

**USING SOCIAL TRANSFERS TO SCALE UP EQUITABLE
ACCESS TO EDUCATION AND HEALTH SERVICES**

Background Paper

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Contents

	Section	Page
	Acknowledgements	1
1	Introduction	3
2	Social transfers: what they are, how they boost demand	4
3	The education and health benefits of social transfers	7
4	Social transfers – do they offer value for money in improving education and health?	12
5	Balancing investment in demand and supply	13
6	Context matters - key considerations in choice of social transfer instruments	15
	Consideration 1: Policy objectives and understanding demand	16
	Consideration 2: Cash or restricted spending choice?	18
	Consideration 3: Targeted and universal approaches	18
	Consideration 4: Political feasibility	20
	Consideration 5: Administrative and institutional capacity	21
	Consideration 6: Governance issues	22
	Consideration 7: Affordability	23
7	Delivering social transfers through country-led approaches	24
8	Social transfers in the context of scaled up resources	25
9	Evidence gaps	26
	Annex 1: Assessing economics of transfers	30
	References	31

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1. Introduction

Slow progress towards MDGs has rekindled interest in social transfers as a means to reduce poverty and accelerate progress towards the Millennium Development Goals (MDGs). For example, the Commission for Africa has called for a major scaling up in social assistance to vulnerable children¹. Social transfers are increasingly recognised as an important component of an overall care package for children affected by AIDS. The World Bank is scaling up its support to social transfers as a key policy response to inequities in health and education opportunities for the poorest and socially excluded groups². UNESCO promotes targeted social transfers as a way of changing the balance of incentives for girls to attend school³. WHO has recently launched a Commission on Social Determinants of Health, which includes a review of the potential of social transfer programmes to improving health.

This paper provides background analysis to support a DFID Policy Division Briefing Note on *Using Social Transfers to Improve Human Development*⁴ produced by the Scaling up Services team in collaboration with the Social Protection team, part of a series of briefing notes on social protection. This work complements DFID's Practice Paper *Social Transfers and Chronic Poverty* (2005)⁵. It also forms one part of DFID's Scaling up Services team's workstream on promoting equitable access to health and education services. Policies that promote poor people's access to health and education services are critical to making best use of scaled up resources. Scaling up poor people's access will require a combination of health and education system investments along with investments outside those sectors. These may include demand side approaches that promote the use of available services, as well as increasing service coverage. This paper focuses on the impact of one form of demand-side policy option – social transfers, particularly cash transfers and vouchers - on access to health and education services by the extreme poor. It also touches upon the broader contribution that social transfers make to human development outcomes.

Section 2 describes social transfers and their relevance to scaling up health and education services and outcomes for the extreme poor. Sections 3 and 4 summarise the evidence on the effectiveness and cost-effectiveness of social transfers in relation to health and education access and outcomes. Sections 5 and 6 outline a range of factors, including service provision context, that need to be considered when assessing policy options in different contexts. Section 7 sets out some of the country ownership and aid instrument issues, whilst Section 8 looks at the opportunities that scaled up resources has for social transfers in the pursuit of equitable human development goals. Section 9 concludes by identifying the gaps we still need to fill in the evidence base.

This report is based on a desk review of published papers, programme evaluation documents and 'grey' literature. Where possible, references have been followed up with country contacts. The databases on social assistance commissioned by the DFID Social Protection team were useful starting points.

2. Social transfers – what they are, how they boost demand

Social transfers are non-contributory, regular and predictable grants, in cash or kind, which are provided to vulnerable households or individuals in order to ensure a minimum level of well-being.⁶ Cash transfers can take the form of income support, child grants, disability benefits, foster care grants, scholarships and stipends, or non-contributory (social) pensions. Vouchers are near-cash transfers that can be redeemed for specific products or services, although they are not always received on a regular basis.

Social transfers are one way to boost demand for services and reduce some of the demand-side barriers (particularly costs) to access by targeting subsidies directly to specific groups of individuals and households. Lack of demand for services can be a major constraint to scaling up effective education and health interventions in low income countries. Many of the world's poorest people cannot use or effectively demand education and health services - even when the government has a policy of free universal services 'free' at the point of delivery to all its citizens. Chronically poor⁷ households face high opportunity costs such as lost income of children giving up work, and out-of-pocket expenses such as travel, medicines, textbooks, uniforms, lodging and food⁸. Discrimination against girls, elderly people, disabled people, and children affected by AIDS can compound these financial barriers. The poorest fifth of children are less likely to start school and more likely to drop out. Similarly, those who need health services the most often, use services the least, and pay the most⁹.

Social transfers are one way to target subsidies to the demand-side.

There is increasing awareness that supply-side subsidies for health and education services often fail to benefit the most vulnerable people. Recent research findings from public expenditure incidence analysis show that spending on education and health typically is skewed to services disproportionately used by the rich and middle class. The share going to the poorest 20 percent is almost always less than 20 percent¹⁰.

Social transfers can also address some of the underlying causes of inequalities in health and education outcomes, such as poverty, social exclusion and malnutrition. A regular source of income allows extremely poor households to eat better food more regularly, leading to improved nutritional status. Improved nutrition in young children will in turn benefit their health, and is important for children's cognitive development and ability to benefit meaningfully from school. Education in turn will lead to healthier children and these benefits will be passed on to the next generation. Evidence shows that in Africa, children of mothers who received five years of primary education are 40% more likely to live beyond the age of five¹¹. Adults with enough to eat are less likely to get ill, and good nutrition is essential for effective treatment with anti-retrovirals.

Many of the large cash transfer programmes and school stipends are conditional, with payments dependent on regular school attendance, or use of

preventive health services or other specified conditions. Whereas, unconditional cash transfers (eg. social pensions, child support grants) are not tied to service use. With both types of cash transfers, human development outcomes may be improved through both increased use of services, or indirectly through increasing food consumption. Other types of social transfers are even more tied to changing demand-side behaviour, by issuing the transfer in kind (eg. school meals) or near cash (voucher, scholarships) to be redeemed against use at specified service providers.

Many social transfers can also be described in terms of consumer-led demand-side financing (DSF) - a term used in education and (to a lesser extent) health sectors to describe a means of transferring purchasing power directly to specified groups of service users for the purchase of defined goods and services¹². It is an output-based form of finance, where the service provider receives the public subsidy after the recipient has used the service, rather than an input-based subsidy to providers based on capital and running costs of service provision¹³. This definition is most commonly associated with competitive vouchers, but can also be applied to incentive-based conditional cash transfers, stipends and scholarships¹⁴. It does not apply so well to un-earmarked, unconditional cash transfers. However, the literature is confused, and some authors argue that only competitive vouchers are true demand-side financing mechanisms because they should impact on supply-side provider behaviour as well as consumer demand and behaviour¹⁵.

This paper draws upon the two overlapping bodies of evidence – social protection and demand-side financing. It reviews a selected range of conditional and unconditional cash transfers (social pensions, child grants, family grants, scholarships/bursaries, stipends) and near cash transfers in the form of consumer-led, demand-side vouchers and entitlement cards. To limit the scope of this paper, consumption transfers (such as fee waivers and exemptions¹⁶), in-kind transfers (such as food aid, school feeding programmes¹⁷) and transfers to communities (rather than individuals or households) through social funds¹⁸ will not be included since they are already well-documented elsewhere. Supply-side vouchers (held by providers) are also excluded¹⁹. For an overview of how these other social protection measures ensure poor and vulnerable people benefit fully from basic services, see Marcus et al (2004)²⁰.

The combination of policy objectives of specific social transfer programmes will therefore depend on whether they emerge from a broader social protection agenda or from a sector financing starting point (see Box 1). The primary policy objective of most social transfer programmes is to reduce poverty, hunger, and income inequality in the short-term, as a form of social safety net for vulnerable and chronically poor people. Some forms of social transfers (conditional cash transfers, vouchers) are also being used to directly contribute to targeted investment in poor people's human development – as a means of breaking the inter-generational cycle of poverty²¹.

Box 1: Range of possible policy objectives addressed by social transfers²²

Reduce risk, chronic poverty and vulnerability:

- Manage risks and protect against impoverishment (eg. South Africa and Namibia's non-contributory pension schemes²³)
- Increase individual or household income (eg. Kenya foster care grants for households looking after children affected by AIDS²⁴)
- Reduce poverty and hunger in destitute groups through increasing household income (eg. Kalomo social cash transfer programme in Zambia²⁵)
- Reduce child labour (eg. Brazil's PETI programme²⁶)

Change or reinforce demand-side behaviour:

- Boost demand and increase utilisation of education and health services (eg. Honduras PRAF conditional cash transfer programme²⁷; Mozambique minimum income for school attendance programme²⁸)
- Reduce direct, indirect and opportunity cost barriers to accessing services
- Reduce gender-based and other discrimination-based barriers to accessing services (eg. Bangladesh female secondary school stipend programme²⁹)
- Empower people with choice of providers (short route of accountability³⁰)

Linking demand to supply:

- Target social sector resources/subsidies to poorest and socially excluded

Change service provider behaviour (supply):

- (Competitive vouchers) Improve service quality and client-focus for poor people by promoting competition and choice for clients with purchasing power (eg. planned maternal health care voucher programme for pregnant women in Bangladesh³¹)

Figure 1 also illustrates the multiple effects of different types of transfers:

Figure 1

Objectives of social transfers

	Reduce poverty and vulnerability	Increase affordability of services and boost uptake	Overcome weak demand* for services and boost uptake	Target public subsidy of service provision on the poor	Risk-pooling and prepayment (health)
Unconditional cash transfers	YES With targeting	Significant secondary effect			
Conditional cash transfers	YES With targeting	YES	YES	YES With targeting <i>and</i> expanded supply side financing	YES With expanded supply side financing
"Near cash" conditional transfers ie. vouchers	Significant secondary effect	YES	YES	YES	

* "weak demand" meaning low value given to services, perhaps by decision-making head of household

3. The education and health benefits of social transfers

Social transfers can make investment in education and health sectors more effective and equitable, by extending the impact and reach of services and through impact on nutrition. This section focuses on the benefits of social transfers in terms of effects on equity of access to education and health services and on education and health outcomes. It draws heavily on the summary of evidence set out in the DFID Practice Paper *Social Transfers and Chronic Poverty* (2005), Ensor (2004), IHSD (2004), Rawlings and Rubio (2003) and Rawlings (2004). It is beyond the scope of this paper to outline the additional impacts of social transfers on income poverty, hunger and food security, child labour, gender equity and empowerment, and local level economic growth³².

The multiple goals of social transfer programmes are not well-handled in the existing evaluation literature. Evaluations tend either to value unconditional transfers purely as income safety nets, or conditional transfers and vouchers largely in terms of their impact on service use and human development. The more robust evidence base is biased towards conditional cash transfer programmes in Latin and Central America, and competitive voucher schemes for education in North America. Rigorous impact evaluations of social transfer programmes in low-income countries are scarce, particularly for health³³. This reflects the limited number of implemented schemes, especially at scale. Even where evaluations are robust, different methodologies and indicators make comparisons difficult.

3.1 Extending the impact of services

Evidence from a range of studies indicates that social transfers do act as effective incentives to increase poor people's demand for services and improve their education and health outcomes. Conditional cash transfer programmes, for example, have increased school enrolment and attendance rates among poor families, often significantly. The Bangladesh cash-for-education programme has resulted in a 20-30 percent increase in primary school enrolment among beneficiaries who are likely to stay in school up to 2 years longer than other children.³⁴ Similarly, in Nicaragua, the *Red de Protección Social* programme brought about a 22 percent increase in primary school enrolment rates for the target population between 2000 and 2003.³⁵ In Mexico, PROGRESA (renamed Oportunidades), the Education, Health and Nutrition Programme's impact on primary school enrolment was less than 2 per cent, reflecting the much higher baseline enrolment rates (90-94 percent). At the secondary level, enrolment rates increased by up to 9 per cent. In both cases, programme impact was greater for girls than boys. Given that PROGRESA serves over 20 million people, these percentage increases result in improvements to thousands of people's lives. A similar trend was seen in Colombia's *Familias en Acción* programme. The PROGRESA evaluation showed more pronounced effects on enrolment than on attendance rates, whereas the reverse was true in Nicaragua where the programme resulted in

30 percent increase in children who had less than six unexcused school absences in a two-month period³⁶. It should be noted that attribution of effect is more difficult in Bangladesh and Brazil (see Box 3), due to a less rigorous evaluation methodology.

Scholarships can help poor households maintain access to services. For example, Indonesia mounted a large scholarship programme to safeguard junior secondary school enrolments during the 1997 economic crisis³⁷. Bangladesh has used scholarships/stipends for girls to increase their secondary enrolment with great success, overcoming gender and financial barriers and extending coverage nationwide through the Female Secondary School Stipend Programme³⁸. An equally ambitious scholarship scheme has been successfully implemented in Malawi as part of the GABLE programme. Originally poverty-targeted, the second phase of the programme extended the scheme to all girls in 1998³⁹. Unfortunately, many primary and secondary school scholarship programmes are implemented on a small scale and without proper evaluation of impact.

Box 2: Children affected by AIDS benefit from social transfers

In line with the UNICEF framework for Orphans and Vulnerable Children (OVC), social transfers can provide an important element of an overall care package. Foster care grants (conditional or not) have great potential to prevent OVC students from dropping out of school and to increase the enrolment of OVCs who are currently out of school. They can also offer direct support to people with HIV/AIDS: improved nutrition will increase resistance to the virus and effectiveness of anti-retroviral drugs.

Initial evaluation of the pilot Kenya Cash Transfer for OVCs⁴⁰ suggests that the transfer of Ksh. 500 (£3.80) per month has been spent on food, clothing, shoes, medical expenses and other minor household purchases. School attendance has increased and some children with HIV/AIDS have been able to obtain anti-retroviral treatment. The project has strong political backing and will scale up to 2,500 orphans.

Such programmes can achieve scale by reaching large numbers of children and at relatively low cost per child. For example, almost 1 million children benefited from conditional transfers in 2003 in Zimbabwe. In Mozambique, conditional transfers support 300,000 OVC students, roughly 10 percent of the 2.3 million primary school-aged children at a total cost per child of \$20.⁴¹

Cash transfers do not need to be made conditional on school attendance to impact on children's education. For example overall absenteeism from school has declined by 16 percent over the first nine months of the Kalomo unconditional cash transfers pilot scheme in Zambia – where transfers are made to the most vulnerable households, often grandparents caring for children affected by AIDS⁴². Social (ie. non-contributory) pensions in Brazil are another example (see Box 3), while, in Namibia, a significant proportion of old-age pensions is spent on their children's education⁴³. This is often the result of older people living with their extended families and pooling their resources, as well as situations where old people are the primary carers for children.

Box 3: Social pensions and conditional cash transfers for education in Brazil

Brazil provides two large-scale examples of unconditional and conditional cash transfers having a positive effect on education.

Old-age pensions - Brazil spends 1 percent of GDP to transfer \$70 a month to 5.3 million elderly poor.⁴⁴ In rural Brazil, pensions are strongly associated with increased school enrolment, particularly of girls aged 12-14 years.⁴⁵

Bolsa Escola – now merged into *Bolsa Familia* – is a national programme that transfers \$6-19 a month to an estimated 5 million families, at a cost of 0.15 percent of GDP⁴⁶. It aims to address high drop-out rates by targeting income subsidies to families with school-age children on the condition that each child attends school at least 90% of the time. Cash transfers are paid directly to mothers. Studies show sharp reductions in school drop-out rates and higher enrolments in post-primary education. Although the amount of the subsidy is less than the expected income from child labour, its dependability, together with the reduction in violence and health problems associated with work in the informal sector, outweighs the loss of income for most families.⁴⁷

Furthermore, social transfers can have a role in raising the completion rates and educational attainment of children in school. By providing children with improved nutrition in their early years, social transfers can also help enhance their long-term cognitive ability once they are in school.⁴⁸ Unlike school feeding programmes, social transfers benefit pre-school children and other household members rather than just those in school. Where payments are made on condition of exam performance, examination pass rates are likely to increase. This was the case among girls supported by the Female Secondary School Assistance Programme in Bangladesh who had higher pass rates than the national average for girls, and drop-outs fell from 15 to 3 percent between 1982 and 1990⁴⁹. However, more recently, drop-out rates for girls have been increasing, raising the question of trade-offs between higher enrolments and lower quality (see section 5).

Social transfers can impact on health outcomes by improving nutrition and by enhancing the ability of those living in extreme poverty to access health services and pay for medicines and other associated costs. A number of social transfer programmes are beginning to provide evidence of sustainable impacts on nutrition. In Mexico, for example, 70% of households participating in PROGRESA have shown improved nutritional status while its impact on stunting has also been impressive, with the growth rate among children aged 12-36 months increasing by one centimetre per child, per year⁵⁰. Similarly, in South Africa, where the pension was received by a woman, a correlation was found with a 3-4 centimetre increase in height among children⁵¹. The association was more marked for girls⁵².

Evidence on the impact of social transfers on health can be found in a unique comparative evaluation from Honduras (see Box 4).

Box 4: Conditional cash transfers for health in Honduras⁵³

A public health programme effectiveness trial in Honduras looked at the question of whether a supply-side investment in improving the quality of basic health services would have an equal or greater impact on use of services than the conditional payments to households under the Programa de Asignación Familiar (PRAF) (Family Allowance Programme). The programme was implemented in 70 rural and mountainous municipalities in the west of Honduras, with the highest prevalence of malnutrition, covering a total population of 660,000. Monetary vouchers were paid to women in households containing a pregnant woman or child younger than 3 years of age, on condition that they keep up-to-date with preventive health services. Average entitlements from the programme exceeded £60 per household per annum for typical families with pregnant women or young children (equivalent to about 4% of annual household income before the transfer). There were just 159 health centres in the area (mid-2000), most of them staffed by a sole auxiliary nurse. There were no significant impacts in the municipalities where just the supply-side improvements were implemented (although this may have been different had there not been legal and logistical problems in transferring resources to health facilities). Whereas, the trial demonstrates convincing evidence that money is a powerful incentive to change behaviour, even in a weak service delivery environment. The household payments resulted in a large and significant impact on coverage of antenatal care, well-child checkups and growth monitoring.

Significant findings are seen in Mexico where PROGRESA has brought about a 12 percent reduction in incidence of ill-health among children aged 0-5 years compared to non-PROGRESA children, and 19 percent fewer days of illness among adults⁵⁴. The rigorous evaluation also saw an 8 percent increase in clinic visits by pregnant women in their first trimester, which led to a 25 percent drop in the incidence of illness in newborns and a 16 percent increase in the annual growth rate of children between 1 and 3 years⁵⁵. In Nicaragua, where the transfer has been conditional on attending clinics for vaccinations and growth monitoring, immunization levels among recipient children aged between 12 and 23 months increased by 18 percent. Participation in growth monitoring increased by 30 percent to 90 percent in programme areas, compared to 67 percent in control areas. In Colombia, the incidence of acute diarrhoea in children under 6 was reduced by 10 percent in urban areas and 5 per cent in rural areas⁵⁶.

As with education, social transfers can have an impact on health without being tied to conditions or vouchers. In Namibia, for example, pensioners spend 13.8% of the unconditional cash they receive on health care and medicines for themselves and this rises to 40% in South Africa. A study in South Africa found that older people who received social pensions had a significantly better health status than other family members, when the household did not pool their resources. In households that pooled income, the health status of all family members was higher than in households that did not contain a pensioner.⁵⁷ Also in South Africa, preliminary findings from a study of the unconditional child support grant in KwaZulu-Natal suggest that the grant has an impact on child height, but only for those children who started to receive it when aged between 0-20 months⁵⁸. Further evaluations will look into this finding more closely, alongside other nutrition and health outcomes.

At the other end of the conditional-unconditional continuum, there is more limited evidence of the impact of vouchers on health. Rigorous impact evaluations are lacking. Ensor (2003) provides an overview of the evidence. Vouchers for STI curative care provided to sex workers and their partners and clients, found a high uptake and use of vouchers and large declines in reported rates of syphilis and gonorrhoea⁵⁹. There is some evidence in China (Yunnan Province) that a voucher scheme for poor pregnant women for free services at public (but fee charging) clinics has increased the use of appropriate treatment for childhood diarrhoea among the very poor⁶⁰. A review of ten targeted financial incentives (mostly in the US) to patients to encourage use of certain services found evidence of impact in tuberculosis DOTS compliance, immunisation and dental checks.

3.2 Extending the reach of services

Social transfers can increase equity in access to services, by targeting their distribution to the extreme poor and vulnerable groups. Effective targeting of vulnerable groups is the key to success for social transfers in scaling up equitable access to services. Many of the educational enrolment voucher programmes prioritise the education of girls and the results indicate that these groups have benefited most from the interventions. The large-scale conditional cash transfer programmes tend to be well targeted to the very poor. Honduras' PRAF, Mexico's PROGRESA and Nicaragua's Social Protection Network (RPS) pilot programme each managed to ensure that more than 50% of beneficiary households (more than two-thirds for Honduras and Nicaragua) were from the poorest 30% of all households.⁶¹ Almost 60% of people reached by PROGRESA belonged to the poorest 20% of the population; 80% of beneficiaries were in the poorest 40% of the population⁶². While not perfectly targeted, this is at least as good an impact on redistribution of benefits as other similar programmes. The least well targeted conditional programme is Bangladesh's cash-for-primary education programme where 40 per cent of beneficiaries are non-poor⁶³. What we still do not know is the whether the health and education outcomes of the programmes are greater for poorer children and adults than those better off.⁶⁴

The unconditional Zambia social cash transfer and South Africa Child Support Grants are both well-targeted (bottom wealth decile in Zambia), but evaluation data is needed before we can see how this translates into equitable human development outcomes.

Competitive voucher schemes in health have had varied success in improving equity. The Safe Motherhood Project of Indonesia distributed vouchers (a booklet of printed coupons) for a basic package of mother and child health care and family planning services to poor women who were either pregnant or who had children under one year of age. Evidence suggests that the distribution of the vouchers has benefited mostly the poor.⁶⁵ Whereas, the Tanzania pilot voucher scheme for bed nets targeted all poor pregnant women using public maternal and child health services in the project area, but take-up by the very poorest quintile was zero⁶⁶. The voucher conferred a subsidy of

17 percent on the cost of a bed net. This was obviously too low and the co-payment deterred the very poor⁶⁷, plus transport costs reduced use of vouchers by people living further away from providers. To increase equity, the project needs to increase the value of the voucher or use poverty targeting and factor in indirect and opportunity costs

Care must be taken not to impose conditions that exclude the very groups that need the transfers. For example, one of the conditions of the Bangladesh Female Secondary Stipend Programme is the performance of girls in her exams. A recent evaluation shows that the girls who are less likely to do well (and therefore to be excluded from the scheme) are the same ones who are more likely to drop out of school without the extra payment.⁶⁸ Indeed, the conditional cash transfer programmes that require adequate health and education service provision will exclude a significant proportion of the poor who may live in remote or disperse communities (see Section 5).⁶⁹

Care must be taken to minimise the inclusion of better-off people in the social transfer scheme. For example, a study into the effectiveness of incentives in Nepal revealed that scholarships were not distributed to the girls most in need. Rather, they were distributed according to political pressure from local leaders.⁷⁰

4. Social transfers – do they offer value for money in improving education and health?

Further work is needed to provide policy makers and donors with information on the relative costs and benefits of social transfers compared to more traditional supply-side subsidies. There is very little information on the costs and benefits of different cash transfers and voucher arrangements.⁷¹ And comparing them with supply-side interventions does not account for the synergies between investment in social transfers and in sectors (see section 5).

Of the conditional cash transfer programmes, only Mexico's PROGRESA has undertaken a cost-effectiveness study. PROGRESA found that programme benefits exceeded the costs of the interventions, and that the rate of return on the education component of the programme (taking into account the costs of grants) was 8 percent per year.⁷² Coady and Parker (2002) found that conditional cash grants were more than 10 times more cost-effective in achieving an extra year of schooling for children than building new schools⁷³. However, some caution is required since the study did not assess the cost-benefits relative to other supply side investments (eg. improving teacher quality or textbook availability), which may have greater impact. Care in interpretation of this finding is also needed because other studies⁷⁴ indicate that achieving an extra year of schooling is not yet translating into better achievement (test scores). This suggests that complementarity is needed between supply-side quality initiatives and demand-side measures, rather than portraying demand and supply in terms of trade-offs (see Section 5).

Very few voucher programmes have comparative cost-benefit data.⁷⁵

Detailed costs analysis has only been found for the Nicaragua vouchers for STI treatment scheme, targeted to marginalised sex workers and their clients⁷⁶. The total annual cost of the voucher scheme was US\$62,495. While start-up, programme and transaction costs (for administration and targeting) were found to be higher than service provision in the absence of vouchers, STIs were treated more efficiently and effectively and the scheme was much more successful in reaching high risk groups. Therefore the average cost per STI cured was US\$82 lower with vouchers than without⁷⁷. Few approaches have demonstrated such positive levels of measurable success in bringing about reductions in STI incidence in marginalised groups vulnerable to HIV, so these data represent value for money.

This review found little cost-effectiveness evidence from scholarship or bursary programmes. One exception is the evaluation of a series of randomised experiments to improve learning outcomes in the Busia district of rural Kenya.⁷⁸ The analyses found that the per pupil costs of a 0.1 standard deviation gain in test scores were lowest (\$0.71) for the girls' merit scholarship ++programme for 13-15 year old girls, compared to supply-side interventions of teacher incentives (\$1.36) and textbook provision (\$5.61). More randomised experiments such as these are needed to build the evidence base, and to look at the cost-effectiveness of scaling up such initiatives.

Conditional cash transfer programmes and social pensions are not necessarily as cheap as abolishing user fees, for example, in expanding access and improving human development outcomes. However, it is their dual impact on reducing current and future poverty that makes them valuable⁷⁹. Again, evidence is limited since many programmes with primary human development objectives (eg. Bolsa Escola) do not evaluate poverty or hunger impact; whilst other cash transfer programmes evaluate income poverty and hunger but not human development outcomes - see *Annex 1: Assessing Economics of Transfers*. Moreover, even in fee-free contexts, social transfers are likely to be vital for the poorest, who face other costs such as transport, and the income foregone from children attending school instead of working.

5. Balancing investment in demand and supply

Investments in social transfers are most effective when complementing efforts to strengthen and extend the provision of health and education services.⁸⁰ Demand-side subsidies have their limits if provided in isolation. Evidence of declining test scores and pupil retention from the Bangladesh female secondary school stipend programme⁸¹, and Mexico's PROGRESA conditional cash transfer programme⁸² suggests that rapid expansion in access can undermine service quality unless there is also increased investment in service provision. This is also true of other demand-side initiatives, for example Uganda's removal of tuition and parent-teacher

association fees led to a massive growth in primary school enrolments, putting pressure on pupil:teacher ratios⁸³.

Quality issues must be addressed if countries are to enjoy and sustain gains achieved by increases in school enrolment or use of health facilities. Some of the conditional cash transfer programmes recognise this. In Nicaragua (Red de Protección Social (RPS)), teachers receive a modest bonus per child participating in the program, half of which is intended to pay for school materials. In addition, NGOs are contracted to provide health services. In Mexico (PROGRESA), resources are now set aside to cover some of the costs of additional health services demanded due to the programme and ensure an adequate supply of equipment, medicines and materials, and NGOs are also used to supplement government capacity⁸⁴.

This highlights the need for sequencing of demand-side and supply-side investments and therefore for coordination between sectoral line ministries and ministries responsible for social protection (see Section 7).

Where cash transfers are conditional on service use, recipients must be entitled to access quality services free at the point of delivery⁸⁵. Cash transfers can complement policies that remove user fees; but in contexts where user fees prevail, eligible groups must be exempted from user fees, or the stipend must be designed so that school fees are paid directly in addition to the extra incentive payment direct to individuals/households (as the Bangladesh female secondary stipend programme did⁸⁶). Even in a middle income country such as Mexico, PROGRESA only operates in those areas where there is adequate health and education service provision (public and NGO)⁸⁷. This raises questions about the overall equity of programmes, since areas lacking basic services are also likely to be the areas where people are most vulnerable.

Social transfers still have a role in areas of weak service provision. The Honduras example (Box 4) demonstrates that the level of public service provision need not be very sophisticated to have a positive impact on uptake of health services. Even in fragile states, social transfers can play an important role in reducing vulnerability and improving access to services. A recent evaluation of the impact of an emergency unconditional cash transfer scheme in Somalia, for example, showed that the provision of cash grants to women not only helped the poor repay debts and improve their food intake, but also empowered them to invest in healthcare⁸⁸. Social transfers can improve health and nutrition outcomes by enabling a household to increase food consumption. Further exploration is needed to look at ways to implement such programmes in areas with limited service provision capacity, perhaps through mobile health clinics, community schools, accreditation of non-state providers, or other innovations.

A precondition for effective competitive voucher schemes is a minimum number of private and public providers willing to take part in the scheme. These providers will need to be willing to adhere to quality standards, to be monitored, and able to serve poor and vulnerable groups

without discrimination⁸⁹. This often limits the operation of voucher schemes to urban areas. The voucher entitles the recipient to a free or subsidised service, thereby tackling at least some of the financial constraints to access.

There is little evidence that social transfers on their own can drive up service quality standards in health or education, or improve accountability of service providers to clients. Some programmes, particularly competitive vouchers, claim that service providers (public and private) will be encouraged to improve their services in order to attract consumers who are empowered by the voucher to 'vote with their feet'. However, most studies that focus on utilisation do not look at the extent to which quality or accountability is improved through greater choice of services (see Box 5)⁹⁰. Where quality has improved, this is more likely to be due to the well-developed quality assurance schemes used in health voucher schemes⁹¹.

Box 5: Vouchers to target reproductive and child health services in urban India⁹²

A Kolkata-based pilot of vouchers to reimburse fees for reproductive and child health care (250,000 urban slum-dwellers) demonstrates good links between a network of private medical practitioners and the government health care system. This has kept scheme costs low and used the existing service infrastructure to increase access for poor urban clients. Whilst the managing NGO ensures that private providers follow standard medical protocols, there is no systematic evidence that quality standards have improved in either public or private sectors as a result of increased demand.

This pilot is being considered for scale-up as part of the Government of India's Reproductive and Child Health II Programme.

There is some evidence that competitive voucher programmes lead to market segmentation that disadvantages the poorest. This has been the case where schools have been able to select higher ability students. Providers need to have the right incentives for efficiency and quality of service to avoid a service for the poor becoming a poor service⁹³.

6. Context matters - key considerations in choice of social transfer instruments

Decisions about the type and value of social transfers are very context-specific. Considerations cover technical, social, service provision, financial, institutional and political dimensions. To a large extent, the choice and design of social transfer programmes reflects the priorities of policy-makers and their political realities, as much as technical feasibility and affordability. Section 4 outlined some of the service provision issues to consider. This section outlines some of the other key questions to ask when assessing the feasibility of a social transfer programme, particularly those aiming to promote equitable access to health and education. Many of these

considerations also apply to alternative ways of scaling up equitable access to health and education. For example, where political, institutional, regulatory and accountability constraints undermine demand-side initiatives, they will also undermine supply-side measures.

Social transfer options are not mutually exclusive. For example, unconditional cash grants to destitute households may move a household from eating one to two meals a day, but may not be sufficient to keep children in school if they cannot afford transport to attend school, or various fees that need to be paid. A scholarship or stipend programme may also be needed.

Social transfers are not a panacea for addressing all barriers to access (information, cultural, lack of facilities, discrimination by providers) – they must be complemented by service improvements and strategies to address other barriers, alongside wider poverty reduction strategies, protection of human rights and other social protection measures.

Social transfers can complement other forms of social assistance such as removal of user fees, or fee waivers and exemptions. Social transfers have a role to play in situations where neither information nor free services boosts service use among the less empowered. In countries where access to education and basic health services is generally low, universal sectoral policies such as waiving school fees and uniform obligations would help increase enrolment rates of all children, including children affected by AIDS (CABA). Where average access to services is high, but the difference in access between the poor and the non-poor and between CABA and other children is large, cash transfers conditional on children attending school may also be needed⁹⁴.

Note: This section does not cover the additional factors that must be considered if weighing up the alternatives or complementarities of in-kind transfers (eg. food, textbooks) against cash and near-cash transfers. Nor does it cover special considerations surrounding the use of cash and vouchers in conflict-affected areas (see ODI paper for more on this⁹⁵).

Consideration 1: Policy objectives and understanding demand

Key questions:

- *What factors make people vulnerable, move people into or keep them in poverty; what can be done to reduce these risks?*
- *What prevents extreme poor and vulnerable boys and girls from enrolling and staying in school? – direct & opportunity costs; gender discrimination and exclusion...*
- *What prevents extreme poor and vulnerable men, women and children from seeking healthcare? – direct & opportunity costs, lack of information, exclusion...*

Social Transfers and Equitable Access to Education and Health Services

- *Will the programme have a direct or indirect impact on health and education goals?*
- *What is the optimal value of cash transfers or voucher required to overcome barriers to access for target groups? This will need to take into account local market conditions and the local poverty line.*
- *How predictable is the demand and cost for services?*

Conditional transfers are most likely to be effective in increasing equitable access to services, where demand for child labour (opportunity cost) is high or discrimination against girls or disabled children leads to low school attendance. Where main barriers to service use are direct costs, a scholarship or stipend (covering fees) with lower administrative demands may be sufficient. It could also be complemented with a fee waiver scheme or, where appropriate, entitlement to free service provision. The transaction costs of alternative policy options will need to be calculated.

Vouchers work best when the main cost involved is paying for the service, and there are no additional out of pocket expenses involved, or people are not giving up work time to access services. Vouchers tend to be more successful when targeted to easily defined vulnerable groups (eg. pregnant women, people needing treatment for chronic illness like TB), and where there is a choice of accredited service providers (public, private or NGO). They are best suited to more focused, non-complex and predictable services or products, such as vouchers for textbooks, or vouchers for sex workers to access STI treatment (Nicaragua)⁹⁶. For these reasons, vouchers have been used more extensively in education than health. However, Bangladesh is piloting vouchers to increase pregnant women's access to the more complex area of obstetric care.

Unconditional cash transfers are more likely to impact on human development where vulnerable groups also have sufficient access to information to make informed choices about health and education. Such transfers may also have indirect benefits such as empowerment of women and socially excluded groups through increased control of household finances. Unconditional cash transfers are more appropriate where service coverage is poor. The unconditional transfers should at least improve nutrition and the physical and cognitive development of children thereby leading to better health. This would create a positive cycle with healthier and more cognitively developed young children, better able to take advantage of educational opportunities in the future if service provision improves. Further, evidence shows that people will often prioritise spending on health and education even when it is not a condition.

When deciding which transfer is more appropriate in certain conditions, it is important to keep in mind that governments have **multiple objectives**. If a government wants, for example, to provide income support to tackle poverty, tackle hunger and improve human development outcomes then both conditional and unconditional transfers would be the most appropriate choice. Vouchers are not so appropriate for achieving these multiple objectives.

However, different ministries tend to have more focused objectives. Decisions around types of transfer are therefore likely to reflect the power of the individual ministries involved (eg. Ministry of Education may favour conditions whilst Ministry of Agriculture may prefer unconditional).

Consideration 2: Cash or restricted spending choice?

Key questions:

- *What are people likely to spend cash on if they are free to choose?*
- *What political pressures do governments and donors face to restrict spending choice through conditions or vouchers?*
- *How will cash be used within the household – do men and women have different priorities? Who should receive the benefit?*
- *Do poor and vulnerable people have sufficient information to make informed choices? (ie. merit good favours vouchers and conditions)*
- *Do the social benefits of using a service exceed the benefits to the individual? (ie. externality favours vouchers and conditions)*

Unconditional cash transfers give poor families most flexibility. Yet vouchers and conditions reassure governments and donors that money will be spent on desired goals. In practice, compliance with conditions is not always enforced rigorously⁹⁷. The Kalomo unconditional cash transfer programme in Zambia⁹⁸ found that recipients (mainly older people caring for children affected by AIDS) made rational spending decisions, including on health and education for families. Some commentators consider that it is the regularity of the payments that make the difference rather than the conditions themselves – further research is needed⁹⁹.

Evidence shows the need to take account of intra-household inequalities¹⁰⁰. Most conditional cash transfers in Latin America are paid to the woman, empowering her and maximising benefits to family members. Bangladesh secondary school stipend payments are made direct to girls' bank accounts.

The Nicaragua STI treatment voucher scheme¹⁰¹ encourages vulnerable sex workers to change their behaviour to use services with wider public health benefits.

Consideration 3: Targeted and universal approaches

Key questions:

- *What is the extent and distribution of poverty and vulnerability?*
- *Which vulnerable groups will the programme target? How will the programme take account of changes in households' vulnerability over time?*
- *How to ensure that targeting includes and excludes right people without becoming too administratively complicated and costly?*

Social Transfers and Equitable Access to Education and Health Services

- *How to target the most excluded, while keeping political support of the majority of the population?*
- *How to target without increasing stigmatisation or introducing social divides eg. for children affected by AIDS?*
- *How to target assistance without transfers becoming an instrument of patronage?*
- *What data is available to inform targeting?*
- *Are there existing targeting mechanisms for other programmes that a social transfer can piggy-back on?*
- *What is the most appropriate targeting approach?*
- *What strategies can be implemented to engage community support for targeting to help reduce corruption and stigmatisation, especially for children affected by AIDS?*
- *What strategies are needed to inform poor people of their entitlements to the transfers (eg. public information campaigns, partnerships with community-based organisations)?*

Ensuring that social transfers actually reach those whom they are intended to benefit is of critical importance in low-income countries. There is uneven evidence on the success of targeting (see Section 3.2). It has been successful in most Latin American conditional cash transfer schemes – an average 81% of programme benefits go to the poorest 40% of families¹⁰². But social pensions in India were used to vote catch by politicians, and mainly benefited people from middle income quintiles¹⁰³.

Universal schemes are simplest and cheapest to administer. However, the total programme cost depends on size of transfer and programme coverage, as well as administration costs. Targeted transfers usually reduce overall programme costs¹⁰⁴.

Universal benefits can gain the support of middle classes in many contexts, eg. Bangladesh female secondary school stipend had to extend the target group to all girls in rural areas (not just the poorest) in order to engage support of the elites¹⁰⁵. The Government sees political merit in keeping the universal approach, whereas donors are questioning whether poverty targeting should now be introduced to reduce costs.

However, universalism is not necessarily politically easier. In some contexts, conditions and targeting are preferred, eg. Brazil Bolsa Familia programme was made conditional on accessing education and health services to gain the support of tax-paying middle classes.

An empirical decision has to be made on trade-offs between accuracy of targeting (who is included that shouldn't be, and who is excluded that shouldn't be) and the cost of targeting. Good implementation of targeting mechanisms is more important for programme effectiveness than the choice

of mechanism *per se*¹⁰⁶. There are several targeting approaches, each with different advantages and disadvantages¹⁰⁷:

Categorical targeting to easily defined groups (eg. all over 65 years, all pregnant women) and geographic targeting is not too complex. The latter is possible where regions have high concentrations of poor people. Individual or household targeting mechanisms, such as the proxy means test (PMT) used in Latin America, requires the greatest administrative capacity and data requirements. However, Bangladesh has found PMT to be potentially feasible¹⁰⁸. Whilst PMT is associated with an increased share of benefits going to the bottom two quintiles, it risks creating social discord in communities between beneficiaries and non-beneficiaries, is often not transparent, and does not meet the needs of some excluded groups eg. mobile populations, indigenous people¹⁰⁹. Community-based selection of vulnerable individuals (eg. eligible children affected by AIDS) can be done using well-defined eligibility criteria produced through a community consultation process. This has the advantage of strengthening community ownership of the programme, although care must be taken not to increase stigma¹¹⁰.

Consideration 4: Political feasibility

Key questions:

- *What are the social and political forces for and against social transfers? Is there a 'constituency for change' in favour of transfers¹¹¹?*
- *What evidence base can be used to build political support, particularly if there is a change of government?*
- *Will government and donor resources be sufficiently predictable and long-term to sustain social transfer programmes?*
- *To what extent will government allow funds to be diverted to non-state providers in the case of a competitive model of vouchers?*
- *What opportunities are there for the transfer scheme to strengthen the social contract between government and its citizens, particularly those who traditionally have not had a voice due to social exclusion ?*

It is crucial that the political economy be taken into account when considering social transfer programmes¹¹². A drivers of change analysis of social protection can help answer some of these questions, as recently commissioned by DFID Zambia. DFID will produce guidance on how to use drivers of change to understand the extent of political resistance to and opportunities for support for social protection strategies¹¹³.

Some politicians worry about making long-term commitments to social transfers and being seen to encourage 'dependency'. Donors are traditionally averse to cash and 'social welfare' type approaches. Targeting public funds to services for stigmatised and disenfranchised groups is often politically unpopular. However, rising social unrest in China related to increasing

income inequalities has put pressure on the Government to introduce a non-contributory medical services fund for the poorest.

There can be political advantages to cash transfers. They allow central governments to have a direct relationship with a target population and to provide a visible and popular form of assistance¹¹⁴. On the other side, they can provide citizens with a sense of entitlement to demand and claim services from government. It is also important to develop processes that include the voices of the poor and socially excluded in policy divisions and national plans around social transfers, eg. Peru.

Capturing and publicising evidence of the programme's effect on poverty reduction and human development is one way to continue political momentum if governments should change. The systematic and independent evaluations of PROGRESA by IFPRI resulted in the programme being continued despite the historic change in government after 2000 elections.

The power dynamics and vested interests of voucher schemes must also be considered. For example, in Bangladesh, powerful public sector bodies have been lobbying against a competitive voucher model for health that would include private sector providers¹¹⁵.

Consideration 5: Administrative and institutional capacity

Key questions:

- *What are the options for delivering cash directly to people (eg. banks, post offices, mobile cash dispensers at health posts, pay agency, automatic teller machine, lottery ticket sellers)?*
- *Do local administrations, teachers and healthworkers have capacity to monitor compliance with conditions?*
- *Is there capacity to deal with the additional administration to redeem competitive vouchers?*
- *Is there sufficient regulatory capacity and an appropriate accreditation agency for a voucher scheme?*
- *How can administrative requirements (eg. birth certificate as proof of scheme eligibility) be minimised to ensure access to entitlements for excluded groups, ie. to strengthen the inclusiveness of the social contract?*

A careful assessment of potential mechanisms to deliver cash or vouchers is needed in each local context, as has been done in Bangladesh in preparation for demand-side financing in health¹¹⁶. Delivering transfers is likely to involve a combination of line ministries, local government and community-based structures. It may also involve NGOs or the private sector in some contexts¹¹⁷.

Some delivery mechanisms may require additional support or finance to expand capacity, but this is not necessarily the case even in poor countries. In fact, transferring resources on the supply-side to peripheral health units can

prove legally and logistically far more complicated for a government agency than distributing cash vouchers to an isolated, rural population – this was an important finding of the Honduras study¹¹⁸.

Conditional cash transfer programmes are often associated with higher burden of administration due to monitoring and enforcing conditions, whereas scholarships tend to be simpler to administer. However, the extent to which programmes monitor compliance with conditions and enforce them varies greatly¹¹⁹.

Where poor or excluded households and children lack documentation of identity or status, additional efforts to support birth registration are required (as DFID has been supporting in Bolivia). Indeed, social transfer programmes such as Bolsa Escola in Brazil have increased incentives for civil registration, and in so doing have strengthened the social contract between government and citizen¹²⁰.

Alternatively a social transfer programme should introduce more flexible approaches, such as community-based verification of identity. Similarly, in the Kalomo cash transfer pilot in Zambia, other households members are allowed to pick up the cash on behalf of the elderly caregivers.

Consideration 6: Governance issues

Key questions:

- *Is the tax-benefit system developed enough to target a simple transfer of resources to poor and vulnerable?*
- *What are the risks of diversion of cash by local elites? How do these compare to the risks of diversion of subsidies to providers?*
- *What monitoring and accountability mechanisms exist to mitigate these risks?*
- *What mechanisms can be put in place to represent the voice of transfer recipients (eg. pensioner associations in Ethiopia)?*
- *Is fiscal decentralisation important for scaling up cash transfers where public accountability systems are weak?*
- *Which different institutions (eg. social welfare, health, education, AIDS commission) and levels of government administration need to cooperate to implement social transfers effectively?*
- *How politically feasible is it to work through non-sectoral line ministries or devolve authority and resources to local government?*

Institutionally, social transfers require both a targeting mechanism and an infrastructure for administering the transfers and monitoring providers and recipients, so governance and accountability arrangements are very important¹²¹. The Jamaica PATH cash transfer programme has about nine conditions to mitigate risks of corruption. However, to minimise corruption, programmes need to build independent mechanisms for monitoring efficacy of

targeting, service delivery quality, costs to users, financial flows, and leakage¹²².

In general, the simpler the targeting mechanism (ie. universal or categorical), the less the scope for corruption.

Strong inter-agency cooperation is required between the ministries responsible for education, health and AIDS service provision, and social welfare ministries administering the social transfer programmes. This cooperation needs to extend to community level, so that local officials coordinate with healthworkers and teachers.

The degree to which a social transfer programme should be decentralised will depend on the institutional context. Many of the Latin American conditional cash transfers are centrally administered, bypassing state and local authorities, to build a direct relationship with citizens. However, this is at odds with the decentralisation of provision of social services. Brazil's Bolsa Familiar, however, claims a bottom-up approach, with all three tiers of government heavily engaged.

Consideration 7: Affordability

Key questions:

- *Will the benefits of the demand side methods (including the actual value of the transfer to the recipient – see Annex 1), exceed the costs of implementing and administering them?*
- *What are the likely costs of a social transfer programme and how do these compare with alternative approaches to increase equitable access to health and education services?*
- *What costs should be considered to build government capacity to run social transfer programmes?*
- *What are the fiscal implications of scaling up social transfer programmes?*

Programme costs depend on the coverage, type of targeting, size of transfer, and its administrative costs. Effective conditional cash transfers can cost as little as 0.021 per cent of GDP (Nicaragua) rising to 0.32 per cent for a wide-reaching programme in middle-income Mexico. In low-income Central Asia, the Kyrgyz Republic's entire social protection system (including cash benefits to poor families with children, old age and disability pensions) costs 3 percent of GDP, scheduled to rise to 3.7 percent by 2005 as benefit levels are increased¹²³. Brazil spends 1 percent of GDP to transfer \$70 a month to 5.3 million elderly poor and 0.15 percent of GDP to transfer \$6-19 a month to 5 million families to support school attendance through the Bolsa Escola programme¹²⁴. PROGRESA administrative costs are 9% of the total – of which 30% is for targeting at household level, and 26% for monitoring conditions¹²⁵.

These are significant costs, but not necessarily prohibitive for low-income countries. It has been estimated that a programme like Kalomo cash transfer

scheme in Zambia, delivering \$15 per month per household to the poorest 10 percent of the population, would cost less than 1 percent of GDP in low-income countries in sub-Saharan Africa, and less than 3 percent of government spending. See *DFID Social Protection Briefing Note Series, Number 2* for further detail on these estimates calculated by the ILO¹²⁶.

Costs can be contained by initially restricting coverage to certain groups, and expanding coverage when additional finance becomes available, eg. South Africa's Child Support Grant extended eligibility from under 7 years at its start to include children less than 14 years¹²⁷. Once again, local analysis is required to inform debates on affordability and programme design, such as recent analysis of the cost of applying the means test for the South Africa Child Support Grant – to assess the costs to Government as well as the costs the means-test imposes on applicants¹²⁸.

7. Delivering social transfers through country-led approaches

Wherever possible, social transfers should be an integral part of country-led poverty reduction plans. Mechanisms to promote equitable access to services strengthen and are strengthened by interventions in other areas. All social transfers must be considered in the context of a country's overall social protection strategy, social policies and sector investments in health and education. The poverty reduction strategy process can be a useful platform for promoting the contribution of social transfers to achieving pro-poor health and education goals alongside poverty reduction. For example, the Bangladesh PRSP promotes social safety nets, including income transfers – and provides an entry point for dialogue with sector ministries on demand-side financing in health¹²⁹.

A key challenge is to enhance policy coherence between specific social transfer programmes and health and education sector programmes¹³⁰. This requires strong coordination by government and donors between and within sectors (health, education, social welfare, agriculture). This can be done through a Poverty Reduction Strategy or a more conscious linking of sector strategies. At an operational level, close cooperation is also required. In Mexico, the Ministry of Social Development manages PROGRESA/Oportunidades, and coordinates closely with, and provides a small subsidy to, Ministries of Health and Education who are responsible for service provision. Such cooperation is not easy, especially where the latter ministries' own budgets have not been increased to cope with the demand created by the new Oportunidades beneficiaries¹³¹.

Moving to demand-side subsidies is a major departure for many governments and donors. Nevertheless, governments are taking ownership of education voucher programmes eg. Bangladesh and Colombia where

municipalities contribute 20% of the local costs in addition to the national government's budget¹³².

Sectoral or general budget support may be a more effective means of supporting social transfers than project-financing¹³³. To date, many scholarship/bursary, voucher and cash transfer programmes have been small-scale targeted projects, financed off-budget by donors (eg. funding to Kalomo social cash transfer pilot in Zambia is complementary to budget support). Demand-side financing initiatives for health and education have been seen largely as a sectoral subsidy. Meanwhile, the large-scale multi-sectoral conditional cash transfer programmes have been co-financed by governments and donors as stand-alone programmes, parallel to sector reform and investment efforts. Depending on country context, it may be possible to integrate cash transfers into general budgetary support or to earmark funds within budget support (eg. DFID will support cash transfers ringfenced under food security in Ethiopia, and will earmark funds to support scaling up of the Zambia pilot).

Where Poverty Reducing Budget Support (PRBS) is not feasible, cash transfers may need to be funded as separate programmes outside the national budget, or through UN agencies, humanitarian coordination bodies and NGOs in the case of post-conflict states¹³⁴. **Whatever the country situation, complementary funding for institutional strengthening may be required.** This could be funded as a parallel technical assistance programme.

8. Social transfers in the context of scaled up resources

Social transfers are a potentially workable and cost-effective way of making scaled up investments in health and education more effective and equitable. Aid flows are likely to be scaled up significantly in the next decade, with strong calls for large proportions of additional aid to be spent on health, education and HIV and AIDS¹³⁵. This increased spending must be combined with measures to ensure that expenditures on education and health will reach poorest and socially excluded populations. Social transfers are one possible policy option for achieving this. The Commission for Africa and World Bank's 2006 World Development Report recommend scaling up their implementation to tackle poverty and inequality more widely.

The prospect of scaled up resources for low income countries lessens the trade-offs between equity and efficiency, between investments in demand and supply sides, and between investments in sectors and multi-sectoral transfer programmes. Social transfers require a genuine additional source of revenue, rather than 'top-slicing' funds needed for service quality improvements. Scaled up resources will allow for a better balance between demand and supply. Under conditions of scaled up resources, it may be realistic to expect a reasonable amount of leakage of targeted social transfers

to the less poor whilst investing in data and the administrative systems to improve the accuracy of targeting.

Scaling up social transfers requires long-term, predictable financing.

Governments are cautious about using donor resources for social transfers (especially cash) without guarantees that funding will be long-term and predictable (this is beginning to happen in Ethiopia and Zambia). As citizens' awareness of their entitlements increase, the political imperative for programme sustainability grows.

Experience suggests a gradualist approach to scaling up social transfer programmes. Successful social transfer programmes have tended to start on a small-scale, and expand coverage over time. Mexico's PROGRESA/Oportunidades, the South Africa Child Support Grant and Bangladesh female secondary school stipend programmes all took this approach.

9. Evidence gaps

A major challenge is to build the evidence base in low-income countries.

Experience from middle-income countries suggests that social transfers can make an important contribution to human development outcomes for the extreme poor. The experience from low-income countries is limited, but does justify wider pilot testing of cash transfers and vouchers in different settings, and scaling up and evaluation of promising programmes. There is an urgent need for robust monitoring and evaluation of social transfers – both conditional and unconditional - in low-income countries to assess their distributional impact on human development outcomes and service use, as well as impact on income poverty and hunger reduction. Piloting and evaluating the feasibility of demand-side financing approaches in health is particularly needed¹³⁶.

This review of the literature points to **priority policy questions** that need further research:

i. Is conditionality needed to achieve effectiveness?

Is conditionality tied to health and education service utilisation a strong determinant of health and education service use, or is the size of the transfer, frequency of payment and its duration more important in shaping health and education-seeking behaviour? Do the benefits of the transfer for different household members vary according to who in the household receives it? What do programme beneficiaries think about conditions – do they impose on their human rights to choose; do they deter people from participating in schemes? Do service providers have the capacity to monitor compliance with conditions, and does this undermine the quality of service they provide? Programme evaluations have not yet addressed these questions, and data on the number of beneficiaries who are suspended due to lack of compliance with the conditions is often lacking.

ii. What are the relative costs and benefits of demand-side targeting compared to more traditional supply-led methods of service provision and financing? What is the optimal balance?

How successful are programmes in reaching households that would not have participated in school or attended health facilities without the social transfers? Cost-effectiveness analysis is scarce in the social transfer and demand-side financing literature. There are inherent methodological difficulties in comparing the impact of investment in sector budget support for health or education, with investment in social transfers designed to address specific financial barriers faced by the extreme poor¹³⁷. This is an important under-researched issue.

iii. What impact can social transfers have on human development in contexts where formal health and education service provision is weak or non-existent?

Conditional cash transfers, vouchers and scholarships are all integrally linked to existing schools and health facilities. They are not implemented in places where service provision is weak or non-existent. What innovations are needed (eg. mobile health teams) to ensure success of demand-side subsidies? However, social transfers focused on poverty and hunger reduction are successfully implemented in very resource-constrained environments. Yet the impact of these on health and education outcomes has not been well-evaluated, with the exception of social pensions in Brazil, Namibia and South Africa. Further research is also needed into the potential for social transfers to increase use of informal service providers, especially in fragile states.

iv. What is the impact of different transfer amounts on schooling and health outcomes?

The size of transfers varies widely between type of transfer, and also within the same type. For example, the value of transfers in conditional cash transfer programmes in Latin America vary from 4% of household income in Honduras PRAF, to 12% in Nicaragua SPN to 33% in Mexico Oportunidades 33%. What is the distributional impact of different transfer amounts on health and education outcomes? How cost-effective are different transfer sizes, balancing size of transfer, depth of poverty, and programme coverage? What is the threshold at which the extreme poor will find it worth their while to encash their vouchers for use of health services? How large an incentive is needed to attract and keep children in school?

v. What is the relative effectiveness of social transfers in promoting equity of access to services compared to other pro-poor sector policies such as elimination of user fees?

Social transfers have been implemented in countries with a wide range of health and education financing policies, and in contexts with varying poverty

lines and poverty gaps. Is the universal approach of elimination of user fees necessary but insufficient to enable the extreme poor to access health and education services? Are targeted social transfers needed in addition? Where poverty is very widespread, is it more or less equitable and efficient to benefit a greater proportion of the less poor population through elimination of user fees than by targeting resources to the extreme poor through social transfers? This review did not find any studies that looked at these questions. Given the heated debate on user fees (particularly in health), it is worth exploring.

vi. How do the poorest people and service providers view social transfer programmes?

There is a lack of empirical evidence on how the poor view these programmes, and what factors lead them to participate or to exit. To what extent is it possible to create or sustain voice in scaled up programmes?¹³⁸ To what extent does a households' sense of citizenship increase as a result of claiming their entitlements? A recent impact assessment of the Bangladesh female secondary school stipend scheme¹³⁹ is note-worthy in providing a wealth of qualitative information about the programme's effects on girls' empowerment, community value of girls' education, and declining importance of the stipend itself as enrolment increases. Similarly, IFPRI's evaluations of PROGRESA/ Oportunidades also provide insight into the perceptions of health workers and teachers. More of such qualitative evaluations from beneficiaries' and service providers' perspectives are needed.

Initiatives to follow up that will explore some of these questions include:

World Bank meta-evaluation of conditional cash transfer programmes in low-income countries and middle-income countries, with a focus on impact on education (report due 2007). Low-income country evaluations to include:

- Burkina Faso - Care and support for HIV/AIDS affected communities
- Lesotho - Pilot program to bring orphans into school
- Bangladesh – Evaluation of conditional cash transfer and grant programs at the primary level
- Cambodia - Scaling up scholarships for girls
- Pakistan – Stipends for girls in Punjab

UNICEF Eastern and Southern Africa Regional Office reviewed innovations in social protection to reduce the impact of HIV/AIDS on children in 15 countries in southern and eastern Africa. This includes reviews of cash transfer, public works, education, food-based and agricultural-based programmes. Findings have just been disseminated¹⁴⁰.

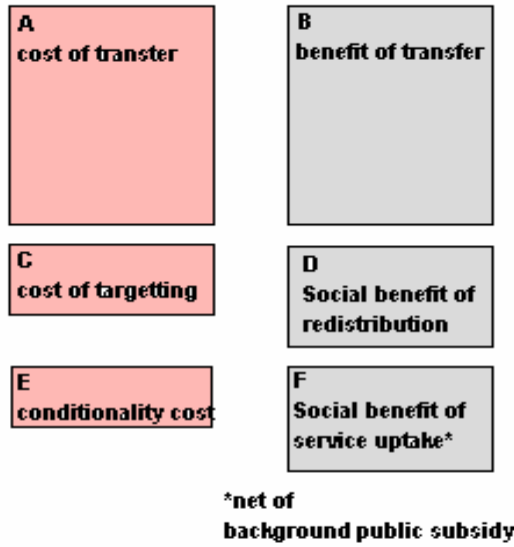
ILO/UNCTAD Minimum Income for School Attendance initiative¹⁴¹, implemented in Tanzania, Senegal and Mozambique. Piloting conditional cash transfer approaches, based on the experience with Bolsa Escola Programme in Brazil. However, this review was unable to verify with ILO whether this initiative is ongoing.

Many initiatives are very new, and it will be important to evaluate and document lessons learned from **DFID** support to, for example:

- Bangladesh – piloting of demand-side financing initiatives for maternal health under the Health, Nutrition and Population Sector Programme.
- China - Medical Financial Assistance (non-contributory township funds) targeting the very poorest, part of Health VIII Support Project.
- Kenya – follow up to SIDA, UNICEF and Government of Kenya’s pilot of cash subsidies for children affected by HIV/AIDS. The pilot was an unconditional cash grant for households fostering children, but education conditionalities may be introduced in future.
- Nepal – cost sharing policy to promote skilled birth attendance, including cash transfers to women, cash to skilled birth attendants and cash to public facilities.
- Nigeria – feasibility study and design (with World Bank) of a targeted conditional cash transfer programme under the DFID Social Protection Trust Fund.
- Zambia – GTZ has piloted an unconditional cash transfer scheme in Kalomo district¹⁴². CARE will be operating one conditional and one unconditional scheme through similar government systems in Chipata and Kazangula districts. CARE, GTZ, Government and DFID will agree common elements to the monitoring and evaluation systems of the pilots to allow for meaningful comparison. These lessons can then be fed into the scale-up of a Government owned multi-annual safety net.

Annex 1

Assessing Economics of Transfers



Cost Benefit: $D+F > C+E$?
all money-metric

Cost Effectiveness: $\frac{C+E}{D+F}$
good for comparisons, D,F don't have to be money-metric

There are two main sources of social benefit from transfers of various kinds. There is the social benefit from successfully redistributing towards the poor (D), as the marginal value of income to the poor is greater than for the average. This depends on the choice of poverty weights and is quite arbitrary. There is also a social benefit from service take-up (F) since the social value of education and health services is thought to exceed their cost or market price. The size of these benefits depends on the services and costs of delivery.

It is difficult to put a money-metric value on D and F, so cost benefit analysis is difficult. Cost effectiveness analysis is easier because D and F can be in non-money metric form. For example, administrative cost per poor family raised to the income poverty line ($C+E/D$). Administrative cost per ante-natal clinic attended ($C+E/F$). However, it is difficult to combine D and F in non-money-metric form.

Omission of either D or F benefits from the cost:benefit ratio leads to an underestimate of the cost effectiveness of an approach. In many of the evaluations of partially or wholly conditional transfers, the benefits of redistribution (poverty reduction) are largely ignored and only the health and education service take up is measured.

C and E are administrative costs. It can be costly to target poor people or enforce conditions about service take up, or to manage voucher schemes. However, caution should be taken not to include the cost of the actual transfers, A, unless the full benefits including B are also included.

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