Social Cash Transfers to Mitigate the Impacts of AIDS in Eastern and Southern Africa

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Introduction
Social cash transfer programmes are becoming an increasingly important social protection instrument both globally and in the region. The case for social protection in general, and cash transfers in particular, can be made on both economics and human rights grounds. On economic grounds, the evidence demonstrates that transfers enable productive investments which increase current income, consumption and health, as well as investments in children’s human capital development which leads to increases in future income and breaks the inter-generational cycle of poverty. On human rights grounds, the right to a minimum level of social services, and the right to social protection for vulnerable children are stated in Articles 22 and 25 of the Declaration of Human Rights, and in Articles 20 and 26 in the Convention on the Rights of the Child.

The purpose of this note is to present evidence on the human development and economic impacts of social cash transfers in Africa, and to argue for their use as a broad based instrument to mitigate the effect of HIV and AIDS among poor and vulnerable households, particularly those with children.

Evidence on the impact of social transfers
Food security and hunger: Cash transfers contribute to improved food security and dietary diversity. In Zambia’s Kalomo Pilot project, the number of household members living on one meal a day decreased from 19 percent at the baseline to 13 percent at evaluation. Program households reported feeling more satiated after having eaten with the percentage reporting that they were still hungry after each meal decreasing from 56 percent at the baseline to 35 percent. Households also had more varied diet with the number of households consuming vegetables, fruits, fish and meat increasing, and an 8 percent decrease in the proportion of underweight children. In Malawi, experimental evidence from the Mchinji scheme shows significant improvements in diet diversity, particularly for protein and fish. For example, program households were 10 and 11 percentage points more likely to consume chicken and fresh fish (respectively) after only 6 months of intervention. Program households were also more likely to have more than 1 week of food stores relative to controls, and were significantly more likely to report having adequate food to eat (70 percentage point difference). In Ethiopia, mothers reported feeding their children more frequently and most mothers reported giving a wider variety of grains and pulses to their children; they also reported increasing the amount of livestock products and oil given to children, and some mothers bought more vegetables. Importantly, none of these studies show evidence of increased consumption of luxury items such as alcohol or tobacco.

Health and nutrition: Social experiments from conditional cash transfer programs (CCTs) in Latin America have documented significant improvements in both child and adult health among recipients. In Colombia, children under age 2 displayed an average increase of 0.164 in the z-score of height (translated into a 7% reduction in stunting) and an 11% reduction in the incidence of diarrhea. Birth weight, perhaps the most important predictor of future nutritional status, showed improvements of 578 and 176 grams in urban and rural areas of the programme respectively. In Mexico, programme participation lead to an increase in mean growth of 17% per year among children aged 12-60 months. In Nicaragua, children in programme households displayed a 5 percentage point reduction in

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1 Sudhanshu Handa and Douglas Webb. Contact dwebb@unicef.org or shanda@email.unc.edu.
2 In ESAR alone 9 countries have initiated some form of social transfer, either a non-contributory pension (Lesotho, RSA, Botswana, Namibia) or a targeted cash transfer (Kenya, Malawi, Mozambique, RSA, Zambia).
stunting rates relative to children in control households, and a 6 percentage point increase in the prevalence of having a complete vaccination record.6

In Africa, studies from unconditional cash transfer programs (CTs) also show evidence of improved health and nutrition among children. The social experiment of the Malawi scheme indicates that children were less likely to be sick in the reference period (10 percentage point difference between treatment and control households) and more likely to be taken for health care when sick (60 percentage point difference).7 A study of the Child Support Grant in KwaZulu-Natal, South Africa, suggests that it has an impact on child height for children who started receiving the grant in their first 20 months of life.8 Similarly, having a recipient of the social pension in a South African household has been correlated with a three-to-four-centimeter increase in height among children.9

Schooling and child labor: There is clear evidence that households receiving cash transfers increase investment in their children's education, even when receipt of the cash is not conditional on doing so. In Malawi, experimental results shows a 4 percentage point increase in school enrolment among children under age 10, mostly from a protective effect, as attendance actually declined in control households during the study period. At the same time there was a 36 percentage point decline in child labor.10 In Zambia's Kolomo Pilot project, overall absenteeism from school declined by 16 percent over the first nine months of the pilot scheme and enrolment rates rose by 3 percentage points to 79 percent over the period of the external evaluation--this increase is statistically significant. Moreover, 50 percent of children who were not in school at baseline were enrolled at evaluation. Half of them started school, while the other half returned to a higher grade, meaning that they had dropped out of school before the scheme started.11 Early findings from the pilot Kenya Cash Transfer program suggest that the program increased school attendance among orphans and vulnerable children.12 And new evidence from South Africa's Child Support grant based on panel data show a 6-8 percentage point increase in attendance among grant recipients relative to non-grant recipients.13 Conditional cash transfers that make receipt of benefits conditional on school enrollment, attendance and progression (Jamaica, Mexico, Nicaragua, Colombia and others) have had demonstrated positive impact on investments in education and progression for those already in school as well as for children previously not enrolled14; however, the appropriateness of conditional cash transfers in ESA is subject to debate.15

Investment and shelter: Cash transfers can also increase investments in productive assets. In the Zambian pilot, 28 percent of the transfers are spent on investments and the scheme seems to have stopped the practice of selling assets for food. In Mexico's Oportunidades, program households used 88 percent of the transfer to purchase consumption goods and services and invested 12 percent. The investments improved the household's ability to generate income with an estimated rate of return of almost 18 percent, suggesting that these households were both liquidity and credit constrained. By investing transfers to raise income, households were able to increase their consumption by 34 percent after five and a half years in the program. In Malawi, experimental data from Mchinji show significant

increases in ownership of productive assets (chickens, goats, pigs, sickles) among intervention households relative to control ones. These households were also 24 percentage points less likely to report having inadequate housing. These results demonstrate that cash transfers to the poor may raise long-term living standards, which can be maintained after program benefits end.16

Dependency, work disincentives and luxury spending: Cash transfers can potentially have perverse effects if recipients reduce their labor force participation or spend transfers on entertainment or non-essential items. However there is no evidence of such perverse behavior in developing countries. The allocation of cash spending by program recipients has been analyzed in all the programs referred to earlier (Malawi, Zambia, Ethiopia, Mexico, Nicaragua, Colombia). None of these studies showed that the transfer leads to an increase in spending on items such as alcohol or tobacco or meals away from home.17 The labor force behavior of program participants was studied in Sri Lanka and Mexico and in neither case did participants reduce their work behavior in response to the program. Indeed, as mentioned above, in Mexico, participant households were more likely to engage in business investment relative to the control group, and to achieve higher levels of land and livestock ownership, leading the authors of the study to conclude that targeted CTs offer the very real possibility of contributing directly to economic growth in the short to medium term.18

Administrative costs: From an administrative perspective, cash transfer programs are more cost effective than food based or public works programs because moving cash from one point to another is less costly than moving food or inputs for public works. Cash is logistically simpler and can be disbursed rapidly, even in remote locations. The administrative cost of delivering pure cash transfers is lower than for other transfer programs because transporting, storing, and distributing food and building materials is more expensive than moving cash around. In Ethiopia, cash transfers are 39 to 46 percent cheaper than imported food and between 6 to 7 percent less expensive than food purchased on the local market.19 DFID estimates that, in Zambia, a food transfer program delivering the equivalent benefits to a national cash transfer program would be almost four times more expensive than a cash transfer and reports that the unit cost of transferring cash to the very poor is around eight times higher for work programs compared with a simple cash transfer.20 Due to high administrative costs, targeting errors and leakages due to corruption, the Maharashtra Employment Guarantee Scheme in India spent 143 rupees to get 60 rupees to the poor.21

Other advantages of cash transfers have been noted. They empower recipients by providing greater freedom of choice and reducing the stigma attached to the use of food aid. The range of food items that can be purchased may be wider and more appealing than the standard food-aid basket. Cash transfers are also less costly to the recipient than food based safety nets, first because distribution points are likely to be closer to the recipients home than food distribution programs and second because cash is universally accepted. Cash transfers can help to stimulate local opportunities for production and trade and stabilize the economy over the harvest cycle. There is some concern that injections of cash into the local markets could increase prices. Although the cash-for-work project in Zambia did seem to result in some inflation (particularly of food prices),22 this is not a widespread phenomenon. Delivering cash rather than food also addresses the problem of identifying

19 Adams, Lesley and Kebede, Ermebet, ‘Breaking the poverty cycle: A Case Study of Cash Interventions in Ethiopia’, Humanitarian Policy Group, Overseas Development Institute, 2005
requirements, since participants are in a position to determine their own requirements. And from a fiscal perspective, cash transfer programs increase the predictability of public outlays because they are not immediately affected by unexpected price surges.

**Social Protection and the impacts of AIDS**

Evidence from household surveys across Africa indicate that poor households are increasingly called upon to care for orphans. The link between poverty and HIV vulnerability is well articulated, while households affected by AIDS characteristically show a higher dependency ratio and lower availability of healthy adult labour. Treatment seeking behaviours and expenditures also lower the asset base of AIDS affected households. The key question is thus: do social cash transfer schemes in countries with high HIV and AIDS prevalence that target a broad spectrum of poor or extremely poor households, but do not explicitly target HIV and AIDS affected persons or households, have a significant AIDS mitigation impact?

A simulation analysis of a cash transfer program targeted to households with children in ultra-poverty, based on national survey data from Malawi, Mozambique, Uganda and Zambia, demonstrate the potential for reaching OVC, most of whom would be orphaned by AIDS in high prevalence countries. For example, within an overall budget of 0.5% of national GDP and a transfer equivalent to median consumption in the poorest quintile, such a program would reach 320,000 orphans in 217,000 households in Uganda. Such a program would further raise school enrolment by approximately 6 percentage points among the beneficiary group.\(^{23}\)

Through analysing literature on the biggest social cash transfer schemes in the Republic of South Africa and data from pilot schemes in Zambia and Malawi, it is estimated that the share of HIV and AIDS affected households as a percentage of all households reached by the respective scheme: the RSA Foster Care Grant and the Care Dependency Grant have a share of approximately 50%, the share of HIV and AIDS affected households among the beneficiaries of the Zambia and Malawi pilot schemes is estimated at 70% even though these households do not explicitly target HIV or AIDS affected households.\(^{24}\)

Factors determining the share of HIV and AIDS affected households reached are:

- Schemes that establish a low poverty line cut-off as an eligibility criterion have a high share because HIV and AIDS affected households tend to be poorer than non-affected households
- Using a high dependency ratio as a targeting criterion further focuses the scheme on HIV and AIDS affected households
- Schemes that target households with orphans also reach an above-average share of HIV and AIDS affected households because the majority of orphans in high HIV/ADS prevalence African countries are orphaned due to AIDS.

In addition to the targeting criteria, the targeting mechanism used has a significant effect. The Kenya and Malawi schemes (which transfer around $15-20 per month to each household) reach the poorest of the poor because targeting and approval is done in a multi-stage participatory process involving community level committees.


 Appropriately designed social cash transfer schemes in low income African countries with high HIV and AIDS prevalence – that do not use HIV and AIDS as a targeting criterion – can reach approximately 80% of those HIV and AIDS affected households *that urgently require social welfare interventions* because they are ultra poor and have high dependency ratios. As approximately 60% of the members of these households are children, social cash transfer schemes have a high mitigation impact on AIDS affected children. This high impact is achieved by those schemes that:

- focus on ultra poor households with high dependency (few healthy prime-age adults relative to children)
- have effective targeting criteria and procedures that reduce the exclusion error to less than 20%
- provide transfers regularly, reliably and at a level sufficient to meet the most essential needs of all household members
- link the beneficiaries to health and welfare services like ART, home based care and psychosocial counselling
- are a component of a social protection policy and programmes that complements social cash transfers for the ultra poor with productivity and employment oriented schemes that target ultra poor households with adult members who are fit for work.

Schemes that fulfil these criteria can be qualified as effective AIDS mitigation schemes. They are inclusive because they reach the worst-off cases of most vulnerable groups (e.g. ultra-poor, old, disabled and chronically ill people and OVC).

In view of the limited resources available for social protection, the limited implementation capacities in low income countries and the stigma associated with using HIV and AIDS as a targeting criterion, *it is not recommended to establish additional schemes that exclusively target HIV and AIDS affected households or HIV and AIDS affected children.*

One exception to this general recommendation could be the case of households with one or more members that are on ART. These households have substantial additional expenses (compared to other HIV and AIDS affected households), because the ART patients have specific nutritional, health care and logistical needs (especially in rural areas). It is recommended to explore the feasibility of a scheme that would facilitate that the hospitals that provide ART also provide a specific cash transfer to ART patients for meeting these costs. This could be done as a universal transfer to all ART patients (at the point of service delivery) regardless if their households receive social cash transfers or not.