

# The Impact of Social Cash Transfers on Children Affected by HIV and AIDS

## Evidence from Zambia, Malawi and South Africa



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# **The Impact of Social Cash Transfers on Children Affected by HIV and AIDS – Evidence from Zambia, Malawi and South Africa**

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## Acronyms

AIDS	Acquired Immunity Deficiency Syndrome
ART	Anti Retroviral Therapy
ARV	Anti Retroviral
CCT	Conditional Cash Transfers
CDG	Care Dependency Grant
CSG	Child Support Grant
CSPC	Community Social Protection Committee
CWAC	Community Welfare Assistance Committee
DEC	District Executive Committee
DG	Disability Grant
DoPDMA	Department of Poverty and Disaster Management Affairs
DSWO	District Social Welfare Officer
DWAC	District Welfare Assistance Committee
FCG	Foster Care Grant
GDP	Gross National Product
GTZ	German Technical Cooperation
HAZ	Height for Age Z-score
HH	Household
HIS	Integrated Household Survey
HIV	Human Immunodeficiency Virus
LCMS	Living Cost Monitoring Survey
MCDSS	Ministry of Community Development and Social Services
MK	Malawian Kwacha
MoWCD	Ministry of Women and Child Development
M+E	Monitoring and Evaluation
NAC	National AIDS Commission
NGO	Non-Governmental Organisation
NSO	National Statistics Office
OAP	Old Age Pension
OVC	Orphans and Vulnerable Children
PWAS	Public Welfare Assistance Scheme
RD	Rand
SCTS	Social Cash Transfer Scheme
SPSC	Social Protection Sub-Committee
UNAIDS	Joint United Nations Programmeme on HIV/AIDS
UNICEF	United Nations Children's Fund
USD	United States Dollar
TOR	Terms of Reference
VDC	Village Development Committee
VG	Village Group
ZMK	Zambian Kwacha

## Executive Summary

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? The study attempts to answer this question by presenting and analysing literature on the five biggest social cash transfer schemes in South Africa and data from pilot schemes in Zambia and Malawi. The analysis tries to establish the degree to which the different schemes reach HIV and AIDS affected households and in which ways the beneficiary households and the children living in these households benefit from the schemes. By comparing the different schemes the study identifies the main factors that determine both the share of HIV and AIDS affected households reached and the impact achieved.

The share of HIV and AIDS affected households as a percentage of all households reached by the respective scheme has been estimated for four of the seven schemes: The RSA Foster Care Grant and the Care Dependency Grant have a share of approximately 50 per cent. The share of the Old Age Pension, of the Child Care Grant and of the Disability Grant could not be estimated. The share of HIV and AIDS affected households among the beneficiaries of the Zambia and Malawi pilot schemes is estimated at 70 per cent<sup>1</sup>. All estimates are based on assumptions that require further research and verification.

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 (labour constrained households) 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/AIDS prevalence African countries are orphaned due to AIDS.

In addition to the targeting criteria, the targeting mechanism used has a significant effect. The RSA schemes (except for the Old Age Pension and the Child Support Grant) have a low take-up rate because the application procedures are complicated and are administered by an overburdened Welfare Administration. For this reason many of the poorest households fail to access the transfers. The Zambia and Malawi schemes reach the poorest of the poor because targeting and approval is done in a multi-stage participatory process involving community level committees.

The impact of social cash transfers on the well-being of members of the beneficiary households and on the children in these households is influenced by:

- The volume of the transfers
- The degree to which the design of the scheme is child-oriented
- Who controls the transfers on household level
- The availability of complementary social services

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<sup>1</sup> The 70 per cent estimate is based on calculations given in Boxes 1 and 2 on pages 15 and 21.

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 per cent<sup>2</sup> of those HIV and AIDS affected households that urgently require social welfare interventions because they are ultra poor and labour constrained. As approximately 60 per cent of the members of these households are children, social cash transfer schemes have a high mitigation impact on HIV and AIDS affected children. This high impact is achieved by those schemes that:

- focus on ultra poor households, which are at the same time labour constrained
- have effective targeting criteria and procedures that reduce the exclusion error to less than 20 per cent<sup>3</sup>
- 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 programme that complements social cash transfers for ultra poor labour constrained households 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. 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 regardless if their households receive social cash transfers or not.

The empirical data base on which the analysis and the conclusions of this study are based is small. To improve this situation the study concludes by listing operational research priorities. It recommends that the data required should be generated by robust quantitative empirical research combined with simultaneously conducted rapid appraisals. Instead of relying on assumptions and simulations researchers should team up with implementing organizations to

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<sup>2</sup> The 80 per cent estimate is based on calculations given on page 29.

<sup>3</sup> The assumption that the exclusion error of the two schemes is less than 20 per cent is highly realistic. The ongoing Boston University evaluation of the Malawi scheme has just stated that the inclusion error (the target for this was less than 10 per cent) is in fact only 6.6 per cent. This resulted from a baseline survey of 800 beneficiary households. To identify the exclusion error a different kind of survey is required which Boston University will do in September 2007. According to our anecdotal evidence we are certain that the scheme will turn out to have an exclusion error significantly below the 20 per cent target.

plan, implement and evaluate pilot activities that are systematically designed to test relevant hypothesis (action research) on the HIV and AIDS mitigation impact of different social protection interventions.

## 1. Background, Objectives and Methodology of the Study

In East and Southern Africa a growing number of children live in ultra poor households<sup>4</sup> or live outside of family care. These children are deprived of their most basic needs in terms of food, basic health care, shelter and education. Many are orphans. AIDS is the main reason – though not the only reason – for the growing number of children living in precarious circumstances.

Governments and donors have responded to this crisis by adapting and expanding existing social protection programmes and by piloting additional schemes. In the Livingstone Call for Action resulting from an intergovernmental regional conference (HelpAge International 2006), countries committed to developing national social protection policies. In this context, some governments are establishing social cash transfer programmes that target individuals or households based on ‘need’, which is defined in poverty terms.

This study seeks to establish to what extent the design and context of social cash transfer programmes influence how they reach households and children affected by HIV and AIDS and have beneficial impacts for them, even when ‘AIDS affected’ is not a targeting criterion for the respective programme. This analysis attempts to test the hypothesis:

**In countries with high HIV and AIDS prevalence, social cash transfer programmes that target a broad spectrum of poor households or persons, but do not explicitly target HIV and AIDS affected households or persons, have a substantial AIDS mitigation impact. The significance of the mitigation impact on HIV and AIDS affected households and on children living in these households varies depending on programme type, on targeting criteria and procedures and on the volume of transfers.**

Objectives of the study are:

1. To increase understanding of the role of cash transfers in mitigating the impact of AIDS on children and households, and determine what priority to give cash transfers in HIV and AIDS programming.
2. To demonstrate if cash transfer targeting based on poverty level rather than on HIV and AIDS status makes sense in heavily HIV and AIDS-affected communities and to understand the appropriateness of programming using ‘AIDS exceptionalism’ as a driver rather than a programming approach.
3. To identify evidence gaps and define an operational research agenda to expand the social protection evidence base.

The choice of countries and programmes to be studied and the methodology used had to take time constraints and data availability into account. Where empirical evidence is lacking, the study is based on anecdotal evidence using assumptions and leading to conclusions that are to some extent hypothetical and require further research.

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<sup>4</sup> For the purpose of this study ultra poor households are households in the lowest expenditure quintile.

Zambia and Malawi have been chosen because they have well documented pilot social cash transfer schemes that target ultra poor households, which are at the same time labour constrained, using a multi stage participatory targeting process. Both schemes have objectives of testing the hypothesis that cash transfers are a feasible and cost-effective mechanism for basic social protection in low income African countries with high HIV and AIDS prevalence. South Africa has been selected because it has a comprehensive and well researched system of social protection programmes that target different types of vulnerable groups using means-tests implemented by social workers<sup>5</sup>.

All three countries have HIV prevalence rates between 15 and 20 per cent of the adult population (aged 15 to 49). Zambia and Malawi are low income countries whereas South Africa is a middle income country. The pilot schemes in Zambia and Malawi are analysed using progress and evaluation reports as well as unpublished internal documents. The analysis of the South African schemes is based on a literature review.

The UNAIDS Monitoring and Evaluation Reference Group recommends the following definition of orphans and other children made vulnerable by HIV/AIDS (OVC) (UNICEF, 2005)<sup>6</sup>:

*An **orphan** is a child below the age of 18 who has lost one or both parents.*

*A **child** made vulnerable by HIV/AIDS is below the age of 18 and:*

- i) has lost one or both parents, or*
- ii) has a chronically ill parent (regardless of whether the parent lives in the same household as the child), or*
- iii) lives in a household where in the past 12 months at least one adult died and was sick for 3 of the 12 months before he/she died, or*
- iv) lives in a household where at least one adult was seriously ill for at least 3 months in the past 12 months, or*
- v) lives outside of family care (i.e. lives in an institution or on the streets).*

However, the UNAIDS definition is not restricted to those that are specifically HIV and AIDS affected. Not all orphans are due to AIDS and not all adult chronic illness is HIV related. Being outside family care is again not necessarily a sign of being HIV or AIDS affected. For the purpose of this study, children are HIV and AIDS affected when they live in a HIV and AIDS affected household or when they live outside the care of a household because the household to which they belonged is or was affected by HIV and AIDS. A household is HIV and AIDS affected when:

- i) one or more household members are living with HIV or AIDS<sup>7</sup>*
- ii) one or more household members in the reproductive age (18-49) have died during the last 10 years due to AIDS*
- iii) the household has absorbed children or adults from other households (e.g. relatives that are not able to fend for themselves), who's caregivers are chronically sick or have died due to AIDS*

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<sup>5</sup> A summary of literature pertaining to social security for children with particular reference to South Africa (UNICEF 2006a) quotes 87 publications. However, none of them deals specifically with the AIDS mitigation impact of social cash transfers.

<sup>6</sup> The author would like to remark that defining all orphans as 'vulnerable' does not justify the conclusion that all orphans require social protection interventions. Many orphans are well cared for by the remaining parent or by other family members. For a discussion of the pros and cons of focusing social protection programmes on orphans or orphans due to AIDS, see Meintjes and Giese (2006).

<sup>7</sup> For definitions i-iii, specific diagnosis is not necessarily carried out and HIV and AIDS is assumed to be present in some cases.

iv) the household has been regularly supported through transfers in cash or kind by relatives living outside the household, but has lost that support because a relative (e.g. a son) is no longer able to provide the support because he/she or his/her household is HIV and AIDS affected.<sup>8</sup>

Chapter 2 of this study summarises the history and the main parameters of each programme included in the study. It presents information on target groups, targeting mechanisms, volume of transfers, and categories of households reached. To the extent possible it gives estimates on the number of HIV and AIDS affected households and HIV and AIDS affected children reached and on the impact of the transfers.

Chapter 3 compares the schemes that have been described and analysed in chapter 2. This chapter also draws conclusions with regard to the extent to which the empirical evidence collected supports the hypothesis given above.

Chapter 4 gives recommendations with regard to:

- Defining the target groups for cash transfers in high HIV prevalence settings
- Specific concerns of different categories of HIV and AIDS affected households
- Targeting criteria and procedures of social cash transfer programmes
- Using 'AIDS exceptionalism' as a driver of change rather than a programming approach.
- Operational research priorities

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<sup>8</sup> The discussion on how to define 'HIV and AIDS affected' shows the complexity of the issues involved in identifying empirically if a household is HIV and AIDS affected or not. All the four criteria are difficult to ascertain because the HIV status is frequently not known. While these difficulties should not discourage the urgently required empirical research (see chapter 4.5 and the annex), they demonstrate the impossibility of using 'HIV and AIDS affected' as a targeting criterion (this issue is taken up in section 4.4)

## **2. Country Studies**

### **2.1 The Kalomo Pilot Social Cash Transfer Scheme, Zambia**

#### **2.11 History**

The recommendation for a pilot social cash transfer scheme transferring cash to ultra poor households in Zambia was first given in a GTZ financed study for the Ministry of Community Development and Social Services (MCDSS) named 'Social Welfare Interventions for AIDS Affected households in Zambia' conducted in April 2003 (Schubert, 2003). The recommendation was accepted and by August 2003 the GTZ assisted Social Safety Net Project of the MCDSS started to design and prepare a pilot scheme to be implemented in two agricultural blocks of Kalomo District.

In 2004 the scheme was launched and by December 2004, the scheme had been rolled out and covered 1,027 households. A comprehensive evaluation report was published in October 2006 (MCDSS, 2006 a)<sup>9</sup>. The scheme was the first of its kind in East and Southern Africa and became the focus of the Livingstone Conference on Social Protection for Africa, held in Livingstone in March 2006 (Helpage International 2006). Attention to the scheme has resulted in scaling up to additional districts and in increasing budget allocations to the scheme by the Government of Zambia and by donors. The Kalomo scheme is an important learning experience for the development of other schemes.

#### **2.1.2 Key Parameters of the Scheme**

##### **Institutional Setting and Objectives**

The scheme is administered by the Public Welfare Assistance Scheme (PWAS) of the Ministry of Community Development and Social Services (MCDSS). The pilot scheme has the following objectives:

- Reduce starvation and extreme poverty in the ten per cent most destitute and incapacitated (non-viable) households in the pilot region (approximately 1,000 households). The focus of the scheme is consequently on 'generation gap' households, headed by the elderly who are caring for OVC because the breadwinners are chronically sick or have died due to AIDS or other reasons
- Generate information on the feasibility, costs and benefits and all positive and negative impacts of a social cash transfer scheme as a component of a social protection strategy for Zambia.<sup>10</sup>

Based on survey results and consultations at national, provincial and district level, a Manual of Operations has been drafted, tested and revised during a preliminary test phase (November 2003 to April 2004). The Manual has been further refined throughout the subsequent pilot phase (MCDSS, 2006 b).

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<sup>9</sup> The preparation, organization, implementation and evaluation of the Scheme is documented in a series of reports accessible at [www.socialcashtransfers-zambia.org](http://www.socialcashtransfers-zambia.org)

<sup>10</sup> Based on the Kalomo pilot scheme social cash transfers have become a core element of the social protection strategy of Zambia (MCDSS 2005)

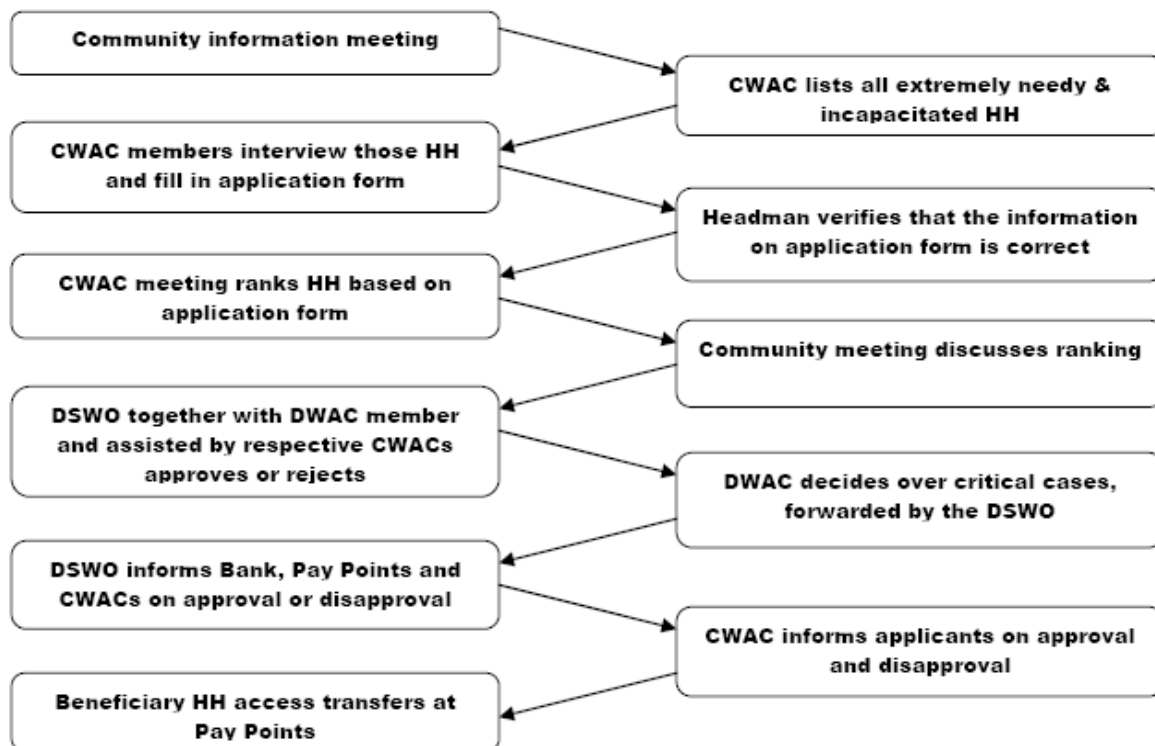
## Targeting Criteria and Targeting Process

Targeting is done by Community Welfare Assistance Committees (CWACs) which are the grassroots level structure of PWAS. The CWACs use a multi-stage participatory process to identify the 10 per cent neediest incapacitated households<sup>11</sup> in their area involving the headmen, the community and the District Welfare Assistance Committee (DWAC). The two criteria a household has to meet to be considered for the scheme are:

- Extreme poverty
- Incapacitated

'Incapacitated' means that the household has no household members who are fit for work and are in the working age group (19 to 64) or that there is a very high dependency ratio (over 3).<sup>12</sup> This criterion is used to focus the programme on households that cannot be reached by labour-based schemes such as food or cash for work or micro-credit and are therefore bypassed by most major poverty reduction schemes operating in Zambia. The targeting process is described in Figure 1 below.

**Figure 1: Targeting Flow Chart**



The process from the first community meeting to paying the first transfers to the approved beneficiaries takes two months. The process is managed by the District Social Welfare Officer

<sup>11</sup> The 10 per cent limit is based on several research findings, among them the results of the National Household Survey carried out by PWAS in September/October 2003. It does not reflect the financial constraints of the scheme but rather refers to a category of households in Zambia that can be classified as 'extremely poor and incapacitated.'

<sup>12</sup> The dependency ratio is measured here as the ratio of unfit members in the household divided by the number of fit household members.

and two assistants. Costs for targeting, approval, delivery and supervision (all logistical and administrative costs) amount to USD 20 per beneficiary household per year.

## **Amount and Intended Use of the Transfers**

The monthly transfers for households approved by the scheme amount to ZMK 30,000 for households without children and ZMK 40,000 for households with children (USD 7.5 – 10).<sup>13</sup> The transfer is based on an average price of a 50 kg bag of maize, which in 2005 amounted to ZMK 30,000 in Kalomo District. The scheme thus allows beneficiary households at least one meal per day. The beneficiary households are free, however, to spend the transfers in any way they want. The scheme applies no conditions on how to use the transfers. It is up to beneficiary households to decide whether they want to consume, save or invest the money according to their needs and interests.

The basic assumption of the scheme is that the beneficiary households spend the money wisely. Experience of this scheme strongly suggests that in this context poor people are not irresponsible and know best how precarious their situation is and what they need most in order to survive and develop. At the same time, households are not supposed to misuse the transfer, meaning that money should not be spent on alcohol, gambling or exclusively consumed by one household member. The transfer is meant for the entire household. It is also assumed that the heads of the beneficiary households (most of them are elderly women) spend most of the transfer on orphans and other vulnerable children (OVC) living in their households. Preliminary evaluation results indicate that both assumptions are realistic (MCDSS, 2006 a).

### **2.1.3 Extent to which HIV and AIDS Affected Households and Children are reached by the Kalomo Scheme<sup>14</sup>**

#### **Types of Households Reached**

Table 1 shows the share of different types of beneficiary households compared to the share these households have in the 2004 Living Conditions Monitoring Survey (LCMS) which is representative for all households in Zambia:

- 54 per cent of the beneficiary households are headed by persons aged 65 and above while the share of elderly-headed households in the LCMS is 9 per cent. By adding the 24 per cent beneficiary households that are headed by persons aged 55 to 64 we arrive at 79 per cent households headed by older persons compared to 19 per cent in the LCMS.
- Two thirds of the elderly-headed households are female headed.
- Of the 21 per cent of households that are headed by persons below the age of 55, about 55 per cent are female-headed.
- 63 per cent of the household heads are widowed (see figure 2).

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<sup>13</sup> Exchange rate: 1 USD = ZMK 4,000.

<sup>14</sup> Chapters 2.1.3 and 2.1.4 are based on an evaluation which included a baseline survey of 304 beneficiary households (done after approval, but before receiving the first transfers) and an evaluation survey of 274 of the same households after they had received monthly transfers for a year (MCDSS 2006a)

**Table 1: Heads of Beneficiary Households by Sex and Age**

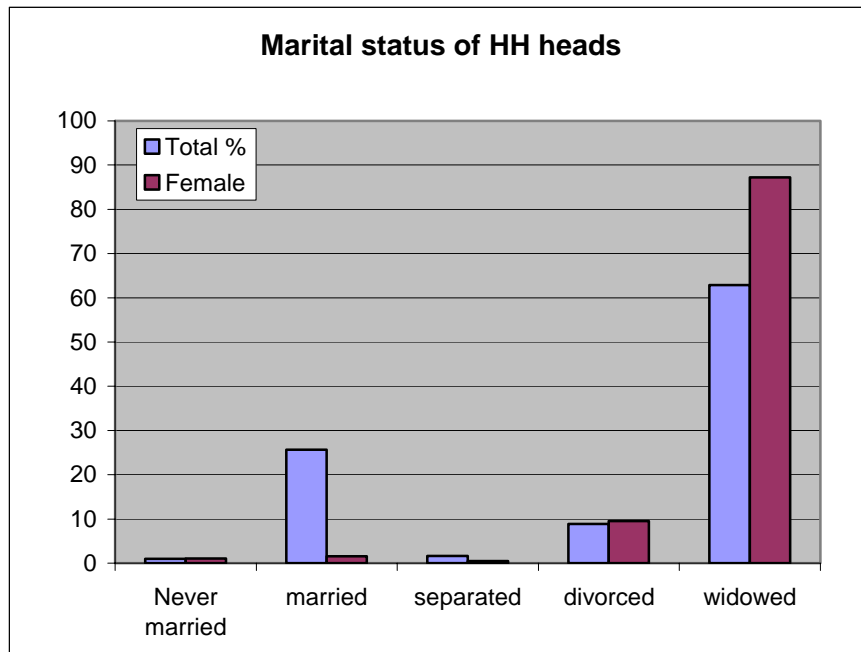
Age group	Baseline			LCMS 2004
	Female	Male	Total	
Below 19	0	0	0	0.6
20 – 34	45.5	54.6	3.6	37.8
35 – 54	57.4	42.6	17.8	42.6
55 – 64	62.3	37.7	25.3	10.2
65 +	64.2	35.8	53.3	8.9
Total population	61.8	38.2	100	100

Sources: SCTS Baseline Survey and LCMS 2004 (MCDSS, 2006 a)

Note: The fact that the baseline survey does not include child-headed households in the random sample of 304 beneficiary households is due to the fact that child-headed households and street children are rarely found in rural areas. Baseline data and LCMS data are not strictly comparable because Kalomo district is a rural area whereas LCMS data are only available as an average from rural and urban areas

These data indicate that the scheme succeeds in targeting elderly-headed, female-headed and widow-headed households. There is, however, no direct empirical evidence on how many of these households are HIV and AIDS affected. The calculation of the share of different categories of HIV and AIDS affected households, given in box 1, is based on assumptions, not on empirical evidence. The analysis leads to the hypothesis that approximately 70 per cent of the beneficiary households of the Kalomo scheme are in one way or other HIV and AIDS affected (see definition of HIV and AIDS affected households in chapter 1). Chapter 4.5 gives recommendations on the research required to verify this hypothesis.

**Figure 2: Marital status of HH heads**



Source: SCTS Baseline survey (MCDSS 20064)

### **Box 1: Assumptions-based Estimate of the Number of HIV and AIDS Affected Households reached by the Kalomo Scheme**

We estimate that 55 per cent of the beneficiary households are HIV and AIDS affected because one or more adult household members have died due to AIDS. The estimate is based on the following assumptions:

- 91 per cent of the beneficiary households are either elderly-headed or headed by a woman below the age of 55 (see table 1)
- We assume that 80 per cent of these households are 'incomplete' because one or more adults (adult children or spouses) have died (estimate based on anecdotal evidence)
- We further assume that 75 per cent of these deaths are due to AIDS. This assumption is based on the information that in Zambia in 2004 the number of death in the age group 15 to 64 was 129,556 (Central Statistics Office, Zambia 2005) of which 98,000 were due to AIDS (UNICEF 2006a).

Of the remaining 45 per cent beneficiary households (those that have not lost one or more members due to AIDS) 29 per cent are estimated to be HIV and AIDS affected because they have absorbed one or more children that have been orphaned by AIDS. These households contribute another 13 per cent (29 per cent of 45 per cent) to the share of HIV and AIDS affected households. This estimate is based on the following assumptions:

- 75 per cent of all beneficiary households have children of which 68 per cent are orphans (MCDSS 2006a)
- 57 per cent of all orphans in Zambia are orphaned by AIDS (UNICEF 2006a)

To the 68 per cent affected households of the two categories given above (55 per cent plus 13 per cent) we have to add an unknown number of households that are HIV and AIDS affected because one or more members are living with HIV or AIDS.

### **Beneficiaries Reached by Age, Sex and other Criteria**

Table 2 gives the share of different age groups of beneficiaries as percent of all beneficiaries and compares this to the share of different age groups in the LCMS:

- 56 per cent of the members of beneficiary households are children (0 - 19<sup>15</sup>). According to the LCMS the share of children on national level is also 56 per cent. However, the beneficiary households have a significantly lower share of the 0 to 4 age group and a higher share of the 10 to 19 age group
- 68 per cent of the children in the beneficiary households are orphans (LCMS 18 per cent), of which 35 per cent are double orphans (LCMS 27 per cent)
- 16 per cent of the members of beneficiary households are 65+ (LCMS 2 per cent). By adding the age group 55 to 64 we arrive at 24 per cent older people (LCMS 5 per cent). Among the older beneficiaries women have a share of 70 per cent
- The share of disabled among the beneficiaries is 18 per cent for the age group 20 to 44 and 34 per cent in the age group 45 to 64
- This means that 78 per cent of the beneficiaries of the scheme cannot work or should not work because they are either children (which should attend school) or older people

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<sup>15</sup> While the Convention on the Rights of the Child defines children as aged 0-18, the Zambia LCMS collects data on those aged 0-19.

(65+) or in the age group 20 to 64 but disabled. Those household members in the age group 20 to 64, who are fit for work, are mostly women.

**Table 2: Beneficiary Distribution by Age and Sex**

Age Group	per cent Total		per cent Female of Total	
	Baseline	LCMS 2004	Baseline	LCMS 2004
0 – 4	8.8	14	50.5	51.7
5 – 9	14.3	15	52.6	51.6
10 – 14	19.3	15	50.0	50.0
15 – 19	13.4	12	52.5	50.0
20 – 24	5.2	11	36.5	47.6
25 – 29	3.1	8	47.4	50.0
30 – 34	2.9	6	51.4	53.8
35 – 39	2.6	5	56.3	50.0
40 – 44	1.8	4	68.2	50.0
45 – 49	2.4	3	75.9	50.0
50 – 54	1.9	2	78.3	50.0
55 – 59	3.6	2	69.8	50.0
60 – 64	4.7	1	66.7	50.0
65 +	15.9	2	69.8	60.0
Total	100	100	56.3	50.0
<i>No. of observations</i>		1210	681	

Source: SCTS Baseline Survey & LCMS 2004 (MCDSS, 2006 a)

In summary: the scheme can be considered a ‘child welfare scheme’ because 56 per cent of the beneficiaries are OVC, mostly orphans. It can also be considered as an ‘AIDS impact mitigation scheme’ because the majority of the beneficiary households are HIV and AIDS affected (the hypothetical calculation given in box 1 arrives at a share of HIV and AIDS affected households of approximately 70 per cent). Other types of vulnerable groups benefiting from the scheme are older people (16 per cent) and the disabled (8 per cent just counting the disabled in the age group 20 to 64). **The scheme covers neither all OVC, nor all HIV and AIDS affected households, older people, or disabled persons in the pilot area. But – because one of the targeting criteria is extreme poverty – it reaches the worst off, neediest and most vulnerable persons of all the vulnerable groups listed above.**

#### 2.1.4 Impact of the Scheme on Members of Beneficiary Households

##### Impact on all Household Members

At baseline, the average cash income per beneficiary household was ZMK 9,670 (USD 2.5) per month. In addition, they had an estimated average income in kind (own production, in kind rewards for piecework, different kinds of in kind transfers) of ZMK 30,000 (USD 7.5). The social cash transfer of ZMK 30,000 (plus ZMK 10,000 if the household has children) increased their cash income on the average by 300 to 400 per cent and their total income (cash and kind) by 75 to 100 per cent.

The additional cash has been predominantly used for purchasing food, for accessing health services (including transport costs to health centres and hospitals), for expenditure related to education (uniforms, books, pens, fees) and for soap (MCDSS 2006a). Households also made investments in assets such as small livestock (chicken and goats) and repaid debts.

The following quotation from the evaluation report summarizes the impact on nutrition and health after one year of receiving the transfers. This impact was achieved in spite of the fact that Southern Province suffered a severe drought in the year before the evaluation was conducted while rainfall was favourable in the year before the baseline survey. The influence of external factors such as drought and interventions of other programmes could not be controlled because the research was conducted without a control group.

*The analysis of the nutritional status of the beneficiary population shows a marked improvement. Households living on one meal a day decreased from 19.3 per cent to 13.3 per cent, while households with 2 meals a day remained the same and households with 3 meals a day increased from 17.8 per cent to 23.7 per cent. Even more importantly, satiation levels improved: the percentage of households still feeling hungry after a meal decreased from 56.3 per cent down to 34.8 per cent and the percentage of households who had either enough or just enough went up from 42.6 per cent to 65.2 per cent. Food intake also improved in terms of quality: the frequency as well as the number of households taking in carbohydrates went up. The intake of fats, proteins and vitamins increased with more households consuming cooking oil, foods rich in proteins as well as cultivated vegetables and fruits. This positive change can most likely be ascribed to the social cash transfer scheme (SCTS), which increased the purchasing power of beneficiary households and thus enabled them to either consume types of food they could not afford before, or to consume more of certain types of food.*

*The SCTS is likely to have had a positive effect on the health status of the beneficiary population. Overall, the incidence of illness decreased, in particular for the group of 65 and above who are particularly vulnerable and who are usually the ones heading the households. The cash transfer probably allowed households to pay for transport to access health services and to cover smaller medical expenses and increased households' resistance to sicknesses through better nutrition. With respect to disability, the main disability of partial sightedness reduced by more than half, probably because the cash transfer enabled household members to access treatment in the district capital (MCDSS, 2006 a, p. 43/44)*

### **Specific Impact on Household Members living with HIV and AIDS**

The evaluation of the Kalomo Scheme did not single out the impact on HIV positive household members. Anecdotal evidence from a limited number of interviews with HIV positive beneficiaries indicates that those receiving ARV drugs use parts of the transfers for the transport costs to collect the drugs and for meeting the dietary recommendations given to ARV drug users by the health workers.

### **Impact on Children**

In addition to benefiting from higher expenditure on food and other basic needs, children benefit from schooling related expenditures. The percentage of overall expenditure on education increased from 3.9 per cent to 5.5 per cent (MCDSS 2006a). The evidence provided seems to suggest that a combination of cash transfers with bursaries (for secondary school) might increase school attendance more than cash transfers alone. However, when assessing the impact on the enrolment rate given below, it has to be taken into account that Kalomo District

has a supply side problem in terms of the quantity and quality of schools available. In remote villages the distance to the closest school is too far for young children to reach.

*Enrolment rates for 7 – 18 years old rose by 3 per cent points to 79.2 per cent at evaluation. The increase is statistically significant and could be an effect of the SCTS. Unfortunately, no definite conclusions can be drawn concerning the impact of the SCTS because comparative data at district or national data on the evolution of enrolment rates is not available. Out of all children (7–17) not enrolled in school at baseline, 50 per cent came back to school at evaluation, showing that the problem for not accessing school might have been rather a demand problem. The impact of the SCTS on absenteeism is less conclusive: while there was an overall increase in the number of days absent, absenteeism reduced for shorter time periods and increased for longer time periods. Focus group discussions and interviews with headmasters rather showed a positive change in school attendance of beneficiary children after the inception of the scheme. However the fact that there were more children absent for longer time periods and that the reasons 'school fees not paid,' 'illness' and 'needed at home' gained in importance show that the cash transfer was not able to compensate for extra costs that arose or for the loss of revenue that might have been caused by the drought or other external factors (MCDSS, 2006 a, p. 38/9).*

## **2.2 The Mchinji Pilot Social Cash Transfer Scheme, Malawi**

### **2.2.1 History**

Since 2004, UNICEF Malawi has advocated that social protection and especially social cash transfers should be integrated into development plans (like the Malawi Growth and Development Strategy) and into the budgets of funding organizations (like the application to the Global Fund for AIDS, Tuberculosis and Malaria). In early 2006, UNICEF organized exposure trips for policy makers and technocrats to study cash transfer schemes in Zambia and Brazil. Simultaneously a consultancy for the Department of Poverty and Disaster Management Affairs (DoPDMA) was financed to facilitate a participatory process of designing and testing a cash transfer pilot scheme. In the process initiated by the consultancy, stakeholders agreed on Mchinji District as a pilot region and using the District Assembly as the implementing agency for the pilot scheme.

It was also agreed that the scheme targets ultra poor households which are at the same time labour constrained (i.e., households that have no adult aged 19 to 64 fit for productive work or more than 3 dependants for one fit adult). It is estimated that about 10 per cent of all households in Malawi (250,000) belong to this category, which cannot benefit from labour based interventions and are unable to fend for themselves. More than 60 per cent of the members of these households are children of which 85 per cent are orphans (unpublished data from the Mchinji scheme). A typical household of this category consists of a grandmother and grandchildren who have been orphaned by AIDS.

Between April and August 2006 procedures for targeting, approval, delivery, training and monitoring were elaborated, tested and documented in a Manual of Operations and in Guidelines for Internal Monitoring. UNICEF also invested in capacity building (equipment and on-the-job training) for officers on national and district level.

In September 2006 the pilot scheme started operations. Monthly monitoring reports indicate that the scheme is progressing as planned. The scheme is rolled out to four village groups per month and will have covered the whole pilot area (approximately 3,000 beneficiary households) by July 2007.

The scheme is frequently visited by policy makers, donor representatives and technocrats from national level and from neighbouring countries. It is acknowledged as a realistic option as a core component of the emerging national social protection policy and programme. In November 2006, Cabinet officially endorsed the Mchinji Pilot Scheme and decided to scale it up to six additional districts. UNICEF presently assists the government to plan the scaling up process and will provide technical assistance throughout 2007.

## **2.2.2 Key Parameters of the Scheme**

### **Institutional Setting and Objectives**

The scheme is implemented by the Mchinji District Assembly, which has set up a Social Cash Transfer Secretariat for the day to day management. On a national level the scheme is supervised by the DoPDMA and the MoWCD. It is integrated into the process of elaborating a Social Protection Policy Framework, which is guided by a Social Protection Steering Committee and a Social Protection Technical Committee. The objectives of the scheme are:

1. Reduce poverty, hunger and starvation in all households living in the pilot area that are ultra poor and at the same time labour constrained
2. Increase school enrolment and attendance of children living in target group households
3. Generate information on the feasibility, costs and benefits and on the positive and negative impact of a social cash transfer scheme as a component of a social protection programme for Malawi.

### **Targeting Criteria and Targeting Process**

The targeting criteria are identical to those used by the Kalomo Scheme. In order to qualify, households have to meet two criteria:

#### **1. Ultra poor**

This means that they are in the lowest expenditure quintile and under the ultra poverty line (only one meal per day; not able to purchase essential non-food items like soap, clothing, school utensils; are prone to begging; have no valuable assets)

#### **2. Labour constrained**

A household is labour constrained when it has no able-bodied household member in the age group 19 to 64, who is fit for work, or when one household member in the age group 19 to 64 years, who is fit for work, has to care for more than 3 dependants (dependants are household members that are under 19 years of age or over 64 or are unfit for work because they are chronically sick, or disabled). In other words: Households are labour constrained when they have a dependency ratio of more than 3. According to the 2004/2005 Integrated Household Survey the average dependency ratio of households in the lowest income quintile is 1.5. The criterion of 'labour constrained' is used in order to focus on those households that are not able to access or to benefit sufficiently from labour based interventions like public works or from informal piece work.

The targeting criteria are used in a multi-stage participatory targeting process:

1. Community Social Protection Committees (CSPCs) at village group level (sub-committee of the VDC) list, visit and interview all households that seem to meet the targeting criteria. They then rank all households that have no labour or have a dependency ratio of more than 3 according to degree of need.
2. The CSPCs present the households selected and the ranking to a community meeting in order to ensure that no households meeting the criteria are left out, that ineligible households are deleted from the list, and that a consensus on the appropriate ranking is achieved. The community meeting should also facilitate that the scheme and the targeting process are as transparent as possible. This methodology has shown to be effective in identifying ultra poor labour constrained households.
3. A Social Protection Sub-Committee (SPSC) at district level (sub-committee of the DEC) assisted by extension workers, checks if the targeting process has been fair and transparent and if the results are correct. The SPSC then approves the ten per cent neediest households. The ten per cent cut off point is based on the assumption that on the average less than ten per cent of the households meet both criteria. Further research to verify this assumption is under way.

### **Amount and intended Use of Transfers**

The monthly cash transfers vary according to household size and take into account if the household has children enrolled in primary or in secondary school:

- 1 person household      MK    600 (USD 4)
- 2 person household      MK 1,000 (USD 7)
- 3 person household      MK 1,400 (USD 10)
- 4 and more persons      MK 1,800 (USD 13)

For children enrolled in primary school a bonus of MK 200<sup>16</sup> is added, for children in secondary school a bonus of MK 400. This bonus is meant to encourage school enrolment and attendance and to discourage child labour and premature drop-outs. It facilitates caregivers meeting schooling related child needs such as food, clothing, soap, exercise books and pencils. However, no conditions are applied.

On the average, the transfers amount to MK 1,700 (USD 12) per household per month. This amount is sufficient to fill the gap of MK 1,343 between the ultra poverty line of MK 6,447 per month for a 5.8 person household and the average monthly expenditure of MK 5,103 of households in the lowest income quintile.

The costs per household per year are USD 144 for the transfers plus USD 24 for operational costs. In case the scheme would be extended to all the 250,000 ultra poor and labour scarce households in Malawi (10 per cent of all households) the annual costs would be USD 42 million. The Scheme would then benefit approximately 1 million persons including approximately 650,000 OVC.

### **2.2.3      Extent to which HIV and AIDS Affected Households and Children are reached by the Mchinji Scheme**

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<sup>16</sup> Exchange rate: USD 1 = MK 140

By November 2006 the Scheme had reached 1,065 households. Table 3 gives the share of different types of beneficiary households compared to the results of the 2004 Integrated Household Survey (IHS), which is representative for all households in Malawi:

- Elderly-headed beneficiary households (65+ years) have a share of 65 per cent while the IHS gives a share of only 12 per cent
- Female-headed beneficiary households also have a share of 65 per cent compared to 23 per cent in the IHS. The share of female-headed households in the age group 20 to 64 is 23 per cent of all beneficiary households
- 1 per cent of all beneficiary households are child-headed.

**Table 3: Heads of Beneficiary Households of the Malawi Scheme by Sex and Age**

Age group/sex of household head	Number of beneficiary households in percent	IHS 2004 in percent
Below 19 years	1 per cent	88 per cent
20 to 64 years	34 per cent	
65 years and above	65 per cent	12 per cent
Male-headed	35 per cent	77 per cent
Female-headed	65 per cent	23 per cent

Source: Monthly Monitoring Reports of the Malawi Pilot Scheme and IHS 2004

Note: Pilot scheme data and HIS data are not strictly comparable because Mchinji is a rural district whereas the HIS data are only available as average from rural and urban areas.

69 per cent of the members of the beneficiary households of the Malawi scheme are children (0-18 years) while the share of children in the IHS is 56 per cent. 85 per cent of the beneficiary household children are orphans (see Table 4) while the share of orphans in the 2004 IHS is 12 per cent.

**Table 4: Profile of Children in Beneficiary Households of the Malawi Scheme**

	Orphans in per cent of all children	Orphans		
		Total number	Single orphans	Double orphans
Malawi Scheme	85 per cent	100 per cent	67 per cent	33 per cent
2004 HIS	12 per cent	100 per cent	81 per cent	19 per cent

Source: Files of the Malawi Pilot Scheme and IHS 2004

**Box 2: Assumptions-based Estimate of the Number of HIV and AIDS Affected Households reached by the Mchinji Scheme**

We estimate that 53 per cent of the beneficiary households are HIV and AIDS affected because one or more adult household members have died due to AIDS. The estimate is based on the following assumptions:

- 88 per cent of the beneficiary households are either elderly-headed or headed by a woman or a child (see table 3)
- We assume that 80 per cent of these households are 'incomplete' because one or more adults (adult children or spouses) have died (educated guess based on anecdotal evidence)
- We further assume that 75 per cent of these deaths are due to AIDS (UNICEF 2006a).

Of the remaining 47 per cent beneficiary households (those that have not lost one or more members due to AIDS) 34 per cent are estimated to be HIV and AIDS affected because they have absorbed one or more children who were orphaned by AIDS. These households contribute

another 16 per cent (34 per cent of 47 per cent) to the share of HIV and AIDS affected households. This estimate is based on the following assumptions:

- 70 per cent of all beneficiary households have children of which 85 per cent are orphans (internal documents of the Mchinji scheme)
- 57 per cent of all orphans in Malawi are orphaned by AIDS (UNICEF 2006a)

To the 69 per cent affected households of the two categories given above (53 per cent plus 16 per cent) we have to add an unknown number of households that are HIV and AIDS affected because one or more members are living with HIV or AIDS.

The analysis of the households reached by the scheme (see box 2) arrives at the hypothesis that approximately 70 per cent of the beneficiary households of the scheme are in one way or other HIV and AIDS affected. A sample survey of 382 beneficiary households of the Mchinji scheme and 403 control group households conducted in March 2007 arrives at the conclusion that '75 per cent [of recipient households] care for orphans or the chronically ill or have had an AIDS related death'<sup>17</sup>. Chapter 4.5 gives recommendations how additional research may be conducted in order to further verify the hypothesis given above.

A robust external evaluation of the Malawi scheme (taking a sample of 400 beneficiary households and a control group of another 400 households that have been targeted and approved at the same time and in the same way as the beneficiary households, but will receive transfers only a year later) is under way and will be completed by mid 2008. The evaluation will identify the effectiveness of targeting, the share of different types of HIV and AIDS affected households reached, the use and intra-household distribution of transfers, the impact on nutrition, health, education and self-esteem of the beneficiaries, the impact on non-beneficiaries and on the local economy, and the cost-effectiveness of the scheme.

However, what has been concluded with regard to the beneficiaries reached by the Zambia scheme can similarly be concluded with regard to the Malawi scheme: the scheme can be considered a 'child welfare scheme' because 69 per cent of the beneficiaries are OVC, mostly orphans. It can also be considered an 'AIDS impact mitigation scheme' because the majority of the beneficiary households are HIV and AIDS affected (the hypothetical calculation given in box 2 arrives at a share of HIV and AIDS affected households of approximately 70 per cent). Other types of vulnerable groups benefiting from the scheme are older people and the disabled. **The scheme covers neither all OVC, nor all HIV and AIDS affected households, older people, or disabled persons in the pilot area. But – because one of the targeting criteria is extreme poverty – it reaches the worst off, neediest and most vulnerable persons of all the vulnerable groups listed above.**

## 2.3 The Social Cash Transfer Schemes of South Africa

### 2.3.1 History and Overview

According to the South African Constitution, Section 27 (1) 1: "... everyone has the right to have access to social security including, if they are unable to support themselves and their dependants, to appropriate social assistance." In order to fulfil the rights granted by the constitution, the Government of South Africa is implementing a number of social cash transfer schemes called social grants. The following paragraphs summarise the history and key parameters of the five biggest schemes.

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<sup>17</sup> Presentation given by Candace Miller, Boston University evaluation team, June 2007.

**The non-contributory, means tested Old Age Pension (OAP)** was introduced in 1928 for Whites and Coloureds and extended to all South Africans in 1944. The pension targets poor men aged 65 and over and poor women aged 60 and over. By 1999, 90 per cent of all Blacks and 16 per cent of all Whites in that age group received a pension (Ferreira, 1999). By 2002, the Department of Social Development paid a monthly pension of R760 (approximately USD 110) to 1.9 million beneficiaries at an annual total cost of R13.2 billion (USD 2 billion), which represents 1.4 per cent of GDP<sup>18</sup>. In 2005 the pension was increased to R780.

**The means tested Child Support Grant (CSG)**<sup>19</sup> targets children aged 14 years and below whose caregivers earn less than R800 per month in urban areas and less than R1,100 in rural areas. Of the 13.5 million children in that age group 8.8 million are eligible, of which 7 million (80 per cent) received the grant by March 2006. The amount paid to the caregivers is R190 (USD 27) per month.

**The Foster Care Grant (FCG)** is paid to caregivers with an annual income of less than R13,440, who care for children aged under 18 years who are neglected, abandoned or otherwise in need of protection outside their families. For each child, R590 (USD 84) are paid per month. The demand for FCGs is huge. But due to complicated registration and approval procedures and the overburdening of social workers only 300,000 children had been approved by March 2006.

**The Care Dependency Grant (CDG)** targets functionally disabled children. The CDG does not explicitly target children living with HIV and AIDS but is in fact used for this purpose in some areas. Caregivers of these children are entitled to a transfer of R820 (USD 117) per month. By March 2006 the number of beneficiaries was 91,000.

**The Disability Grant (DG)** targets functionally disabled adults. HIV-positive adults qualify for a DG when their CD4+ counts fall below 200 (Jacobs et al 2005). The value of the grant is R780 (USD113) per month. HIV -positive children are not eligible for this grant.

### 2.3.2 Impact of the South African Schemes

South Africa's **Old Age Pension** scheme has a significant poverty reduction impact. The generous value of the transfer (R780 per month) and the fact that transfers are shared with other household members have contributed to making the OAP a success story.

Figure 3 gives a breakdown of the expenditures of older people in South Africa. The figure falsifies the notion that elderly men are less family oriented in their spending patterns compared to elderly women. In fact the elderly men have spent on the average more on education and food compared to elderly women. Figure 3 also falsifies the notion that male beneficiaries spend substantial amounts on tobacco and alcohol. In fact such expenses are only 8 per cent of their total expenditure.

The impact of the **Disability Grant** is in some ways similar to the OAP. The value is high and it is shared with other household members. The main difference is that the DG is discontinued once the beneficiary has recovered his/her ability to work. This happens for instance when people living with AIDS regain their working capacity as a result of being on ART. In case the

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<sup>18</sup> Exchange rate: USD 1 = R 7

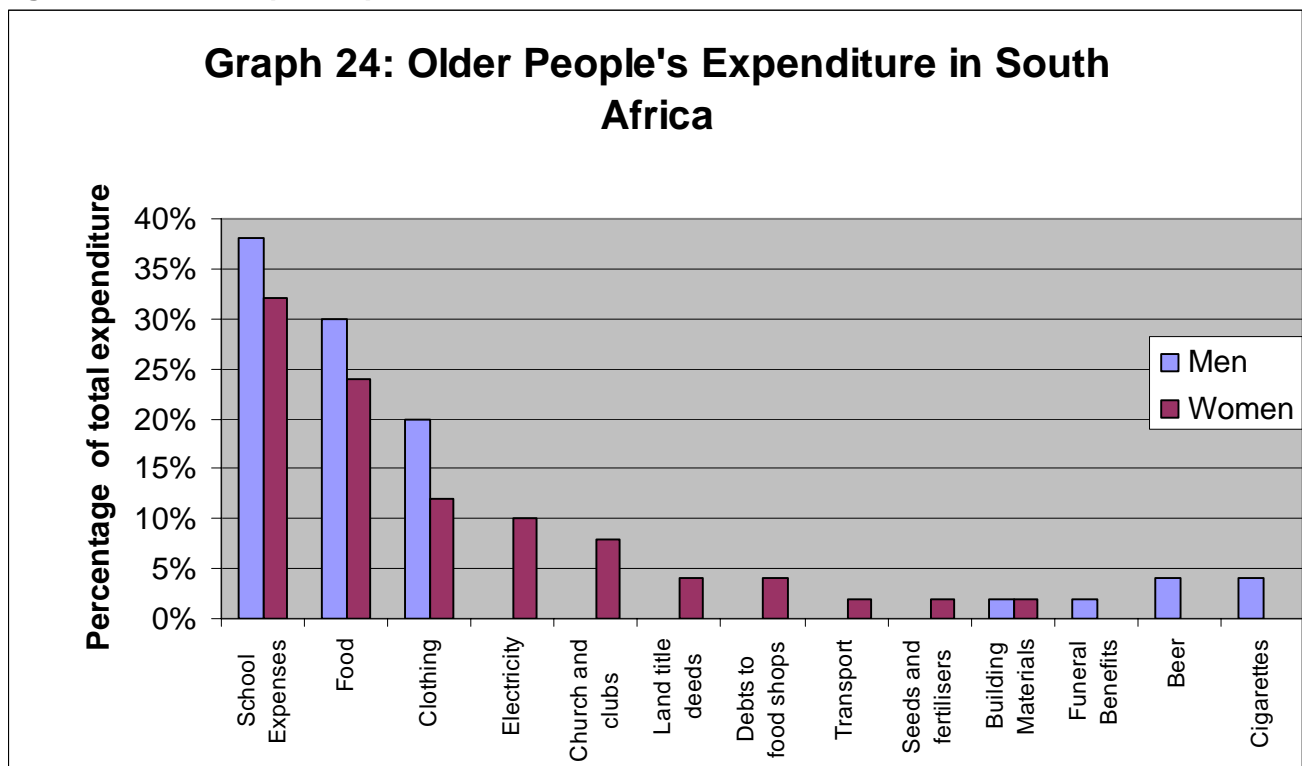
<sup>19</sup> For updated info – see [http://www.socdev.ecprov.gov.za/services\\_service\\_delivery/grants/children.htm](http://www.socdev.ecprov.gov.za/services_service_delivery/grants/children.htm)

respective person does not find an income generating occupation, the termination of the DG can plunge the whole household into destitution.

Research on the impact of the **Child Support Grant** has identified significant improvements of the height to age z-score (HAZ) when the CSG is accessed at an early age. *“The impact of the CSG on height-for age is positive when treatment started at the youngest age, but the magnitude of the impact decreases with the age of the initial treatment”* (Agüero et al, 2006). If the child accesses the CSG before age 1 and continues to receive the grant for two thirds of the first 3 years of life, the gains in the child’s z-score are estimated to be around 0.4. The authors further assume that *“a z-score gain of 0.4 translates into a 3.5 cm or 2.1 per cent gain in adult height”*.

Based on a number of assumptions, the authors further estimate that an increment in height of 2.1 per cent would result in gains in monthly wages between R190 and R262 from age 25 to 65. At an annual real discount rate of 5 per cent this yields a discounted present value between R11,123 and R15,357 at birth. *“This simple analysis ignores the impact that z-scores can have on educational attainment and progress. Second we did not include the potential gains from receiving the grant from age three to fourteen.”*

**Figure 3: Older People’ Expenditure in South Africa**



Source: Helpage International (2002), State of the World’s Elder People

The **Foster Care Grant** has become an income generating activity for poor families who have no other means of income. As this grant is much higher (R590) than the CSG (R190), it has created a perverse incentive for impoverished families to place their children in the care of others. It has been suggested that the poverty reduction motive of the foster families tends to distract from the purpose of protecting vulnerable children (Jacobs, 2005). To reduce misuse of the FCG the number of eligible children per household is limited to six. Properly administered,

the grant – which is not only a grant, but also involves social service oversight – should ensure care for children who would otherwise be without family, or experience violence, neglect and exploitation.

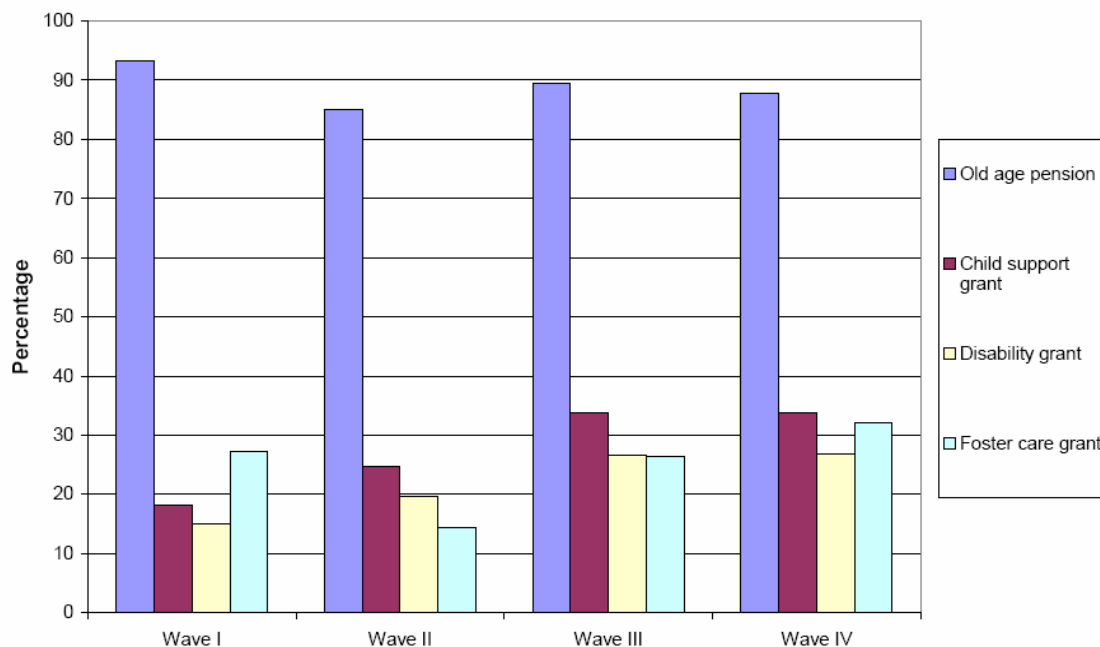
Booyson (2003) summarizes the impact of the South African social cash transfer schemes as follows:

*“The child support, disability and foster care grants play an important role in mitigating the impact of HIV/AIDS, given that eligibility for these grants is driven largely by the increasing burden of chronic illness, the mounting orphan crisis and the impoverishment of households associated with the epidemic. Yet, take-up of these grants remains low and much scope remains to improve take-up rates. Social grants also play an important role in alleviating poverty in affected households, resulting in significant declines in the severity of poverty. Income received from social grants also saw expenditure on food increase in affected households, while old age pensions saw household expenditure on education increase. Given that many orphaned and other children live in households headed by their grandparents, these transfers targeted at the elderly benefit children indirectly.” (Booyson, 2003, p.1)*

Figure 4 shows the degree of access to social grants for 296 HIV and AIDS affected households in two communities in the Free State province, which were interviewed by Booyson in five months intervals between May 2001 and December 2002. The data show that the Old Age Pension – though not targeting HIV and AIDS affected households – is accessed by over 80 per cent of the affected households in the sample, while all other grants are accessed by less than 30 per cent of the affected households.

**Figure 4: Access to different social cash transfer schemes of a sample of HIV and AIDS affected households in two communities in Free State Province**

*Figure 5: Access to social grants for affected households (%)*



Source: Booyson, 2003, page 16

Even though Booyson's findings cannot be generalized to households across South Africa, they indicate the potentially important AIDS mitigation role of the OAP.

Booyson also compared the socio-economic situation of HIV and AIDS affected households that were eligible for a grant and had actually accessed the grant with the situation of affected households that were eligible but had not been able to access the grant (see Table 5). The results indicate that the poorest among the affected households are to a large extent not able to access the grants to which they are entitled.

**Table 5: Comparison of socio-economic parameters of affected households eligible for a social grant, who accessed the grant, with affected eligible households that failed to access the grant in two communities of Free State Province**

<i>Indicator</i>	<i>Poor, eligible affected households with complete access to grants</i>	<i>Poor, eligible affected households with no access to grants</i>	<i>P</i>
<b><i>Access to social support networks:</i></b>			
No access to a social support network	32	63	0.008
Never asked and received help from family or friends	52	18	0.002
Never received remittance income	88	47	<0.001
<b><i>Access to economic support networks:</i></b>			
Never included an employed person	16	8	0.232
Never included a person in formal employment	20	27	0.333
Never owned dwelling	0	2	0.713
<b><i>Access to public services:</i></b>			
No access to electricity	0	24	0.004
No access to water in dwelling	0	27	0.001
No access to waterborne sanitation	100	100	-
No access to refuse removal by local authority	4	21	0.044
No access to telephone	12	45	0.003
<i>Sample (n)</i>	25	62	

Source: Booyson, 2003, page 18

The 147 HIV and AIDS affected households in Booyson’s small sample, who accessed a social grant benefited significantly with regard to reducing the incidence of poverty, the depth of poverty and the severity of poverty (see Table 6). Booyson concludes: “*This suggests that social grants play an important role in alleviating poverty (bringing people closer to the poverty line), more so than eradicating poverty (lifting people out of poverty)*” (Booyson, 2003, p. 26)

**Table 6: Poverty measures of a sample of HIV and AIDS affected households in two communities in Free State Province inclusive and exclusive of receiving social cash transfers**

*Table 8: Poverty measures inclusive and exclusive of government grants (%)*

	<i>Affected households (n=147)</i>			<i>Households that have not experienced morbidity or mortality (n=103)</i>		
	<i>Income excluding government grants</i>	<i>Income including government grants</i>	<i>Reduction in poverty measure (%)</i>	<i>Income excluding government grants</i>	<i>Income including government grants</i>	<i>Reduction in poverty measure (%)</i>
<i>Incidence of poverty (P<sub>0</sub>):</i>						
Wave I	58.5	42.2	28	38.8	26.2	33
Wave II	55.1	35.4	36	38.8	25.2	35
Wave III	57.1	37.4	35	39.8	23.3	42
Wave IV	63.3	37.4	41	43.7	27.2	38
<i>Depth of poverty (P<sub>1</sub>):</i>						
Wave I	40.1	17.1	57	23.7	11.0	54
Wave II	42.4	15.2	64	23.1	11.3	51
Wave III	40.5	14.7	64	26.1	10.6	59
Wave IV	42.4	11.7	72	28.0	10.6	62
<i>Severity of poverty (P<sub>2</sub>):</i>						
Wave I	33.0	10.0	70	18.3	6.2	66
Wave II	36.0	9.7	73	17.7	6.6	63
Wave III	35.3	8.5	76	20.8	7.1	66
Wave IV	35.4	5.6	84	22.8	6.0	74

Source: Booyson, 2003, page 25

### 3. Conclusions

#### 3.1 Extent to which Social Cash Transfer Schemes reach HIV and AIDS Affected Households and Children

None of the programmes studied targets explicitly HIV and AIDS affected households or children. However, the share of HIV and AIDS affected households, as a percentage of all households reached by a specific scheme, ranges from an estimated share of approximately 50 per cent for the Foster Care Grant (FCG) and for the Care Dependency Grant (CDG)<sup>20</sup> to a share of approximately 70 per cent for the pilot schemes in Zambia and Malawi (see chapters 2.1.3 and 2.2.3). The South African Disability Grant (DG) is quoted to reach in certain areas 73 per cent of adults in HIV and AIDS affected households (Jacobs et al 2005). The percentages given above are crude estimates based on assumptions. For the Old Age Pension, the Child Support Grant and the Care Dependency Grant it was not possible to come up with estimates on the share of HIV and AIDS affected households in percent of all beneficiary households reached by these schemes.

The proportion of HIV and AIDS affected households within the total number of households reached by a specific scheme seems to depend on the following factors:

- HIV and AIDS affected households are on average poorer than other households<sup>21</sup>. The schemes targeting ultra poor households (Zambia and Malawi schemes target the lowest income quintile) therefore have a significantly higher share of HIV and AIDS affected households compared to schemes that use a higher poverty line cut-off like the Old Age Pension and the Child Support Grant.
- As many HIV and AIDS affected households are labour constrained because breadwinners are sick or have died, schemes that target households with no adult fit for productive work or with a high dependency ratio (again the Zambia and Malawi schemes) reach more HIV and AIDS affected households than schemes that do not use this criterion.
- Schemes that target abandoned, neglected and abused children (many of whom are orphans), like the Foster Care Grant, have a relatively high proportion of HIV and AIDS affected households, because in high HIV and AIDS prevalence countries the majority of orphans have been orphaned by AIDS (57 per cent in Zambia and Malawi according to UNICEF 2006a).
- Schemes that target people who are unable to work (like the DG) or target children with severe disabilities (like the CDG) also seem to have a high proportion of HIV and AIDS affected households.

Above we have analysed the composition of beneficiary households of different schemes and have identified the share of HIV and AIDS affected households in percentage terms of all beneficiary households reached by the respective scheme. However, we also want to know:

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<sup>20</sup> The estimates are based on the fact that the FCG is concentrating on children that are neglected, abandoned, abused or otherwise in need of social protection outside their families. Many are orphans of which in RSA on the average 49 per cent are orphaned by AIDS (UNICEF 2006a). The CDG seems to have a high proportion of HIV and AIDS affected children because children living with HIV and AIDS are eligible for this grant.

<sup>21</sup> All the four categories of HIV and AIDS affected households listed in chapter 1 are economically disadvantaged compared to non-affected households: they have either to care for a chronically sick person (which involves costs in terms of labour and money) or have lost a breadwinner, or have absorbed additional dependants (mostly orphans) or have lost transfers from relatives (UNICEF 2006a)

- What share of all likely HIV and AIDS affected households in a country or in a district are reached by social cash transfers
- For social protection programming purposes, it would be even more important to know how many likely HIV and AIDS affected households that have fallen under a certain poverty line are reached by social transfers.

In this context the following information is available: both the South African CSG and the OAP have high uptake while the take-up rate of the FCG, the CDG and the DG are low, resulting in high exclusion errors. In addition it has been observed that the South African schemes reach only a small share of the poorest and most needy households (see Table 5). Only 20 per cent of the eligible HIV and AIDS affected female-headed households in two communities in Free State province receive transfers (Booyson, 2003). This means that a large number of HIV and AIDS affected households that are eligible do not access any of the schemes.

The reasons why the poorest fail to access the grants are lack of information on how to apply, complicated approval procedures and limited capacities of the social welfare administration (Barrientos and DeJong 2004). *“Sadly, experience shows that most of the HIV/AIDS patients die during the process of application before the Disability Grant is even allocated”* (Legido-Quigley, 2003). The fact that many of the poorest households do not benefit from any social transfers reduces the AIDS mitigation impact of the South African schemes. In other words: a large number of the neediest households in South Africa (including the neediest HIV and AIDS affected households) and the large number of children living in these households have in practice no access to the social protection that is guaranteed by the South African constitution.

In contrast to the South African schemes, the pilot programmes in Zambia and Malawi focus on ultra poor households that are at the same time labour constrained. Members of these households are either older people (65+) or children (<18) or persons aged 19 to 64 who are unable to work because they are sick or disabled. It is estimated that 10 per cent of all households in Zambia (200,000 households) and in Malawi (250,000 households) belong to this category. The schemes try to reach all these households in their respective pilot areas.

Assuming an exclusion error of 20 per cent<sup>22</sup>, the Zambia and the Malawi schemes reach 80 per cent of all ultra poor and at the same time labour constrained households in the pilot area. This means that they also reach 80 per cent of those HIV and AIDS affected households that belong to the category ultra poor and labour constrained. The reasons why the Zambia and the Malawi schemes reach such a high share of the labour constrained and ultra poor HIV and AIDS affected households are:

- Precise targeting criteria (ultra poor and either no adult fit for work in the household or one fit adult has to support more than three dependants)
- A multi-stage participatory and transparent targeting process in which community level committees play a decisive role.
- The initiative to apply for the transfers is not taken by the households but is taken by the respective committees, which have the task to ensure that the neediest households are given priority.
- An effective and swift approval and delivery mechanism managed at district level, which ensures that the time span between application and receiving the first transfers does not exceed two months.

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<sup>22</sup> For both schemes an exclusion error of less than 20 per cent is one of the objectively verifiable indicators in their planning documents.

In both schemes the average number of persons per beneficiary household is 4. In Kalomo 56 per cent of the household members are children, in Mchinji 69 per cent. Should the schemes be scaled up to the national level, the Zambia scheme will reach approximately 800,000 persons of which more than 400,000 are OVC, while the Malawi scheme will reach about one million people including 680,000 OVC. It is estimated that approximately 70 per cent of these children are HIV and AIDS affected. This hypothesis has to be verified by the ongoing evaluations (see chapters 2.1.3 and 2.2.3).

However, the Zambia and the Malawi schemes do not reach HIV and AIDS affected households that are only moderately poor or not poor. They also do not reach HIV and AIDS affected households that have a low dependency ratio – even if these households are ultra poor. The share of HIV and AIDS affected households that are ultra poor but have a low dependency ratio as a percentage of all households of that category is probably significantly lower than the share of HIV and AIDS affected households in the category ultra poor and labour constrained. However, many of these households are HIV and AIDS affected because they care for orphans, over half of which are orphaned due to AIDS<sup>23</sup>.

In order to reach all households that are ultra poor – and in order to reach all children that live in ultra poor households – the social cash transfer schemes in Zambia and Malawi have to be supplemented by social protection programmes that target ultra poor households that are not labour constrained. The number of households in this category is estimated at 400,000 in Zambia and at 300,000 in Malawi. The number of children in this category of households is approximately 900,000 in Zambia and 700,000 in Malawi. All of them are extremely needy and vulnerable irrespective of whether they are orphans or children living under conditions of ultra poverty.

By focusing exclusively on ultra poor households, the Zambia and Malawi schemes do not reach children with multiple, often AIDS-related vulnerabilities, who live in moderately poor or non-poor households, street children and children living in institutions or at the work place or are highly mobile.

### **3.2 The Impact of Social Cash Transfers on HIV and AIDS Affected Households and Children**

The impact of social cash transfers on the well-being of members of beneficiary households and specifically on children seems to be influenced by the following factors:

- The size of the transfers
- The degree to which the design of the scheme is child-oriented
- Who controls the transfers at household level
- The availability of complementary social services

#### **Size of Transfers**

The size of the transfers determines to a large extent the amount of consumption of additional goods and services and the amount of savings and investment a beneficiary household can afford. The fact that the generous South African Old Age Pension transfers the equivalent of USD 113 per month to its beneficiaries is the main reason for the significant poverty reduction impact of this scheme. The high volume of the transfers makes it possible for the pensioners to

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<sup>23</sup> For Zambia and Malawi the proportion of orphans that are orphaned by AIDS is estimated at 57 per cent of all orphans (UNICEF 2006a)

allocate a substantial share of the transfers to the nutrition and education of the children in their households (see Figure 3). In summary: the members of households with an elderly person receiving the OAP – and especially the children in these households – are able to meet their basic needs.

But even less generous schemes do have an impact. The study on the impact of the South African Child Support Grant (see chapter 2.3.2) concludes that the transfers have a significant impact on children's height to age scores. Even the extremely low transfers of the Zambia scheme (USD 10 per month to a household with children) have a positive impact on children, though they only lift the household from ultra poverty to moderate poverty (see chapter 2.1.4).

Unfortunately, what has been said above is based on statistics that give averages. The data available on impact do not single out HIV and AIDS affected households. Anecdotal evidence indicates, however, that a household with a member suffering from AIDS related infections has to spend substantial amounts on transport to hospitals, medical treatment and the specific food requirements of people living with HIV and AIDS. This absorbs a large share of the income of poor households. The members of certain types of HIV and AIDS affected households – households where a member suffers from advanced stages of AIDS – may not benefit much from the transfers because priority is given to the needs of the person living with AIDS. This is especially the case when this person is the main breadwinner.

On a conceptual level this problem has been reduced in South Africa by the Disability Grant that can be accessed by adults who are unable to work due to AIDS and by the Care Dependency Grant that can be accessed by children living with HIV and AIDS. In practice the take-up rates for these two grants are low due to operational problems (see chapter 2.3.1).

In summary: The impact of social transfers is positively correlated with the level of the transfers. However, even small transfers have a significant impact. Children benefit above average compared to other household members due to large education expenditures (see chapter 2.1.4, figure 3, and Booyson 2003). In households with members suffering from advanced stages of AIDS, however, a large share of the transfers is absorbed by the needs of the person living with AIDS, leaving little for the other household members.

### **Degree to which the Design of the Schemes is Child-Oriented**

The design of most of the schemes described here takes the needs of children into account. But the degree of child-orientation varies considerably:

- The Child Support Grant (CSG), the Foster Care Grant (FCG) and the Care Dependency Grant (CDG) are exclusively tailored to the needs of poor, orphaned, abandoned or disabled (including HIV positive) children in need of protection.
- The transfers of the Malawi scheme are scaled according to household size. This means that households with children receive higher transfers than households without children because the households with children are usually bigger. In addition the transfers are topped up with MK 200 (USD 1.5) for each child enrolled in primary school and MK 400 for children in secondary school (for details see chapter 2.2.2).
- Compared to the schemes listed above, the Zambia scheme has the weakest child-orientation. It pays USD 8 per month irrespective to the size of a household, but adds USD 2 if a household has children.

Linking the beneficiaries to other social services that provide for the needs of children is another form of child-orientation. The South African schemes are well placed to link their beneficiaries to

educational, basic health and home based care services, because the targeting and approval process is handled by social workers who should have the information on and the referral contacts to other services.

The Malawi and Zambia schemes also try to coordinate with and refer their beneficiaries to other social services using district, sub-district and community level committees. They also arrange for extension workers (health, nutrition, hygiene) to counsel beneficiaries when they gather monthly at pay points. For example, in Malawi the social marketing of mosquito nets for children is done at the pay points. However, this is easier in densely populated Malawi (about 100 persons per square km) than in Zambia (about eight persons per square km) where social services have extreme difficulties to reach households in rural areas.

In summary: on a conceptual level most schemes are making efforts to give priority to children's needs in general and also to the specific needs of children living in HIV and AIDS affected households or those that are living with HIV and AIDS themselves. They do this by either focusing on children (three of the five big South African schemes), by taking children's needs into account when determining the size of transfers, and/or by linking beneficiary households to other services that provide for children's needs. In practice operational problems like the low take-up rates in some of the South African schemes or the limited outreach of social services in Zambia hamper the implementation of these concepts.

### **Control of the Transfers at Household Level**

The academic discussion on the pros and cons of social cash transfers is filled with fears that the heads of beneficiary households or whoever has control over the transfers will misuse them for selfish reasons and for 'undesirable consumption' like tobacco, alcohol, gambling and prostitution. To control and reduce this perceived risk, most Latin American schemes impose conditions on their beneficiaries. The so called conditional cash transfer (CCT) schemes make a kind of contract with the recipients of the transfers. In these contracts, the transfer recipients commit themselves to ensure regular school or health service attendance of children living in the respective household. There are indications that CCTs are not suitable for African countries (controversial views on this issue are discussed in Schubert and Slater, 2006). However, this important discussion is not covered in this paper because none of the studied schemes imposes conditions.

Figure 3 and other empirical evidence (Booyson, 2003; Legido-Quigley, 2003) indicate that grandparents in South Africa, Namibia, Zambia and Malawi allocate substantial parts of their transfers to meet the needs of children. Booyson's findings strongly support the evidence given in Figure 3: *"Income received by affected households in the form of Old Age Pensions saw household expenditure on education increase"* (Booyson, 2003, p. 32). *"Girls in households receiving R500 of government pension are six percent more likely to be enrolled in school. This effect is twice that of the effect on boys"* (Samson et al 2005). Figure 3 even contradicts the widely held belief that elderly women are more generous in meeting the needs of children compared to elderly men.

Anecdotal evidence from the Zambia and Malawi schemes shows that not only elderly persons, but also mothers of all ages and even children heading a household use transfers wisely and to the advantage of the children. The slogan of the Kalomo Pilot Scheme *"The poor are not irresponsible"* seems to be valid beyond Zambia. Therefore *"poor households should be less regarded as clients and more as the main managers of change"* (Barrientos and DeJong 2004). However, it is also worth noting Booyson's observation that in order to access the Foster Care Grant, some poor families adopt children as an income generating activity. We have no

information on the intra-household allocation of transfers when the transfers are controlled by men in the working age. For social cash transfer schemes that are targeting households that are ultra poor and at the same time labour constrained (like the schemes in Zambia and Malawi) this is not a significant issue because few of these households are headed by men in the working age.

In summary: there is evidence that transfers controlled by older people as in the case of the OAP or the Zambian and Malawian pilot schemes (approximately 80 per cent of their beneficiary households are headed by persons aged over 55) are to a large extent used to meet children's needs.

### **Availability of Social Services**

Social cash transfers can go a long way to improve the well-being and/or reduce the suffering of children living in HIV and AIDS affected households or of children living with HIV and AIDS. Cash gives access to food, clothing, shelter, hygiene, school expenses and to transport. Being able to meet school expenses (like pens, books, uniforms, fees) and to buy soap (to wash school going children and their clothes) gives access to education – if there are schools of a minimum quality and not too distant.

People living with HIV and AIDS in rural areas have to travel long distances to access ARV drugs. Without cash, sick or weak persons cannot access transport to essential services. The more remote the area, the more essential is transport to clinics and hospitals – if these services are available at all. In rural Zambia it is not uncommon that villagers, who have no money for transport, carry sick persons on a wheel-barrow over distances of more than 20 km to the next health centre or hospital. In many cases the patient dies on the way or at the clinic for lack of essential drugs and the corps has to be brought back on the same wheel-barrow.

In summary: even small amounts of cash provide access to basic needs. Once the households had been provided with cash they were able to buy food, soap, clothes and similar basic necessities available at the local markets and to pay for transport to access more distant services – if those services are available. However, cash alone is not sufficient. To meet the essential needs of children living in ultra poor HIV and AIDS affected households, social cash transfer schemes have to be complemented by and coordinated with other social services in the areas of education, health, home based care and psycho-social support, family support and alternative care (Barrientos and DeJong 2004).

### **3.3 Summary of the Conclusions**

The conclusions drawn in chapters 3.1 and 3.2 support the hypothesis given in chapter 1: all social cash transfer schemes studied have a substantial AIDS mitigation impact in terms of reaching a large number of HIV and AIDS affected households and in terms of improving the well-being of the children living in these households. It is also important to note that all schemes included in this study focus in some way on the most in need among the HIV and AIDS affected households.

Having said this, it has to be added that the different schemes studied have a different degree of AIDS mitigation relevance:

- In terms of the share of HIV and AIDS affected households benefiting from the scheme, the Zambia and Malawi schemes seem to have the highest share of HIV and AIDS affected households as a percentage of all beneficiary households. Approximately 70

per cent of the beneficiary households seem to be HIV and AIDS affected, even though they do not use HIV and AIDS as a targeting criterion. The Disability Grant, the Care Dependency Grant and the Foster Care Grant also seem to have a high share because HIV -positive adults (if unable to work) are eligible for the DG, because infected children are eligible to the CDG, and because the FCG is targeting orphans who may be to a large extent orphans due to AIDS<sup>24</sup>.

- With regard to focusing on the ultra poor and neediest of the HIV and AIDS affected households the Zambia and Malawi schemes score high whereas the South African schemes score low.
- With regard to the impact on children in HIV and AIDS affected households reached by the different schemes, the OAP, the DG and the CDG score highest. The generous amounts transferred by these schemes go some way to ensuring that the basic needs of children are met.

## 4. Recommendations

### 4.1 Defining the Target Groups for Social Cash Transfer Schemes

Policy makers involved in designing social cash transfer schemes in low income countries with high HIV and AIDS prevalence can choose between the following approaches:

1. Schemes that target exclusively persons who are members of a specific 'vulnerable group' like older people, OVC or disabled persons. All South African Schemes are based on this concept. All the schemes are means tested restricting the eligibility to those 'vulnerable persons' that are poor.
2. Schemes that target all poor or ultra poor households. This is the most inclusive concept because it includes all households that fall below a certain level of income, expenditure or consumption. Most emergency aid interventions are based on this concept.
3. Schemes that target all households that are poor or ultra poor and at the same time labour constrained like the Zambia and Malawi pilot schemes. This concept excludes households who have a low dependency ratio, as these households can access labour-based schemes where such schemes are available.
4. Universal schemes that do not target within a selected population group, e.g., all children or all disabled people receive benefits.

Before choosing between these concepts - using the AIDS impact mitigation as a consideration – policy makers have to make three additional decisions:

- Should all HIV and AIDS affected households be reached or only those that fall below a certain poverty line? Not all HIV and AIDS affected households are poor and not all children orphaned by AIDS live in poor households?
- Should all poor HIV and AIDS affected households receive social cash transfers or only those that are labour constrained (not all HIV and AIDS affected households are labour constrained)?

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<sup>24</sup> All estimates of the proportion of HIV and AIDS affected households in the different schemes are based on assumptions (see chapters 2.1.3, 2.2.3 and 2.3.2) and will have to be verified by empirical research as recommended in chapter 4.5

- What additional provision may be required to reach those children most at risk: children experiencing discrimination or exploitation within the home, and those outside family care?

Policy makers also have to ensure that the approach they adopt is feasible according to the financial and administrative capacities of their countries. Taking all these factors into account the study arrives at the following conclusions:

- **Social cash transfers for all poor households** would not include all HIV and AIDS affected households but all **poor** HIV and AIDS affected households. South Africa is even considering to go one step further and will probably launch a **Universal Cash Transfer Scheme**, which – by definition – would reach all households in the country and would therefore include all HIV and AIDS affected households regardless if they are poor or not (Meintjes 2003 and Ledigo-Quigley 2003). A universal scheme could replace some of the current schemes like the OAP, the CSG and the FCG. Unfortunately this is a high cost concept and therefore hardly feasible for a low income countries like Zambia or Malawi
- Having a **mixture of sub-sector schemes for each ‘vulnerable group’** may also reach many HIV and AIDS affected households if effectively implemented. However, even the relatively well-organized and effective South African Social Welfare Administration is overwhelmed by the implementation problems involved in administering a system of sub-sector schemes. The low take-up rates of most South African schemes and the fact that many of the poorest households fail to access the social transfers reduce the AIDS mitigation impact. These problems signal that the multi-scheme approach is not a feasible concept for low income countries with weak administrative capacities.

Recent developments in Kenya demonstrate the practical importance of the inclusive-exclusive issue. Kenya is piloting a social cash transfer scheme focusing on OVC. The scheme excludes all households that do not have an OVC. Does Kenya have the financial and administrative capacity to complement the OVC scheme with other social cash transfer schemes that target households, which are also in desperate need of social protection (including HIV and AIDS affected households), but are excluded from the OVC scheme? The study results lead to the conclusion that such issues have to be taken into account when starting a scheme that focuses on one ‘vulnerable group’ (like OVC) only.

- **Social cash transfers focusing on ultra poor households that are labour constrained** do not use any kind of ‘vulnerable group’ (older people, OVC, disabled, HIV and AIDS affected) as a target group criterion. However, ultra poor and labour constrained households are by definition households that are composed of household members that cannot or should not work. The members of these households are older people, OVC (all children living in an ultra poor household are extremely vulnerable), disabled persons or chronically sick persons. The concept is inclusive in the sense that it reaches most ‘vulnerable groups’. It is at the same time exclusive because it excludes low dependency ratio households, which may be able to access labour-based schemes because the households include members that are fit for productive work.

Schemes like the Zambia and Malawi pilots, which are based on this concept, have to be complemented by schemes that target ultra poor households with labour. If complemented by labour-based social protection schemes, the concept of social cash transfers targeting ultra poor labour scarce households seems to be the appropriate

choice for low income countries with a high HIV and AIDS prevalence. In combination with complementary labour-based schemes they reach all ultra poor households including all HIV and AIDS affected ultra poor households. The Zambia and Malawi pilot schemes are testing the hypothesis that social cash transfers for all ultra poor and labour constrained households is an affordable and feasible concept for low income countries. In order to test if the benefits of this approach can also be maintained in a large national programme, the Malawi pilot scheme will be scaled up to additional six districts in 2007/08.

## **4.2 Specific Concerns of Different Categories of HIV and AIDS Affected Households**

A household that has lost a breadwinner due to AIDS has similar needs to a household that has lost a breadwinner due to malaria or a traffic accident. A child orphaned from AIDS experiences similar problems to other orphans. But there are also differences:

- Members of HIV and AIDS affected households, orphans due to AIDS, and people living with HIV and AIDS often suffer from stigma. Social cash transfer schemes have to be organized in such a way as to not increase the stigma. This is one reason why targeting based on the HIV and AIDS status is problematic.
- Some children orphaned from AIDS may suffer from psychological distress. Children living with parents in advanced stages of a chronic disease and experiencing the slow death of a parent, or even a sequence of relatives passing away, may require psychosocial support
- Most people living with AIDS will eventually require ARV therapy and at a certain stage home-based-care. Where ART is available, people on it require specific diets and have logistical and medical needs that involve additional expenses. These expenses use up a considerable amount of the transfers, potentially leaving little for other household members.

A number of HIV and AIDS affected households and children living in these households therefore have specific needs beyond the need for cash transfers. These needs can be met by referring the specific households to other social services like psychosocial counselling, home-based-care, alternative care and ARV programmes – if such services are available. Social workers and community level committees involved in implementing social cash transfer schemes need to be trained to perform this linking function.

The additional expenses for the specific medical, nutritional and logistic needs of persons taking ART could potentially be solved by combining the provision of ARV drugs with a specific cash transfer that is paid when the patient collects the drugs. The transfers could be paid to all ARV patients without means-testing at the hospital or wherever they collect their drugs. The desirability and feasibility of this needs further enquiry,

## **4.3 Targeting Criteria and Procedures**

To be eligible for a social cash transfer scheme of the type recommended in chapter 4.1, a household has to be ultra poor and has to have either no fit adult household member or a high dependency ratio. There are no additional criteria. The degree to which the household is HIV and AIDS affected is not considered – for targeting the only criteria used are the poverty status

and the dependency ratio. Questions regarding the HIV and AIDS status need not to be asked. Stigmatisation in the process of targeting is avoided.

However, while it is relatively easy to determine if a household is labour constrained, it is not easy to establish its poverty status. Most schemes that use the degree of poverty as an eligibility criterion get either stuck in bureaucratic means-testing procedures which are so complicated that they exclude the poorest households (like the South African schemes) or are dominated by local elites resulting in high inclusion errors (like most emergency aid programmes – see World Bank 2006). As a result of evaluating the targeting effectiveness of more than 100 social transfer schemes, Grosh (1992) concludes that a multi-stage participatory targeting process is the most promising targeting concept – if well implemented.

The targeting procedures of the Zambian and Malawian schemes are examples of a multi-stage participatory targeting process in which community level committees play a decisive role. In both cases the procedures have been elaborated together with local stakeholders. They are examples of how targeting can be organised – not blueprints that can be transferred without adaptation to other countries (in Zambia and Malawi, targeting procedures are similar but not identical because the institutional frameworks are different).

In her comparative analysis of different social transfer schemes Grosh concludes that the quality of implementation is even more important than the choice of the targeting mechanism. She also observes that the effectiveness of targeting is positively correlated with the income level of the countries in which the schemes operate. She concludes that poor countries have weak administrations, leading to implementation deficits, leading to low effectiveness of targeting.

For low income countries like Zambia and Malawi – who have weak social welfare systems – these conclusions lead to the following recommendations:

- Implementation capacities are the main bottleneck for establishing effective social cash transfer schemes on a national scale. The schemes should therefore be organised as simple, transparent and administratively undemanding as possible.
- Even the most undemanding schemes will only perform effectively if assisted by long term system and capacity building efforts.<sup>25</sup>

#### **4.4 Using ‘AIDS Exceptionalism’ as a Driver of Change rather than a Programming Approach**

The study supports the hypothesis that social cash transfer schemes in low income African countries with a high HIV prevalence - that do not use HIV and AIDS as a targeting criterion - can reach approximately 80 per cent of the HIV and AIDS affected households, which urgently require social welfare interventions because they are ultra poor and labour constrained. As approximately 60 per cent of the beneficiary household members of these schemes are children and as all children living in ultra poor HIV and AIDS affected households are extremely vulnerable, social cash transfer schemes can have a high mitigation impact on HIV and AIDS affected children. This high impact can be achieved in those schemes that:

- focus on ultra poor households, which are at the same time labour constrained

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<sup>25</sup> Both pilot schemes are adapted to the financial and administrative potential available in Zambia and Malawi. The pilots are based on the hypothesis that the schemes can be successfully scaled up. The scaling up process has started in Zambia (with GTZ technical assistance) and will start in Malawi in 2007 (with UNICEF technical assistance). In both countries the scaling up process will be closely monitored.

- have effective targeting criteria and procedures that reduce the exclusion error to less than 20 per cent
- provide transfers regularly, reliably and at a level sufficient to meet the most essential needs of all household members
- are linking the beneficiaries to health and welfare services like ART, home based care, alternative care, and psychosocial counselling
- are a component of a social protection system that complements social cash transfers for ultra poor labour constrained households 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.

In view of the limited resources available for social protection, the limited implementation capacities in low income countries, and the difficulties to establish if a household is HIV and AIDS affected or not (see the discussion on the definition of 'HIV and AIDS' affected in chapter 1), it is not recommended to establish additional schemes that exclusively target HIV and AIDS affected households or HIV and AIDS affected children. A number of other studies arrive at the same conclusion (Meintjes and Giese 2006; Slater 2004). The political will and the resources mobilized by 'AIDS exceptionalism' should be used to strengthen the efforts of low income country governments to establish social protection systems that effectively reach and benefit all ultra poor households irrespective if HIV and AIDS affected or not.

One potential exception to this general recommendation is 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, medical and logistic needs (especially in rural areas). The desirability and feasibility that hospitals that provide ART also provide a specific cash transfer to ART patients for meeting these costs should be assessed. This could be done as a universal transfer to all ART patients regardless if their households receive social cash transfers or not. An ultra poor and labour constrained household with members who take ARV drugs could thus receive transfers from two different sources.

#### **4.5 Operational Research Priorities**

This study is partly based on anecdotal evidence, estimates and assumptions because the empirical database on the AIDS mitigation impact of social cash transfer schemes in low income countries is small. The estimates on the proportion of HIV and AIDS affected households reached and on the impact of ongoing schemes given in the study are therefore to some extent hypothetical. This is largely due to the fact that most low income countries do not yet have a consistent social protection policy and programme. Some plan to start social cash transfer schemes, some have arrived at the pilot stage, some are currently evaluating these schemes (Lesotho, Kenya, Malawi) but the data are not yet available.

What is required is comprehensive empirical evidence (beyond desk studies and simulations with 'bold assumptions') that provide data on:

- The specific basic needs of different categories of poor and ultra poor HIV and AIDS affected households and children (compared to other poor and ultra poor households and children) and a realistic assessment of the costs involved to meet these needs
- The share that different categories of HIV and AIDS affected households (see list of categories in chapter 1) have in percentage terms of all beneficiary households of ongoing social cash transfer schemes

- The share of different categories of poor or ultra poor HIV and AIDS affected households in a country or region that are reached by social cash transfer schemes
- The types of poor or ultra poor HIV and AIDS affected households that are unable to access social cash transfers, even when they meet the eligibility criteria of the respective schemes and the reasons why these households fail to access the transfers
- The intra-household distribution of benefits resulting from cash transfers to different categories of HIV and AIDS affected households
- The extent to which the schemes meet the essential needs of different categories of poor and ultra poor HIV and AIDS affected households and of the children living in these households
- The impact that different schemes have on people and especially on children living in different categories of poor or ultra poor HIV and AIDS affected households
- The impact that social cash transfers have on HIV prevention
- The impact of cash transfer schemes that are linked with complementary social work services
- The costs and cost-effectiveness of different schemes and the financial and administrative implications of scaling them up to national level
- The financial sustainability of social cash transfer schemes in low income countries
- Capacity building needs (capacity required to establish effective social cash transfer schemes on national scale)
- How to eliminate bottlenecks preventing the creation of effective social protection systems

Considering the costs in terms of funds, research capacity and time of robust quantitative studies (some of them may take years before results are published), it is recommended that rapid appraisals are simultaneously conducted. For example, a rapid appraisal of 200 beneficiary households (all beneficiary households in two village groups of the Malawi pilot scheme) using a checklist could be conducted and analysed in a month. Such rapid appraisals can be conducted at limited costs by the implementing organizations and/or by donor agencies assisting governments to pilot and scale up social cash transfer schemes in low income countries.

In addition to doing research and evaluations of on-going interventions, the author recommends to increasingly use an action research approach. Researchers and implementers should team up in order to first agree on relevant hypothesis and research questions. They should then jointly design, implement, monitor, analyse and document pilot activities in such a way as to systematically generate knowledge on relevant issues. This type of action research could facilitate a learning process for the improvement of the respective schemes and would at the same time provide information to the ongoing international debate.

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