., 2008, viii).

children in comparison households, representing a difference in enrolment of 12 percentage points (Miller et al., 2008, 29).

Although absences were roughly equal at baseline, after a year, children from households receiving the Mchinji cash transfer were absent 1.3 days fewer (the previous month) than children from comparison households. Drop-out rates were higher in the comparison group (5%) compared to rates among intervention children (2%). The transfer may also have had an effect on school performance—14% of intervention household heads reported that their children had excellent school performance compared to 10% of comparison household heads; however, the study could not confirm these findings with school officials due to inadequate data from local schools (Miller et al., 2008, 29-31).

The 2006 evaluation of the Ethiopia Productive Safety Net Programme (PSNP) did not measure changes in rates of school enrolment or attendance, but rather asks whether households enrolled more children and kept children in school longer in the present year vs. the previous (pre-programme) year. Thirty-nine percent of households reported that they had enrolled more children, with 32.6% attributing this to the PSNP. Almost 50% of households said that they had kept children in school longer, rather than withdrawing them when cash or food was short, with 43% attributing this to the programme (Devereux et al., 2006, 36). A more recent and larger evaluation of the PSNP found that households receiving at least half the transfer amount they should have received⁵⁷ over a one-year period showed a large increase in boys' (age 6-16) school attendance of 12 percentage points, increasing boys' average attendance rate to 51% relative to 39% in the control group. However, there was almost no impact on girls' school attendance. In fact, the study found some evidence suggesting that time on domestic chores fell for boys, while rising for girls (Gilligan, Hoddinott, & Taffesse, 2007, 56-58). These gender differences found in Ethiopia and elsewhere highlight the importance of attention to reaching girls in programme design (this could include, but is not limited to, CCTs).

⁵⁷ Equivalent to 90 birr per person (at a wage of 6 birr per day, equivalent to 15 days work per person). Households were intended to receive up to five days work per month for each household member, but actual employment, as well as payments, were less than that planned.

Table 7.1. Impacts of unconditional cash transfers on education

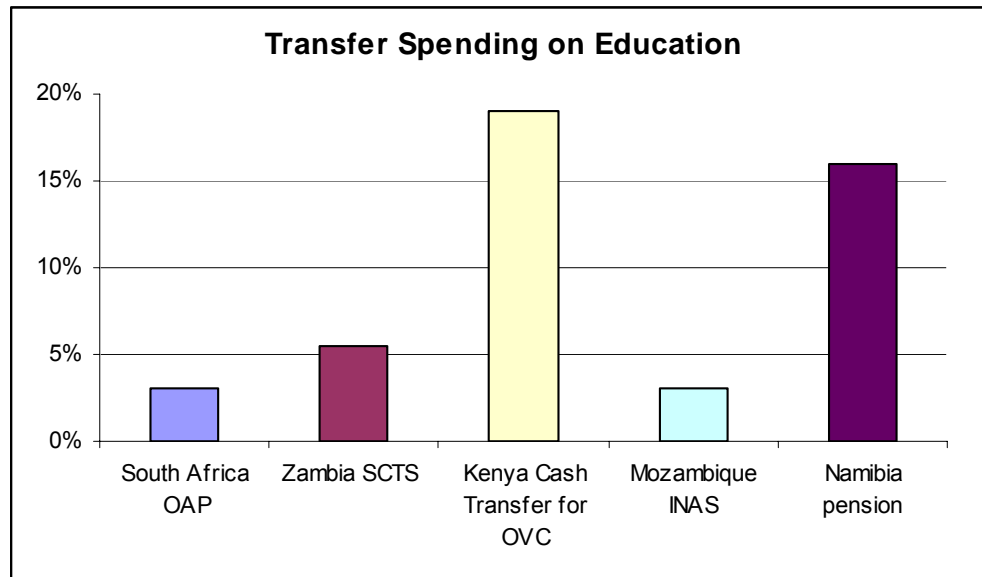
Country/Programme	Enrolment	Attendance
Ethiopia PNSP		+12% points (boys 6-10) No impact (girls)
South Africa CSG	+8.1% points (age 6) ¹ +1.8% points (age 7) ¹	+25% ²
South Africa OAP		+20-25% ² +3% (boys); +7% (girls) ³
Zambia SCTS ⁴	+10.4% points (ages 5-6) +3% points (ages 7-18) +8% points (ages 14-15) -2% points (ages 16-18)	
Malawi Mchinji Cash Transfer	+12 % pts enrolment rate +5% pts newly enrolled -3% pts dropout rate	-1.3 days absent in previous month

Sources: Case, Hosegood, & Lund, 2005; MCDSS/GTZ, 2006; Samson et al., 2004; Miller et al., 2008.

¹ KwaZulu-Natal, Umkhanyakude District; ² National, Income and Expenditure Survey 2000 and The Labour Force Survey Sept. 2000; ³ National, OHS data; ⁴ Kalomo District.

The remaining findings on the impact of unconditional transfers on education come from assessments of how the cash transfer was spent, or general distribution of expenditures, looking at the proportion spend on education expenses (see Figure 7.1). While not an indication of the impact of grants on education, it does suggest that the grant helps parents to afford education. Some studies are specific with respect to percent of the grant or overall income spent on education, while others report on whether or not some grant income was spent on education. Where proportions are included, the amount spent on education is usually quite small, with food and food-related expenses by far the largest use of the grant. Given that the poorest normally spend a greater proportion of income on food, this is to be expected, and is not out of line with the main programme objectives. Furthermore, expenditures on school expenses do not capture the contributions to education from having healthier and better nourished students. Nevertheless, expenditures contribute to the education impacts of cash transfers.

Figure 7.1. Unconditional cash transfer spending on education^a



Sources: Acacia Consultants, 2007; Devereux, 2002; Moller and Ferreira, 2003; MCDSS/GTZ, 2006

^a In the case of Zambia SCTS, the figure represents the proportion of overall spending by beneficiaries on health.

Education spending was one issue examined in a study of social grants by Booyesen (2004b) in two communities in South Africa's Free State Province in 2001-2002. This study compared HIV and AIDS affected-households (defined as experiencing morbidity or mortality with at least one person known to be HIV positive or to have died in the past six months) with non-affected households. An earlier study by Booyesen et al. (2004) found that AIDS-affected households spent less on education than non-affected households, probably due to expenditures on health care and funerals, the need to take children out of school to help the household cope with illness and death, or the inability to pay for school fees. Comparing employment with grant income, Booyesen (2004b, 22-23) found that employment income led to greater expenditures on food, education, and health care. Grant income resulted in a higher rate of increase in food expenditures as compared to employment income. However, social grants did not increase expenditure on education; in fact, receipt of the CSG was associated with a reduction in education spending.⁵⁸ There are a few possible explanations for these results. One is that people prefer to use the

⁵⁸ Spending on education was also positively associated with more educated and with younger household heads, and with urban households.

additional income from grants to increase food intake. Another is that the CSG is used for the entire family, not for specific child-based expenditures. Booysen clarifies that given the small sample size and purposive sampling the findings cannot be generalized to other parts of South Africa. Still, at least where these spending patterns hold, Booysen asks whether reaching school-age children more directly might require grants administered by the education system, for example, via a system paying for school fees.

In Malawi, recipients reported spending some of the cash transfer from the DECT programme on school uniforms, pens, books, and other education costs, but this amount was very small: between January and March 2007, an average of only 3% of the transfer was spent on education (Devereux et al., 2007, 38, 72). In the FACT programme in Malawi, education and health expenditures are reported together so we cannot disaggregate education spending; however, the average for both over the January to March period was 9.7% of total expenditures. It appears that more of this was spent on health costs than on education, because the study reports that the second major item of spending after food and groceries was health care, and devotes some discussion to what the health expenditures were on, whereas no mention was made of education spending (Devereux, Mvula, & Solomon, 2006, 29-30).

The Zambia SCTS study did not capture spending of the transfer specifically, but rather looked at the breakdown of overall consumption at baseline and evaluation (a better measure, since the cash is fungible). Expenditure on education increased by a small amount during the evaluation period: from 3.9 to 5.5% of overall expenditures (MCDSS/GTZ 2006, 49). Education spending varied widely across locations, however: in two of the three blocks, almost no one reported spending on education, whereas in the third entirely rural block, the percent of households spending some amount on education rose from 15.2 to 29.7%, which may reflect the required contribution from parents to the schools in rural areas (MCDSS/GTZ 2006, 37, 49).

In the pre-pilot cash transfer programme in Kenya, 67% of households reported spending some of the grant on school fees. Breaking down the use of the grant across expenditure categories, 19% of the grant was spent on school expenses (Acacia Consultants 2007). Caretakers' claims to have spent some of the grant on school expenses was backed up by

children, “who more often than not, proudly showed off new school uniforms. Many of the children who had been out-of-school said that they were now attending classes again” (CRIN, 2005, 4).

Old-age pensions also appear to be affecting children’s education via spending allocations. In Lesotho, 50% of pensioners spend some of their pension on education and associated costs (Croome 2006). In Namibia, 15.5% of the pension income diverted to grandchildren is spent on education-related expenses including school funds (for building upkeep), uniforms, hostel fees, books, and exam fees (Devereux 2001, 43, 49). In the north, due to higher income levels and value on education, the percent of pension income going to education is 28.6%. There is no evidence of gender discrimination in pension income benefits (Devereux, 2001, 48). Moller and Ferreira (2003) report that in South Africa, only 3% of the OAP was spent on education expenses. However, a report by HelpAge International (2002, cited by Schubert et al., 2007) finds that between 30 and 40% (for men and women, respectively) of South African older people’s expenditures were on school expenses. Although one measures pension spending and the other overall expenditures, the discrepancy appears large and the reason not clear.

A less positive assessment of the impact of unconditional cash transfers on schooling is found in the simulations undertaken for 15 African countries by Kakwani, Soares, and Son (2005). The first study is an ex-ante assessment of the impact of a cash transfer on national poverty and school attendance. It examines the determinants of school attendance based on household demand for education to determine the impact of the different transfer scenarios on school attendance. The analysis indicates that a transfer worth 0.5% of GDP does not bring about significant increases in school attendance rates. Even if the transfer is targeted only to the poor, the boost in attendance is negligible (ranging from 0.04% in Malawi to 0.42% in Côte d’Ivoire). If 30% of the poverty line is transferred to all school-age children, impacts range from negative in Nigeria to just shy of 3% in Burundi and Zambia (Kakwani, Soares, & Son, 2005).

A second study in the same 15 African countries offers a more positive outlook with respect to old age pensions. Kakwani and Subbarao (2005) examine whether children living in elderly-headed households or with elderly alone suffer a disadvantage in education

compared to children not living with the elderly. They find that for boys, moving from a non-elderly-headed household to an elderly-headed household increases the probability of school attendance, particularly in urban areas. For girls, the relationship varies by country: in Burundi, Burkina Faso, Côte d'Ivoire, Ghana, and Guinea, the probability of girls attending school falls when they shift to elderly-headed households. In Cameroon, Nigeria, Uganda, and Zambia, the opposite is true. The authors conclude that a social pension targeted to poor elderly-headed households *could* contribute to reducing female disadvantage in schooling (Kakwani and Subbarao, 2005, 26-27).

7.2 Impacts of conditional cash transfers on education

Cash transfers conditioned on education are the oldest form of CCT, seen as early as 1995 at a regional level in Brazil, and the most commonly implemented. Table 7.2 summarizes some key impacts of CCTs on education in 11 countries. The education component of CCTs normally require school enrolment, followed by a school attendance rate of around 85%. With respect to these conditionalities, education CCTs tend to have less variation than the health and nutrition components that have more varied requirements with respect to service participation, age of family members targeted, and adult education. The main variations with respect to education CCT design are, first, whether they condition on primary school only, secondary school only, or both; second, whether they offer a different transfer size for girls and boys; third, whether they include an in-kind transfer of school supplies; and fourth, whether they include a small transfer intended for the teacher or for school improvements. Other variations may include voluntary forms of participation for parents, such as in parent-teacher associations. For CCTs with primary and secondary school conditions, the transfer is higher for secondary school because the opportunity cost of children's schooling is normally higher for older children, and because parents are more likely to send their children to primary school, giving less priority to higher levels of education. Children who themselves decide to drop out are also more likely to make this decision at the secondary level. It is most often at the transition from primary to secondary that children are likely to be taken out or decide to leave school. These risks tend to be more pronounced for girls than for boys (except for the opportunity cost of schooling, which in many contexts tends to be higher for boys than girls), so CCTs often provide a higher transfer for girls than for boys, both at primary and secondary levels.

Conditional cash transfers have had dramatic impacts on education outcomes for children. The magnitude varies considerably, often based on the level of education indicators at baseline, i.e., if pre-programme enrolment levels are very high, the CCTs impacts tend to be lower. The type of impact also varies, including, among others, enrolment, attendance, grade progressions, return of school drop-outs, and school achievement. The impacts reported are from evaluations conducted in Mexico, Nicaragua, Honduras, and Ecuador using randomized designs,⁵⁹ and evaluations in Brazil, Turkey, Colombia, Cambodia, Bangladesh, and Pakistan using quasi-experimental methods. A number of African countries are piloting or have proposed to pilot CCTs, including Kenya, Zambia, Uganda, and South Africa, with others under discussion. As noted in Section 5, some of the evaluations involve comparisons of conditional and unconditional transfers.

Mexico

Schooling impacts for Mexico's *Programa de Educación, Salud y Alimentación* (*PROGRESA*) are based on a panel survey carried out in 1998-99 by IFPRI. *PROGRESA* was found to have brought about a minimal change in primary school enrolment of only about 1.45⁶⁰ percentage points for girls, and 1.07 percentage points for boys. This was because primary school enrolment started out very high, between about 90 and 96% at baseline. At the secondary school level, where enrolment started out low—at 67% for girls and 73% boys—impacts were much higher: 9.3 percentage points for girls (a proportional increase of 14%) and 5.8 points for boys (an 8% increase). The largest impact was on girls enrolling in grade 7, the transition year when they most often drop out: 14.8 percentage points (Schultz, 2001, 2004). For all children ages 11 to 14, the programme was especially effective at reducing the drop-out rate, encouraging the transition to secondary school. It also encouraged school re-entry, although this only lasted about a year and children tended to drop out again. For children ages 6-10, the programme was associated with less grade

⁵⁹ The first three of these evaluations, by IFPRI, used a “difference in difference” methodology, where control and treatment groups are compared at baseline and some point in time (often several points in a repeated panel) after program implementation. Because there are likely to be some observable or unobservable differences between the two groups at baseline, and because changes are likely to occur in both groups that are not attributable to the program, the difference in difference methodology subtracts these differences in the control groups from that in the treatment, to get a measure of impact from the program. Note that these evaluations used the fact that the program could only be rolled out gradually, to identify control groups—localities that were not yet in the program.

⁶⁰ The enrollment impact figures reported are from a smaller “unpooled” sample that only includes households interviewed in every round of the panel survey.

repetition and better grade progression (Behrman, Sengupta, & Todd, 2001). The programme was also associated with a reduction in child labour. For boys ages 8 to 17, there was a reduction in the probability of working of about 10 to 14%, even higher for ages 12 to 15. Girls 8 to 17 also had about a 15% reduction in the probability of working. The programme had no impact for boys or girls age 16 to 17, however (Parker and Skoufias, 2000). *PROGRESA* had very little impact on school attendance, on achievement as measured by cognitive achievement test scores, and on bringing children back to school who had dropped out (it brought them back initially, but they tended to drop out again after a year (Behrman, Sengupta, & Todd, 2000, 2001).

PROGRESA turned into *Oportunidades* in 2001, and a subsequent evaluation found a 24% increase in secondary school enrolment in rural areas, and 4% in urban areas. The effects were again stronger for girls than boys, and almost twice as high for girls in urban areas. The programme is credited with increasing the number of girls enrolled in rural secondary school from 83 to every hundred boys enrolled, to 96 per hundred boys (Parker, 2004).

Nicaragua

Nicaragua's *Red de Protección Social* (RPS) provided a cash transfer conditioned on primary school enrolment and attendance (not secondary school). The IFPRI evaluation was of a pilot programme in two rural "departments" that started in 2000 and expanded in 2002.⁶¹ Primary school enrolment was low at baseline, at 72%. Enrolment impacts were huge: for programme participants, enrolment increased by about 20 percentage points by 2002. However the rate for the control groups also rose by 7.6 percentage points, so that the net programme impact was 12.8 percentage points. This control group increase was greater than the national rural average and appears to have been the net effect of several factors possibly "contaminating" the controls, including (1) increases in school feeding in the area; (2) possible crowding out at the school level; (3) improvements in supply as a result of the programme; and (4) likely changes in expectations in the control group, where some hoped that school attendance might hasten their incorporation into the programme. The impacts were greatest for the extreme poor, at 25 percentage points vs. 14 points for the poor and 6% for the nonpoor (although there were few nonpoor in the sample). There

⁶¹ In 2004, 21,619 families were enrolled in the program, but the program has since been cancelled.

was no significant difference between impacts on girls and boys, an outcome more expected at the primary than secondary level (Maluccio and Flores, 2005).

Nicaragua's RPS also had very high impacts on school attendance rates, at 20 percentage points on average, and as high as 33 percentage points for the extreme poor, 23 points for the poor, and 12 points for the nonpoor. There was a relatively small gender difference, with the programme increasing attendance of girls 17% and boys 23%. Although the programme was implemented in areas where schools were generally available, supply-side interventions were also undertaken to accommodate the large enrolment changes: this included increasing the number of sessions per day and the number of teachers. The schooling outcomes are thus interpreted to be a combined effect of the demand and supply interventions (Maluccio and Flores, 2005).

Another programme impact was school continuation rates, measured as grade advancement for two consecutive years, which was 7.3 percentage points on average. An unanticipated impact was a large impact on students making a transition to fifth and sixth grade, because fifth grade enrolment and higher was not a programme requirement. This could have been a result of confusion as to this requirement, an income effect, or a result of changing attitudes toward education. More evidence on the sustainability question was provided by a follow up survey two years after households were rotated out of the programme. An enrolment drop of 12.5 percentage points indicates that, for many, the cash incentive was driving the impact more than a change in attitude toward education. However, enrolment remained 8 percentage points higher than at baseline, suggesting that for this substantial group, the programme had some sustainable impact. The programme impact on child labour was a 4.6 percentage point decrease in 2001 and 5.6 points in 2002, although child labour decreased significantly among both groups in 2001 due to an economic downturn (Maluccio and Flores, 2005). RPS was also found to have protected human capital during the shock of the coffee crisis of that period, with programme impacts on enrolment and child labour greater in coffee-growing regions than in non-coffee growing areas (Maluccio, 2005).

Other programmes in Latin America and the Caribbean: Brazil, Colombia, Ecuador, and Jamaica

In Brazil's *Bolsa Escola*, the average programme impact on attendance was 3 percentage points among boys ages 10-15, which was not small, given that the attendance rate of the comparison group was around 92% (Cardoso and Souza, 2003). The programme was associated with a 7.8 percentage point reduction in drop-out rates (improvement in complete year attendance) and gain of 6.2 percentage points in grade promotion (de Janvry, Finan, & Sadoulet, 2006).

Colombia's *Familias en Acción* had an enrolment impact on 8-13-year-olds of 1.5 and 2.5 percentage points in urban and rural areas, respectively, probably explained by the high enrolment starting point. Secondary school enrolment impacts were higher: 13.9 percentage points in urban areas and 17.2 points in rural areas. Attendance increased by between 4.6 and 10.1 percentage points among children 12-17 in rural areas and by between 3.5 and 5.3 percentage points in urban areas (Attanasio and Gomez, 2004).

Ecuador's *Bono de Desarrollo* programme increased primary school enrolment of by 9.8 to 12.8 percentage points, and reduced child labour by 15.4 to 20.7 points. The effect on sixth graders was 17.8 percentage points (Schady and Araujo, 2006). The programme did not include a secondary school transfer. The evaluation found no impact on achievement test scores (Ponce, 2006).

The evaluation of Honduras' *Programa de Asignación Familiar (PRAF)* showed a huge 17 percentage point increase in the probability that children ages 5 through 12 who were out of school in 2000 would enrol in or return to school in 2001, but this dropped to zero when comparing average rates using a double difference approach. It may be a result of started high levels of enrolment or that the control group also sent children to school, hoping to receive the cash transfer. However, the programme did show robust impacts on attendance rates of approximately 4.4 to 4.5 percentage points and reduced drop-out rates from 7 to 2.4% (IFPRI, 2003b).

Jamaica's Programme for Advancement through Health and Education (PATH) focused on school attendance, because enrolment was already very high in Jamaica, finding an

attendance increase of about 3%. There was no significant difference found in grade advancement or grades (Levy and Ohls, 2007).

CCT impacts on education in Asia: Cambodia, Turkey, Bangladesh, and Pakistan

The highest impact of any CCT programme was in Cambodia, where pre-programme secondary school enrolment for girls was very low. Cambodia's Scholarships for Girls Programme was found to have increased enrolment by 22 to 33 percentage points and increased attendance by 43 percentage points (Filmer and Schady, 2006).

Bangladesh has experimented with three programmes: the Bangladesh Primary Education Stipend programme (PESP), the Bangladesh Female Secondary School Assistance Project (FSSAP), and the Bangladesh Reaching Out of School Children Programme (ROSC). At the baseline for evaluations of the first two programmes, girls attendance rates were very low, at 65% and 42%, respectively (Ahmed, 2004). For FSSAP, results come from a model, as no control group was available. School-level data indicate that, on average, an additional year of stipend programme duration increases the female student secondary enrolment of an incoming cohort by as much as 8%. Household-level data, considered a better measure, suggest that an additional year of programme duration increases the school enrolment rate of girls age 11-18 years by 12 percentage points, and has no discernable effect on boy's enrolment (Khandker, Pitt, & Fuwa, 2003, 24-25).

Implemented in 2005, the ROSC project was designed to bring out-of-school children to school with (1) a cash educational allowance for students, and (2) grants to schools where these children enrol. In 60% of the project area, both educational allowances and grants to schools were provided. In the remaining 40% of the area, only grants to schools were provided, but the amount of the grant was almost double than the amount received by grant-plus-allowance schools. In grant-only areas, the ROSC Project did not seem to bring about any significant net change in enrolment in primary school. In grant-plus-allowance areas, however, the ROSC Project induced an average net increase in primary school enrolment of 8.9 percentage points for children ages 6-14 and 10.6 percentage points for children ages 6-8, implying the importance of the demand-side stimulus, over supply-side

alone. The actual increase in programme areas was 21%, but the control areas also saw increased enrolment of 12.1% during the project period, resulting in the 8.9% programme-related impact (Ahmed, 2006). A CCT programme in Pakistan also had an impact on girls' secondary school opportunities. The Female Secondary School Stipend programme in Punjab increased enrolment by 9 percentage points (Schady and Fiszbein, 2007).

The CCT programme in Turkey had a strong objective of increasing education, particularly for girls. It had little impact on primary school enrolment because of the high enrolment rate at baseline, but large effects for secondary school girls, raising enrolment by 10.7 percentage points. In rural areas, there was a 16.7 percentage point increase in the probability of enrolment in secondary school; for boys, this impact was 22.8 percentage points. The programme raised primary school attendance for girls by 1.3 percentage points, and secondary school attendance for girls by 5.4 percentage points. The programme appears to have improved test scores for primary school children, but given the small impact on school attendance, the authors propose that the effect may be through helping beneficiary households to make better use of the schooling inputs, and increasing the attention on schooling within the family. The programme had no effect on the rate of progression from primary school to secondary school (Ahmed et al., 2007). Adato et al. (2007) used ethnographic research that helped to explain the education results, including the reasons why girls schooling rates did not increase more than they did, particularly in socially conservative parts of southeastern Turkey. Women's primary roles as wife and mother, concerns over honour and reputation, compounded by long distances that would need to be traveled to reach secondary schools, and other issues often overpowered the cash incentive—pointing to the importance of a contextual understanding of the constraints to increasing demand for education if CCTs are to be effective (Adato et al., 2007).

Table 7.2. Impacts of conditional cash transfers on education

Country/ Programme	School Enrolment				School Attendance	
	Primary		Secondary		Primary	Secondary
	Girls	Boys	Girls	Boys		
Mexico <i>PROGRESA</i>	+1.45% points	+1.07% points	+9.3% points	+5.8% points	*	*
Mexico <i>Oportunidades</i>			+24% (rural) +4% (urban)			
Nicaragua <i>RPS</i>	+12.8% points		NA	NA	+17% girls +23% boys	NA
Brazil <i>Bolsa Escola</i>					+3% points (age 10-15; not reported by level of school)	
Honduras <i>PRAF</i>	*				+4.5 % points	
Colombia <i>Familias en Accion</i>	+2.5% points (rural) +1.5% points (urban) (age 8-13)		+17.2 (rural) +13.9 (urban)			
Ecuador <i>Bono de Desarrollo Humano</i>	+10 % points		NA			
Bangladesh <i>FSSAP</i>	NA	NA	+12% points for girls (11-18)	*	NA	
Bangladesh <i>ROSC</i>	+8.9% points (age 6-14) +10.6% points (age 6-8) (grant + allowance) * (grant-only)					
Pakistan			+9% points	NA		
Turkey	*		+10.7% points	+22.8% points (rural)	+1.3% points (girls)	+5.4% points (girls) * (boys)
Cambodia	NA	NA	+22-33% points	NA	NA	+43% points (girls) *(boys)
Jamaica <i>PATH</i>					+3 %	

Sources: Ahmed, 2006; Ahmed et al., 2007; Attanasio et al., 2006; Attanasio and Gomez, 2004; Filmer and Schady, 2006; IFPRI, 2003b; Khandker, Pitt, & Fuwa, 2003; Levy and Ohls, 2007; Schady and Fiszbein, 2007; Schultz, 2001.

* No significant impacts found.

7.3 Complementary activities in education and new programme designs in the context of AIDS

Cash transfers can support AIDS-affected families by helping them to keep their children in school, where families face financial constraints that might force children to leave school. Children may also leave voluntarily. For certain age groups, leaving school may not only affect their future economic prospects, but also pose a risk to their health. As noted above, recent studies have found that girls enrolled in school are less likely to engage in risky behaviour than those who are not enrolled. A new study by the World Bank will try to determine how effective monetary incentives can be in promoting schooling and

reducing risky sexual behaviour and HIV/AIDS risk. A small CCT in Malawi is targeted to a random subset of young girls who have dropped out of school (Standard 7 and 8 in primary; Form 1 and 2 in secondary). A cash grant is given conditional on school attendance. Variations will also be tested in the size of the transfer and length of time out of school (Ozler, Baird, & McIntosh, 2007).

Opportunities for education programmes for children and adults can be provided in association with cash transfers, even where participation in services is not obligatory but rather voluntary. The existence of a cash transfer programme can be used creatively to encourage participation in activities that strengthen the human capital of children and adults. Some examples follow.

Early childhood development

One of the opportunities under exploration is for Early Childhood Development services (ECD). Many aspects of the HIV/AIDS epidemic can jeopardize early childhood development. Young children depend on caregivers, who may be overworked and demoralized—and possibly ill themselves—and therefore less attentive to and less able to meet children's needs. As discussed earlier, young children suffer from the trauma of facing the illness and death of parents and other family members, social instability as they are moved across families, abandonment, and other stresses. These conditions can compromise children's physical and psychological development (Richter, Foster, & Sherr, 2006, 8). An ECD component of a cash transfer programme could boost the effect of the transfer on child development and promote better learning and other outcomes as children reach school age (Kakwani, Soares, & Son, 2006). The World Bank explored options for conditioning ECD in a session on this topic at the Third International Conference on Conditional Cash Transfers in 2006 (World Bank, 2006a).

In South Africa, the Human Sciences Research Council (HSRC) has designed a demonstration project to test alternative approaches to ECD, such as home vs. centre-based care and alternative job hierarchies in provision and supervision suitable to low-skilled service providers (Altman, 2007). Although it is not currently linked to a cash

transfer, ideas have been discussed for creating synergies with the child support grant.⁶² In Malawi, the Ministry of Education, along with UNICEF, is supporting expanded ECD services. Guides for ECD caregivers were distributed to community-based childcare centres and initial efforts have been made to incorporate ECD into the country's primary curriculum (UNICEF, 2007a). In Malawi's Social Cash Transfer Scheme, the idea is for community-based organizations (CBOs) to follow up with especially vulnerable beneficiaries and, along with extension workers and child protection workers, ensure that these children can access ECD services (UNICEF, 2007b).

School-based interventions

Other plans envision the extension of linkages (hard or soft conditionalities, or unconditional linkages) between cash transfer programmes and schools, through school-based interventions such as after-school programmes, care and support programmes, and AIDS education.⁶³ In South Africa, the KwaZulu-Natal Department of Education and the Media in Education (MiET) has recently piloted a programme based on MiET's concept of "Schools as Centres of Care and Support," including a package of training for school management, staff, and support teams, to identify vulnerable children, refer them to support agencies, and assist them in gaining access to resources such as food, grants, and psycho-social support. Training is also provided to peer educators on HIV and AIDS, including coping, access to treatment, and other information.⁶⁴ In Cambodia, World Education's in-School Information, Education, and Communication (IEC) and Life Skills Training for HIV/AIDS combines a life skills approach with peer education for in-school youth. Another part of the strategy creates health clubs for in-school youth, where members engage in HIV education and outreach activities, community mobilization, and IEC development and dissemination.⁶⁵

If cash transfers succeed in increasing children's presence in school, their benefits multiply by increasing children's exposure to these additional services. In turn, contacts with

⁶² Personal communication with Miriam Altman, March 2007.

⁶³ Exploring the potential of these linkages was a proposal that emerged from a meeting of international organizations in late 2007 (UNICEF, 2008).

⁶⁴ See <http://www.miet.co.za/content.aspx?ContentId=12>.

⁶⁵ See <http://www.worlded.org/WEIInternet/projects/ListProjects.cfm?Select>.

children and parents through schools could also serve as a means of promoting awareness of and access to cash transfers.

8. Cash transfers and health

Cash transfers can affect families' health in several ways. The income can help to cover costs directly associated with accessing health care, including transportation expenses, medical fees, and the opportunity costs of time. Beyond facilitating access to services, cash transfers can contribute to increased food consumption, providing better quantity and quality of nutrients, protecting health in this way. Health education can also be integrated with cash transfer programmes. Finally, other investments associated with income gains, such as improved hygiene and sanitation, can stimulate better health.

8.1 Impacts of unconditional cash transfers on health

Access to health services/service utilization

Evaluation results from Concern Worldwide's Dowa Emergency Cash Transfer (DECT) project in Malawi found that the transfer contributed to better access to health care during the five months of the programme. The DECT transfer provided purchasing power for expenses such as transportation, hospital bills, and medicines, which enabled beneficiaries to access health-care services more easily. In qualitative interviews, programme participants reported improved access to health care, leading to overall improvements in their health status and general well-being. This benefit is particularly noteworthy because it occurred during the time of year when disease prevalence is highest in rural Malawi. These improvements were important for groups with the weakest resistance to disease such as malnourished individuals and those affected by HIV and AIDS (Devereux et al., 2007, 40). A factor that may have facilitated this outcome is the fact that Concern community liaison staff delivered health-related messages as part of sensitization campaigns on DECT paydays. Messages promoted using the transfer for feeding the family and investing in farming, and also conveyed information about HIV prevention. Concern Worldwide staff also targeted chiefs and elders separately, in an effort to reach more men with sensitive messages about HIV and AIDS (Devereux et al., 2007, 9-10).

Evaluation results from the scaling-up Mchinji Cash Transfer programme illustrated important improvements in health-care access for both adults and children. At baseline in

March 2007, the share of households reporting inadequate health care for adults was about equal between intervention and comparison households at roughly 80%. By June 2007, about three months after the start of the programme, less than 20% of intervention households claimed inadequate health care, compared to over 60% of comparison households (Miller et al., 2007). Members of intervention households—both adults and children—were also more likely than those in comparison households to get care when they were ill: 84% of beneficiary adults received care when sick compared to 10% of nonbeneficiary adults and 80% of beneficiary children received care compared to 8% of nonbeneficiary children. Of all children, 80% of those in intervention households were reported to receive “just enough” or “more than enough” health care when ill compared to only 20% of children in comparison households (Miller et al., 2008, 23, 25). As of September 2007, of all children who did not receive care during their last illness due to lack of money, 75% were from comparison households and only 14% were from intervention households. Among intervention children, there was an increase in the use of private hospitals and medicines such as antibiotics and painkillers, as well as decreased use of herbs for treatment (Miller et al., 2007).

In South Africa, a study of barriers to health-care utilization and illness-related impoverishment involving 280 households across two communities (Goudge et al., 2007; Goudge et al., forthcoming) found that cash transfers accelerated access to health care beyond the effect of the income transfer. The study found that people seeking treatment at health facilities were far more likely to be granted the fee exemptions for which they are eligible (based on their poverty status) than those eligible for the exemptions but not receiving grants: 100% of CSG recipients, and 82% of pension and disability grant recipients, received the exemptions. For those neither receiving grants nor earning income, only 55% received the exemptions. Those receiving grants were assumed to be eligible and thus not required to show proof of income, while those not receiving grants had to document their eligibility (Goudge et al., 2007). Qualitative research also found that cash transfers protected against illness-related risks by making health care and transportation to clinics and hospitals more affordable, by enabling automatic qualification for fee exemptions, and by strengthening social networks that could be called upon if needed (Goudge et al., forthcoming).

Health outcomes

Although there is limited evidence documenting the impact of unconditional cash transfers on health outcomes—mostly because quantitative impact evaluations of unconditional cash transfer programmes measuring these have not yet been completed—evidence from several countries shows a protective effect of cash transfers on health (see Table 8.1 below).

Much of the important evidence on health impacts comes from studies of impacts of the Old Age Pension (OAP) in South Africa. These are important findings because so many households affected by AIDS have pensioners, either in three-generation households or skip generation households (grandparents caring for children in the absence of parents). Over 60% of orphaned children in Namibia, South Africa, and Zimbabwe live with their grandparents and over 50% in Botswana, Malawi, and Tanzania. The responsibility of elderly caring for orphaned children is increasing as the AIDS epidemic advances. For example, in Namibia between 1992 and 2000, the overall percentage of orphans living with their grandparents increased from 44 to 61% (Gorman, 2004, 18; UNICEF, 2003). Children and adults in the household are likely to benefit if the pensioner is healthier and therefore better able to provide care and to improve living standards in the household (e.g., through food and health-care expenditures for all, affording piped water, etc.).

In South Africa, Case (2001) compared the self-reported health status of adults living with pensioners with those living without pensioners. She finds that pension income (at 520 rands per month) had a positive impact on the health of *all* adults in households that pooled income, but only on the health of pensioners in households that did not pool income. This is consistent with the expectation that in non-income pooling households, pensioners would use a larger share of the pension for personal use, including health needs. Indeed, in income pooling households, every adult in the household experienced an improvement in health status of 0.5 points on a five-point scale, while in non-income pooling households, pensioners benefited by a full point. The number of non-pension-receiving household members was not associated with health status in income pooling or non-income pooling households (Case, 2001, 7-10).

Case also explored the mechanisms by which pension income improved health status. In response to open-ended questions, some beneficiaries reported using the pension to purchase more food and some said they upgraded household facilities through the purchase of paraffin stoves, phones, or improved kitchens, some of which can have consequences for health (Case, 2001, 12). Having a pensioner in the household was positively and significantly correlated with the presence of a flush toilet in the home and negatively correlated with an off-site household water source, and the likelihood of having a toilet increased significantly as the duration of pension receipt increased (Case, 2001, 14-15). Samson et al. (2004) reports a similar finding about piped water: the amount of the Old-Age Pension and receipt of the Disability Grant were significantly associated with a higher probability that the household had access to piped water (Samson et al., 2004, 85), an amenity that can affect the health of adults and children in the household.

According to the 2006 evaluation of the Social Cash Transfer Scheme (SCTS) in Zambia, the incidence of illness among SCTS beneficiaries declined between the baseline and the follow-up evaluation. At baseline, 43% of beneficiaries reported having some illness,⁶⁶ and by the evaluation one year later, only 35% reported an illness. The most significant impact (a 14.2-percentage-point change) occurred among the elderly (65+), who experienced the highest rate of morbidity at baseline (82%). Children under-5 and adults of productive age (19-64) also experienced a 12-percentage-point reduction in incidence of illness. The evaluators speculate that this is probably due to improved nutrition and hygiene (MCDSS/GTZ, 2006, 43).

The 2008 evaluation results from Malawi's Mchinji Cash Transfer indicate improvements in health status for both children and adults. After the programme had been in place for one year, the percentage of adults who reported being ill in the previous month had fallen by 21 percentage points among intervention households (from 80 to 59%) compared to 8 percentage points for comparison households (from 81 to 73%) (Miller et al., 2008, 23). Similar gains were noted among children. The percentage of children under 18 who were sick in the previous month before the survey was 13 percentage points lower among intervention households compared to comparison households (42 vs. 55%). Evaluation

⁶⁶ Illnesses included measles, malaria, tuberculosis, AIDS, asthma, bronchitis, diarrhea, vomiting, anemia, abdominal pains, skin infection, pneumonia, cough, eye and ear infection, high blood pressure, chest pain, toothache, mouth infection, backache (MCDSS/GTZ, 2006, 43)

results also showed a difference in the percentage change in child illness. In intervention households, 23.4% fewer children experienced illness in the previous month versus only 12.5% fewer children in comparison households. Intervention households were also more likely than comparison households to report that their children had excellent health (31 vs. 13%) and less likely to report that their children had poor or fair health (13 vs. 33%). Among intervention households, 81% reported that their children's health had improved from March 2007 to March/April 2008, compared to 15% among comparison households. At the same time, 3% of intervention households said their children's health had worsened compared to 14% of comparison households (Miller et al., 2008, 26).

Spending on health

In the absence of more impact data on access to health services, health service utilization, or health outcomes, some evaluations have used documented changes in household spending on health as an indicator of likely health impacts. Results should be interpreted cautiously, however, because high or increased health spending after receiving a transfer can have very different meanings. While increased spending could indicate improved access to services, low or decreased spending could indicate reduced need for health-care services.

Health expenditures among Zambia's SCTS beneficiaries fell from baseline to evaluation, perhaps indicating that spending priorities had changed or that there was less need for health-related spending since illness prevalence had decreased (MCDSS/GTZ, 2006, 49). At evaluation, beneficiaries spent an average of 1.2% of the transfer on health, but 13.2% on hygiene products, which could have made some contribution to improving health (MCDSS/GTZ, 2006). Similarly, health spending in South Africa fell slightly in the presence of social grants, by just under 1 percentage point for the OAP and just under a quarter of 1 percentage point for the CSG (Samson et al., 2004, 76). Again, this may be because social grants promote better nutrition and education outcomes, which can lead to better health outcomes, making medical spending less necessary.

Croome (2006) found that elderly pensioners in Lesotho spent more on health (hospital/clinic visits and medicine) after they received the transfer compared to before,

and that overall, beneficiaries used an average of 8% of their pension income on health (Croome, 2006). The Namibian social pension provided N\$160 per month to the elderly over age 60, an amount estimated to be sufficient to feed three adults, on average across the country (Devereux, 2001, 43). Of the total pension, 13.8% was dedicated to pensioner health expenses. Only 28% of total pension income was spent on pensioners themselves, the remainder going to the household or relatives. Grandchildren were the largest group of secondary beneficiaries, receiving more than half of the remaining pension income (55%), followed by adult children (25%), and spouses (9%) (Devereux, 2001).

According to the 2006 evaluation of Ethiopia's PSNP, 29% of beneficiaries spent some of their cash benefits on health (Devereux et al., 2006, 34). Of these beneficiaries, the poorest beneficiaries were almost twice as likely to use PSNP cash to pay for health care (56% in the two poorest quintiles, versus 23% in the two richest quintiles) (Devereux et al., 2006, 35).

Three-quarters of all households receiving the Mchinji Cash Transfer in Malawi spent some of the transfer on health care (Miller et al., 2008, 40). According to data from September 2007, the average expenditure represented 12.3% of the monthly transfer (Miller et al., 2007).

A 2007 evaluation of Kenya's Cash Transfer for orphans and vulnerable children found that 37% of beneficiaries spent part of their transfer on medical fees, with the average expenditure on health at 6% of the cash transfer. The report also noted that HIV-positive children received ARV treatment, which they had not been able to afford before the cash transfer programme, and that some adult beneficiaries, 30 to 50% of whom were HIV-positive or had developed AIDS, used the transfer to purchase ARVs (Acacia Consultants, 2007, 16, 24).

Table 8.1. Impact of unconditional cash transfer on health

Country/Programme	Use of transfer for health	Health outcomes
Ethiopia	29% of households spent some of the transfer on health	
Kenya	6% of transfer spent on health	
Lesotho	8% of pension spent on health	
Malawi DECT	5% of transfer spent on health	Reported improvement in health status (qualitative assessment)
Malawi Mchinji Cash Transfer	75% of households spent some of the transfer on health	Reduced illness in past month: -21% pts (adults) -13% pts (children) Improvements in child health: +67% pts improved health -56% pts no change -11% pts worse health
Namibia	13.8% of pension spent on pensioner health	
South Africa OAP	3% of pension (rural black households)	Improved health for all household members when income is pooled
South Africa OAP and CSG	Grant made health care affordable and ensured automatic hospital fee waivers	
Zambia SCTS	1.2% of transfer spent on health ^a	Reduced incidence of illness: -12% pts (children 0-5 and adults 19-64) -14.3% pts (elderly)

Sources: Acacia Consultants, 2007; Case, 2001; Croome, 2006; Devereux, 2001; Devereux et al., 2006, 2007; Goudge et al., 2007; MCDSS/GTZ, 2006; Miller et al., 2008; Moller and Ferreira, 2003.

^a Figure represents the proportion of overall spending by beneficiaries on health.

8.2 Impacts of conditional cash transfers on health

Among the documented health-related impacts of conditional cash transfers (CCTs), there is more evidence of changes in the use of services (i.e., health checkups and growth monitoring) and less evidence of changes in health outcomes, such as illness prevalence. Table 8.2 and Figure 8.1 summarize health-associated impacts of CCTs in five countries.

Use of preventive health services

The Honduras *PRAF* evaluation compared three types of CCT interventions: the demand-only intervention involved cash transfers contingent on attendance at health centres, growth monitoring, and school; the supply-only intervention involved the improvement of health and education services; and the demand + supply intervention involved a conditional transfer along with service improvement. Beneficiary groups receiving each of these interventions were compared to a control group that did not receive any intervention. The impact evaluation showed that the type of intervention affected changes in health

service usage. For example, the percentage of children under-3 who visited health-care provision units increased by 21 percentage points under the demand-side intervention (a 45% relative increase) and 15 percentage points under the demand + supply intervention. This effect did not vary by child age. The supply-side only intervention had no impact on health-care visits.

PRAF impacts on beneficiary participation in child growth monitoring and prenatal visits followed the same pattern according to type of intervention. The percentage of children under-3 attending growth monitoring as reported by mothers increased by 22 percentage points under the demand-side intervention and 17 percentage points in the demand + supply intervention. Again, the impact was consistent across all ages. While attendance remained stable under the supply-only intervention, this represented an improvement over the control group, whose attendance decreased. Administrative data (from *Tarjetas del Niño*, or Child Cards) showed a smaller impact than did interviews with mothers, but the relative changes remained unchanged: the demand-side intervention brought about a 16-percentage-point increase in growth control visits; the demand + supply intervention, a 13-percentage-point increase; and the supply-side intervention, an 8.3-percentage-point increase. The percentage of pregnant women having attended five or more antenatal care sessions increased by 19.5 percentage points under the demand-side intervention, 18 percentage points under the demand + supply intervention, and 14 percentage points under the supply-side intervention (albeit slightly less statistically significant) (IFPRI, 2003b, 36-45).

The fact that the supply-side interventions showed small and statistically insignificant impacts on service usage and that the combination of demand and supply added little significant additional impact above and beyond the impact of the demand-only intervention was attributed to the low degree of supply-side implementation (IFPRI, 2003b, 70). This is unfortunate as it would have shed light on an important debate about conditionality, i.e., whether improving supply is sufficient to bring about human capital improvements, without the need for conditionality. It did, however, provide evidence on another issue in the conditionality debate, that is, the implementation difficulties that can be encountered as a poor country attempts to improve the supply of services. Nicaragua provides a contrary example, however, as it was able to successfully improve supply.

In Nicaragua, RPS resulted in an increase in the percentage of children under-3 attending well-child visits at an average increase of 16.3 percentage points in 2001 and 8.4 percentage points in 2002. The reduction in impact measured in the second year was due to greater attendance among the control group in 2002 (10.5 percentage points) and only a slight decline in intervention areas. There was also a 13.1 percentage point double-difference estimate in the percentage of children taken to health-care providers and weighed. From 2000 to 2002 the control group increased attendance at health-care providers by 15.2 percentage points, whereas beneficiary households increased attendance by 28.3 percentage points, nearly double the increase in the control group. Several hypotheses exist to explain the increase in control group usage of health services. It could be because other providers established new health-care services in the area, because RPS drew beneficiary families away from public clinics, reducing wait time and making these health centres more inviting to control households, or because control households increased their use of services in anticipation of the CCT (Maluccio and Flores, 2005, 24, 44).

Impacts on attendance at both health centres and growth monitoring were larger among poorer RPS households. Extremely poor households experienced a 29.9 percentage point increase in children age 0 to 3 getting weighed in the previous 6 months compared to poor households, which experienced a 23.5 percentage point increase. Effects for children age 3 to 5 were even greater than those for children age 0 to 3 (Maluccio and Flores, 2005, 45-46).

In Colombia, *Familias en Acción* brought about significant increases in preventive health-care visits. Attendance at growth monitoring and development checkups, in which children are weighed and mothers receive child nutrition advice, increased by 22.8 percentage points for children below 24 months and by 33.2 percentage points for children 24-48 months (Attanasio et al., 2005, 10).

In Jamaica, PATH increased the average number of preventive health-care visits for children 0-6 by approximately 38% (or .28 visits per 6-months), but had no impact on child immunization rates or on health-care utilization by the elderly (age 60 or over) (Levy and Ohls, 2007). This difference may be because compliance with health conditions was

not enforced for the elderly, but was frequently enforced for children, creating incentives for children's attendance at health centres. The limited impact of PATH on immunization may be because immunization rates of both beneficiaries and nonbeneficiaries were high at the outset. Forty-six percent of the families who took their children to health checkups more regularly said they did so because of the PATH requirement and the majority reported "change in health circumstances" (Levy and Ohls, 2007, 76, 80).

Mexico's *PROGRESA* required beneficiaries to attend public clinics for preventive health visits. Depending on the regression specification used,⁶⁷ *PROGRESA* beneficiaries averaged 2.09 to 11.49 more visits per day to clinics in *PROGRESA* areas compared to those in non-*PROGRESA* areas. The lower estimate represents about 18% more visits—by both beneficiaries and nonbeneficiaries—to clinics in *PROGRESA* areas compared to control areas. If all the increase were attributed to *PROGRESA* beneficiaries, visits would have increased by roughly 60% among this group. Because beneficiaries represent roughly 20% of the total number of families in *PROGRESA* service areas, the impact estimates suggest that beneficiary visits increased twice as much as visits by non-*PROGRESA* families (Gertler, 2000, 10; Gertler and Boyce, 2001, 11).

Disaggregating the attendance at public and private clinics indicates that utilization in public clinics increased by 53% overall. There was no reduction in the usage of private health providers, suggesting that increases in the use of public clinics was not a result of substitution of public care for private care (Gertler, 2000, 12).

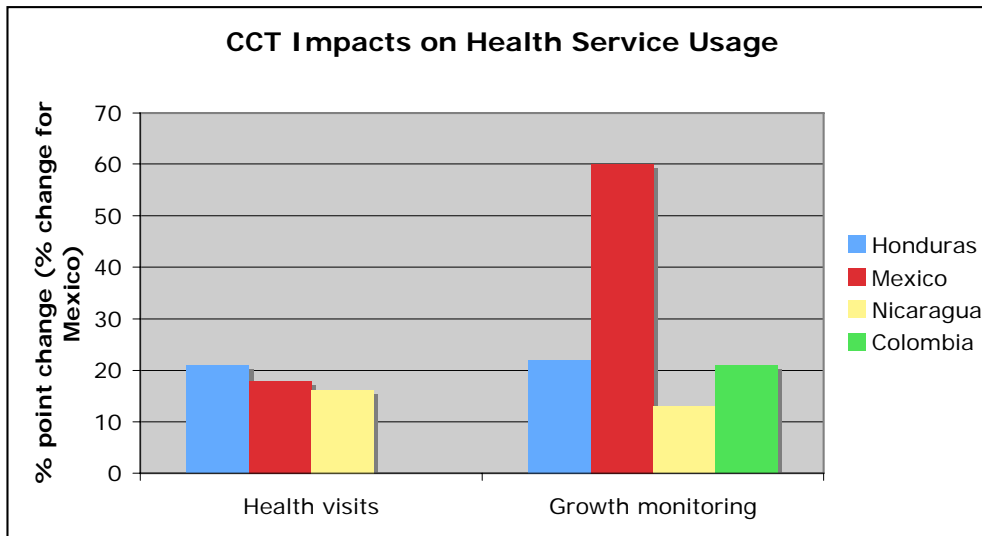
PROGRESA increased growth monitoring visits for beneficiary children age 0 to 2 by 30 to 60% and children age 3 to 5 by 25 to 45%, based on different regression models⁶⁸ (Gertler, 2000, 13). Additionally, *PROGRESA* resulted in an 8% increase in initial prenatal visits during the first trimester of pregnancy. This focus on earlier prenatal care reduced the number of initial visits in the second and third trimesters of pregnancy, a behaviour change that is recognized to improve the health of pregnant women and their infants (Skoufias, 2005, 56).

⁶⁷ The smaller figure comes from a regression using a dummy to indicate whether the facility was located in a *PROGRESA* service area; the larger figure emerges from a regression using the number of families in the service area receiving *PROGRESA* benefits (Gertler and Boyce, 2001, 10).

⁶⁸ One model adds per capita income to try to separate the transfer income effect from the impact of the nutrition and preventive care (Gertler, 2000).

Figure 8.1 summarizes the results on health service usage.

Figure 8.1. CCT impacts of conditional cash transfers on health service usage, by programme beneficiaries



Sources: Attanasio et al., 2005; Gertler, 2000; Gertler and Boyce, 2001; IFPRI, 2003b; Maluccio and Flores, 2005.

Notes: Upper estimates plotted in the graph for Mexico and Honduras. Also, the figure for Mexico represents percent increase while other figures represent percentage points (explaining the large difference).

Health outcomes

Only CCTs in Mexico and Colombia show evidence of impacts on health outcomes. Other programme evaluations either do not measure this (Nicaragua and Brazil) or demonstrate no impact (Jamaica and Honduras). In Honduras, it was hoped that *PRAF* would reduce the prevalence of diarrhea because required growth monitoring, conducted via the AIN-C strategy, also provided counselling to help mothers modify hygiene and eating behaviours related to diarrhea risk. Diarrhea prevalence was very high before the project started, but instead of reducing prevalence, the percentage of children experiencing episodes of diarrhea increased from 2000 to 2002 in all intervention groups. The most significant increase was among supply-only group, again explained at least in part by the low levels of supply-side implementation (IFPRI, 2003b, 71, 84). In Jamaica, the lack of impact could have been because changes in health outcomes take longer than beneficiaries had been exposed to the programme, or because the measure of health status was fairly crude (since

it was not a primary outcome indicator of the PATH evaluation) (Levy and Ohls, 2007, 82).⁶⁹

Mexico's *PROGRESA* significantly lowered illness rates among children age 0 to 5, as reported by mothers, but only for children who had been receiving benefits for at least 12 months (Gertler and Boyce, 2001, 13). *PROGRESA* children age 0 to 5 had a 12% lower incidence of illness than non-*PROGRESA* children (Gertler 2000, 14). This estimate should be considered a lower bound of the impact of *PROGRESA*, because mothers' definitions of illness may have changed due to health and nutrition messages conveyed in the regular lectures (also a condition of the programme) and because the increased frequency of well-child preventive health visits may have made mothers more likely to report illness than before (Gertler and Boyce, 2001, 13).

Adult *PROGRESA* beneficiaries also benefited from improved health outcomes. Even though adults were only required to attend one preventive health visit per year, 70% of the monetary transfer, on average, was used for increased quantity and quality of household food consumption, perhaps contributing to improved health status (Gertler and Boyce, 2001, 13). Adult *PROGRESA* beneficiaries (age 18-50) experienced 17% fewer days incapacitated by illness, 22% fewer days in bed due to illness, and 19% fewer days of difficulty with daily activities. Beneficiaries over 50 also benefited from fewer days of incapacitation or "in bed" and fewer days of difficulty in daily activities compared to nonbeneficiaries of the same age (Gertler, 2000, 15; Gertler and Boyce, 2001, 16).

Oportunidades (the follow-up to *PROGRESA*) was associated with an 11% reduction in maternal mortality and a 2% reduction in infant mortality. The effect of *Oportunidades* on maternal mortality was stronger in municipalities characterized by high marginality and the effect on infant mortality was stronger in municipalities characterized by very high marginality. The protective effect of the programme manifested itself immediately after programme implementation and there was no evidence that the effect changed over time (Hernández et al., 2004).

⁶⁹ The PATH survey asked: "Relative to last year, is [NAME's] current health: much better, better, about the same, worse, or much worse?" (Levy and Ohls, 2007, 82).

In Colombia, *Familias en Acción* resulted in a reduction of nearly 11 percentage points in diarrhea incidence in the previous 15 days among children age 0-4 living in rural areas. There was no statistically significant impact on diarrhea incidence for children living in urban areas or for respiratory disease incidence in either rural or urban areas. These results may be a result of the educational lectures, focusing on nutrition and hygiene, which trained mothers to better recognize symptoms of diarrhea (Attanasio and Gomez, 2004, 145; Attanasio et al., 2005, 10).

Table 8.2. Impacts of conditional cash transfers on health

Country/Programme	Attendance at growth monitoring	Attendance at health check-ups/visits	Illness prevalence
Honduras <i>PRAF</i>	+17-22% pts (age 0-3) ⁷⁰	+15-21% pts (age 0-3)	*(diarrhea)
Mexico <i>PROGRESA</i>	+30-60% (age 0-2) ⁷¹	+18.2% (clinics in <i>PROGRESA</i> areas)	-12% (age 0-5) (-4.7% pts)
Nicaragua <i>RPS</i>	+13.1% pts	+16.3% pts	
Colombia <i>Familias en Acción</i>	+16% pts (age 0-2 urban) +21% pts (age 0-2 rural) +48% pts (age 2-4 rural)	+23% pts (0-2) +33% pts (2-4)	-11% pts in diarrhea incidence (age 0-4, rural)
Jamaica <i>PATH</i>	NA	+38% (age 0-6, no impact on elderly)	No significant impact

Sources: IFPRI, 2003b; Gertler and Boyce, 2001; Gertler, 2000; Skoufias, 2005; Hernandez-Prado and Hernandez-Avila, 2006; Maluccio and Flores, 2005; Attanasio et al., 2005; Levy and Ohls, 2007; Attanasio and Gomez, 2004.

*= No impact.

8.3 Complementary activities for health and new programme designs in the context of AIDS

As with education services, health services and related activities can be linked with cash transfer programmes, whether or not they involve conditions. People's contact with health facilities, for example, where young children are brought in for immunizations or people seek treatment for illnesses, can be used as an opportunity to promote access to cash transfers. Health facility visits and home-based care (HBC) could be used for identifying people who are eligible but not receiving benefits, for providing information and support with respect to transfer eligibility and the application process, and for facilitating access to

⁷⁰ The group exposed to demand-side incentives exhibited a 21.7-percentage-point increase in growth monitoring attendance and the group exposed to both demand- and supply-side incentives experienced a 17.4-percentage-point increase (IFPRI, 2003b, 36).

⁷¹ Difference reflects two models: one controls for per capita income (Gertler, 2000).

documents needed to access cash transfers, such as birth certificates (see, also, Section 10.4).

There is also research examining new forms of linking cash to health interventions that are particularly relevant in the context of HIV and AIDS. Below are some examples.

Voluntary testing and counselling

Voluntary testing and counselling (VTC) for HIV/AIDS is considered an effective HIV prevention and control strategy. In Sub-Saharan Africa, where most new infections occur through heterosexual transmission, this is a particularly promising approach. A study by Bakari et al. (2000) in Zambia looked at appropriate formats and venues for VTC using a community survey of attitudes toward VTC (comparing those seeking and declining HIV testing), pre and post-counselling surveys of HIV knowledge, and a pilot study of same-day VTC in urban antenatal care clinics. Results indicate that 98% of participants supported the promotion of VTC in the community. The majority thought that community workers were most effective at promoting this and 83.8% preferred same-day testing. Counselling accompanying VTC was found to improve knowledge by reducing incorrect knowledge of transmission by at least one-half. Even with strong community support for VTC, however, there are often important logistical constraints to testing, such as costs faced by potential beneficiaries (e.g., transportation, testing fee, opportunity cost of time), hours of operation (e.g., convenient times available for both men and women), availability of childcare on site, and the regularity of couples testing (giving couples an opportunity to consult beforehand) (Bakari et al., 2000).

Three studies have been planned or are underway to look at the effectiveness of incentives related to testing and staying STI-free. These studies are testing conditionality, and are discussed here, as elsewhere in this report, to present examples of adapting cash transfer programmes (conditional or unconditional) to respond to priority issues in regions highly affected by AIDS. From these studies, it may be possible to learn about what an effective complementary programme of cash transfers and STI testing, counselling, and related support would look like.

In South Africa, a study is proposed to provide a small cash transfer to young people age 18-24, for staying STI-free, as well as helping them to set goals and plan to achieve them. This group will be compared to another group receiving standard HIV prevention counselling. The hypothesis is that young people may engage in risky sexual behaviour when they do not have hope for a better future, and that providing financial and other support will encourage this optimism (Richter et al., 2006). A similar rationale, although not articulated in the same way, underpins a study in Tanzania, where the World Bank is piloting a CCT to prevent HIV and other STIs among young adults age 18-29 in rural areas. Participants will be monitored for a set of common STIs, serving as a proxy for risky sexual behaviour and vulnerability to HIV. All participants will receive a small payment throughout the course of the study (in part to prevent attrition). Those testing positive for an STI will receive treatment and counselling and those testing negative will receive an additional stipend per quarter. The size of the stipend will vary (from \$10-30/quarter) to test the effects of varying transfer size. This evaluation will run from 2007-2009 (World Bank, 2007a). In three districts of Malawi, researchers will use a panel study of 1,200 men and women who will receive monetary incentives to stay HIV-negative for one year. The transfer size will vary randomly among beneficiaries. Data collection will involve self-administered sexual diaries reporting changes in behaviour in response to the monetary incentives (Poverty Action Lab/MIT, 2007).

Antiretroviral therapy

Antiretroviral drugs can be an effective way to inhibit viral replication and reduce viral load, and can also improve nutritional status. Highly active antiretroviral therapy (HAART) has been shown to positively affect child growth among children with advanced disease and poor nutritional status prior to taking ARVs, and to promote sustained weight gain, increase BMI, and reduce anemia among adults (Verweel et al., 2002; Silva et al., 1998; Schwenk et al., 1999; Semba, Shah, & Vlahov, 2001, cited in Gillespie and Kadiyala, 2005, 56). Kenya's Cash Transfer for OVC plans to provide referrals to programmes that provide ARVs for beneficiaries who voluntarily declare that they are HIV-positive or living with AIDS (OVPMHA, 2006, 9).

Of course, the provision of ARVs does not guarantee their benefits; compliance with the drug regimen is critical. It may be possible to use cash transfer programmes as a means of strengthening communications systems and counselling around drug regimen adherence, for example, by using lay providers and expert patients (van Damme and Kegels, 2006). In Uganda, a study by Weidle et al. (2006) found that adherence interventions, including individual and group counselling, personal adherence plans, and weekly home delivery of ART, improved adherence. Of course cash transfers can also improve adherence through enabling purchase of food, reducing side-effects of the drugs.

Home-based care

The World Health Organization defines home-based care as “any form of care given to sick people within their homes [including] physical, psychosocial, palliative and spiritual interventions.” A study by ActionAid in Zambia showed that 90% of HIV-affected individuals prefer to be cared for in their own homes (Voluntary Service Overseas, 2006). Home-based care (HBC) can include physical palliative care, such as treating illnesses and managing pain, nutritional counselling and support, support for ARV adherence and mitigating side-effects, and psychosocial support both for PLWAs and their families (Slater, 2004). In Zambia, community nurses provide examinations and care plans; home visits and consultations; prescription and provision of drugs free of charge; general nursing care; training family members about how to care for patients; patient assessment and referral; pre- and post-test counselling; counselling for family members and children; provision of information and awareness raising; and training community volunteers. Community HBC volunteers, in turn, identify patients with chronic illness; provide information, basic nursing care (including drug provision), and practical household support (e.g., household activities, farming, funeral arrangements). They also counsel individuals before and after HIV tests and family members of people with HIV, often incorporating spiritual and emotional support (Nsutebu et al., 2001). Zimbabwe’s Red Cross Home Based Care (HBC) programme has been operational since 1992 and benefits an estimated 40,000 patients (McCord, 2005). As noted earlier, there are various ways in which HBC programmes could build mutually supportive links with cash transfer programmes. In Malawi’s Social Cash Transfer Scheme, CBOs, extension workers, and

child protection workers are tasked with providing access to Home Based Care for cash transfer beneficiaries (UNICEF Q&A, undated).

Despite the promise of HBC, there are several important constraints to its expansion. First, many programmes rely on volunteers who may themselves face challenges associated with HIV/AIDS, including taking care of ill family members or being sick themselves. Given the likelihood of conflicting demands on HBC volunteers' time, some programmes have introduced incentives to increase motivation. A cash transfer offers this potential, in effect creating a work-based transfer programme. In fact, public works programmes paying people in cash or food to work in HBC has been considered in several countries. For example, The Ndola Catholic Diocese HBC programme in Zambia allows HBC volunteers to purchase food at a reduced rate, and the Red Cross HBC programme in Zimbabwe pays HBC workers low wages as part of the public works programme (Voluntary Service Overseas, 2006).

South Africa's Department of Health, as well as its Expanded Public Works Programme, are also scaling up Home and Community-Based Care, involving training and payments to volunteers, providing forms of social protection for caregivers and care recipients. More information is provided on these initiatives in Section 10.6.

9. Cash transfers, food consumption, and nutrition

Children in AIDS-affected families face multiple sources of risk that threaten to undermine their food security and nutritional status. As discussed in Section 2, malnutrition at early ages, particularly under two years of age but also continuing through early childhood, has long-term impacts on children's school enrolment and performance, cognitive development, and their productivity and earnings later in life. For these reasons, we focus on the potential of cash transfers to affect nutritional status, reviewing the evidence to date. This evidence includes cash transfer impacts on expenditures on food, the quantity and quality of food consumed, and changes in measures of child malnutrition: stunting, underweight, and wasting.⁷²

9.1 Impacts of unconditional cash transfers on food consumption and nutrition

Food expenditure and consumption

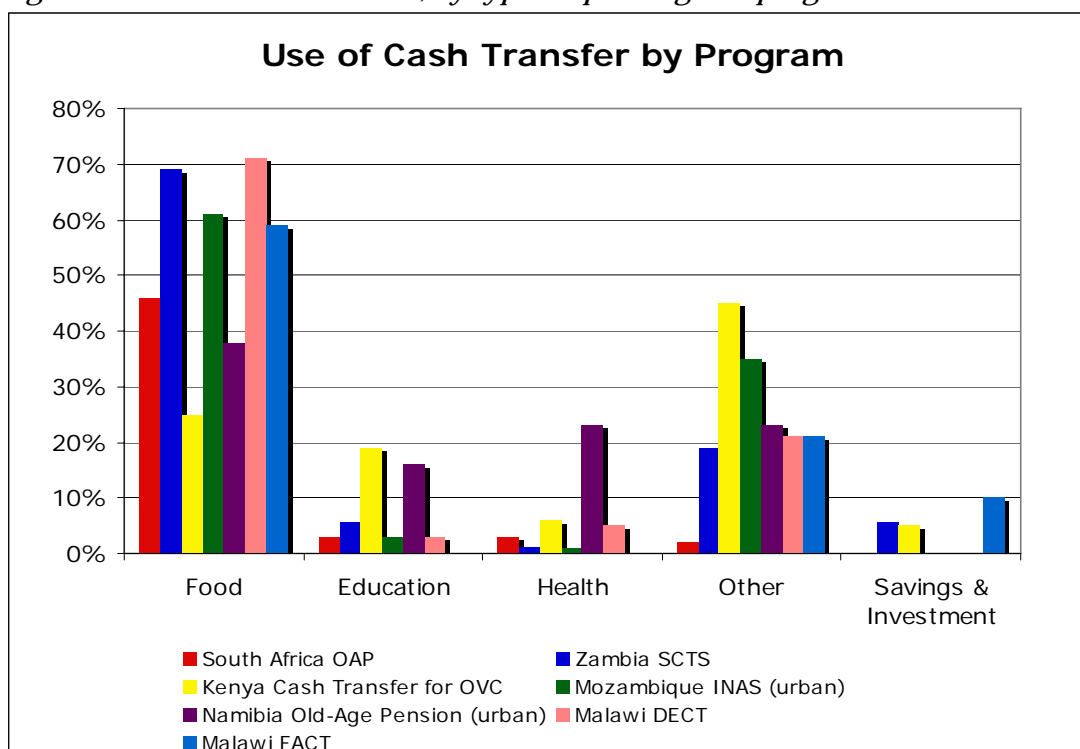
There is considerable evidence that unconditional cash transfer programmes have increased food expenditure and food consumption. In most programmes, beneficiaries use the majority of the transfer to purchase food. Figure 9.1 illustrates the relative shares of transfer spending, with the highest spending on food, followed by spending on other goods (including clothing and shoes, blankets, transportation, and household spending, e.g., water and electricity, hygiene, and livestock).

According to Samson et al. (2004), in South Africa the number of male OAP pensioners was significantly associated with a larger share of household expenditure dedicated to food, although this had no impact on reducing hunger. On the other hand, the number of female pensioners was associated with lower prevalence of hunger, but had no impact on the share of household expenditure on food. These results are consistent with the theory of the non-unitary household in which increases in household expenditure do not

⁷² Stunting (height-for-age more than 2 standard deviations below the international reference level), reflects past as well as current nutrition and illness and is considered the best measure of long-term undernutrition. Wasting (weight-for-height more than 2 standard deviations below the international reference level) indicates significant recent or current weight loss. Underweight (weight-for-age more than 2 standard deviations below the international reference level) can reflect either stunting or wasting (World Bank, 2006b).

automatically translate into improved household consumption for all household members. Male pensioners may have spent pension money on food for themselves instead of other household members, while female pensioners may have allocated more of the pension to young children and other household members (Samson et al., 2004, 82). In Namibia, 27% of pension income was dedicated to food for the family and 10.6% to food for the pensioner (Devereux, 2001).

Figure 9.1. Use of cash transfer^a, by type of spending and programme



Sources: Acacia Consultants, 2007; Devereux, 2002; Devereux, Mvula, & Solomon, 2006; Devereux et al., 2007; MCDSS/GTZ, 2006; Moller and Ferreira, 2003.

^a In the case of Zambia SCTS the figure represents the proportion of overall spending by beneficiaries on health. In the case of Malawi DECT, these spending numbers refer to 3 months of the 5-month programme period: January-March 2007.

A 2006 evaluation of Ethiopia's PNSP found that 80% of beneficiaries used some cash to purchase staple foods and 11% used some of the transfer for other foods (Devereux et al., 2006, 34). The 2007 PSNP evaluation found no significant effect of PSNP transfers on per capita food consumption, although other measures of food security improved (Gilligan et al., 2007, 39, 42).

On average, beneficiaries of Kenya's Cash Transfer for Orphans and Vulnerable Children spent at least half of the transfer on expenditures related to programme objectives (food, health, and education) (Acacia Consultants, 2007, 16). Eighty-six percent of households reported spending some of the transfer on food, mostly purchasing maize, as well as tea, sugar, beans, rice, and fruit. The relatively smaller share of the transfer spent on food (25%), compared to other programmes (Figure 9.1), may have occurred because the transfer was given in a six-month lump sum, making it difficult to spend all the money on immediate consumables (Acacia Consultants, 2007, 15).

Bazo (1998) noted that in Maputo, Mozambique's GAPVU cash transfer had no effect on food consumption because the transfer was too small. If the entire monthly subsidy (\$3-6/month) had been used to purchase food (which, in general, it was not), it would only have provided 225 calories per day for one person. The study found that mean per capita calories were nearly identical for beneficiaries and nonbeneficiaries, with the sample of 41 elderly beneficiaries consuming 1,403 kilocalories per day compared to 1,453 per day for the 40 elderly nonbeneficiaries. However, there were other programme impacts. Beneficiary reliance on food donations from family and friends and begging declined as beneficiaries began to purchase more food in the market (Bazo, 1998 as cited in Low, Garrett, & Ginja, 1999, 39 and Tarp et al., 2002, 108).

The majority of the cash provided by Malawi's Dowa Emergency Cash Transfer (DECT) programme was spent on food (64% on average), but this share varied over the 5-month period from 70 to 80% between December and February, the most severe months of the food crisis, to 60% in March and 30% in April, when the maize harvest began, contributing to reductions in both prices and demand for maize (Devereux et al., 2007, 33). The transfer was indexed to maize prices to protect beneficiaries against seasonal price fluctuation; however, this adjustment was imperfect, resulting in a disproportionate cut in transfer value with respect to maize price variation in February. This month represented the lowest maize value of the DECT cash in the project period, diminishing households' ability to purchase nonfood items, such as health care, education, and other goods and services. Notwithstanding this drop in the level of cash, taken as a whole, the project helped households cover their missing food entitlement during a difficult time (Devereux et al., 2007, 34).

As in DECT, FACT beneficiaries exhibited different spending patterns over the life of the project (January-April 2006). From January to February, spending on food increased from 63 to 69%, but in March spending on food fell to 45% as beneficiaries spent more of the cash on nonfood items (all compared to mean spending on food of 59%). The authors note that this could be interpreted as a sign of the flexibility of cash transfers, which allow beneficiaries to meet essential nonfood needs, or it could be a sign of over-funding on the part of the FACT programme (providing more than the minimum subsistence needs). However, since nonessential spending was low (less than 15%), it is likely that over-funding was less of a problem than the timing of the receipt of the grant (Devereux, Mvula, & Solomon, 2006, 29).

FACT beneficiaries reported that cash acted as an important complement to the food package for two reasons. The food ration contained insufficient supplies to make the typical meal, so beneficiaries used the cash to purchase other necessary food items (e.g., vegetables or dried fish). Beneficiaries also used cash to cover the cost of milling maize (either purchased or provided in the food package). Milling represented a sizeable share of household expenditure: up to 18% (Devereux, Mvula, & Solomon, 2006, 30). According to a cluster analysis of household spending strategies among FACT beneficiaries in Malawi, 47% of households were categorized as “food first,” meaning they spent the transfer almost exclusively on food. More specifically, these households spent 84% of the transfer on food, followed by maize milling and other groceries (Devereux, Mvula, & Solomon, 2006, 33).

Samson et al. (2004) report impacts of social grants in South African on the share of household expenditure on food items. Receipt of the Child Support Grant was associated with 1.5 and 1.2 percentage point increases in all food items and basic food items, respectively, and receipt of the Disability Grant had a slightly greater impact, with increases of 2.5 and 1.3 percentage points respectively. Each thousand rand of annual pension receipt under the Old-Age Pension was associated with increases of 1.5 and 1 percentage points in all food items and basic food items respectively (Samson et al., 2004, 79).

In a study focusing on HIV-affected households in Free State Province, Booysen (2004b) found that grant income had a greater impact on household food expenditure than

employment income, suggesting that beneficiaries preferred to use the additional resources of social grants to purchase food. Both the Disability Grant and the Old-Age Pension were associated with increases in real adult food expenditure (12.9 and 10.5 percentage point increases, respectively). The impact of the Child Support Grant on food expenditure was slightly negative but statistically insignificant (Booyesen, 2004b, 22- 23).

Hunger and meal frequency

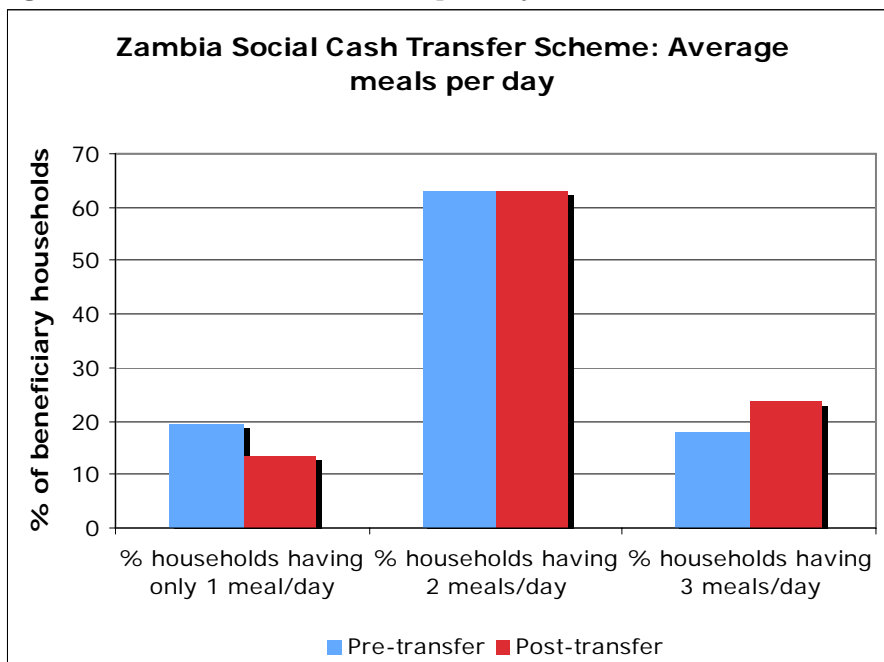
Cash transfers have been found to increase the number of meals consumed per day and reduce the number of skipped meals. Case (2001) found that in South African households where pension income is pooled, the presence of a pensioner lowered the probability that an adult in the household had skipped a meal by approximately 25%. This was supported by open-ended interviews, in which pensioners reported that the pension allowed them to purchase enough food (Case, 2001, 15). According to Samson et al. (2004), having a female pensioner in the household had a greater impact on child hunger than adult hunger: the presence of a female pensioner was associated with a 5.8% lower probability that a young child in the household experienced hunger, and a 4.3% lower probability that adults and older children experienced hunger (Samson et al., 2004, 82).

Lesotho's social pension also resulted in fewer skipped meals by beneficiaries. The percentage of beneficiaries indicating that they never have sufficient food to fill them fell from 20% before receiving the pension to 10% with the pension and the percentage reporting they always had enough food to fill them increased from 36% before receiving the pension to 46% with the pension (Croome, 2006).

An evaluation of Zambia's Social Cash Transfer Scheme indicates a reduction from 19 to 13% in the percentage of households having only one meal a day and a reduction from 56 to 34% in the number of beneficiaries reporting hunger pangs after a meal, suggesting an increase in the quantity of food consumed. Although the percentage of households eating two meals per day remained constant, the percentage eating three meals per day increased by 6-percentage points (see Figure 9.2 below). This result masked differences between the two agricultural blocks, however. Although beneficiaries in Kalomo agricultural block experienced an increase from 1.89 to 2.13 meals per day, on average, beneficiaries in

Kanchele agricultural block barely experienced any change at all, moving from 2.06 to 2.08 meals per day, on average. This may be due to the proportional decline in food aid in Kanchele from baseline to the evaluation and the proportional increase in food aid in Kalomo over this same period (MCDSS/GTZ, 2006, 40-41).

Figure 9.2. Zambia SCTS: Meals per day



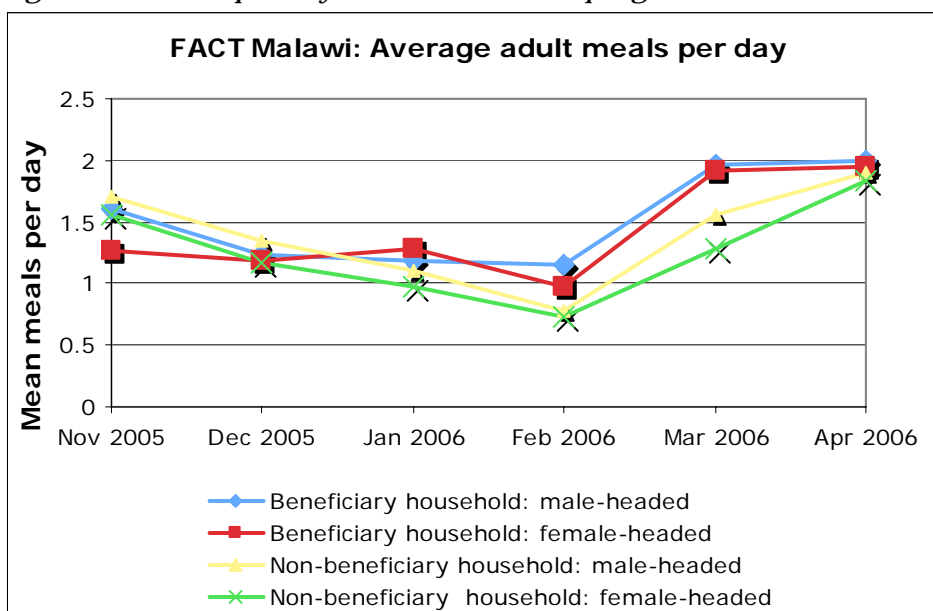
Source: MCDSS/GTZ 2006.

Malawi's DECT programme brought about significant increases in meals per day for beneficiaries, from an average of 1.5 meals per day for children and adults at baseline to an average of 2.4 meals per day at evaluation (Devereux et al., 2007, vii). Meals per day increased by as much as 40% for adults in female-headed households immediately following the transfer, and stayed high throughout the duration of the programme. This increase in meals per day suggests that DECT protected consumption during the annual hungry season. Also, the gender gap in food consumption between male- and female-headed households was eradicated after receipt of the transfer. However, Devereux et al. point out that while "meals per day" is a good indicator of general food security, it is a weak proxy for food intake because families could maintain the same meal frequency while consuming smaller portions. Given the absence of a control group of nonbeneficiaries for

the DECT evaluation, it is not possible to conclusively attribute positive findings on household food security to receipt of DECT transfers (Devereux et al., 2007, 34-35).

The FACT programme in Malawi had a control group, and prior to the provision of FACT transfers, there was no statistically significant difference in average meals per day between beneficiary and nonbeneficiary households, although nonbeneficiaries consumed marginally more than beneficiaries. After the transfer was provided and throughout the project period (January-April 2006), food consumption was higher in beneficiary households compared to nonbeneficiary households (see Figure 9.3 below). The transfers prevented beneficiary households from suffering the same degree of rationing and hunger that nonbeneficiary households experienced in early 2006 (Devereux, Mvula, & Solomon, 2006, 36-37).

Figure 9.3. Meals per day in Malawi's FACT programme



Source: Devereux, Mvula, & Solomon, 2006.

Evaluation results from Malawi's Mchinji Cash Transfer programme also highlight improvements in food consumption. From March 2007 to March/April 2008, 93% of intervention households reported improved food consumption compared to 11% of comparison households. At the same time, only 1.3% of intervention households reported worsened food consumption, whereas 36% of comparison households reported this. On

the whole, intervention households experienced greater satisfaction after meals (23 percentage points higher than comparison households) and were less hungry after meals. Among intervention households, only 6.4% reported being somewhat hungry, and 1.1% being very hungry, after meals compared to 32% and 4.8%, respectively, of comparison households. On average, comparison households experienced 5.2 days without enough food in the previous month, compared to 1.2 days in beneficiary households. There were notable differences in perceptions of whether the household had sufficient food between intervention and comparison groups. Among the intervention group, 80% expressed that they had sufficient food for consumption and 10% reported that they did not have enough, whereas among the comparison group, only 20% said they had enough food to eat and 80% said they had too little. Nearly half (44%) of all household heads from intervention households had eaten three meals the day previous to the final follow-up survey compared to 8% of comparison household heads (Miller et al., 2008, 34).

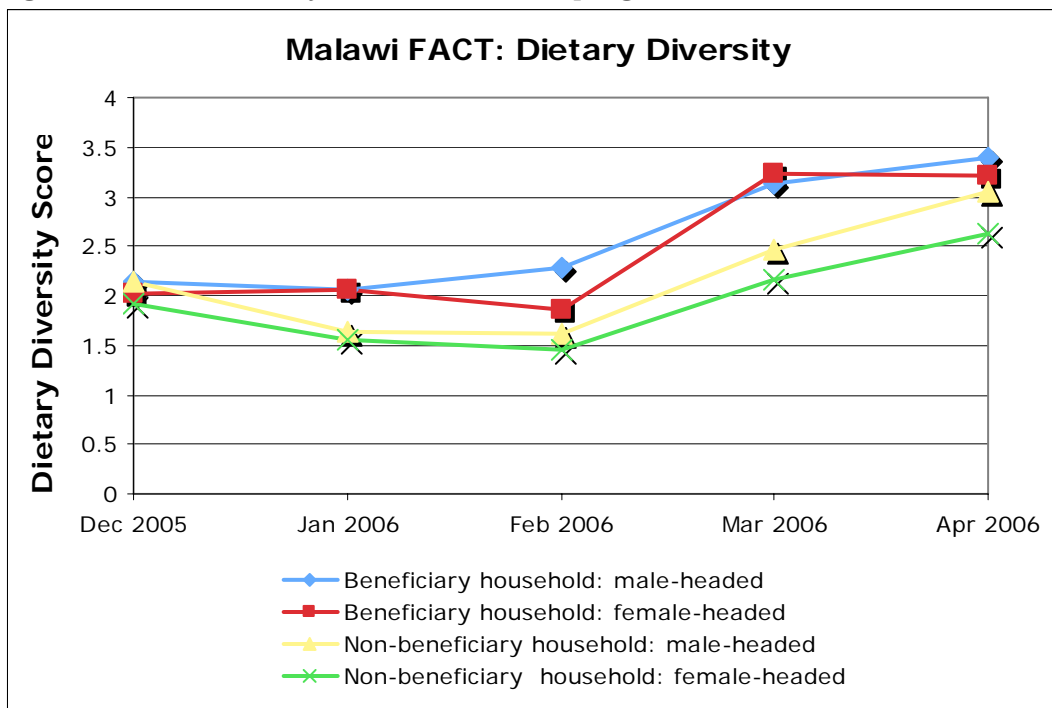
According to the 2006 evaluation of Ethiopia's PNSP, three-quarters of beneficiary households reported consuming more and/or better quality food after receiving the transfer and 94% of these households attributed the improvement to PSNP. Approximately 60% of beneficiaries were able to keep more of the food they produced for their own consumption rather than sell it for other needs and 90% of these credited this change to the programme. Still, despite these improvements, reports of hunger and rationing continued because the transfers were small and unpredictable (Devereux et al., 2006, 40). The larger 2007 impact evaluation of the PSNP found that households receiving at least half the transfer amount they should have received had (a) significantly lower probability of having low per capita calorie availability (< 1,800 kcal/capita/day) of 10.6 to 11.2 percentage points; and (b) increased mean household calorie availability of 181 to 183 kcal per person per day in the previous 7 days compared to control households (Gilligan et al., 2007, 38-42).

Dietary diversity

Most programmes demonstrated positive impacts on dietary diversity. FACT beneficiary households consumed more diversified diets compared to nonbeneficiaries. In late 2005, all households had very low Dietary Diversity Scores, indicating that they were eating an

average of two distinct food groups per day. For nonbeneficiary households (and to a lesser degree female-headed beneficiary households), these scores fell during the hungry season (January and February), until March harvests provided staple cereal and root crops, pulses, and vegetables. Beneficiary households, in contrast, experienced consistently higher Dietary Diversity Scores throughout the programme period, and by March Dietary Diversity Scores for both male- and female-headed beneficiary households surpassed a score of 3 (see Figure 9.4 below). One explanation for this higher score is that FACT provided three food groups in its food package—cereals (maize), pulses (beans), and fat (oil)—which improved both food consumption and dietary diversity for recipient households. In addition to the food transfer, the FACT cash transfer enabled beneficiaries to purchase additional foods, including vegetables, meat, and fish (Devereux, Mvula, & Solomon, 2006, 37-38).

Figure 9.4. Diet diversity in Malawi's FACT programme



Source: Devereux, Mvula, & Solomon, 2006.

During the first four months of the DECT project in Malawi, beneficiaries experienced a slight increase in dietary diversity—from consuming an average of 2.5 food groups in November 2006 to an average of 3 food groups in male-headed households and 2.8 in

female-headed households in March 2007. In April 2007, when spending of the DECT transfer on food was at its lowest, dietary diversity increased by even more, reaching 4 food groups for male-headed households and 3.6 for female-headed households. According to the evaluation of DECT, this makes it difficult to attribute changes in dietary diversity to the cash transfer, but does not diminish the impact of DECT on increasing the purchase and consumption of basic food items (Devereux et al., 2007, 36).

Zambia's Social Cash Transfer Scheme improved the dietary diversity of beneficiary households. Average weekly fat consumption rose from 0.67 days a week to almost 2 days a week and the percentage of households consuming oil at least once a week rose from 18 to 48%. The percentage of households consuming proteins 7 days a week increased from 23 to 35% and the percentage of households consuming vitamins 7 days a week increased from 72 to 84%. Programme beneficiaries also increased their consumption of cultivated and wild vegetables (66 to 82% and 69 to 76%, respectively), cultivated fruits (17 to 18%), and dried vegetables (1 to 16%). Consumption of wild fruits fell from 57 to 26%, indicating an improved food situation since consuming wild fruits is often a coping strategy of last resort when no other food is available (MCDSS/GTZ, 2006, 41).

As of September 2007, approximately 6 months after the transfers began, 92% of households that had been receiving Malawi's Mchinji Cash Transfer said they were more likely to eat higher quality foods, including fish, chicken, beans, and some vegetables, because of the transfer. Dried fish consumption rose more than five times (from 12 to 63%) among intervention households, while it nearly doubled (from 5 to 9%) among comparison households; fresh fish consumption nearly doubled (from 11 to 19%) among intervention households and fell by one-third (from 6 to 4%) among comparison households; and beef consumption increased fourfold (from 2 to 8%) among intervention households and fell slightly (from 1% to less than 1%) among comparison households (Miller et al., 2007). By March/April 2008, intervention households consumed 8.1 food groups, on average, compared to comparison households, which consumed 4.9 groups (Miller et al., 2008, 35).

In Lesotho, about one-third of pension income, on average, was used for food for the household, often for the purchase of items like meat, eggs, and sugar. However,

pensioners themselves only ate 40% of this extra food, on average, so 60% of the total additional food benefited other household members (Beales, 2007; Croome, 2006).

Nutrition

The best empirical evidence of impacts of unconditional transfers on nutrition comes from South Africa, for both the Child Support Grant and the Old-Age Pension. Using data from KwaZulu-Natal, Agüero, Carter, and Woolard (2007) find that large “dosages” of the CSG in early life increased child height. The impact of the CSG depended on the age of introduction of benefits and the regularity of these benefits during what is considered the “nutrition window of opportunity,” a child’s first three years of age. During this time children are most susceptible to nutritional shortfalls—they are growing very quickly so have high nutritional needs and tend to experience disease (especially diarrhea when they transition from breast milk to adult foods)—and any growth faltering is likely to have a permanent effect on physical and cognitive development. Receipt of the CSG during this “window of opportunity” was found to be critical to the grant’s impact on child growth. Indeed, children who first received the CSG transfer after age two or who benefited for less than 20% of the nutrition window of opportunity experienced no statistically significant impact. Effects were insignificant for children receiving CSG support for less than 50% of the three-year window. However, children who received the transfer before age two and continued to receive benefits for at least two-thirds of the first three years of life experienced a significant improvement in height attainment. These children had height-for-age *z*-scores 0.25 higher than children who received benefits for only 1% of the first three years of life.⁷³ Taking a specific case, a male child who received the CSG before age 1 and received benefits for two-thirds of the first 3 years of life experienced gains in height-for-age of 0.4 or approximately 3.5cm, leading to a 2.1% gain in adult height. These increased future earnings are estimated to be 1.5 to 2 times, or 60 to 130%, higher than the cost of CSG support (Agüero, Carter, & Woolard, 2007, 3, 6, 17-21).⁷⁴

⁷³ The authors use three categories of children as the control group: children who received the CSG after they were 3 years old, children who applied for the grant but whose applications were rejected or whose benefits had not yet begun, and children for whom applications for the CSG were never made (Agüero, Carter, and Woolard, 2007, 8).

⁷⁴ Using Thomas and Strauss (1997)’s estimate of the elasticity of wages for urban males in Brazil, the gains in South African wages from an increase in height of 2.1% would be between R190 and R262 (Agüero, Carter, and Woolard, 2007, 19).

Several studies illustrate impacts of the South Africa OAP on child growth. Duflo (2003) analyzed the impact of the OAP on child nutritional status using data from a 1993 national household survey, when most pension beneficiaries (men over 65 and women over 60) received roughly twice the median per capita income in rural areas (Duflo, 2003, 3). Duflo found an improvement in under-five child nutrition, especially for girls, when the grant pension recipient was a woman (Duflo, 2000, 398). On average, pension income contributed to an increase of 0.68 standard deviations in height-for-age for girls. Pensions received by women were associated with increased height-for-age (1.16 standard deviations) and weight-for-height (1.19 standard deviations) for girls, but had a smaller and statistically insignificant effect for boys: height-for-age increased by 0.28 standard deviations (Duflo, 2003, 14-16). This is a large effect for girls, considering that the average eligible child had a height-for-age z-score of -1.4. Converted into centimeters, these anthropometric improvements represent a 2.23 cm increase in girls' height and a 0.88 cm increase in boys' height over a two-year period, when the pensioner was a woman. Pensions received by men were not associated with improved nutritional status of either girls or boys (Duflo, 2000, 398; Duflo, 2003, 3). According to Duflo, the differential effect of pension income on child nutrition was a result of female recipients being younger (their eligibility begins at 60 compared to 65 for men) and living longer. Duflo hypothesized that compared to older pension-receiving grandfathers, pension-receiving grandmothers were apt to have stronger incentives to invest in children because they would benefit from their support for a longer period of time in the future (Duflo, 2003, 19-20).

Case (2001) found a slightly larger impact of the South Africa OAP. According to her analysis, a pensioner in the household was associated with a 5-cm increase in child height and a one standard deviation increase in height-for-age, equivalent to 6 months worth of growth for black and colored children age 0-6 (Case, 2001, 11).

In Zambia, monitoring reports for the Social Cash Transfer Scheme noted a 9-percentage-point decrease in the proportion of underweight children (from 41 to 32%) (MCDSS/GTZ, 2005). Qualitative data also indicated that households benefited from improved dietary intake and, therefore, may have experienced improved nutritional outcomes; nevertheless, the survey figures should be interpreted very cautiously. The study reflected a small subset of beneficiary children since not all had growth monitoring cards and only a small number

of children were weighed. Furthermore, the anthropometric data may have reflected weight fluctuation due to seasonal food availability and disease (Sridhar and Duffield, 2006, 13).

The Mchinji Cash Transfer Scheme demonstrated some impact on child underweight, but no impact on mean weight (measured as weight-for-age z-scores). At baseline (March 2007), the percentage of underweight children in both intervention and comparison groups was roughly 35%. One year later, 15% of intervention children were underweight (a reduction of 20 percentage points) and 26% of comparison children were underweight (a reduction of 9 percentage points), representing an impact of 11-percentage points (Miller et al., 2008, 28).

Table 9.1 provides a summary of impacts of UCTs on food consumption and nutrition.

9.2 Impacts of conditional cash transfers on food consumption and nutrition

CCTs can affect nutrition through several pathways. One is the cash transfer. In addition, they usually offer counselling about food consumption, dietary diversity, and various aspects of nutrition, often through regular workshops that are required in order to receive the cash transfers. Furthermore, there are often required health and growth promotion visits for young children, and sometimes mothers. Evidence of CCT impacts indicates that food consumption has improved across programmes—in terms of quantity of food/calories, or dietary quality—but results for nutritional status and anemia are less consistent.

Table 9.1. Summary of impacts of unconditional cash transfer programmes on food consumption and nutrition

Country/Programme	Food consumption	Hunger/ meals per day	Dietary diversity	Nutritional status
Ethiopia PSNP		-10.6-11.2% points likelihood that household had low calorie intake; +181-183 kcal per person		
Lesotho Old-Age Pension		-10% pts never enough to eat +10% pts always enough to eat		
Malawi DECT		+ .9 meals/day +40% meals/day (female-headed households)	No impact	
Malawi FACT		+ .75 mean meals/day (female-headed households) + .4 mean meals/day (male-headed households)	+1 food category per day, on average	
Malawi Mchinji Cash Transfer	+83% pts food intake improved -35% pts food intake worsened	+23% pts satisfied after meal -25.5% pts somewhat hungry after meal -3.7% pts very hungry after meal	+3.2 food groups consumed per day, on average	-11% pts child underweight No change in mean WAZ
Mozambique GAPVU		No impact (Low et al. 1999)		
South Africa CSG	+1.5% pts (all food items); +1.2% pts (basic food items)			+3.5 cms, on average, if received CSG during first year of life and for at least 2/3 of first 3 years
South Africa OAP	+1.5% pts (all food items) +1% pt (basic food items) +10.5% pts in real adult food expenditure (HIV-affected households)	-25% chance that adult skipped meal (if pension income pooled) -5.8% probability of hunger (young child) -4.3% probability of hunger (adults and older children) (if pension received by woman)		+2.23 cms (girls) +.88 cms (boys) if pension received by woman (national) +5 cms (black and colored children) (Western Cape)
Zambia SCTS		-6% pts households eating one meal/day +6% pts households eating 3 meals/day	+12% pts households consuming vitamins 7x/week +11.6% pts households consuming protein 7x/week +30.4% pts households consuming oil 1x/week	Possible reduction in % of underweight children

Sources: Agüero, Carter, & Woolard, 2007; Booysen, 2004a; Case, 2001; Croome, 2006; Devereux, Mvula, & Solomon, 2006; Devereux et al., 2007; Duflo, 2003; Gilligan, Hoddinott, & Taffesse, 2007; MCDSS/GTZ, 2006; Low, Garrett, & Ginja, 1999; Miller et al., 2008; Samson et al., 2004.

Even if the food share remains unchanged, households may benefit from higher caloric availability. In Mexico, *PROGRESA* brought about a 10.6% increase in the median value of food consumption and a 7.8% increase in median caloric acquisition from March 1998 to November 1999 (benefits began in May 1998). Improvements were proportionally greater for the poorest households: food consumption was 13.5% higher among beneficiary households in the 25th percentile compared to being only 5.1% higher among beneficiary households in the 75th percentile (Hoddinott, Skoufias, & Washburn, 2000, 20, 35).

In Turkey households that received regular cash transfers experienced a 22.6% increase in per capita calorie availability compared to the comparison group, but households receiving irregular transfers demonstrated no difference from the comparison group (Ahmed et al., 2007).

Dietary diversity

In Nicaragua, whereas at baseline all households ate an average of 12.1 different food items, by the end of the two-year evaluation RPS households reported consuming 4 additional food items, on average, compared to control households. Furthermore, beneficiaries consumed food with higher nutritional quality. RPS beneficiaries consumed less of the two staples (grains and beans), which had made up more than half of their pre-RPS diet and consumed more nutrient-dense foods, such as meats, vegetables, and fruits, which were encouraged in the RPS education sessions. Expenditures on these items increased both in absolute terms and as a percentage of total expenditures (Maluccio and Flores, 2005, 32). Ethnographic case studies observed the resistance people had to consuming unfamiliar foods, however, revealing the difficulties of improving nutrition through “behaviour change” components. Programme volunteers sometimes organized fairs where they prepared new foods (such as soy and less familiar vegetables), but enthusiasm was low (Adato and Roopnaraine, 2004).

In Colombia, the increase in food consumption was proportionally as large as the increase in total consumption, implying that *Familias en Acción* did not change the food share among beneficiary households. However, despite the constant share of household budget allocated to food, the increase in protein consumption was proportionally greater than the

increase in food consumption, representing an increase in the share of protein consumed (Attanasio and Mesnard, 2006, 437). Meat and dairy consumption increased by 19%, fats by 14.3% (urban) and 24% (rural), and grains by 9.3% (urban) and 16.7% (rural) (Attanasio and Gomez, 2004, 2). These impacts did not appear to depend on programme intensity or duration (Attanasio and Mesnard, 2006, 438). There was no mention in the evaluation reports of any impact of the nutrition “classes” provided by the CCT.

Results from an analysis of the impact of Brazil’s *Bolsa Alimentação* on food consumption indicate an increase in dietary diversity of approximately 9%. Using a relationship documented by Hoddinott and Yohannes, in which a 1% increase in dietary diversity is associated with a 0.7% increase in per capita caloric availability, the authors expect that *Bolsa Alimentação* contributed to a 6% increase in per capita caloric availability and a 12% increase in caloric availability from healthier non-staples (especially fruits and vegetables) (Olinto et al., 2003).

In Mexico, *PROGRESA* caused beneficiary households to consume more calories from vegetables and animal products than control households. Among households interviewed in both 1998 and 1999, there was a 36% increase in beneficiary households reporting eating chicken, compared with a 19% increase in control households. There was less difference between beneficiary and control households in the consumption of staples and other commonly consumed foods (e.g., tomatoes, onions, beans, oil), suggesting that *PROGRESA* enhanced dietary diversity. Overall, dietary quality improved for beneficiaries through at least one of the following channels: an increase in the variety of foods consumed; an increase in the likelihood that a household consumed fruits, vegetables, or animal products; or an increase in calories acquired from these sources (Hoddinott, Skoufias, & Washburn, 2000, 19, 21). There was some evidence that messages provided in nutrition education sessions (*pláticas*) to women with preschool children (on such topics as the importance of a diversified diet) affected eating habits among beneficiaries and no evidence that the nutritional supplement provided to small children (*papilla*) crowded out the acquisition of calories. There was no evidence of a difference in food prices faced by *PROGRESA* and control households (Hoddinott, Skoufias, & Washburn, 2000, 36).

Several years later, *Oportunidades* also demonstrated an impact on dietary diversity with increased frequency of consumption of fruits and vegetables for children age 2-4. However, there was no impact on the number of foods consumed (Hernandez-Prado and Hernandez-Avila, 2006, 91).

In Honduras, neither demand-side nor supply-side *PRAF* interventions demonstrated an impact on food consumption or dietary diversity. This is likely to be due to the small size of the transfer, which represented less than 3.6% of average beneficiary expenditure (IFPRI, 2003b, 69). However, according to another food consumption analysis using longitudinal data from 2000 to 2002, there was variation in food quality according to the education level of the household head. In households where the household head had a primary school education, there was an increase in consumption of healthier foods like meat, fish, eggs, dairy, and fruits. Conversely, in households where the household head had no education, changes in consumption took the form of increased oils, fats, and junk food (Wiesmann and Hoddinott 2007).

Nutrition

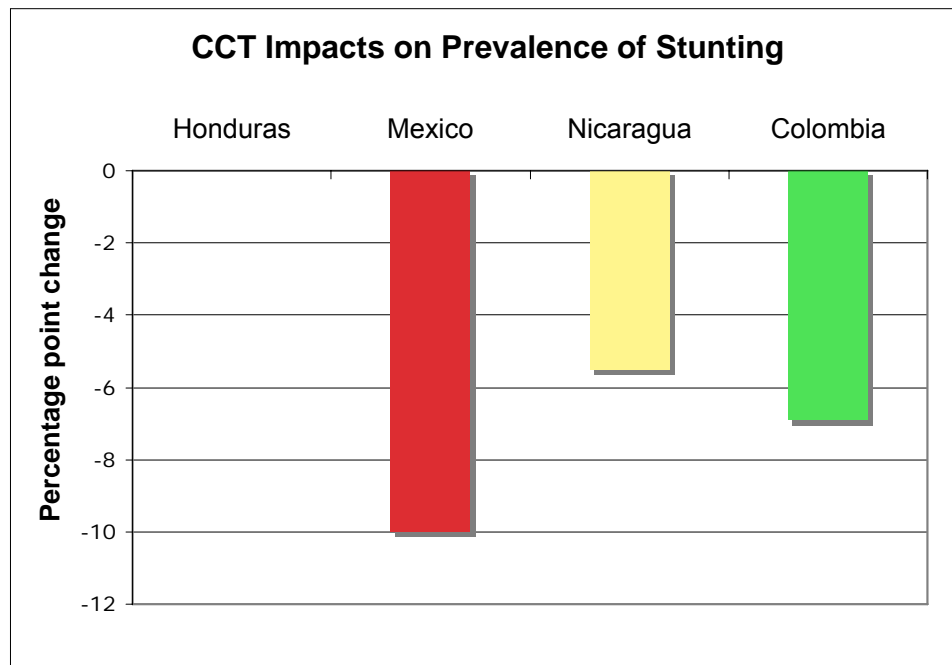
The nutrition outcomes of interest measured in CCT evaluations are stunting and iron-deficiency anemia. Two indicators are used to assess stunting: prevalence of stunting among children (usually age 0-2, sometimes age 0-5) and mean height-for-age z-scores, an expression of anthropometric values as a given number of standard deviations below or above the international reference mean or median value for healthy children. Iron-deficiency anemia is measured as hemoglobin level <11 g/dL.

While some CCT programmes have demonstrated success in improving the nutritional status of child beneficiaries, in terms of both reduced stunting and reduced anemia, there is considerable variation among programmes, with some programmes demonstrating no impact or even negative impacts (Figures 9.5 and 9.6).

According to the randomized evaluation comparing treatment and control groups before and after programme implementation, conducted from 1997 to 1999, *PROGRESA* reduced the prevalence of child stunting by 10 percentage points among children 12-36 months (Hoddinott 2007) and increased average child height by 1-4% (Gertler and Boyce, 2001).

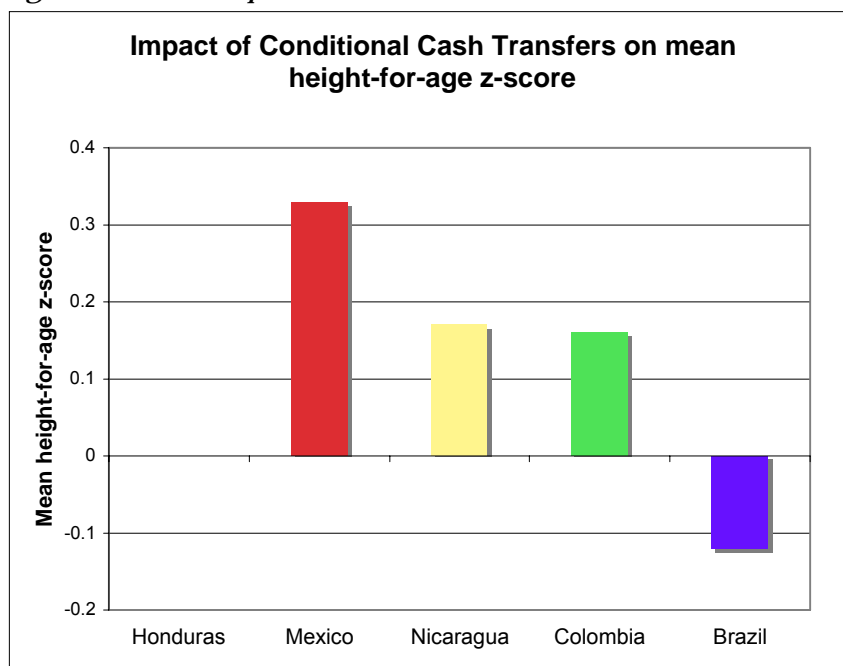
Height-for-age z-scores also increased by 0.33. An average child participating in *PROGRESA* experienced an increase in height of about 1 cm/year, or a 1.2% increase. The estimated impact of this increase in height alone is a 2.9% increase in lifetime earnings (Behrman and Hoddinott, 2001).

Figure 9.5. CCT impacts on stunting



Sources: Attanasio, et al. 2005; IFPRI, 2003b; Hoddinott, 2007; Maluccio and Flores, 2005.

Figure 9.6. CCT impacts on mean HAZ



Sources: Attanasio et al., 2005; IFPRI, 2003b; Behrman and Hodinott, 2000; Maluccio and Flores, 2005; Morris et al., 2004.

Colombia's *Familias en Acción* programme resulted in a 6.9 percentage point reduction in the probability of children 0-24 months being stunted, but there was no impact on children older than 24 months. Mean height-for-age z-scores also increased by 0.16. This increase is consistent with the notable increases in health service utilization by programme children under-two: increases in attendance at growth and development visits by 16 percentage points in rural areas and 21 percentage points in urban areas and a 23 percentage point increase in preventive health visits. Additionally, the programme provided courses on hygiene, diet, and other topics related to health and nutrition for mothers, but although attendance was encouraged, it was not mandatory (Attanasio et al., 2005, 3).

According to the 2002 impact evaluation, Nicaragua's RPS resulted in a 5.5 percentage point reduction in the number of stunted children age 0-5 over two years and an increase in mean height-for-age z-scores by 0.17. This represents a reduction more than one-and-a-half times faster than the national rate of annual improvement (based on the period 1998-2001). This positive result may have been affected by the transfer size, representing 18% of average monthly household expenditure, and the inclusion of multiple nutrition-related conditions, including health checkups for children under-5, participation in community-

based growth monitoring for children 0-2, and mothers' attendance at health/nutrition education sessions, which covered topics like household sanitation, nutrition, reproductive health, and breastfeeding. RPS also provided iron supplements and de-worming medicine to children (Maluccio and Flores, 2005).

Honduras' *PRAF*, on the other hand, had no impact on stunting. While the percentage of stunted children remained essentially unchanged across all three intervention groups and the control group, there was an increase in the percentage of underweight and wasted children, suggesting that *PRAF* did not protect children against deteriorating nutritional status, caused at least in part by the coffee crisis (Flores et al., 2003). In Honduras, there was also no impact on height-for-age z-scores. Double-difference impacts in mean HAZ fell under the demand-side intervention by 0.02 and under the supply-side intervention by 0.03, but rose slightly under the combined intervention by 0.02 (IFPRI, 2003b, 73). This lack of impact is somewhat surprising, given that the programme required attendance at regular health checkups by children and pregnant women as well as participation in monthly growth monitoring sessions⁷⁵ by all children under-two, which included individualized counselling for mothers on topics such as infant feeding and hygiene practices. However, the monthly transfer size was small, representing only 4% of average monthly household expenditure (Maluccio, 2004; Schady, 2006). Taken together, the small transfer size, sporadic transfer distribution, and insufficient supply-side services may have accounted for *PRAF*'s failure to produce anthropometric results (IFPRI, 2003b).

While CCTs in Mexico, Nicaragua, and Colombia all resulted in lower prevalence of stunting and higher mean height-for-age z-scores (HAZ) for young children, Brazil's *Bolsa Alimentação* demonstrated a negative impact on HAZ.⁷⁶ The final impact evaluation found the programme to have an adverse effect on nutritional status. A comparison of beneficiary and excluded children⁷⁷ showed that even though beneficiary children began to eat a better quality diet as a result of the programme, they experienced *less* weight gain than their nonbeneficiary counterparts—31 grams/month less according to Morris et al. (2004) and 37 grams/month less according to IFPRI (2003a). Furthermore, beneficiary

⁷⁵ Growth monitoring in *PRAF* was based on the country's national community-based nutrition program, *Atención Integral a la Niñez Comunitaria* (AIN-C).

⁷⁶ Estimates of impact on stunting prevalence are not noted in the literature.

⁷⁷ The evaluation compared beneficiaries with a control group of nonbeneficiaries who were selected to receive program benefits, but subsequently excluded due to random administrative errors (Morris et al., 2004).

children began to grow *less* rapidly once the transfer became available to the family, even though these children had exhibited a tendency to grow faster than excluded children before they received the transfer (IFPRI, 2003a, 29). In sum, *Bolsa Alimentação* resulted in beneficiary children age 0-2 having lower weight-for-age z-scores by 0.25 and lower height-for-age z-scores by 0.11 compared to nonbeneficiaries (Morris et al., 2004, 2339).⁷⁸ These results (that have subsequently been reversed) were not large, but the possible explanations are instructive with regard to understanding the types of incentives to which one must be attentive in a conditioned programme. A previous milk powder distribution programme had removed families from the programme once children gained weight, and even though this was not the case with *Bolsa Alimentação*, beneficiary mothers may have assumed that benefits would be discontinued for children exhibiting healthy growth and, hoping to extend the duration of their CCT benefits, may have limited the food intake of their children. Alternatively, health personnel may have manipulated weight data, again in an effort to increase the probability that children would remain covered by *Bolsa Alimentação* benefits (IFPRI, 2003a; Morris et al., 2004).

Anemia

CCTs have demonstrated mixed results on anaemia. *PRAF* demonstrated no evidence of impact on anaemia rates among children 12-23 months in any of the intervention groups (IFPRI, 2003b). This is consistent with the lack of impact on any nutritional indicator, but the results do not indicate the specific reason behind the lack of impact.

Even though RPS provided iron supplements, the programme demonstrated no impact on anaemia in beneficiary children. This lack of impact may have resulted from inconsistent delivery, shortages, and incomplete doses. The programme had a large impact on the percentage of mothers receiving iron supplements for their children in the previous 4 months. The double-difference average impact was 38%, in spite of substantial increases among the control group (Maluccio and Flores, 2005, 53). Still, these supplements were not necessarily consumed. The qualitative study in the 2002 evaluation uncovered the fact that some RPS mothers did not give the iron supplement to their children because of its perceived bad taste and negative gastrological effects (Adato and Roopnaraine, 2004).

⁷⁸ Results were adjusted for household demographic composition and *Bolsa Escola* beneficiary status (Morris et al., 2004).

Finally, if children are already deficient in other micronutrients that limit the haematological response to iron supplementation, they would not exhibit reduced anaemia rates (Hoddinott, 2007).

Results from *PROGRESA/Oportunidades* in Mexico show positive impacts on anaemia. According to Gertler (2004), *PROGRESA* resulted in a 25.5% reduction in the likelihood of a child 12-48 months being anaemic (Gertler, 2004, 340). Rivera confirmed this, finding in an experimental study that exposure to *PROGRESA* had a positive impact on anaemia rates (Rivera et al., 2004). According to a 2004 study, *Oportunidades* was associated with greater haemoglobin concentration (0.3 g/dl) in children 24-35 months, resulting in anaemia rates 5 percentage points lower for beneficiary children compared to nonbeneficiary children in this age group; no impact was noted for older children (36-47 months). These results are not surprising since iron needs are much higher for children 24-35 months and, therefore, any additional iron intake would be likely to have a proportionally larger impact for this age-group (Hernandez-Prado and Hernandez-Avila, 2006, 58).

Oportunidades did not demonstrate an impact on maternal anaemia rates (the sample included women over 18 who were not pregnant). There are several possible explanations for this lack of impact. First, there was only a small percentage of lactating women who reported consuming the nutritional supplement (which contains iron). Second, the iron content of the supplement was characterized by poor bioavailability, so even if consumed, it would not improve haemoglobin content as much as expected. Finally, iron requirements are significantly higher during pregnancy. Differences in anaemia rates may also have resulted from the study design in which there were many more women with recent pregnancies (and higher anaemia rates) in the first year of evaluation when the study found higher anaemia rates, than in the follow-up evaluation when the study found lower anaemia rates (Hernandez-Prado and Hernandez-Avila, 2006, 110).

The success of *PROGRESA-Oportunidades* in reducing both stunting and anaemia among young children may be due to the large transfer size (representing over 20% of average monthly household expenditures) and high programme coverage (76% of households in programme areas were selected to participate, and 97% of these accepted) (Sridhar and

Duffield, 2006, 16) as well as the broad a range of nutrition-specific conditions targeted to high-risk groups: pregnant and lactating women, children 6-23 months of age, and children 2-4 years old with low weight (Neufeld, 2006). In addition to required health checkups and child immunization, mothers must attend health and nutrition education sessions and take their under-five children to be weighed on a monthly basis. The programme also provides children with antiparasitics, multivitamins, and iron supplements, and pregnant and lactating women, children between 4 and 24 months, and between 2 and 5 years old with any signs of malnutrition, with a nutrition supplement (called a *papilla*) (Handa and Davis, 2006; Skoufias, 2005). There is evidence that *PROGRESA's* positive impact on child height is greater in households that received the nutritional supplement (*papilla*); thus, it is likely that the supplement plays an important role in these improvements in nutritional status (Hoddinott, 2008). *Oportunidades* has not shown a positive impact on breastfeeding practices—in fact there was a 1.5-month decrease in breastfeeding duration, although not statistically significant—suggesting that the education component could be strengthened (Hernandez-Prado and Hernandez-Avila, 2006, 74).

Understanding the reasons for CCT impacts on nutritional status is difficult because, to date, CCT impact evaluations have not been able to disentangle the differential impact of individual programme components (i.e., income transfer vs. additional programme activities), nor of programme conditions in the area of nutrition, on observed outcomes. Further analysis comparing different types of nutrition-related activities linked to CCTs and testing conditionality attached to these would provide much-needed information about optimal design of CCTs (Bassett, forthcoming). These results would also inform unconditional cash transfer programmes and affect decisions about the complementary activities they might include.

Table 9.2 outlines the range of CCT impacts on food consumption and nutrition.

Table 9.2. CCT impacts on food consumption and nutrition

Country/ Programme	Household food consumption	Stunting prevalence	Mean HAZ	Anaemia prevalence
Brazil <i>Bolsa Alimentação</i>	+6%: caloric availability +9%: dietary diversity +12%: caloric availability from healthier non-staples (esp. fruits and vegetables)		-0.11	
Colombia <i>Familias en Accion</i>	No change in food share, but dietary quality improved; Meat and dairy: +19%; Fats: +14.3% (urban), +24% (rural); Grains: +9.3% (urban), +16.7% (rural)	-6.9% pts (age 0-2) No impact (age 3-7)	+0.16	
Honduras <i>PRAF</i>	No impact on total food consumption	No impact	No impact	No impact
Mexico <i>PROGRESA</i>	+10.6% in mean per capita food consumption	-10% pts (age 12-36 mos) ^a	+0.33	-10.6% pts -25.3 % pts ^b
Mexico <i>Oportunidades</i>	Increased dietary diversity (especially vegetables)	-5.5% pts (age 0-5)		-5% pts (age 24-35 mos) No impact (age 36-47 mos & women)
Nicaragua <i>RPS</i>	+4.5% pts in food share (as % of household budget) Increased dietary diversity	-5.5% pts	+0.17	No impact

Sources: Attanasio and Mesnard, 2006; Attanasio and Gomez, 2004; Attanasio et al., 2005; Gertler, 2004; Hoddinott, 2007; Hoddinott, Skoufias, & Washburn, 2000; IFPRI, 2003b; Maluccio and Flores, 2005; Morris et al., 2004; Olinto et al., 2003; Hernandez-Prado and Hernandez-Avila, 2006; Rivera et al., 2004.

^a Taking into account nonrandom nature of the papilla allocation.

^b Low figure from Rivera et al. 2004; high figure from Gertler 2004.

9.3 Complementary activities for nutrition

In addition to the increased expenditures on food and improved nutrition that cash assistance alone can lead to, complementary services such as nutrition education classes, growth monitoring accompanied by counselling, and micronutrient and/or nutritional supplementation, can further improve dietary and caloric intake, while also improving caring and feeding practices associated with healthy infant development. These activities can be, but do not necessarily need to be, conditions of receiving the grant. Instead, the grant could be used as a way to facilitate access and participation, and to put households in a better financial position to take advantage of new knowledge. Many food and nutrition programmes implemented by NGOs, CBOs, international organizations, and governments provide lessons for complementary activities in nutrition that might be integrated with cash transfer programmes.

Micronutrient supplementation

One option is the provision of micronutrient supplements. There is some evidence that micronutrient supplementation can be effective in reducing risks associated with Mother-to-Child Transmission (MTCT) of HIV. A study by Filteau in Bangladesh and Tanzania in which women took antioxidants, particularly vitamin E, late in pregnancy and early in lactation suggests that this may have contributed to lower risk of sub-clinical mastitis, which can affect HIV transmission via breastfeeding (Filteau et al., 1999, cited in Gillespie and Kadiyala, 2005, 50). While trials of Vitamin A supplementation among pregnant women in Tanzania, Malawi, and South Africa did not demonstrate reductions in MTCT—and even increased the risk of vertical transmission in Tanzania—multivitamin supplementation (vitamins C, E, B) for breastfeeding women in Tanzania moderately reduced HIV transmission at this phase, even for women with poor nutritional status (Kumwenda et al., 2002; Coutsooudis et al., 1999; Fawzi et al., 2000, 2002, cited in Gillespie and Kadiyala, 2005, 51). Overall, the evidence suggests that micronutrient supplementation during pregnancy can improve pregnancy and birth outcomes, but has not been shown to decrease MTCT, except multivitamin supplementation during lactation, which can reduce transmission during breastfeeding. Vitamin A supplementation for preschool children suffering from HIV has been shown to reduce morbidity and mortality, alleviate persistent diarrhoea, and improve height and weight (Coutsooudis et al., 1995; Fawzi et al., 1999; Villamor et al., 2002, cited in Gillespie and Kadiyala, 2005, 52, 55).

Conditional cash transfer programmes in Nicaragua and Mexico have included the provision of micronutrients (Skoufias, 2005; Maluccio and Flores, 2005). The conditional component of Kenya's Cash Transfer for OVC requires children age 1-5 to attend growth monitoring sessions where they receive vitamin A (OVPMHA, 2006). Fortified food transfers (see Food, nutrition, and ART section below) and interventions to increase dietary diversity are other ways of increasing micronutrient intake.

Nutrition counselling

Perhaps the most important intervention to prevent MTCT are centres on infant feeding. Because HIV can be transmitted through breast milk, replacement feeding is recommended when it is culturally acceptable, affordable, safe, and sustainable. However,

in many places ravaged by the HIV/AIDS epidemic, replacement feeding does not meet these criteria because mothers cannot afford replacement milk and clean water is not available. A recent review of breastfeeding and replacement feeding found that replacement feeding in low-income countries is associated with a higher risk of infant mortality (Coutsoudis and Rollins, 2003, cited in Gillespie and Kadiyala, 2005, 53). A modelling exercise by Ross and Labbok (2004) shows that for HIV-infected women, exclusive breastfeeding for 6 months is less risky than replacement feeding (with HIV-free survival increased by 32 per 1,000 live births), but after six months, replacement feeding is safer. Given that these recommendations are somewhat complicated and change over time, counselling and follow-up that would help women make appropriate decisions about infant feeding could contribute to improved child outcomes.

More generally, nutrition counselling targeted to HIV-affected individuals can extend the asymptomatic period, stave off opportunistic disease, and prolong lives (Piwoz and Preble, 2000, cited in Gillespie and Kadiyala, 2005, 53). A study of the effectiveness of nutrition counselling in improving health outcomes for HIV-affected adults not taking ARVs in Ghana by Tabi and Vogel (2006) demonstrated that receiving 7 months of nutrition counselling about protein intake led to significant weight gain among HIV-affected adults. Although the study allowed for detection of a statistically significant increase in weight in the first month, the small sample size (25) made it impossible to detect the smaller increases in weight that occurred after the second month. Tabi and Vogel recommend individualized nutrition counselling tailored by gender, age, socioeconomic, and cultural background (Tabi and Vogel, 2006).

Food supplements

In some cases, nutritional supplements or food transfers may also be necessary to help HIV- and AIDS-affected individuals meet their heightened nutritional needs. Food rations can prevent mild weight loss and therapeutic foods can help rehabilitate moderately and severely malnourished children and adults who are HIV-positive (Gillespie and Kadiyala, 2005, 54). Kenya's Cash Transfer for OVC plans to provide UNIMIX, a fortified and enriched nutrient customized for malnourished children (OVPMHA, 2006, 9). Of concern, however, is the fact that although studies of high-energy and high-protein supplementation

have demonstrated that consuming these in addition to the home diet can lead to weight gain (largely fat rather than lean muscle mass), it does not prevent or reverse muscle wasting, a key factor that determines survival (Piwoz and Preble, 2000, cited in Gillespie and Kadiyala, 2005, 55).

Food, nutrition, and ART

Food and nutrition are increasingly being associated with the efficacy of ART and patient compliance with drug regimens. There are complex interactions between the consumption of different macro- and micronutrients and the bioavailability, and therefore, efficacy of ARVs. For example, a meal high in fat, energy, and protein increases the bioavailability of some types of ARVs (e.g., tenofovir), while decreasing the absorption of others (e.g., indinavir). Furthermore, some ARVs should be taken with food, while others should be taken on an empty stomach; some should be taken with particular foods; and others are contraindicated with specific foods (Castleman, Seumo-Fosso, & Cogill, 2004, 5-6). ART management and nutritional recommendations, therefore, need to be drug specific.

Difficulties in complying with food and nutrition recommendations—often due to inability to access the right foods or absorb them due to existing malnutrition—can lead to poor adherence to ARV regimens. This, in turn, can increase the likelihood of drug resistance, which facilitates opportunistic disease and onset of AIDS (Jones and Holloman, 2000, cited in Gillespie and Kadiyala, 2005, 57). According to a study conducted by C-SAFE in 2005 in Zambia and Zimbabwe, the provision of CSB rations resulted in higher acceptability of ARV treatment and better adherence to drug regimens (Greenblott, 2007). Cash transfers accompanied by nutritional counselling tied to specific ARV regimens could do the same, although food and cash transfers in combination may be the most effective means of supporting patients and their families—this is an issue that needs further investigation.

10. Complementary approaches: Legal, psychosocial, adult education and awareness; microcredit and work

Poverty has many determinants, and the extent to which cash transfer programmes respond to these depends on how they are designed, as well as a broad array of starting conditions, from micro to macro levels. Linking cash transfers to education, health and nutrition services, and other activities, conditional or not, is one set of approaches discussed in the previous sections. Outreach and informational activities, cash disbursements, and other operational processes of the transfer programmes present opportunities to involve beneficiaries in complementary activities. The cash itself can also be used to invest in other activities, depending on the size of the grant, the circumstances of the individual, household, and community, and the nature of supporting services. Other complementary activities offering many forms of care, services, and information can benefit all types of beneficiaries.

There are a number of ways to arrange the provision of complementary services. A first consideration is which services and activities respond to the highest priority problems and needs. Complementary activities can include, e.g., adult literacy classes; credit and job training to address household poverty; immunization drives; health and nutrition education to address child and family health, and HIV and AIDS awareness; home-based care and referral for ARVs.

A second consideration is who should benefit from the activities. Some activities would be useful for all beneficiaries, while others would target smaller subsets of the beneficiary population. One way to arrange complementary services to key subgroups is to apply a life-cycle approach, which involves considering each stage in the life cycle and determining the key interventions at critical periods that can have a positive long-term impact (Tinker, Finn, & Epp, 2000, 5). For example, children age 0-5 would have access to nutrition, health, and sanitation services, children 6-11 would have access to quality schooling, and children 12-17 would receive vocational training as well as health and sex education (Devereux et al., 2005). Another set of interventions would respond to the needs of adults, and then the elderly. Similarly, complementary services can be tailored to different stages of HIV/AIDS progression. That is, complementary activities can provide specific services

to the following groups: HIV-negative, HIV-positive but asymptomatic, people living with AIDS, children living with ill adults, and orphans and other household members left behind when families members die of AIDS (Slater, 2004).

The third consideration—and least developed at this stage—is how complementary activities can be linked with cash transfers. One option is to provide services that can easily be delivered at cash pay points, following a model used in ICDS Nutrition and Health Days in India. In that programme, on days when people come to receive a food transfer, pregnant women and children under-two receive a range of health and nutrition interventions on a single day in a single place, including iron-folic acid supplements, nutritional supplements, immunizations, vitamin A, and nutrition education (Nemer, Gelband, & Jha, 2001, 42). This approach is convenient for beneficiaries and may reduce costs for providers due to economies of scale. Another approach is to create specific linkages between the cash transfer programme and other organizations that provide services, and to connect cash transfer beneficiaries—by referrals or personalized visits—with these services. Finding ways to link complementary services with cash transfers without requiring participation (as in a conditional programme) remains a challenge, but some interesting examples are emerging. Table 10.1 illustrates a range of complementary activities provided by existing cash transfer programmes. Most of these are conditional programmes, although some newer programmes are mixed, with both unconditional and conditional components. Another challenge is to determine whether uptake of complementary services will work without conditions, and, if not, what types of conditionality would be appropriate.

Table 10.1. Complementary activities in existing and planned cash transfer programmes

Country/Programme	CCT?	Complementary activities/services
Argentina <i>Jefes de Hogar</i>	Y	Professional and other training programmes (mainly for principal beneficiaries); labour-related activities and job placement support
Brazil <i>Bolsa Familia</i>	Y	Breastfeeding and healthy nourishment programmes for mothers (offered by local governments); youth and adult literacy; employment and income generating programmes offered by municipalities
Chile <i>Chile Solidario</i>	Y	Signature and compliance with a contract committing to participate in activities identified as personalized assistance in one of several areas (e.g., health, education, employment, housing, income, family life, legal documentation)
Colombia <i>Familias en Acción</i>	Y	Network of beneficiary mothers (women's rights, programme management); identification documents; registration; women's empowerment; resource management; mothers encouraged to attend courses on hygiene, diet and other topics related to health and nutrition, but this is not compulsory
El Salvador <i>Red Solidaria</i>	Y	Support in obtaining identification documents
Honduras <i>PRAF</i>	Y	Productive training for youth; credit programmes directed to adults; training to parents' associations
Jamaica <i>PATH</i>	Y	Referral of youth who didn't qualify for programme benefits to social workers who provide advice on accessing benefits from other agencies geared towards youth support; training for beneficiaries and primary agents in schools and health facilities; rehabilitation grants for parents of some beneficiaries (for starting income generating projects); case management; social worker referral
Kenya <i>Cash Transfer Programme for OVC</i>	Y/N	Awareness sessions to promote household skills to deal with health and family issues (nutrition, child and maternal health, social health, prevention and treatment of chronic illness such as malaria, HIV/AIDS, STDs, etc.)
Mexico <i>PROGRESA/Oportunidades</i>	Y	Training workshops on self-care health issues; savings support for retirement; Heritage Component: economic benefit gradually accumulated and to which students can gain access when and if they complete middle and higher studies before age 22; information portals
Pakistan <i>Child Support Programme</i>	Y	Preparation of computerized national ID cards; opening of bank accounts
Paraguay <i>Red de Protección y Promoción Social</i>	Y	Adult literacy; diagnosis, detection, and attention to children 0-5 regarding malnutrition problems; identification campaigns directed at undocumented mothers; committees of beneficiaries
Uganda <i>Community-Led HIV/AIDS Initiatives (CHAI)</i>	Y/N	Home-based care and food (for regular and orphan-headed households); vocational training materials, fees and other dues to orphans; HIV/AIDS education through drama and film; shelter construction; basic household items.

Sources: Ayala Consulting, 2006; World Bank, 2007b; Plaatjies, 2006; Attanasio et al., 2005.

There are many other complementary services and activities that would be appropriate to link to cash transfer programmes serving families affected by HIV and AIDS. These are discussed in the sections below.

10.1 Facilitating access to institutions and documents

One constraint limiting the uptake of social grants is the lack of identification documents, often required for programme application and receipt. A number of studies have found that one of the principal reasons that primary caregivers in South Africa do not access the CSG is because people do not have documents needed to obtain it, such as birth, marriage, and death certificates (Hunter and Adato, 2007a; Hunter and Adato, 2007b; Woolard, Carter, & Agüero, 2005). UNICEF explains that “registering a birth is integral to a child

realizing the right to a name, nationality and legal identity.” Children who are not registered at birth are vulnerable and experience difficulties establishing their identity and forming family ties. In addition to supporting these fundamental elements of child identity, birth certificates can facilitate access to basic services, such as schooling and social assistance, and protect them against many forms of abuse (UNICEF, 2007e). In South Africa there is a negative correlation between poverty and birth registration, and yet such registration is needed in order to access a cash transfer for the child. In other words, those who most need state support are the least likely to have the documents needed to access that support, and the difficulties of registering births are exacerbated in the context of HIV and AIDS. Birth registration and ID books are needed to access not only cash grants, but also housing subsidies, job creation programmes, and death benefits (Giese and Smith, 2007). The requirement for a birth certificate is a hindrance for accessing cash transfers, but the immediate incentive to register births in order to get the grant will result in that child being more likely to have access to other benefits over his or her lifetime. Cash transfer programmes can also play a role in supporting birth registration and facilitating access to identification documents for beneficiaries (Chapman, 2006). For example, in Paraguay a cash transfer programme involved identification campaigns directed at undocumented mothers (Ayala Consulting, 2006). Another option to overcome the lack of birth documentation is to give midwives birth registration forms to fill in when babies are born (van Dijk, 2007).

In Turkey, the CCT requires that applicants provide marriage certificates or divorce papers to apply for benefits for their children,⁷⁹ and that parents and children have citizen cards and numbers. In an evaluation of the CCT, officials and beneficiaries said that for a large number of women this resulted in their formalizing their marriages and obtaining birth certificates for their children, and that these requirements have allowed poor families to obtain citizenship cards and numbers, facilitating the processing of their requests from a range of state institutions (Kudat et al., 2006).

⁷⁹ In Turkey, single, never-married parents are rare among the poorest 6% of the population eligible for CCT benefits.

10.2 Information and awareness campaigns

Some cash transfer programmes disseminate information about health, nutrition, HIV, and other topics related to promoting human capital. For example, Kenya's Cash Transfer for OVC provides lectures on child and maternal health and nutrition, and prevention and treatment of chronic illness (malaria, HIV, STDs) for beneficiaries receiving both conditional and unconditional transfers. These awareness sessions are based on UNICEF modules used for community health/nutrition training and are coordinated by UNICEF and the Government of Kenya (OVPMHA, 2006, 6).

Malawi's DECT programme included a well-developed system of sensitization messages delivered on paydays. While beneficiaries were waiting for their turn to collect the cash payment, the DECT programme disseminated messages using teachers and facilitators, as well as local music and drama groups that shared messages via songs and plays. Often trained government staff delivered messages, but when no one of this level was available, Concern field officers stepped in. The provision of messages varied across DECT locations based on staff availability and timing. If a field team arrived late to the pay point, they did not provide messages (Devereux et al., 2007, 8).

The key messages provided to DECT beneficiaries were related to the primary, secondary, and complementary objectives of the programme. They included use of the transfer for family food consumption and farming (coupled with nutrition messages on the last two paydays), HIV/AIDS prevention, and use of smart cards. Concern community liaison staff conveyed behavioural messages about HIV and AIDS, taking aside chiefs and elders to teach them separately in an effort to inform more men about this sensitive issue. Beneficiaries recalled messages about condoms and HIV-testing. However, the variation in coverage of sensitization messages resulted in some beneficiaries reporting never or rarely having heard such messages. Programme evaluators surmised that HIV/AIDS information may have been presented before some beneficiaries arrived at or after they departed from the pay point, or while they were involved in the administrative activities of picking up the transfer (Devereux et al., 2007, 9-10). In general, beneficiary impressions of the sensitization campaign were largely positive. The use of local musicians and actors, as well as the dancing that often accompanied the music, mitigated the boredom of waiting

in line for the cash transfer. And beneficiaries often found the teachers and facilitators to be effective and funny (Devereux et al., 2007, 11).

Information campaigns alone may not be sufficient to significantly affect health outcomes, however, particularly with respect to HIV transmission. According to Malawi's 2004 Demographic and Health Survey, despite overall advanced knowledge about HIV transmission and infection vectors, HIV prevalence remains high. This suggests that Malawians may understand the causes of HIV/AIDS, but have not adapted their behaviour. Information campaigns, then, are unlikely to be successful without other services that help overcome key constraints to behaviour change, such as free condoms, VCT, or ARVs (McCord, 2005). (See also Section 9.3 on complementary activities for nutrition.)

10.3 Psychosocial support

Children living in households affected by HIV and AIDS can experience a range of hardships from poverty and ill health, to social instability and grief, all of which bear on the child's physical, cognitive, and psychological development. Psychosocial needs—"to be happy, creative, to belong in social groups, and to have hope for the future"—can be addressed at home by strengthening children's daily routines and seeking opportunities for normal childhood behaviour (e.g., playing) or through programmes or activities beyond what children receive in their home environment (Richter, Foster, & Sherr, 2006, 9, 16-17).

Richter, Foster, and Sherr argue that psychosocial support, care, and rehabilitation are best provided by the family and/or the community because children who experience lasting supportive, stimulating, and affectionate relationships are more likely to feel hope for the future as well as develop resources for coping with the challenges of HIV and AIDS. The authors recommend involving local community-based organizations and prioritize placing and keeping children in settings with supportive family or other caregivers before looking to outside interventions. For children who suffer from extreme mental or behavioural disorders, the support of trained professionals may be necessary (Richter, Foster, & Sherr, 2006, 11).

Cash transfers could link to psychosocial support services. One such example is Mozambique's INAS programme, which provides psychosocial support (Devereux et al., 2005). In Malawi's Social Cash Transfer Scheme, community-based organizations (CBOs), extension workers, and child protection workers collaborate to link cash transfer beneficiaries to psychosocial support services (UNICEF Q&A, undated). Psychosocial services would be particularly helpful for, and can be tailored for, groups affected by HIV and AIDS in specific ways, such as orphans and girls experiencing abuse.

10.4 Social welfare services, child protection, and other legal protections and entitlements

A growing interest has emerged among a number of international organizations in examining the potential for increasing the role of social welfare services (SWS) in the context of social protection. Social welfare services include family support services such as early childhood development (ECD), assistance with access to services and transfers, parenting support, substance abuse counselling, legal support, and home-based care. SWS also include child protection service provided to abused, neglected, or exploited children, including early detection and response, policy enforcement, and case management. Social protection is seen as an access point through which SWS can play an increased role, and SWS are seen as a means of complementing and improving transfer programmes. Among the issues discussed at an international meeting on this topic in 2007 was the need to investigate means of building linkages between SWS and cash transfers. Ideas included potentially using the targeting process, where families or individuals are screened for benefit eligibility, to identify their social service needs. Follow-up can then occur, whether or not the family qualifies for transfers. Another opportunity for linkages would be to use pay points (where people collect their transfers) for making contact with large number of families, to gather information on social welfare needs, and provide information on available SWS (UNICEF, 2008).

Cash transfer programmes provide the benefit of increasing legal protections and entitlements through some of their documentation requirements. As noted above, they provide incentives for families to obtain documents such as birth certificates and marriage and divorce certifications that can also provide a range of legal protections over time.

Other forms of legal protection with special relevance to AIDS-affected families and individuals could also potentially be facilitated through linkages with cash transfer programmes, such as child protection, inheritance protection, and other legal services. Children may need special attention in the context of changing household structures, as well as new vulnerabilities created by illness and death of parents and other relatives, and increased levels of poverty in their households and communities. Women may also need special attention, as they face a variety of abusive circumstances, including vulnerability to asset loss in the case of the death of a spouse. In Zimbabwe, a programme called Linkages for the Economic Advancement of the Disadvantaged (LEAD) helps protect assets of low-income AIDS-affected households by providing vouchers for legal services (e.g., drawing up wills, handling guardianship and maintenance claims for orphans). The voucher ensures that a beneficiary can select and consult with a lawyer from a firm participating in the LEAD programme free of charge (AED, 2003, cited in Gillespie and Kadiyala, 2005, 73). A Save the Children report about inheritance problems for vulnerable members of society, including orphans (especially girls) and widows, suggests training community workers to disseminate information about legal rights, wills, and other legal issues via radio, theatre, brochures and leaflets, posters, and discussion groups (IRIN News, 2007).

As cash transfer programmes expand, it is important to pay attention to how these may be affecting the need for child protection and other social welfare services in unanticipated ways. For example, in South Africa there have been at least a few cases reported of conflicts between family members over who will take charge of children who have lost their parents, related to the opportunity presented for access to the large foster care grant (about three times the size of the Child Support Grant). This may result in relatives who are more powerful, but worse caregivers, taking charge of children (Meintjes and Giese, 2006, 420; Giese, 2007/8, 18). There has been no documentation of the extent to which this is a problem, but these cases highlight the importance of effectively functioning social services that can detect and respond to these situations where they arise, particularly in cases of abuse. A related problem in the South African case is that the Department of Social Development (DSD) is responsible for administration of both the social security grants and social services, such that the impressive roll out of the grants has resulted in a “crowding out” of social welfare services. According to a DSD document, “the crowding-out effect of

the social security budget has resulted in the severe curtailment and neglect of other services” (South Africa, 2007).

10.5 Microcredit, access to finance, and productive activities

As discussed in Section 2, there are both hopes and doubts about the potential for microfinance to play a significant role in assisting HIV-affected individuals and communities. While HIV-affected households, and particularly foster families and single parents widowed by AIDS, could certainly benefit from the income and productive investments, there are risks to targeting high-risk groups with microcredit programmes (World Bank, 2005). Households affected by HIV and AIDS are likely to experience more difficulty in repaying loans due to the combination of increased household expenses (e.g., medicine) and loss of income providers in the household. The diversion of loans from productive uses to immediate HIV/AIDS-related expenses (e.g., medicines, caretakers, funeral costs), and the possible lack of availability both of productive members of the household and members with knowledge about running businesses, can exacerbate repayment difficulties and lead to higher default rates. Borrowers affected by HIV and AIDS may also be less able to attend meetings. In many cases, when a family member is diagnosed with HIV or AIDS, the borrower stops repaying the loan due to diminished motivation and psychological trauma (Bondevik, 2003; Wilkinson, 1999).

Despite these risks, there are innovations to make microfinance viable for HIV/AIDS-affected clients. From the perspective of microfinance institutions (MFIs), maintaining a diverse portfolio—a mixture of HIV-affected and non-affected beneficiaries—can preserve profitability (Nyamandi, 2005; United Nations Capital Development Fund/Special Unit for Microfinance (UNCDF/SUM), 2003). From the perspective of households, microfinance can play a role in mitigating the impact of HIV through providing cash that serves protective and preventative functions (Nyamandi, 2005). Arguments for additional roles that microfinance can play are based on the facilitating role that MFIs and implementing partners tend to play in the course of programme operations: these include organizing community gatherings, which are opportunities for sharing information and implementing prevention activities (e.g., using nonformal education techniques to promote behaviour change, linking clients to other prevention services) at low cost (Nyamandi, 2005). For

example, by relying on existing financial staff to deliver preventive HIV/AIDS messages to large numbers of microfinance clients during monthly microfinance gatherings, the NGO Credit with Education can provide these important additional services at low cost (Bondevik, 2003). The IMAGE programme in South Africa also linked poverty-targeted microfinance with participatory adult learning on topics such as sexual behaviours, gender-based violence, and HIV prevention (IMAGE, 2002, cited in Gillespie and Kadiyala, 2005, 72). As suggested above, these kinds of adult education and awareness campaigns can take place in the context of a cash grant as well as a loan, but microcredit can take advantage of the infrastructure and staff of existing loan dispersal programmes.

In addition to linking of microfinance with health information, awareness raising, and education, several design elements have been suggested for microfinance programmes in an HIV/AIDS context. The U.N. recommends that microfinance services be targeted to clients who are HIV-positive, but still productive family members of HIV-positive individuals, and surviving family members (United Nations Capital Development Fund/Special Unit for Microfinance (UNCDF/SUM), 2003). Loans can be designed with built-in flexible terms that provide a “rest” for clients between loan cycles and do not require that clients necessarily move to larger loans (Nyamandi, 2005). MFIs can incorporate innovative financial products including health insurance covering costs involved with dealing with opportunistic disease, burial and funeral insurance, insurance of outstanding balance against the client’s death, or emergency loans (Bondevik, 2003; Nyamandi, 2005).

An example with some of these features is the Zambuko Trust in Zimbabwe. The programme only lent money to HIV-affected clients who were economically active, and included several requirements: a mandatory one percent insurance fee that would cover the loan if the client died, obligatory savings, and strict enforcement of group responsibility for loans. The Trust’s HIV-affected clients showed a higher percentage of school enrolment among boys age 6-16, and more savings accounts, compared to non-HIV-affected clients (Barnes et al., 2001, cited in Gillespie and Kadiyala, 2005, 72).

There are some examples of cash transfer programmes with links to microcredit and income-earning opportunities. Mozambique’s INAS programme (which followed the

GAPVU cash transfer programme) provided support for income-generating projects (Devereux et al., 2005). In a few countries in Latin America, there are plans in development for linking cash transfers with savings and loan programmes. El Salvador's *Red Solidaria* has as one of its planned interventions a "Sustainability Network for Families," which promotes and funds productive projects and microcredit to support the CCT beneficiaries, and particularly small farmers (Government of El Salvador, 2007). However, in the very poorest regions, a straight conditional cash transfer is being rolled out on a large scale, with the microcredit to follow later, and the reach of the programme is uncertain—certainly it is likely to be far more limited than the scale of the CCT. This all returns us to the point made in Section 2: while microfinance and livelihoods activities have potential to help poor, AIDS-affected families secure livelihoods, and such programmes should be promoted and adapted to reach these families at the pace and scale possible, it is likely that the most destitute will not be well positioned to benefit, and a cash transfer should be there as a safety net.

Apart from microfinance, cash transfers provide other types of opportunities for poor people to access finance and to save. Cash transfer programmes that transfer funds through bank accounts have allowed people who have never had an account to open one. In Mexico, *Oportunidades* began depositing the cash transfers in bank accounts for some beneficiaries, and by 2006 about 1.2 million beneficiary families received their transfers this way. This opened up their access to other financial services (*Oportunidades* 2006b). In socially conservative regions of Turkey, female CCT beneficiaries' interactions with banks and government departments for the first time have a particular significance, empowering women who have never had any contact with a bank, as they now deal with bank officials, ATMs, and deposit books (Adato et al., 2007; Kudat et al., 2006).

10.6 Public works

Public works programmes provide payment in cash or in kind in return for labour. There is no consensus among governments, donors, and NGOs about the appropriateness of these programmes for HIV/AIDS-infected and affected households, which often face labour constraints. Some argue that public works are never suitable to HIV/AIDS-affected households, while others assert that asymptomatic HIV-positive individuals, who may be

“vulnerable but viable,” can participate in public works schemes and that their inclusion in such programmes is an important way to minimize stigma (Harvey, 2004, 35). As with the case of microcredit and livelihoods programmes, public works can provide cash with valuable spin-offs, including those specific to the needs of people affected by AIDS, but they will serve the subset of the better-off. Also, the more intensive and integrated the activities in a public works programme, the fewer people can be covered (Adato et al., 1999).

Targeting in public works programmes may not be optimal for HIV/AIDS-affected households. Self-targeting—offering low wages—is frequently used to ensure that only poor households participate in public works projects. However, for HIV-positive individuals who have particularly high nutritional needs, self-targeting processes that induce households to either lower consumption (due to low wages) and/or take on physically challenging work without sufficient caloric intake, could accelerate the onset of AIDS (Slater, 2004).

Appropriate employment for HIV/AIDS-affected households usually differs from that of a healthy population, which can undertake physically demanding labour. HIV-positive individuals may need programmes offering a reduced workload, low input activities (e.g., bee keeping, low intensity horticulture) and labour-saving techniques. These arrangements can allow beneficiaries to continue work even after some illness has set in (McCord, 2005; Slater, 2004). A CARE Food for Work programme in Zimbabwe made separate arrangements for ill beneficiaries, such as light work duties (e.g., childcare for children whose mothers were working on the project) and restricted tasks (e.g., smaller bucket sizes or reduced work norms). The Zibambele Programme in KwaZulu-Natal targeted extremely vulnerable labour-constrained households affected by HIV/AIDS. It offered flexible work time (e.g., 8 days/month) and flexible hours to allow beneficiaries to cover their caring duties in the home (McCord, 2005). The Mashuro Small Scale Irrigation Project in Gutu, Zimbabwe, applied light productivity work norms to PLWA who participated in earthworks, nursery management, and development of canals (Kayira, Greenaway, & Greenblott, 2004, 10).

Instead of providing employment exclusively to individuals, some programmes have utilized household contracts, which allow households to substitute a different worker if the primary public works beneficiary falls ill or dies. Household contracts can also allow for the diversification of household income because the primary public works programme beneficiary can take another job while the secondary beneficiary continues to work in the public works project (McCord, 2005). The Working for Water programme in South Africa, which utilized teams of exclusively HIV-positive workers, trained two workers for every one worker needed. This enabled both the work and beneficiary household income to continue uninterrupted, although it also doubled training costs (McCord, 2005). The Zibambele Programme also provided household contracts. According to recent research on the programme, despite the low monthly income—due to the low wage and the fact that most workers were working part-time—the Zibambele Programme had a significant impact on education and food consumption outcomes for children in public works households. The percentage of households who reported regularly reducing children's meal sizes because they could not afford food fell from 34% to 1% and regular school attendance increased from 67 to 90%. At the same time, beneficiaries reported engaging in fewer activities that caused them shame (e.g., need to beg), experiencing a lesser psychosocial burden, and being more likely to carry out ceremonies to mark the anniversary of family deaths (McCord, 2005, 36-37).

Even with limited work responsibilities and household contracts, demands on care-takers in households with a public works beneficiary and other sick household members may increase significantly. In these conditions, public works programmes that pull the remaining viable household member(s) away may be detracted from household well-being unless other services, such as support for orphans and other vulnerable children, are provided (Slater, 2004; McCord, 2005).

Another approach that offers a partial solution to this problem is a form of public works that involves direct provision of social services for those affected by HIV and AIDS. This can include paying beneficiaries to work in HBC, ARV roll-out, ECD, voluntary counselling and testing, and birth registration, among other services (McCord, 2005). For example, the Zimbabwe Red Cross HBC programme has provided work for more than 2,000 HBC facilitators selected by their communities. These facilitators were generally unemployed,

minimally educated women, who had been affected by HIV/AIDS in some way: many were HIV-positive themselves, while others were caring for an ill family member or had experienced the loss of a family member. This way, the facilitators understood on a personal level the challenges of living with HIV and AIDS and the stigma associated with this. Facilitators were trained in both the theoretical underpinning of HBC and the practical tasks (for a total of about two months) and tested for competence before starting work independently. Once working, they trained family members in appropriate care, monitored patient conditions and offered basic nursing and referral, identified children affected by HIV/AIDS, disseminated information about drug side effects and compliance, and networked with other service providers (McCord, 2005, 42). In Mozambique, a WFP programme has provided food as an incentive to HBC workers since 2002. By providing one-third of the ration that chronically ill beneficiaries receive, the programme brought about improved quality of HBC care, as HBC workers were then able to meet their own food needs and meet HBC responsibilities (Kayira, Greenaway, & Greenblott, 2004, 17).

Public works programmes can also target youth, who may be losing knowledge passed down through generations as parents die of AIDS. The Junior Farmer Field and Life Schools (JFFLS), run by FAO and WFP in Mozambique, provided food for training to out-of-school youth, especially teen orphans, who learned technical and entrepreneurial skills. Orphans and other vulnerable children aged 12-17 were trained for one year in both traditional and modern agricultural techniques. To complement the technical training, participatory educational drama helped the youth groups explore sensitive issues around HIV/AIDS, psychosocial problems, gender roles, and health and nutrition (Kayira, Greenaway, & Greenblott, 2004, 16).

Experience from a number of public works programmes illustrates that such programmes are conducive to linkages with Information Education and Communication (IEC) components. For example, some Food for Training (FFT) programmes have paid community activists to learn about IEC for HIV/AIDS prevention and care and then teach these concepts to the broader community. Other programmes have targeted truck drivers transporting food and workers at food or wage distribution points with HIV prevention messages (McCord, 2005).

Using public works beneficiaries to provide key services for HIV/AIDS-affected households (e.g., HBC and ECD) raises the concern that if poorly trained, these workers could harm rather than help households affected by HIV/AIDS and orphans and other vulnerable children. Proper coordination, training, and supervision is needed to provide quality service (McCord, 2005; Altman, 2007). This raises a trade-off, however, between scale and quality of training—the number of people who can be reached will be a small fraction of those in need—similar to that faced by South Africa’s National Public Works Programme that aimed to provide formal qualifications as well as significantly reduce unemployment, which proved to be a difficult combination (Adato et al., 1999).

South Africa’s Expanded Public Works Programme (EPWP) is emphasizing new forms of training. Its current programme includes a social sector, involving Home and Community-based Care (HCBC) and Early Childhood Development (ECD) programmes. These are a response to both unemployment, providing a form of social protection, and to the AIDS epidemic, where the programmes are designed to benefit those providing services (mainly women who normally do this work without training or payment), as well as those adults and children receiving care. The HCBC component has emphasized stipends for volunteers and provision of accredited training. The ECD component has thus far focused mainly on skills provision for carers. In addition to carers, the ECD plan envisions providing work for gardeners, cooks, and administrators as part of ECD provision. South Africa’s Department of Health and Department of Education also have HCBC and ECD programmes, respectively, which are linked in varying ways with the EPWP. The social sector component of EPWP has moved slowly and not yet received the priority that was envisioned (Prenzee and Budlender, 2007). However, it has important potential as a model for HIV/AIDS-responsive social protection in South Africa and elsewhere.

Beyond providing services tailored to HIV-affected households, public works programmes can support the creation of private assets for households affected by HIV/AIDS, such as simple kitchen gardens and school gardens (McCord, 2005, 20). Kitchen gardens, generally placed near homesteads, can boost household consumption of fruits and vegetables and, in times of surplus, can generate additional household income. Community gardens run by HIV-positive self-help groups and those caring for children affected by HIV/AIDS can provide similar benefits, and school gardens can produce food

for school-based consumption and generate income to support vulnerable school children. Home gardens in Ethiopia, Uganda, and Zimbabwe focused on increasing crop diversity and planting vegetables with high protein and micronutrient value and medicinal herbs as well as storage and processing techniques. PLWA have received food rations for participating in training to start their own home gardens and targeted community members received food rations for working on trench, kitchen, and community gardens for labour-constrained, HIV/AIDS-affected households. Similarly, households have also received payment for participation in training about home sanitation, water treatment (drinking water and wastewater management), composting, developing wood fuel briquettes from home waste, maintenance and treatment of water supply facilities and pit latrines, and behaviour change (Kayira, Greenaway, & Greenblott, 2004, 13).

11. Conclusions

Social protection must become part of an integrated response to HIV and AIDS. It is needed to break the vicious circle of HIV/AIDS and food insecurity, and to stem the loss of human capital among AIDS-affected families. Cash transfers have demonstrated a strong potential to reduce poverty and strengthen children's education, health, and nutrition, and thus can form a central part of a social protection strategy for families affected by HIV and AIDS. This conclusion is based on evidence from (1) studies of several large-scale, well-established transfer programmes in southern Africa; (2) studies from newer, smaller cash transfer programmes in southern and eastern Africa; (3) modelling of impacts of cash transfers in Sub-Saharan Africa; and (4) studies of conditional cash transfers in Latin America and Asia.

A review of research on cash transfers conditioned on household participation in education, health, and nutrition services have demonstrated large, statistically significant impacts on poverty, and on education, health, and nutrition outcomes, mainly for children. With respect to education, many CCTs have substantially increased school enrolment, attendance, and grade progression. There has been less demonstration of impacts on achievement, a challenge to future programme designs. There is variation between the magnitude of impacts across country, type of indicator measured, and target groups, e.g., between primary and secondary school, girls and boys, and rural and urban, but most programmes show consistent, significant, and substantial impacts, particularly where indicators are low at baseline.

In terms of health and nutrition, CCT programmes have increased health service utilization, and reduced the incidence of illness, although evidence of the latter is weaker than the former. They have achieved impressive results with respect to increases in the quantity and quality of food consumption, and improvements in nutritional status, although the latter varies more across countries and types of indicators.

These CCT impacts have been established using large-scale data sets, often in multi-year panels, mostly with control groups, using state of the art econometric methods for establishing causality, i.e., that the programmes are responsible for the changes measured.

These impacts have been found in many countries, mainly in Latin America and Asia. While most of these countries have better infrastructure, services, and administrative capacities than most countries in which AIDS-affected families reside, CCT impacts have been achieved in some very poor countries with low levels of infrastructure and implementation capacities. Design and implementation approaches have been adapted to different country conditions, capacities, and objectives.

Unconditional cash transfers, with a growing presence in eastern and southern Africa, have also demonstrated substantial positive impacts on the well-being of families and children. These results come from modelling using large national data sets in South Africa, and empirical studies at the provincial, district, or subdistrict level in several countries. The strongest impacts demonstrated have been on school enrolment and attendance, and on nutrition, mainly in South Africa, where the grants have been established for a long period and operate on a larger scale. In South Africa, receipt of the Child Support Grant and the Old Age Pension were associated with increases in school enrolment and attendance, with some important gender differences, e.g., receipt by a female pensioner has a much larger effect on attendance than receipt by a male pensioner. Increases in school enrolment were found between baseline and evaluation of the Social Cash Transfer Programme piloted in one district in Zambia. Here, girls were disadvantaged compared to boys, with evidence suggesting that with a very low transfer level, parents often send only one child and it is usually a boy. In both countries, the largest impacts identified were on enrolment rates for very young children starting school, suggesting that improved nutrition and health might have increased school readiness. As Malawi moves from its initial pilot through an ambitious scaling-up process, results show the cash transfer provides a protective function with respect to schooling: after one year, children in beneficiary households had enrolment rates more than twice as high as children in comparison households, and dropout rates half as large as children in comparison households. The receiving group also had fewer school absences per month. Recent data from Ethiopia also show positive impacts on schooling, but only for boys. These weak impacts on girls schooling in Ethiopia and Zambia (as well as evidence of increased domestic chores for girls in Ethiopia) indicate that it is critical to pay attention to gender issues in designing programmes.

Studies in Kenya, Malawi, Zambia, Mozambique, and Namibia infer some impacts on schooling via spending of cash transfers. While large proportions were spent in Kenya and Namibia, the proportions spent in Malawi, Zambia, and Mozambique were very small (however, since cash is fungible, the transfers could free up other money for schooling). In all countries, the largest grant expenditures by far were on food. This may have an indirect effect on schooling via nutrition and health improvements, although these studies did not examine this impact pathway. Old age pension spending on education in Namibia and Lesotho, together with large pension-driven enrolment and attendance effects found in South Africa, suggest that old age pensions are one effective way of supporting children's education. Modelling based on data from 15 African countries provides further support for this proposition, where an unconditional transfer to the household was found to have negligible impacts on schooling, but a transfer targeted to elderly-headed households would have a significant impact on girls' schooling.

Impacts of unconditional cash transfers on health were found in Zambia, South Africa, and Malawi. In Zambia the self-reported incidence of illness among SCTS beneficiaries fell, with the largest impacts among the elderly, followed by children under-five, and adults of productive age, possibly as a result of improved nutrition and hygiene. In Malawi, evidence from the Mchinji Cash Transfer programme shows that beneficiary households (compared to comparison households) reported that both adults' and children's health status had improved, and that household members were more likely to get health care, since the start of the programme. In South Africa, pensions were found to improve the health status of pensioners themselves, but also that of other members of the household where pension income pooled.

Evidence of impacts of unconditional cash transfers on nutrition comes mainly from South Africa, as it was not directly assessed elsewhere—a gap that should be addressed in future cash transfer evaluations. The Child Support Grant was shown to increase child height, but only if it was received sufficiently early in a child's life and covered the majority of the first three years of life. This demonstrates the importance of cash transfers for very young children, and of guaranteeing continued receipt during this critical period for child growth and development. Evidence from South Africa also suggests that cash transfer programmes targeted to the elderly can have a positive impact on children's nutritional

status, particularly if they are received by female pensioners. These impacts were particularly pronounced for girls. There is also some evidence from Malawi indicating that the Mchinji Cash Transfer Scheme reduced underweight rates among children under-five.

Impacts on health and nutrition from other country studies are also inferred from expenditures. Cash transfer recipients in Ethiopia, Kenya, Lesotho, Malawi, Namibia, South Africa, and Zambia reported expenditures on health, although the amounts were very small, with the exception of Namibia's old age pension. Health spending could imply improved health but not necessarily, as lower health spending can represent a diminished need to spend on health care resulting from better health.

Unconditional cash transfers were largely spent on food and led to increased food consumption in beneficiary households. In most of the programmes evaluated, grants were associated with a reduction in hunger and an increase in average meals per day, except when the transfer size was too small (as in Mozambique). In South Africa, having a female pensioner in the household had a greater impact on child hunger than adult hunger. In Malawi and Zambia, the transfer is also associated with an increase in dietary diversity. The role of factors such as seasonality or nutrition education is sometimes unclear, but cash transfers are boosting household food intake, resulting in less hunger.

Among the evaluations of unconditional transfers in Africa, the sample sizes vary considerably, as does the quality of the control or comparison groups (most of the South Africa studies, and the Ethiopia and expanded Malawi programme evaluations, are stronger, while the pilots in Zambia, Kenya, and Malawi are weaker), so the results of the less rigorous studies should be interpreted cautiously. Still, collectively they make the case that unconditional transfers have had an impact on human capital, even if the magnitude of those impacts and isolation of programme impacts are not yet definitive. Larger-scale evaluations underway of the cash transfer programmes scaling up in Zambia and Kenya will add to the evidence.

Analysis of eight existing cash transfer programmes and 15 country simulations demonstrate that these programmes have the potential to reduce poverty, particularly the poverty gap and severity of poverty, if they are targeted to poor households, households

with children, households without able-bodied members, or the elderly. Impacts on headcount poverty tend to be smaller, showing that the poor are generally not pushed above the poverty line, but the fact that the poverty gap and severity of poverty measures improve as a result of cash transfer programmes illustrates that the very poor would benefit.

In addition to assessing impacts, this paper addresses two central policy debates with respect to cash transfer design: targeting and the use of conditionality to increase human capital impacts. The targeting debate centres mainly around who to target—who most needs benefits, whether to target AIDS-affected families or very poor families and how to reach both, and what criteria and processes will best reach them. There is ample evidence that HIV and AIDS drive many processes that decrease food security and increase poverty. Targeting the “extreme poor,” using indicators that capture the very poor *and* those who are affected by AIDS (such as those related to poverty, prime-age disability, and high dependency ratios), can effectively reach those who are the most vulnerable, and least resilient, in the face of HIV and AIDS. It is important that multiple criteria are used in combination as using one alone can result in mis-targeting.

A more difficult ethical quandary surrounds targeting those on ARVs. Evidence on the importance of nutrition to the effectiveness of ARVs has motivated programmes providing food transfers to people on ARVs, and more recently there have been suggestions to similarly target cash transfers. Food may be a better form of transfer for those on ARVs, given the direct nutritional objective of the transfer. However, cash provides flexibility to meet other needs of patients, such as transportation to pick up their drugs. Research is needed to look at the impacts of different approaches, but it is likely that a direct food transfer for ARV patients, plus a household-level cash transfer, would be the best set of interventions. It is difficult to argue against targeting ARV patients, when the intervention is likely to save lives. There are still, however, equity, stigma, and related sustainability questions leading back to the conclusion that targeting extreme poverty, in a way that captures both those on ARVs, and their destitute neighbors who are not, is a better option.

An important process of political mobilization for social protection in the context of HIV and AIDS has convened largely around orphans and other vulnerable children, but

dilemmas have also arisen here. Questions are posed around how to define a vulnerable child, whether orphans are disadvantaged in relation to non-orphans, including children with ill parents as well as those suffering other forms of deprivation and trauma, and whether children affected by AIDS are more in need of material assistance than poor children affected by other misfortunes, e.g., other diseases, conflict, or conditions making their families chronically unable to secure a livelihood. The evidence is complex. Orphans may be in very poor households, or in better-off households that can afford to take them in. Some studies find that orphans are disadvantaged with respect to food security, nutrition, health, and education; other studies find they are not. This is not necessarily contradictory, but rather contingent on variables such as the relationship between children and caregivers, poverty/wealth status, and household demographics and structure. Targeting to respond to these variations at a household level would be infeasible. However, research can shed light on how AIDS-related specificities, articulated with other social and contextual variables (e.g., gender dynamics or household structure), can inform targeting criteria at a broad level, or complementary programming that responds to the unique circumstances of or orphans or other vulnerable children where they arise. In light of concerns around accuracy, equity, and stigma, a consensus is building around targeting cash transfers based on poverty and multiple vulnerability criteria, rather than targeting orphans or families living with AIDS.

Another approach is to use categorical targeting of the elderly. More than half of orphans living in six countries in southern and east Africa were living with grandparents, and there is considerable evidence of the positive impact of old age pensions on children. An old age pension can be means tested (or not, depending on costs and benefits), or additional criteria such as dependency ratios could be applied where narrower targeting is necessary. However, targeting the elderly would reach many, but not all, children in need of support.

There are also questions about what targeting mechanisms are most appropriate for reaching AIDS-affected families and under available administrative resources. There are currently three main systems that predominate with respect to targeting cash transfers. In Latin America, where administrative and financial capacity exists to carry out data-intensive proxy-means test surveys and analysis, these programmes tend to perform well in targeting extreme poverty. They are often not perceived that way, however, at the

community level, where people often do not understand or agree with distinctions made between people above and below a poverty line. This method is probably not practical or cost-efficient in the context of low administrative capacity and sparsely populated areas, and would also likely be problematic if there is no community involvement. The system used in South Africa, applying an application-based means test, results in low errors of inclusion but in the past had large exclusion errors. These have been substantially reduced, but remaining exclusions are a concern, resulting mainly from constraints people face in accessing required documents and negotiating the application process.

The most commonly used system in the new generation of cash transfer programmes in southern and eastern Africa is community-based targeting, where local committees or other public forums use a set of criteria to identify those who most need the assistance. In some programmes this set of criteria has been standardized; in others the criteria, too, are community-determined. The criteria have mainly reflected these interrelated categories of families: (1) living in extreme poverty, reflecting, e.g., destitution; lack of assets; (2) labour constrained or incapacitated, e.g., due to illness, disability, death; (3) high dependency ratios; and (4) without other private or public social assistance. Kenya's cash transfer programme uses additional criteria to focus more sharply on orphans and young children out of school. These community-based processes are reported to generally work smoothly and provide a basis for consensus rather than conflict—important when just a small portion of the population will get assistance.

With respect to accuracy of the systems, effectiveness is judged in two ways: one is how well they do at reaching the people intended by the current targeting criteria; the other is whether the criteria are the most appropriate for reaching AIDS-affected households, or those otherwise in need. Current community-based programmes have tended to get good performance assessments based on both of these measures. However, concerns remain that they may not be sufficiently effective and cost-efficient, particularly as programmes scale up to a national level. The extent to which the outcomes of community-based processes correlate with “external,” conventional indicators for poverty targeting or AIDS-affected proxies has not yet been evaluated, although some of this type of work is underway, and ideas for combining or otherwise improving indicators and methods are being tested. A reasonably systematic, cost-efficient approach will be needed for cash

transfers to scale up to a national level. However, despite the flaws of community-based processes, some process of local participation or review will need to remain, especially in rural areas, where it is seems likely that an externally-driven, non-transparent process would be problematic. Furthermore, given the variation in household conditions, and complex configurations of deprivation and dependency, a generic targeting formula using standard poverty proxy indicators applied uniformly would probably have high errors. Complexity is better managed at a local level, with communities better positioned to judge circumstances, and such attention to detail feasible.

Several conclusions emerge from recent experience with targeting. First, targeting on poverty, incapacity, or dependency ratios alone will invite errors; instead these criteria must be applied together. Second, the right balance must be found between using an equitable, uniform process of applying criteria, and a qualitative assessment that catches errors of application, or what the other criteria miss. Third, there need to be layers of review, providing checks and balances. Fourth, the transfers should probably be given to women; this has been a very successful design feature in Latin America and elsewhere, improving women's status, increasing their autonomy, and (based on what we know from the literature on intrahousehold spending patterns) probably resulting in more expenditure on children's needs than had the transfer gone to men, with minimal negative intrahousehold repercussions. This would also ensure that women in polygamous households are not disadvantaged. Fifth, in urban areas, geographic targeting, survey methods, and community-based processes are more difficult to use than in rural areas. Programme application methods are often used in urban areas, but these require strong outreach efforts and should not be overly-burdensome or they will miss many of the most disadvantaged who most need the assistance. Also, special design features, or other forms of assistance altogether, are needed for reaching hard-to-reach children, such as street children and those in child-headed households. Sixth, in all of the alternative targeting methods, from proxy means tests to community-based methods, there are risks of missing certain kinds of households and individuals, e.g., remote households living in difficult terrain, migrants, and people who self-exclude or face discrimination by other community members due to race, ethnicity, caste, severe disability, or other factors. Ways to reach these groups, through eligibility criteria and targeting methods, should be carefully designed into the process. Seventh, given the impacts of HIV and AIDS, the human costs

of errors of exclusion are graver than the financial costs of inclusion errors, assuming the latter are not so high as to make the programme non-viable. It is worth allowing in some inclusion errors in order to reduce exclusions.

This paper has focused heavily on the implications of cash transfers for protecting human capital, because of the threats that HIV and AIDS pose to the human capital of families, including the health, nutrition, and education of children. These threats result from a vicious downward spiral involving illness, loss of income and assets, decreased food security, need for children to care for the ill or otherwise work, inability to afford health care and school expenses, and stigma and emotional distress that reduce participation or performance in school. A concern over the ability of cash transfers to affect human capital is also driven by the evidence on the interactions between early childhood nutrition, health and education, and the effect of these interactions on long-term income earning potential and thus long-term intergenerational transmission of, or emergence out of, poverty. In other words, many children who are not protected now from the effects of HIV and AIDS on their families will never recover.

For these reasons, we examine not only unconditional cash transfers in southern and eastern Africa, but also conditional cash transfers in Latin America and Asia, which have rigorously demonstrated high impacts on children's education, health, and nutrition. There are important debates on conditioning transfers, involving issues of social externalities, power, autonomy, and political economy. Each of these issues involves arguments for and against conditionality, but all suggest that conditionality should be considered cautiously. At the same time, given the importance of children's health, nutrition, and education, the main concerns to address are those that relate to whether conditionality is likely to strengthen human capital, or work against it. Most of the global evidence to date on impacts of cash transfer programmes come from evaluations of conditional cash transfer programmes. This is because of the large number of these programmes implemented in the past ten years, and the quality of the evaluations conducted that leave little doubt about impacts. The context is very different than that of Sub-Saharan Africa, but the impacts are of such magnitude that if there is anything worth learning from them, these programmes are important to consider.

It is not as yet clear whether conditions would make a difference in the demand for and supply of services in the African context, or whether conditionality would work at all. There is limited evidence on the role of conditions in explaining impacts of CCTs, although the studies that have compared them in Latin America found significant impacts attributed to conditionality. This question needs to be tested in the new generation of cash transfer programmes in Africa, under the gamut of contextual specificities. Such evaluations are underway in several countries thus far, with more under discussion.

The strongest concerns about conditionality in Africa relate to the availability of services, and administrative capacity to support a conditional programme—cash cannot be conditioned on services that are nonexistent, too far away, or of very poor quality. Some very poor countries in Latin America and Asia have managed CCTs, experiencing some high impacts, and have used the programme as an impetus to improve supply, bringing in NGOs to support government provision where needed. It cannot be assumed that this is impossible in new programmes in Africa by governments and their partners. Given the importance of improving services, regardless of the issue of cash transfers, it would be worth considering whether the current interest in CCTs could be used to accelerate service improvements. However, supply improvements will at best be very slow. For this reason, unconditional cash transfers are most appropriate for the near-term. Conditionalities can be tested on a small scale, under appropriate circumstances where supply is available or can be improved in the near term.

The other important question: on what should any given programme condition? Conditionalities should not all look alike—rather, they should be tailored to the problem that the country or region needs to solve, rather than target the wrong outcome. For example, a cash transfer may help children stay in school by substituting for children's contribution to subsistence production, or by paying for school expenses. However, it may not solve the need for girls to take care of ill relatives or small children (in which case an alternative or complementary programme of HBC or ECD would be needed). The condition also does not need to apply to primary school enrolment if this is already very high, or where parents want to enrol children but there is no school nearby. Conditionality is a form of incentive and can be designed to encourage participation in, for example, secondary school, health awareness (including HIV prevention) services, or STI testing.

Conditionality may be appropriate for particular geographic areas under particular combinations of circumstances, e.g., very poor areas with high numbers of fostered orphans, low attendance rates, and evidence of discrimination against orphans in education outcomes. Furthermore, design can adapt to administrative capacity, with conditions simple, un-enforced (“soft,”) or waived altogether in the case of the mobility impaired or areas without services. Finally, there are ways in which services and activities—from productive economic activities and early childhood development to adult education and health awareness—can be linked to cash transfer programmes, facilitating participation in these activities without requiring it. This is a new area that needs further experimentation in terms of mechanisms for linkages, and where governments promoting cash transfers can team up with NGOs who are delivering these kinds of services.

How the evidence on the impacts thus far of cash transfers in Africa is interpreted will vary, perhaps depending on where one sits. Economists preferring the “gold standard” evaluation designs used in the Latin American CCT evaluations may have doubts as to whether evidence of impacts from the African programmes thus far are reliable enough without valid control groups and counterfactuals. Reflecting this standard of expectations are the large-scale impact evaluations currently underway in Kenya, Zambia, and Malawi—these will supply important new information. The other side of the argument is that there is sufficient, quality evidence of impacts on poverty and human capital, and there is an urgent need to act. Research underway will provide important new information on implementation lessons, and on the effects of alternative designs (e.g., targeting, conditionality) on impacts and costs.

Other questions will emerge around the relative benefits of other approaches to social protection for families affected by HIV and AIDS—on one side driven by a concern about building sustainable livelihood opportunities, and on the other by a concern about meeting urgent needs via food and nutrition transfers where these may be more appropriate. With respect to livelihoods activities and related microcredit, these are also important parts of a strategy, and should continue to be supported to reach as many people as possible. Like public works programmes designed for HIV/AIDS-affected contexts—which also have significant potential as part of a social protection strategy—they are likely to be most appropriate for AIDS-affected families that are “less affected”—less labour constrained and

less destitute, and possibly better off in various asset endowments. Livelihoods activities will not be able to reach as many people as cash transfers. These activities are on the higher end of the capacities/scalability/inputs continuum. Even where they can be designed to be pushed toward the middle of that continuum—as public works can be through less physically demanding work, or livelihoods activities can be through home gardens or small livestock—they will still be hard to scale up to meet the urgent and huge need that currently exists—a demand that will only continue to grow as disease stages progress and the regional impacts approach their peak.

With respect to food transfers and nutrition programmes, these are also important parts of a social protection strategy, which do not run into the household-level capacity constraints, and do respond to urgency. They may be most useful for subgroups of the most AIDS-affected, e.g., people on ART, children in need of nutrition rehabilitation. Research using an HIV/AIDS lens is needed to understand these conditions, in order to develop the best mix of interventions. Food assistance will continue to play an important role in social protection. However, issues of logistics, economics—including rising food prices and political-economy at the international and national levels—make it unlikely that food transfers would be scaled up as a national strategy of social protection. Cash has been gaining more momentum in recent years in countries looking at national social protection systems for children affected by AIDS.

“AIDS-affected families” do not comprise a homogenous category; they involve many variations with respect to wealth or poverty, education, household structure, stage of illness progression, dependency ratios, social status, and access to assets. This argues for a mix of approaches rather than a single approach. However, pursuing a mix does not conflict with a national strategy of scaling up cash transfers for the most vulnerable families. Cash transfers appear to offer the best strategy for reaching AIDS-affected families who are the very poorest, most constrained and at-risk with respect to human capital, in large numbers, relatively quickly. These are important considerations, given the extent and nature of deprivation, the long-term risk to human capital, and the current international and national political willingness to act.

Additional knowledge gaps remain. These include operational issues such as appropriate size of the cash transfer and flexibility under changing circumstances (e.g., prices, markets), number of transfers per household, whether, when, and how to transition households out of a programme (hopefully into something better), the pace of scaling up, and the roles for government, NGOs, and CBOs in programme implementation and service delivery. Other questions pertain to human capital objectives and service delivery: what is the current status of services, what is the potential for scaling up, and how can constraints be overcome? Still others pertain to political-economy: how much will the programmes cost, is this “affordable,” who will pay for it, and how can this strategy be made politically viable? The last question is perhaps the most critical, as ambitious plans to scale up in some countries have not received the follow-through anticipated, in substantial part due to political ambivalence. These are issues relevant to a wider antipoverty and social protection agenda, but require further analysis through an HIV/AIDS lens. Such analysis can take place in the course of action, as part of current efforts underway to scale up cash transfer programmes, and current political processes underway to motivate for social protection as an integral part of the response to HIV and AIDS.

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Appendix: Unconditional cash transfer programme evaluations reviewed for programme impacts

Country	Programme	Study area	Study sample	Time period	Methods	Comments
Ethiopia	Productive Safety Net Programme	8 <i>woredas</i>	960 households	April-June 2006	Household and community questionnaires; key informant interviews, market survey	Sample not representative of all of Ethiopia nor all communities where PSNP implemented
Ethiopia	Productive Safety Net Programme	262 <i>woredas</i>	3,700 households	June-Sept 2006	Household and community questionnaires	Data collected more than 1 year after programme began, so long recall period; control group formed using matching methods
Kenya	Cash Transfer Programme for OVC	3 districts (Garissa, Kwale, and Nairobi)	500 beneficiary households; 250 control households	December 15-29, 2006	Household questionnaire; key informant interviews	No control group Long recall period (6 months)
Malawi	DECT	Dowa district	31 households (DECT and excluded); 37 key informants; 2 pay-points	April 2007	Secondary data review; qualitative fieldwork (focus groups, interviews, observation at pay points)	No control group
Malawi	FACT	3 districts (Dowa, Lilongwe, and Nkhhotakota)	1,000 households (500 beneficiary and 500 control)	Nov 2005-May 2006	Monitoring data; household and market surveys; qualitative fieldwork	
Malawi	Mchinji Cash Transfer programme Scheme	4 Traditional Authorities within Mchinji District	819 households (round 1) 789 households (round 2) 766 households (round 3)	March 2007 – March/April 2008	Household questionnaire, qualitative fieldwork (focus groups, key informant interviews)	No strict control group, but used a comparison group.
Mozambique	GAPVU	Maputo	41 beneficiaries 40 nonbeneficiaries (meet eligibility criteria)	Dec 1997	Single-visit 24-hour recall for food consumption	Small sample size, exclusive focus on elderly beneficiaries in capital city
South Africa	Social grants	Free State Province	163 HIV-affected households; 72 affected households that experienced morbidity or mortality in 3 or 4 periods; 108 households that did not experience morbidity or mortality	May 2001-Dec 2002	Household questionnaire	Small, purpose sample
South Africa	Social grants	National	30,000 households (2000 Income and Expenditure Survey); 30,000 households (September 2000 Labour Force Survey); 20,000 (1998), 30,000 (1999) (October Household Surveys)	2000	Household questionnaire; poverty simulations, analysis of administrative data from the Department of Social Development	

Country	Programme	Study area	Study sample	Time period	Methods	Comments
South Africa	Child Support Grant	KwaZulu-Natal Province	245 children receiving the CSG before age 3 (from KwaZulu-Natal Income Dynamics Study (KIDS))	1993, 1998, 2004	Household questionnaire	
South Africa	Child Support Grant	Umkhanyakude District, KwaZulu-Natal Province	11,178 households (data from the Africa Centre for Health and Population Studies longitudinal demographic surveillance system)	2002-2004	Household questionnaire	No strict control group, used older siblings
South Africa	Old-Age Pension	Langeberg Health District, Western Cape	1300 individuals in 300 households	1999	Household questionnaire; anthropometry; some open-ended questions	Self-reported health status
South Africa	Old-Age Pension	National	9,000 households	Aug-Dec 1993	Household questionnaire, anthropometry (children 0-7)	
Zambia	SCTS	2 agricultural blocks in Kalomo District	Randomized sample of 303 households (274 at end line)	Kalomo: Sept 2004-Sept 2005 Kanchele: Dec 2004-Dec 2005	Household questionnaire, focus groups, key informant interviews with stakeholders	No control group

Sources: Acacia Consultants, 2007; Agüero, Carter, & Woolard, 2007; Bazo, 1998; Booysen, 2004a; Case, 2001; Case, Hosegood, & Lund, 2005; Devereux, Mvula, & Solomon, 2006; Devereux et al., 2006; Devereux et al., 2007; Duflo, 2000, 2003; Gilligan, Hoddinott, & Taffesse, 2007; MCDSS/GTZ, 2006; Miller et al., 2007; Samson et al., 2004; Tarp et al., 2002.

^a Kalomo central agricultural block: baseline: 146 households; end line: 128 households; Kanchele central agricultural block: baseline: 157 households; end line: 146 households.