

Flagship Report Paper Series

Paper 5: How to use natural resource revenues to enhance demand for public services through social protection



AFRICAN DEVELOPMENT BANK GROUP

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Preface

History shows that an abundance of natural resources does not necessarily improve a country's human development. How can governments turn new discoveries of natural resources into outcomes that matter for their citizens – including better health, better education, and access to quality social services?

Most governments have expressed a commitment to turn revenues from new natural resource discoveries into outcomes that matter for their citizens: better health, better education, and access to quality social services. They also want to make sure the discovery of extractives translates into more and better jobs and business opportunities. Yet they are also aware that delivering on those commitments demands tough and sometimes complex policy choices, including balancing the need for social sector investments with the needs of other sectors across the economy, being transparent and carefully managing citizen expectations, and adequately distributing benefits both between extractives and non-extractives communities and between current and future generations.

In light of these challenges, the African Development Bank (AfDB) and the Bill and Melinda Gates Foundation (BMGF) came together to produce a joint Flagship Report: *'Delivering on the promise: Leveraging natural resources to accelerate human development in Africa'*.

This paper is one of a series of eight in-depth technical background papers which supported the development of the flagship publication. While each background paper can stand alone, they also build on each other. Paper 1 sets out a framework for understanding four key channels through which natural resources can translate into improved human development: 1# public spending on health, education, and social protection; 2# public spending aimed at fostering growth and economic diversification; 3# industry spending on infrastructure, procurement, skills, and employment; and 4# companies' spending on social investments. Paper 2 estimates the likely timing and magnitude of revenue from new discoveries of oil, gas or minerals in six African countries: Ghana, Liberia, Mozambique, Sierra Leone, Tanzania, and Uganda.

The next three papers examine the public spending channels described in the first paper. Paper 3 discusses the macroeconomic risks and policy choices associated with an influx of new revenues from natural resources. Paper 4 explores the potential of new revenues to improve health and education services, comparing the expected scale of revenues to financing needs in the six featured African countries and introducing a diagnostic framework for policy choices. Paper 5 looks at the case for using new revenues to fund basic social protection programs, including the potential to boost demand for health and education services.

The final three papers examine the industry activity channels described in Paper 1. Paper 6 looks at how policies on local content can leverage spending on extractives industry projects to create more broad-based economic growth. Relatedly, Paper 7 explores the policy choices involved in leveraging extractives projects to build skills and human capital. Finally, Paper 8 asks how governments and industry can maximize the human development impact of companies' social investment, a relatively small but potentially important part of company spending in extractives industry projects.

To access the Flagship Report and the other seven background papers presenting complementary in-depth discussions of the policy choices described in this paper, readers are encouraged to consult the dedicated website at: www.NaturalResourcesForHumanDev.org.

Paper 1 – A framework: Human development and the links to natural resources

Paper 2 – Timing and magnitude of new natural resource revenues in Africa

Paper 3 – Natural resource revenues and macroeconomic policy choices

Paper 4 – How to use natural resource revenues to improve health and education in Africa

Paper 5 – How to use natural resource revenues to enhance demand for public services through social protection

Paper 6 – Creating local content for human development in Africa's new natural resource-rich countries

Paper 7 – Leveraging extractive industries for skills development to maximize sustainable growth and employment

Paper 8 – Extractive industries and social investments: Principles for sustainability and options for support

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Disclaimer

This series of papers focuses on one part of the extractives debate and reflects research gaps identified by the contributors within their areas of expertise. The contributors are not held responsible for the views expressed in this report. This paper is based on research, analytics, and expert consultations completed during the writing of the eight background papers. However, this paper should not be considered as an alternative to in-depth technical expertise. Any mention of specific entities, individuals, source materials, trade names, or commercial processes in this publication does not constitute endorsement by the AfDB or the BMGF.

Key messages

- **It is feasible for new natural resources revenues in selected African countries to contribute meaningfully to social protection.** Our order-of-magnitude estimates show that if smoothed over 30 years, new natural resources revenues are projected to fall in the same ballpark as the cost of a basic social protection package – in the region of 1 to 5 per cent of gross domestic product (GDP). It is not suggested that it would be realistic to use all revenues for social protection – and governments need to be aware that once social protection schemes are set up they are politically difficult to reverse if money becomes tight. Nevertheless, there is scope to use smoothed revenues to cover scale-up costs, and even some recurrent costs, while other funding sources are found.
- **Cash transfer (CT) programs offer the potential to increase accountability in respect of natural resource revenues, and call for intersectoral collaboration.** One argument for explicitly linking new natural resources revenues to social protection schemes is that it gives citizens an interest in demanding accountability in respect of how the revenues are spent. To maximize their potential, CT programs benefit from close coordination among ministries of finance, health, education, and social welfare.
- **Benefits of CTs include tackling poverty in the short run, improving social cohesion, boosting local economies, and building human capital in the long term.** Social cohesion is improved by reducing inequality and mitigating social tensions. Reducing the stigma and stress of extreme poverty also improves demand for health and education services. Local economies are boosted through the multiplier effect of increased purchasing power. And, in the long run, better health and education increases the employability and productivity of new generations, and leads to more inclusive growth.
- **CTs can help to tackle demand-side barriers to health and education services – that is, reasons why people do not access those services.** These include indirect costs associated with accessing those services: for example, travel to hospital, school books and uniforms, or the opportunity cost of time not spent working. CTs can mitigate such costs. A combination of demand-side (CT) and supply-side (health and education) spending can be especially effective in boosting human development.
- **CTs can be specifically designed to encourage certain behaviors, such as attending health check-ups or sending children to school.** This can be achieved through explicit conditionality; however, this can be costly to administer and results have also been achieved through ‘nudges’, such as: distributing the cash with information suggesting how it could be used; delivering cash at – for example – the start of the school year, when costs of uniforms and books arise; delivering the cash into the hands of a female household member; or even giving the program a suggestive name, such as ‘child support grant’.
- **There is mounting evidence regarding the most effective ways to design CT programs that are tailored to each country’s need and fiscal space.** Policy decisions include: whether to make CTs universal, or widely or narrowly targeted; the level at which they should be set (often at a meaningful but modest percentage of household budgets); frequency of payment, with evidence pointing to the benefits of predictability; and whether it is possible to distribute the cash electronically, which has been shown to increase savings rates;

- **Flagship national CT programs already exist in many African countries, including some that have made recent natural resources discoveries.** Kenya, Mozambique, Ghana and Uganda are among the countries in which programs have already been developed and are in the process of being scaled up. The possibility of supporting existing policy processes is an argument against distributing new natural resources revenues using a ‘direct dividend’ model.

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List of abbreviations

AfDB	African Development Bank
BDH	<i>Bono de Desarrollo Humano</i>
BMGF	Bill and Melinda Gates Foundation
CB-CCT	Community-Based Conditional Cash Transfer, Tanzania
CCT	Conditional cash transfer
CDG	Centre for Global Development
CF-SCT	Child-Focused Social Cash Transfer, Senegal
CSG	Child Support Grant, South Africa
CT	Cash transfer
CT-OVC	CT for Orphan and Vulnerable Children
DFID	Department for International Development, UK
DSD	Department of Social Development, South Africa
FAO	Food and Agriculture Organization, UN
GDP	Gross Domestic Product
GSDRC	Governance, Social Development, Humanitarian, Conflict
HSNP	Hunger Safety Net Programme, Kenya
IMG	International Monetary Fund
IPC-IG	International Policy Centre for Inclusive Growth
LCT	Labeled cash transfer
LEAP	Livelihood Empowerment Against Poverty
NCTPP	Nahouri CT Pilot Project, Burkina Faso
M&E	Monitoring and evaluation
MIS	Management information system
OECD	Organisation for Economic Co-operation and Development
OPM	Oxford Policy Management
PSNP	Productive Safety Net Programme, Ethiopia
RCT	Randomized control trial

SAGE	Social Assistance Grants for Empowerment, Uganda
SASSA	South African Social Security Agency
SCT	Social cash transfer
SSA	Sub-Saharan Africa
STI	Sexually transmitted infection
SWF	Sovereign wealth fund
UCT	Unconditional cash transfer
WHO	World Health Organization

1 Introduction

Natural resources revenues can create fiscal space in as much as they generate increased resources that are available to allocate to public priorities. This represents a great opportunity for the development of social protection interventions, and systems that are not donor dependent, across African countries.

Since the early 2000s social protection has been firmly at the center of the policy agenda in Africa. The shift from emergency response – largely through food aid – to large-scale nationally-owned CTs (and/or public works) programs has been gradual but incremental—partially thanks to increased funding that has been made available by donors and governments alike. In 2010 almost every country in sub-Saharan Africa (SSA) had at least some form of policy dialogue surrounding social protection, most of which involved the scaling-up of some kind of CT program.^{1,2}

Advancing human development in countries with new natural resources discoveries through social protection is an opportunity that governments should not waste. Apart from directly addressing poverty and inequality, and stimulating growth, social protection initiatives can also be designed to increase access to health and education services. This, in turn, can have implications for the accumulation of human capital among children, contributing to breaking inter-generational poverty traps, and, over the long run, increasing productivity and sharing the benefits of economic growth among the poor.

Specifically, the level of access to health and education services is not always high in African countries. Even where the supply of such services is adequate, demand-side barriers (i.e. unwillingness to access, despite the presence of services) and social inequalities can be as important as supply factors (i.e. availability of facilities and staff) in deterring patients from obtaining treatment in hospitals, or parents from sending their children to school. Still, relatively little attention is given to ways of minimizing the effect of such barriers. These barriers are likely to be more important for the poor and other vulnerable groups, as the costs of access, lack of information and cultural barriers impede them from benefiting from public spending (Ensor and Cooper, 2004; Crombie et al., 2004; Wilkinson et al., 2007; Marmot, 2005).

This paper assesses what governments in countries with new natural resources discoveries need to consider when spending natural resources revenues on social protection in order to expand and maintain access to services. In doing so, this paper complements Paper 4's focus on how to improve the supply side for health and education services. The paper approaches this by posing the following questions that are of practical importance for policy-makers:

- Why is it worth investing natural resources revenues in social protection?
- Is investing natural resources revenues in non-contributory social protection financially and politically feasible?
- Is it feasible to use new natural resources revenues in spending on social protection?
- How should non-contributory social protection interventions be designed to enhance access to health and education services, and human capital accumulation?

The rest of the paper is structured as follows:

¹ The exceptions in 2010 were Chad, Cameroon, the Comoros, Gabon, the Gambia, Guinea and Guinea-Bissau. Also note that Mauritius, South Africa and Namibia's old-age pensions have been ongoing since the 1990s (World Bank, 2012).

² Countries where that policy dialogue had not yet led to the implementation of a CT programme in 2010 are Angola, Equatorial Guinea, Madagascar and Mauritania (World Bank, 2012).

- Section 2 analyses why it is worth spending natural resources revenues on social protection, with a particular focus on human capital accumulation;
- Section 3 discusses whether investing natural resources revenues in non-contributory social protection is financially and politically feasible in Africa. It also examines the scale of the natural resources revenues that are likely to be available;
- Section 4 analyzes how non-contributory social protection interventions should be designed and implemented so as to enhance human development outcomes. It does so by analyzing the main barriers to accessing health and education services and identifying which type of social protection intervention is most likely to address these barriers. Having identified CTs as the most effective approach, it discusses the multiple channels through which effects are generated and analyzes what design and operational aspects can help enhance impact;
- Section 5 concludes by discussing policy implications; and
- The annexes provide additional tables and information, evidence of the impact of CTs on health and education, and an overview of barriers to accessing health and education services.

2 Why spend natural resources revenues on social protection?

Natural resource revenues can be spent on many different government priorities, many of which can have direct and indirect effects on human development outcomes. This section discusses the four main reasons why spending on social protection should be a priority for governments in Africa with new natural resources revenues, given the social and economic context they face. Three of these reasons have to do with impact and one with other political economy considerations:

- Addressing poverty, inequality and vulnerability;
- Promoting access to health and education services, human capital accumulation, and ultimately human development;
- Promoting growth and sharing its benefits among the poor; and
- Supporting existing policy processes across Africa, and specifically ongoing pilot programs

Social protection encompasses a wide range of policies and intervention types (see Box 1), which have in common the objective of increasing households' and individuals' ability to cope with the risks they face throughout their lifecycle, so as to avoid exposure to shocks that erode the physical, human and social capital of a society. Within this paper, we will primarily focus on non-contributory social protection, and more particularly on 'social assistance'.³ This is because social assistance is the most appropriate tool to respond to the challenges of low human capital accumulation and poverty faced by African economies – the core topic of this paper – where most individuals do not have jobs in the formal sector, and are therefore largely excluded from contributory social protection schemes (see also Section 0).

³ Note that these two definitions will be used interchangeably throughout this paper, though non-contributory social protection could also be defined as including further interventions (see Box 1).

Box 1: Defining social protection

Social protection can be defined as ‘all public and private initiatives that provide income or consumption transfers to the poor, protect the vulnerable against livelihood risks and enhance the social status and rights of the marginalised; with the overall objective of reducing the economic and social vulnerability of poor, vulnerable and marginalised groups’ (Devereux and Sabates-Wheeler, 2004; GSDRC, 2015). Social protection can be classified into two main categories:

Non-contributory social protection comprises all measures to protect the vulnerable that are tax funded (or externally supported) and do not require beneficiaries to contribute toward the costs. This mainly encompasses *social assistance*: non-contributory regular and predictable cash or in-kind resource transfers to poor and vulnerable individuals or households (sometimes also called ‘social safety nets’ or ‘social transfers’ (Gentilini et al., 2014)).

Some definitions of non-contributory social protection (which are not analyzed in this review) also include:

- *Subsidies*: keeping prices of basic goods and services consumed by the poor low;
- *Social care and support*: addressing the interaction between social and economic vulnerability, through services such as home-based care and family support services;
- *Free access to public services*: abolition of fees for accessing basic services (including health and education) or reduction of user fees for poor and marginalized households; and
- *Labor market interventions*: protection for poor people who are able to work, with the aim of ensuring basic standards and rights; and active investment in vocational training; and create opportunities in the labor market.

Contributory social protection (or *social insurance*) includes programs where participants make regular payments to a scheme that will (partially) cover costs associated with life-course risks (old age, disability, unemployment, illness, etc.).

Source: Devereux and Sabates-Wheeler (2004); GSDRC (2015); Gentilini et al. (2014)

2.1 Addressing poverty, vulnerability and inequality

Across Africa, despite record growth in recent years, poverty levels are high and they may continue to remain high in the medium-term, with a likely increase in inequality (Chandy et al., 2013). In such a context, investing natural resources revenues in social protection helps to redistribute income toward those in need, reducing the depth and severity of poverty while also:

- Ensuring basic acceptable livelihood standards and relief from deprivation (including improved consumption and nutrition);
- Providing protection against individual risks (death, illness, unemployment or loss of production) and covariate shocks (natural disasters, financial crises, market failures), protecting asset stocks and livelihood sources, and increasing resilience at the individual, household and community level;
- Reducing the risk of accelerated growth processes taking place to the detriment of the most poor and increasing the economic and social divide (‘jobless growth’); and
- Contributing to equality and social justice, with potential knock-on effects on the promotion of social cohesion and social solidarity (and, hence, social stability) (GSDRC, 2015; Norton et al., 2001).

2.2 Promoting access to health and education services and human capital accumulation

The large gap in access to health and education – and, ultimately, outcomes – between different economic and social groups in both developed and developing countries is well established, and presents a particular challenge in Africa.

As investments in health and education only pay off in the medium to long run, poor households are often trapped in a ‘low access state’ because of immediate resource (liquidity) constraints and/or the inability to access credit to bear initial costs. This is compounded by a range of other non-monetary factors, explored in more detail in Section 4.1 and 0. The likelihood of a poor household accessing preventive care, for example, is particularly low because the benefits are not immediately apparent and are therefore not considered ‘useful.’⁴ Moreover, children in a multitude of studies and impact evaluations have explained that not having appropriate clothes and shoes or being labeled as ‘poor’ by their peers makes them embarrassed and ashamed to go to school (Attah et al., 2014; Adato, Devereux and Sabates-Wheeler, forthcoming). In short, it is primarily the poorest and most vulnerable households who face the highest barriers to accessing health and education services – even where such services are offered and are of a decent quality.

The risk this poses in many countries is that traditional investments in public sector healthcare and education infrastructure and other supply-side interventions do not primarily benefit the most vulnerable in society, or achieve desired outcomes in terms of increased access or human capital accumulation. Internationally, this has translated into a call for action for policy-makers to acknowledge the ‘social determinants’ of health and education outcomes so as to tackle the problem comprehensively.⁵ Interventions to reduce poverty and social exclusion are listed among priority policy solutions (World Health Organization (WHO), 2011; Wilkinson et al., 2007; Marmot, 2005).

Social assistance interventions have a proven impact on access to health and education services (and ultimately outcomes). This is particularly the case for CTs – predictable amounts of money transferred regularly to poor households, as summarized in Box 2 below, and described in 0. In Section 4 we explain further why CTs can be most effective in regard to achieving these outcomes, what transmission channels allow CTs specifically to address barriers to access for health and education, and how CTs can be best designed to enhance these outcomes.

Box 2: What is the impact of CTs on access to health and education?

While international evidence on access to education and health services is overwhelming, effects in SSA have been slightly disappointing for health but very encouraging for education, especially for older children. This is partly because many CTs in SSA were not tailored to have an impact on human development, but rather they were primarily tailored to have an impact primarily on food security. Interestingly, qualitative evidence helps to establish the causality for, and explain, these findings. For example, CTs lower the need for the distress sale of assets and other negative coping strategies when accessing healthcare (prescription medicines, major operations), with important long-term consequences for beneficiary households.

⁴ An interesting study in Uganda suggested, for example, that one reason women do not attend antenatal care sessions is that, because they are not routinely given medicines, the consultation is perceived as worthless (Ndyomugenyi et al. 1998, cited in Ensor and Cooper 2004b).

⁵ As an example of this stance, a 2003 WHO publication on the social determinants of health called ‘The Solid Facts’ explains: ‘While medical care can prolong survival and improve prognosis after some serious disease, more important for the health of the population as a whole are the social and economic conditions that make people ill and in need of medical care in the first place’.

The opposite holds true when assessing impacts on ultimate outcomes. Various studies – in Africa and internationally – have demonstrated improved health outcomes for both children and mothers, ranging from reduction in maternal and child mortality and morbidity, improved hemoglobin level and rates of anemia; reduction in prevalence of underweight children and stunting; to reduction of respiratory and diarrheal illness (WHO, 2011). However, the evidence is more limited and less conclusive in terms of whether CTs result in improvements in educational performance and skills acquired, highlighting the importance of service quality in addition to access.

Source: authors, based on literature review provided in 0

2.3 Promoting inclusive growth

Social protection can enhance inclusive growth through:

- Human capital accumulation (fostering a skilled, productive workforce – see above);
- Support to asset accumulation, livelihood diversification (potentially into higher-risk, higher-return activities) and earning potential; and
- Increased social cohesion (necessary for long-term economic development) (Norton et al., 2001; Department for International Development (DFID) 2011).

CTs, in particular, can also provide an indirect stimulus to local demand and to local markets. When beneficiaries spend their transfer money they transmit the impact to others inside and outside the local economy, most often to richer non-beneficiary households who tend to own most of the local businesses. For example, a recent UN Food and Agriculture Organization (FAO) study has shown that in Ghana's Livelihood Empowerment Against Poverty (LEAP) CT program, every dollar transferred to poor households had the potential to raise local income by a factor of 2.5 (FAO, 2014).⁶

Ultimately, social protection is a tool by which governments can spread the positive impact of exhaustible natural resources to future generations, through current spending.

2.4 Supporting domestic policy processes across Africa

Social protection interventions – and especially social assistance and CT programs – have expanded rapidly across Africa in recent years. Countries such as Mauritius, South Africa and Namibia have had such programs in place since the 1990s, and by 2010 almost every country in SSA had at least some form of policy dialogue regarding social protection (especially CTs).^{7,8} With middle-income countries in the region leading the way, many lower income countries are now making efforts to scale up their pilots and integrate fragmented CTs into a national social protection strategy. This is due to ever-increasing government ownership of these programs, which has led to large investments in the core systems (targeting, payments, monitoring, etc.) necessary for their success (World Bank, 2012).

An important push toward the expansion of social protection systems has come from the African Union, which since 2004 has encouraged countries to develop their own social protection frameworks. In 2007 the Yaoundé Declaration encouraged governments to incorporate plans for

⁶ The impact on the local economy was simulated using a local economy wide impact evaluation (LEWIE) model.

⁷ The exceptions in 2010 were Chad, Cameroon, The Comoros, Gabon, The Gambia, Guinea and Guinea-Bissau (World Bank, 2012).

⁸ Countries where that policy dialogue had not yet led to the implementation of a CT program in 2010 were Angola, Equatorial Guinea, Madagascar and Mauritania (World Bank, 2012).

social protection into their national budgets, poverty reduction strategy papers and development plans. This initiative includes the development of strategies for ‘introducing and extending public-financed, non-contributory cash transfers’ (African Union, 2008). Such commitments were most recently reinforced in May 2014, with the Union’s ‘Addis Ababa Declaration on Strengthening the African Family for Inclusive Development in Africa’.

In most of the newly natural resource-rich countries discussed in this paper series – including Kenya, Mozambique, Ghana, Tanzania, and Uganda – flagship national CT programs have already been developed and are in the process of being scaled up, proving a commitment in regard to social protection spending (see the summary table in 0). These programs have not yet received financial support from extractive industries revenues and are still struggling to leverage fiscal space and become independent from donor funding and budgetary pressures. This lack of support is an issue, given the large investments in systems development that are needed for scale-up to national level. But it is also an opportunity: natural resources revenues can be used in support of existing government initiatives, and to build on the know-how and systems developed in recent years by donors and governments alike. Moreover, the existing ‘social contract’, social accountability frameworks (including grievance mechanisms and links to community committees) and monitoring and evaluation (M&E) systems developed for the provision of social assistance would help to ensure accountability in respect of natural resources revenue expenditure.⁹

⁹ In Mozambique, for example, the national flagship social cash transfer programme (*Programa de Subsídio Social Básico* (PSSB)) is subject to a periodic community monitoring exercise, with the involvement of civil society organizations, which produces independent results on beneficiaries’ and communities’ perceptions of the program. In Uganda and Ghana the impact and operational effectiveness of the existing cash transfer programs were analyzed as part of a rigorous external evaluation exercise based on quasi-experimental methods and a comparison group. The government of Ghana is also in the process of establishing an ongoing monitoring system in respect of its main CT programme (LEAP) to achieve internal performance management and external accountability.

3 Is it feasible to spend natural resource revenues on non-contributory social protection?

Having discussed why investing natural resources revenues in social protection may be a good idea for countries that have made recent natural resources discoveries, the next important question is whether it is financially and politically feasible for such programs to be entirely financed by the state.

To answer this question, it is important to keep in mind the very specific nature of natural resources revenues, which provide fiscal space in a different way than do tax-based domestic revenues. The nature of the difference is explored extensively in papers 2, 3, and 4 in this series. To summarize the most pertinent points: first, natural resources – and the revenues they generate – are, by definition, finite. Second, unless attempts are made to smooth them over time, they tend to be characterized by an initial peak followed by a long decline. Third, natural resources revenues are unpredictable as international prices tend to be volatile. Fourth, there is a risk of adverse macroeconomic effects, such as Dutch disease, damaging other economic sectors, unless the influx of new foreign currency is managed carefully. Finally, natural resources revenues arguably pose political economy risks, in that public pressure for accountable spending can be less than is the case for spending funded by general taxation.

3.1 Financial feasibility of a social assistance ‘package’

3.1.1 Estimated costs of current social assistance systems

Rough estimates and existing country data show that a basic social assistance package costs between 1 and 5 per cent of GDP, with exact estimates depending on the mix and types of scheme adopted and the demographic profile of the target population (DFID, 2011; UN Children’s Fund (UNICEF), 2009).¹⁰ In many developing countries, the range is closer to 1 to 2 per cent of GDP (GSDRC, 2015; Weigand and Grosh, 2008). A World Bank review in 2014 showed that 107 developing and emerging countries spend an average of 1.6 per cent of GDP on social assistance (Gentilini et al., 2014). As an example, programs in Brazil, Indonesia and Mexico reach between a quarter and a third of their national population with relatively modest transfers, at a cost of between a third and two-thirds of a per cent of GDP (DFID, 2011).

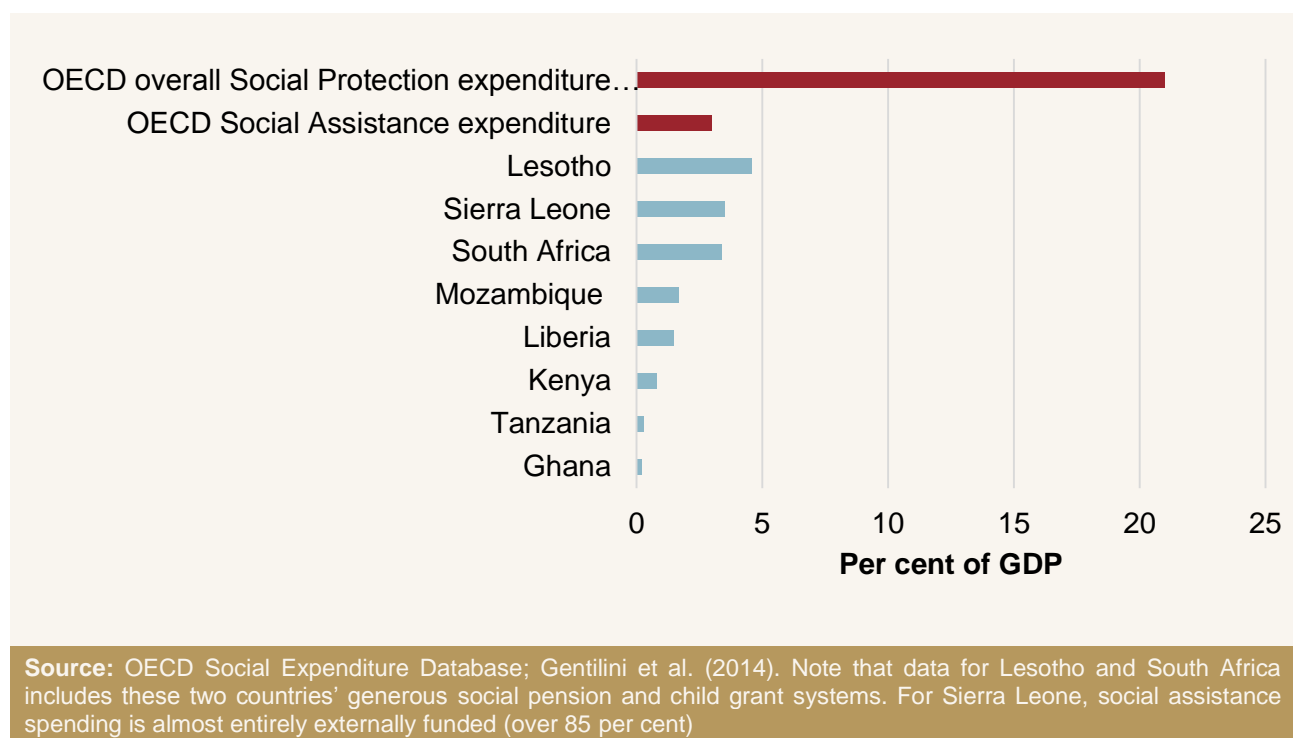
Focusing on Africa specifically, and on actual cost calculations of existing programs, Figure 1 shows how relatively small spending in this area is at present. Current spending in Africa is lower than for Organisation for Economic Co-operation and Development (OECD) countries, where non-contributory social assistance spending averages 3 per cent of GDP, while wider social protection (including social insurance) amounts to 21 per cent of GDP on average (Townsend, 2009; OECD Social Expenditure Database). Only in a handful of southern African countries, where extensive rights-based grant systems and social pensions have been developed, does social assistance expenditure exceed 3 per cent of GDP (World Bank, 2012; Gentilini et al., 2014).¹¹ It should also

¹⁰ The basic social protection package (used for our estimates) includes universal social assistance in the form of a disability and old-age pension and a child-related transfer. Targeted pensions and child transfers could be provided at a fraction of this cost.

¹¹ Specifically, this includes Botswana, South Africa, Namibia, Mauritius and, recently, Lesotho (where donor funding is still the major source of financing of a universal social pension).

be noted that external sources of financing play a key role in most of these lower income countries, often representing the main sources of funding (Gentilini et al., 2014).

Figure 1: Current funding of social assistance – OECD vs. selected African countries



3.1.2 The challenge of long-term recurrent costs of social assistance systems

Given the 'sticky' nature of public spending – that is, only a very small percentage of the budget gets reallocated to new policy initiatives from year to year – revenues from recent discoveries of natural resources are a great opportunity for the expansion of social protection interventions. In a recent International Monetary Fund (IMF) working paper, Deléchat, C. et al. (2015) conclude that in two of this research's sample countries (Liberia and Sierra Leone) and two others (Côte d'Ivoire and Guinea), it is feasible for a fraction of new natural resources revenues to be used to expand social safety nets.

Nevertheless, social assistance systems require governments to enter into recurrent long-term commitments that can be politically very difficult to reverse (see below) and therefore require ongoing fiscal space in future years. While many programs have strategies for 'graduation' out of poverty (often much more bluntly defined as 'exit' from the program), these are rarely fully applied and in any case graduation of some beneficiaries is accompanied by new targeting of others. For this reason, UNICEF (2009) suggests that the best options for creating fiscal space for social assistance systems is by mobilizing domestic revenues and reallocating spending in order for it to be sustainable over the long term – a consideration which points to the need to devote at least some natural resources revenues to boosting broad-based, long-term economic growth.

As an example, we look at the cost structure of a hypothetical CT intervention to assess how this compares to revenues from natural resources. Figure 2 provides a schematic representation of how, after a small-scale pilot and significant investments to scale-up to national coverage (i.e. capacity building and training, development of management information systems, payment

systems infrastructure, etc.), administrative costs decrease over time, given economies of scale.¹² Yet, unavoidable recurrent costs – to cover the transfers' costs themselves and the administrative costs of distribution, case management, and monitoring – will continue (World Bank, 2012). These will not be static, as some fluctuations may result from re-targeting every two to four years, retraining and systems improvement.

Figure 2: Typical cost structure of a CT program – a strong recurrent profile with some relatively large start-up costs



It is clear that in order to finance social assistance systems with natural resources revenues one real challenge will be for countries to ensure a stable flow of revenue year after year. Sound macroeconomic management will have to address both the bell shaped curve of the revenues (see Paper 2 for details of revenue projections) and short-term fluctuations in prices. Paper 3 discusses in detail the challenges of successfully using macroeconomic management to 'smooth' natural resources revenues over time using policy tools such as sovereign wealth funds (SWFs) and up-front borrowing. If the revenues are large enough to justify it, the creation of an SWF could not only assist with navigating macroeconomic challenges but also put in place a long-term source of funds to guarantee the sustainability of CT programs after natural resources are exhausted. Countries like Ghana and Chile show how such macroeconomic policy decisions can influence the opportunities for public spending (see details in Paper 3).

In Figure 3 we compare the likely cost of delivering a basic social assistance package, which we estimate at between 1 and 5 per cent of GDP, with two extreme scenarios for projected revenues:

1. The projected revenues are left unmanaged and are allocated directly in the budget as being available for social assistance spending; and
2. Government manages revenues from natural resources to create a smooth stream of funds (as a share of GDP) over a period of 30 years.

Neither scenario is likely to reflect the actual profile of natural resources revenues, for three reasons. Firstly, in reality, revenues tend to be partly but imperfectly smoothed over time. Secondly, the mid-point estimates given here could easily be significantly higher or lower based on

¹² Note that, for example, programs with efficient management information systems (MISs) and targeting systems require a larger up-front investment, but they present benefits in terms of program efficiency and ability to scale up.

the direction of international commodity prices (see Paper 2 for further analysis of price sensitivity). And, thirdly, strong political pressure may lead to natural resources revenues being brought forward through borrowing (see Paper 3 for more on these macroeconomic choices).

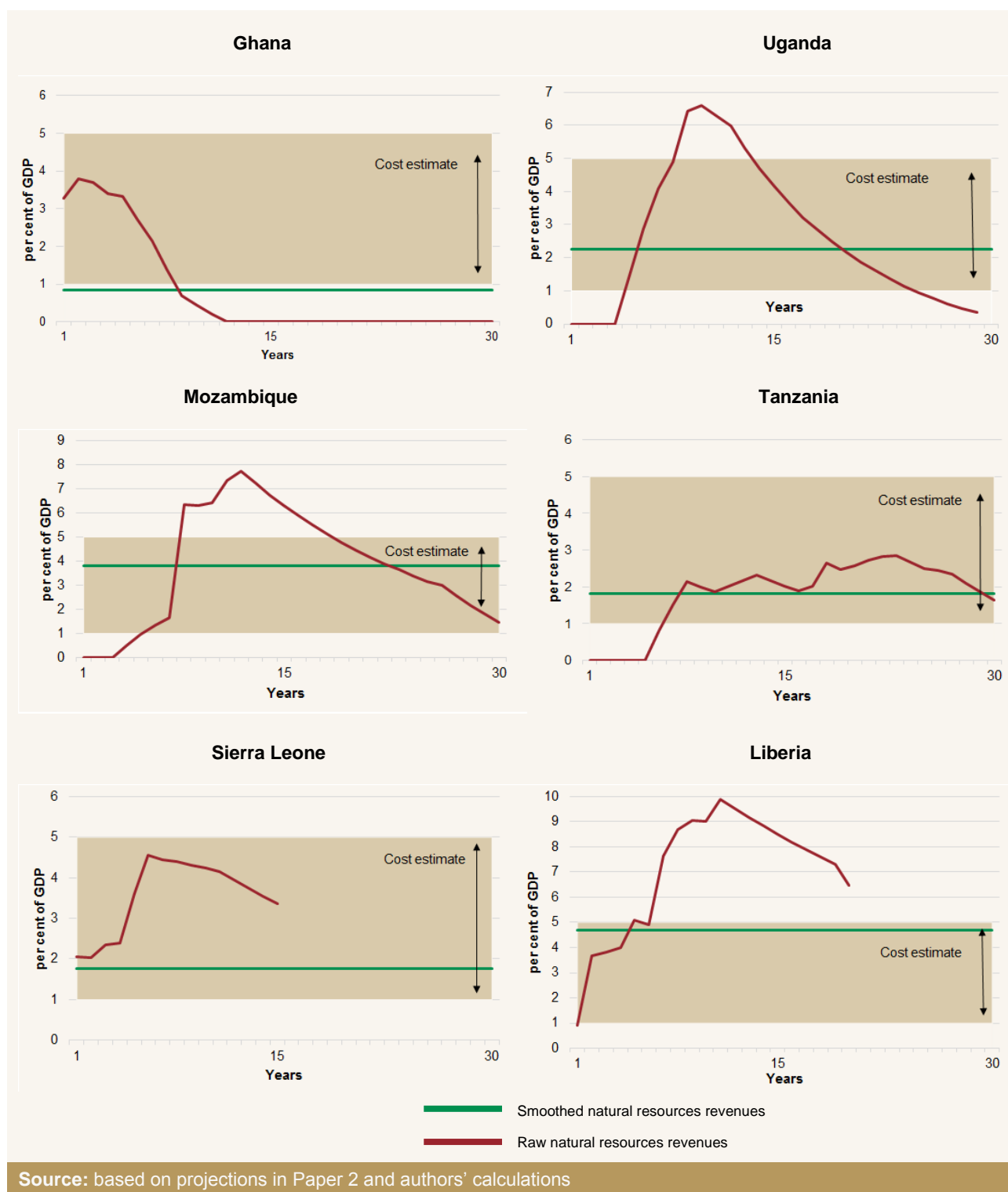
Moreover, this comparison is not intended to suggest that all natural resources revenues should be allocated to social protection – as explored in other papers in this series, there is also a strong case for spending on health, education and strategies to boost economic growth. Indeed, as discussed in Section 4.4.5 below, CT interventions are likely to have a greater effect on health and education when they are combined with supply-side measures.

Nonetheless, the comparisons provide a useful order-of-magnitude context. They show that the scale of income from natural resources across the selected African countries is, in most cases, in the ballpark of the cost of a basic social assistance package. It is not unrealistic to consider spending part of new natural resources revenues on interventions characterized by recurrent spending over a 30-year timeframe (with a possible exception in the case of Ghana) when looking at mid-point estimates.

Even where the fiscal space generated by natural resources revenues is not sufficient to cover a full social assistance package, social protection can still be advanced as one possible use of those revenues. Natural resource revenues could, for example, cover CT start-up costs, while the government looks for other solutions – perhaps by saving revenues in an SWF, or investing them in strategies to diversify and grow the economy – to finance longer-term recurrent costs.¹³

¹³ Recurrent costs for CTs can be easily simulated depending on the number of targeted households and the payment amount – for details on how to do this, see O'Brien (2013).

Figure 3: How do natural resources revenues compare to basic social assistance packages?



3.1.3 Is a 'direct dividend' model viable?

As an alternative to financing social assistance programs through a government's standard budget process, the Center for Global Development (CGD) argues in favor of an "Oil to Cash model: directly paying a taxable 'direct dividend' to all citizens, as in the US state of Alaska. The rationale for this is to avoid the 'black box' of the government budget; increasing transparency by distributing revenues directly; and increasing accountability by taxing the transfers (meaning citizens have more of a stake in how that money is used by government) (CGD, n.d.; Devarajan et al., 2011). In Box 3 we discuss, based on our projections and recent work by CGD, whether this would be a feasible and desirable option in the countries considered by this study. In a nutshell, the scale of natural resources revenues predicted in our sample countries is not sufficient to have a significant impact on human development if they are distributed as direct dividends, while not to support existing government social assistance initiatives would be a missed opportunity.

Box 3: Why are direct dividend transfers not an ideal option?

Why are direct dividend transfers less appealing than supporting existing social protection systems for our group of sample countries?

- Overall, it would be a missed opportunity not to support existing government initiatives and build on the know-how and systems developed in recent years by donors and governments alike. The existing 'social contract', social accountability frameworks (including grievance mechanisms and links to community committees) and M&E systems developed for the provision of social assistance would make accountability more effective than the setting up of a parallel system, and this would also contribute to the long-term sustainability of system investments.
- The size of natural resource revenues projected in Paper 2 does not predict that any of our sample countries will become the next Angola or Gabon, where distribution of 10 per cent of annual natural resources revenues as direct dividends could eradicate half or more of their average depth in poverty (as estimated by a recent CGD study (Giugale and Nguyen, 2014)).
- A transfer to all citizens, irrespective of their poverty status or category, in our sample countries would result in very small amounts being distributed per citizen, drastically limiting transformative impacts and undermining the poverty alleviation benefits of CTs. Based on the revenue projections in Paper 2, we estimate between US\$ 13 and US\$ 32 could be distributed to each family per quarter¹⁴ across our sample countries (see Figure 4 below).¹⁵

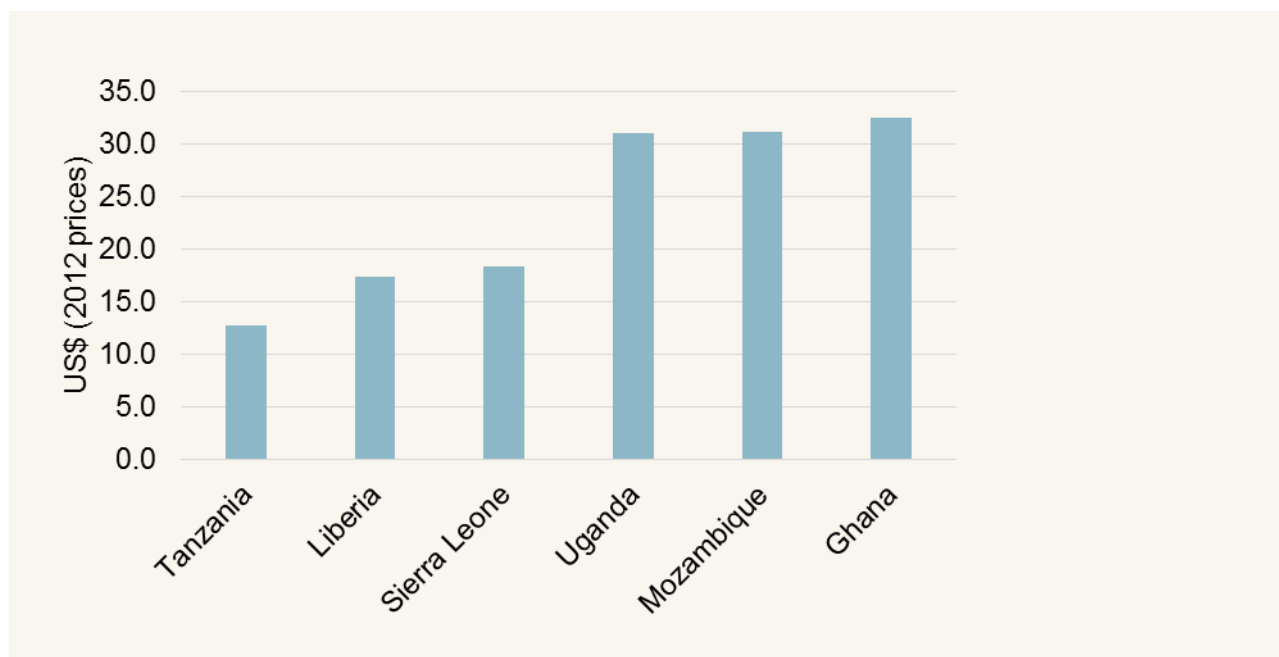
These findings are similar to those reported by Giugale and Nguyen (2014). Assuming an all-knowing government makes cost-free, perfectly targeted transfers to close natural resource-rich countries' poverty gaps, they show that most existing resource-rich countries would not be able to eradicate poverty even if they used all their natural resources revenues for this purpose. They conclude that 'the impact of Direct Dividends depends as much on the volume of natural resources as it does on demographics and the initial position of the national poverty line'.

Source: Giugale and Nguyen (2014); authors

¹⁴ It should be noted that monthly transfers of existing CTs are also relatively low, but could be significantly increased through natural resources revenues. For example, transfer size in Mozambique is about US\$ 13 month, and in Uganda it is US\$ 9 per month.

¹⁵ We calculate a rough estimate of the average direct dividend available to each five-person family every quarter during the first 10 years of production in our sample countries. We assume that a quarter of the revenues will have to be spent on administration, and after distribution a third will be collected in tax by the government.

Figure 4: Order-of-magnitude of potential quarterly direct dividends per family during the first ten years of production



Source: based on projections in Paper 2 and authors' calculations

Note: values in the figure are based on estimates for per capita natural resources revenues and it is assumed that 25 per cent will be spend on administration, and 33 per cent will be collected by government taxation. Note that if production has already started, the first year is 2016

3.2 Political feasibility

Rolling out non-contributory social protection interventions has large political economy implications. As with any decision regarding the allocation of scarce resources, politics determines the level and outcomes of the bargaining process. Ultimately, how these decisions are made and whether permanent systems for social assistance are adopted will depend on 'public support for policy; the 'voice' or degree of representation of different groups; and the social contract between political institutions and other actors' (Bastagli, 2013).

Several factors should be reviewed and addressed when considering the political feasibility of using natural resources revenues to finance social assistance.

First, social assistance – and CTs especially – are one of the few policies with longer-term impacts that also have short-term effects that are visible within an electoral cycle. While this is one of the key success factors of such policies, issues regarding reversibility should be considered from the outset, as phasing out such programs or developing a strong graduation strategy could result in political suicide. This raises concerns regarding the financial and fiscal sustainability of social assistance financed through finite natural resources revenues.

Second, public support and acceptability needs to be managed carefully for such policies to work. On the one hand, they could lead to increased support from low income households, who most often benefit from such programs. On the other, they could generate a potential backlash from middle classes, especially when the poor are perceived as less productive and to some extent undeserving. Attaching conditionality to assistance has been used as a tool to avert this, given that

conditioning the transfers on the adoption of positive behaviors creates a sense of the ‘co-responsibility’ of the poor (Fiszbein and Schady, 2009; Bastagli, 2013).

It is particularly important to consider the existence of such conflicting interests when the introduction of targeted social assistance programs is pursued in the context of a partial reallocation of existing social expenditure. For example, CTs have been introduced in a number of countries to mitigate the elimination of blanket subsidies (e.g. fuel subsidies, fertilizer subsidies) that are generally regressive, but attractive to middle class voters.

Third, given the cross-cutting nature of social protection and social assistance specifically (whereby impacts can range widely), the emergence of political support and the subsequent fine-tuning of program design and implementation will require good coordination across several line ministries. This may be difficult to achieve in some country contexts.

4 How should non-contributory social protection interventions be designed and implemented to enhance human development outcomes?

Assuming non-contributory social protection measures can be – at least partially – funded through natural resources revenues, a critical question from a public investment standpoint is: how to ensure that funds distributed through social assistance schemes achieve the maximum possible impact on human development, and ultimately growth? In order to answer this question, this section reviews the main barriers to human capital accumulation in developing countries: the demand-side barriers to accessing health and education services. It then identifies which type of social assistance intervention is most likely to address these barriers. Having identified CTs as the most effective approach, it discusses the multiple channels through which effects are generated and analyzes what design and operational aspects can help enhance impact.

4.1 What are the main barriers to accessing health and education services?

Access can be defined as ‘the timely use of a service according to need’ (Peters et al., 2008). Two types of barriers can impede access. Supply-side barriers are aspects inherent to the health or education system that hinder service uptake by individuals, households or the community. These might include the number of schools or hospitals, their overall quality and their cost. Demand-side barriers are factors that influence people’s ability and willingness to use health or education services at the individual, household or community level.

Recent literature has shown that demand-side barriers can play a larger role than supply-side barriers in impeding access, especially for the poor and other vulnerable groups (Ensor and Cooper, 2004; Crombie et al., 2004; Wilkinson et al., 2007; Marmot, 2005). Two examples are discussed in Box 4. The central concern when defining access is therefore whether individuals that can potentially benefit from effective healthcare or education do in fact receive them.

Box 4: Evidence shows that demand-side barriers are prominent

The baseline evaluation of a large CT in Northern Kenya (the Hunger Safety Net Programme (HSNP)) found that among children aged 6–17 who had never attended school the most common reasons given were domestic duties (49 per cent), working for the household's own production (13 per cent), parental attitudes (15 per cent) and costs (6 per cent). Only 2 per cent claimed the problem was the lack of a school or the distance of the school – that is, supply-side factors.

A similar evaluation of the Child Grant Programme in Lesotho showed the prominence of cost barriers (40 per cent), children's lack of interest (30 per cent) and embarrassment (10 per cent) – all demand-side factors.¹⁶

Source: OPM (2011); OPM (2014a)

Based on the existing literature, we have developed a novel reference framework for analyzing demand-side barriers.¹⁷ This links:

- The three main categories of barriers to access:
 - *Costs*: direct, indirect and opportunity costs;
 - *Preferences and attitudes*: strongly linked to prevailing cultural norms (socio-cultural context), but shaped by the particular background and beliefs of each household member; and
 - *Knowledge and information*: regarding the long-term benefits of accessing health and education services, regarding the options available (different facilities, which is best, etc.), and regarding how to negotiate access to them (overcome the bureaucracy, etc.).
- Household endowments: financial assets (income and wealth), human assets (especially the education level of decision-makers), social assets (networks, etc.), natural assets (ownership, use, and disposal of land) and physical assets (entitlement to, use, and ownership of productive and non-productive assets).
- The societal context: the socio-cultural, political and market context.

Table 1 below provides a summary overview of this framework, including relevant examples of health-related and education-related barriers. Further details regarding the framework and the relevant literature are discussed in 0.

Table 1: Overview of demand-side barriers to access in health and education

Area	Key demand-side barriers	Sub-categories	Relevant health-related examples	Relevant education-related examples
Household	Household endowment and 'livelihood assets'	Especially financial and human, but also social, physical and natural assets	Higher income and higher educated households more likely to access healthcare	Higher income and higher educated households more likely to pursue education

¹⁶ Importantly, it should be remembered that the rationale for setting up conditional CTs (CCTs) in most Latin American countries was exactly to tackle the demand-side barriers to households' under-investment in health and education (Pellerano and Barca 2013; Glassman et al. 2006; Gaarder et al. 2010).

¹⁷ Two different strands of literature exist on the topic, depending on which of the two sectors is analyzed. For health, the best overviews can be found in Ensor and Cooper 2004; O'Donnell 2007; Jacobs et al. 2011. For education, relevant information is compiled from FHI 360 2013; OPM 2010. A further strand of literature also focuses on the five 'A's of access (affordability, availability, accessibility, accommodation and acceptability), but these are too focused on supply-side interventions to be useful for this paper (Penchansky and Thomas 1981).

Area	Key demand-side barriers	Sub-categories	Relevant health-related examples	Relevant education-related examples
Specific Barriers	Costs	Direct costs and prices	Fees (if any); medicines	School uniform and shoes; books and school materials; school fees (if any); cost of trips, etc.
		Indirect costs	Travel costs, bribes	Travel costs
		Opportunity costs	Foregone earnings (the need for patient and carer to stop working for long periods in order to seek care)	Foregone earnings (e.g. child labor vs education); domestic chores
	Household /individual preferences and attitudes	Asymmetric control over household resources and bargaining power	Preference for spending on males over females	Preference for spending on males over females
		Impatience, myopia, bounded rationality, etc.	Under-investment in preventive cures; under-estimation of illness; illness seen as the norm	Perceived returns from children's education underestimated; high discount rates on benefits from schooling
		Lack of confidence and stigma (psychological barriers)	Social status and social inclusion affecting health choices and outcomes	Stigma linked to poverty (e.g. embarrassment regarding clothes); lack of confidence linked to failure in examinations, etc.
		Demand responses to poor quality (low trust in services)	Perceptions based on supply-side failures, such as: unpredictability of opening hours; absenteeism of doctors; hostile staff; lack of medicines and equipment; misdiagnosis, etc.	Perceptions based on supply-side failures, such as: teacher absenteeism; lack of equipment and books; bad teaching; inadequate catering to needs (e.g. toilets); perceived lack of safety
	Knowledge and information	Lack of sufficient information about options and long-term benefits	Low ability to assimilate health choices and negotiate access to appropriate providers; insufficient information about benefits of cures/preventive care	Insufficient information about long-term benefits of schooling; insufficient information about schooling options and support available (scholarships, etc.); low ability to negotiate access
Context	Prevailing socio-cultural norms, political and market context		Continued preferences for traditional over modern therapies; gender norms; power dynamics	Gender norms; early marriage; value given to labor; peer pressure etc.; prospective rewards to education (salary, etc.)

Source: authors

4.2 What kind of non-contributory social protection intervention is most likely to address these barriers?

Among non-contributory social protection policies, a wide variety of interventions exist, all of which have the potential to impact access to health and education services, and ultimately human development outcomes.

Table 2 below outlines the main sub-categories, and provides a brief description of each intervention type and the potential impact on access. A set of large and small ticks and crosses are also used to indicate whether that specific intervention addresses poverty and the barriers related to costs, preferences and attitudes, and knowledge, as discussed above. Note that this information is provided within Table 6 in 0 for other types of social protection (social insurance, labor market interventions, etc.), for illustrative purposes.

Table 2: Non-contributory social protection interventions: which are most likely to address poverty and promote human capital accumulation?

Non-contributory social protection type	Description	Potential impact on access to health and education	Addresses: ¹⁸			
			Poverty	Costs	Preferences	Knowledge
CTs	Direct, regular and predictable transfers that raise and smooth incomes to reduce poverty and vulnerability	Large: poverty focus and fungibility of cash. Strong potential for addressing demand-side barriers to health and education. For more details, see Section 4.3 below.	✓	✓	✓	✓
Social pensions	Non-contributory pensions, a form of CT targeted by age	Similar to CTs, but having no explicit focus on children and human capital accumulation (elderly recipients)	✓	✓	✓	✓
In-kind transfers	Economic/livelihood asset transfers to households. Either large one-off or small, regular transfers, e.g. food	Low: assets/food less fungible	✓	✗	✗	✗
School feeding	Free nutritious meals at school – usually lunch – and sometimes take-home rations for children most in need	High potential impact on access to education, not necessarily health (although it has impact on nutrition outcomes)	✓	✗	✓	✗
Public works programs	Provide jobs on infrastructure projects for cash or food	Focused on non-labor-constrained households only (less poverty focused), but similar impacts to CTs if payments are in form of cash. Provision of infrastructure (e.g. roads) can also affect access.	✓	✓	✗	✓
Direct dividend payments¹⁹	Occasional one-off transfers to citizens, distributing the resource rents that would otherwise accrue to government	No focus on poverty; not regular and predictable (so less likely to have an impact on health/education access)	✗	✓	✗	✗

Source: Authors, based on classification within GSDRC (2015)

¹⁸ These columns should be read as answers to the following questions: does this intervention address: a. poverty and vulnerability?; b. the cost barriers associated with accessing health and education?; c. barriers linked to attitudes and preferences?; d. barriers linked to knowledge and information?

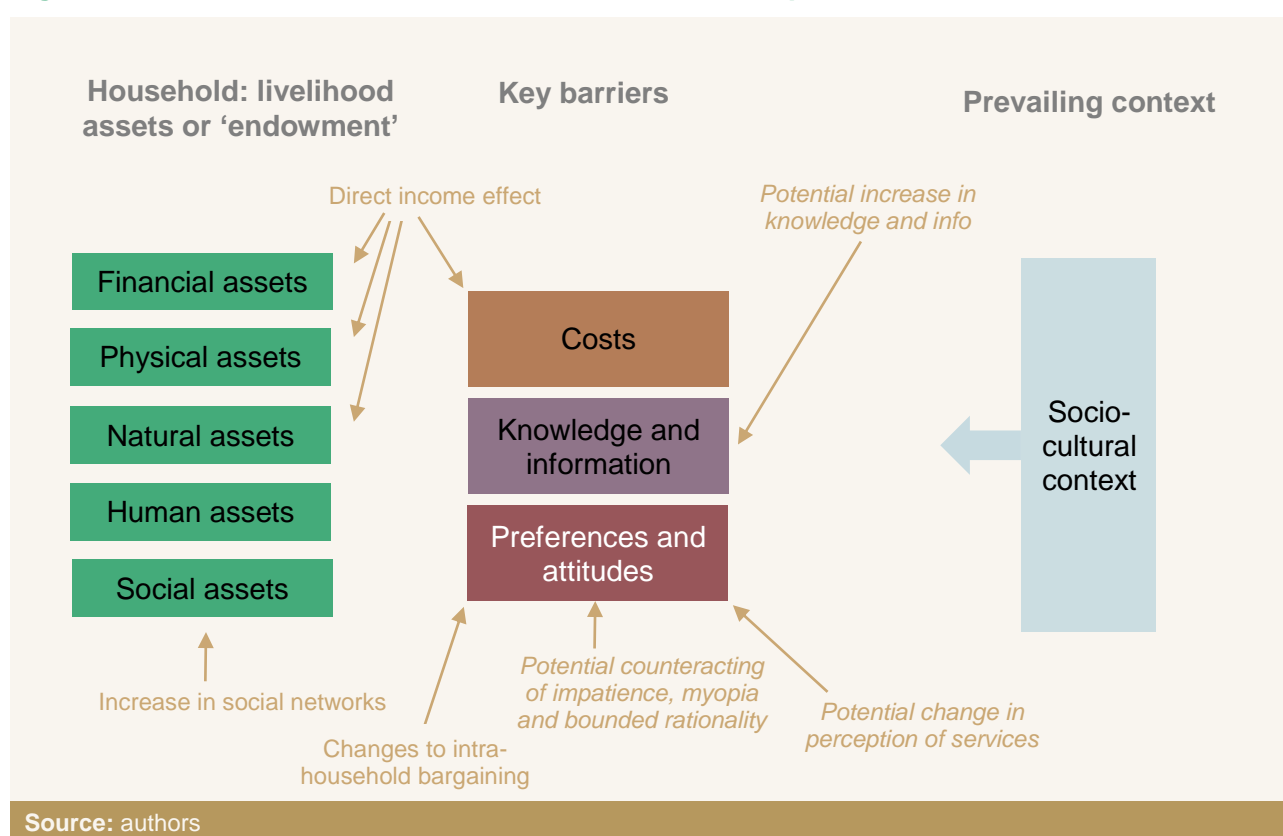
¹⁹ Note, we have included these in this table for comparative purposes given the topic of this paper, despite direct dividends not being officially cited as a form of social assistance.

Overall, CTs – currently one of the most popular social protection interventions in SSA – appear to have the highest potential in terms of addressing the main barriers to access. This is mostly due to their focus on poverty, the fungibility of cash, and their potential effects on preferences and knowledge. The remaining sections of this paper focus on CTs alone, and untangle the channels through which they are able to address demand-side barriers to health and education, and the design and implementation factors that can help to enhance these outcomes.

4.3 What are the channels through which CTs can affect the demand for health and education services?

The flexibility and fungibility of cash means that the channels of impact of CTs are wide-ranging. This contrasts with many other policy interventions that focus on providing one specific good or service to selected households. This section traces how the injection of cash into a household can affect the barriers to accessing health and education services described above. Some of these channels will be obvious and intuitive, some more complicated to trace and only potential in many cases. A summary visualization of these channels, how they can be triggered through tailored program design, and how they affect demand-side barriers, is presented in Figure 5.

Figure 5: CTs and demand-side barriers: channels of impact



First of all, through a simple direct income effect, the additional cash provided to households boosts the overall household income and reduces the household liquidity/credit constraints in regard to covering the direct, indirect and opportunity costs associated with school attendance and

health service access.²⁰ The extent of this effect is mediated by the size, frequency and predictability of the transfer, as further described in Section 4.2.2 below.

Second, in the medium-term, the provision of cash to the poorest and most marginalized households has been proven to have an effect on their social networks, with knock-on effects on their access to services. For example, a multi-country study conducted in Kenya, Malawi, Ghana, Lesotho, Zimbabwe and Ethiopia (OPM, 2014b) concluded that CTs ‘increased the ability of the poorest and most vulnerable beneficiaries to participate in and/or ‘re-enter’ the social life of their extended families and communities, decreasing the social distance between the poorest households in the community and local institutions, and strengthening overall connectedness’.²¹ Beneficiaries who are able to access contribution-based networks and risk-sharing arrangements (reciprocal lending and borrowing, burial societies, etc.) are less vulnerable to shocks, less marginalized and more likely to mimic the behavior of the richer members of the community (e.g. in terms of accessing services).

Third, and linked to the above, CTs increase beneficiaries’ self-acceptance, self-esteem and hopefulness – all important aspects of their psycho-social wellbeing.²² This is due to beneficiaries being able to be better dressed (new clothes, and school shoes and uniforms for children), clean (purchase of soap, etc.), and able to plan for the future (reliability of the transfer). As a female beneficiary explained in Abi Adi, Ethiopia: *‘When we were dirty other community members would ignore us, they did not greet us, but now they do’*. How does this affect access to services? Stigma, stress and lack of psychological wellbeing are all attitude-related demand-side barriers that block people from accessing healthcare or children from going to school. We focus on schooling as an example. ‘On one hand, children who pay their fees and come properly equipped to class elicit more favorable treatment by teachers and other classmates On the other, the self-acceptance and self-esteem that derive from owning proper education materials and being well-presented in school can also boost children’s confidence and reduce their sense of shame’. The result is increased attendance and improved performance (Attah et al., 2014).

Fourth, CTs can have effects on intra-household bargaining processes and decision-making. Having an additional source of income that is not ‘earmarked’ in the household budget means that money can be spent outside the standard spending categories of that household (this is based on the idea of ‘mental accounting’).²³ Moreover, some evidence shows that when money is transferred to women this can focus spending on human capital outcomes (see Section 4.2.2 for more details). Evidence from a wide range of countries has also shown that CTs have successfully tackled regressive gender norms by increasing the voices of women, opening up new economic opportunities by addressing child care responsibilities, and increasing women’s sense of security and self-esteem – with important indirect effects on their sense of agency (World Bank, 2014).

Fifth, CTs can counteract impatience and ‘myopia’, either through explicit conditionality (as is the case in CCTs) or through milder forms of conditioning (see Section 4.4.1 below for more details).

Sixth, CTs can change perceptions of services by coupling interventions to increase the coverage and quality of those services with increased beneficiaries’ knowledge and information regarding schooling and healthcare practices through communication strategies, targeted training or implicit endorsement, as discussed in Section 4.4.4.

²⁰ There can also be effects in terms of increasing resilience and building assets, which in turn allows households to access services in the future.

²¹ Other evidence from Colombia (Attanasio et al., 2009) confirms that CTs can have a positive effect on social capital.

²² In practice, ‘psycho-social’ wellbeing mixes the concept of psychological (or subjective) wellbeing and an attempt to draw more attention to social influences on wellbeing. Psycho-social therefore refers to the dynamic relationship between internal psychological processes and external social processes (see Attah et al. 2014 for more details).

²³ For more details on why this is the case, see Thaler’s seminal paper titled ‘Saving, Fungibility and Mental Accounts’ (1990).

These points are summarized in

Table 3 below, which also includes a column that summarizes the operational factors that can affect impact, as discussed in more depth in Section 4.4. In the background, of course, are also the contextual factors that mediate impacts. Prevailing socio-cultural norms and the political context, for example, will affect the level to which gender and social empowerment will take place, including the possibility for increased engagement, voice and accountability of service recipients. The market context, on the other hand, determines the extent to which the CT can have wider local economy impacts and spill-over effects.

Table 3: Channels through which CTs can affect key barriers to access health and education services

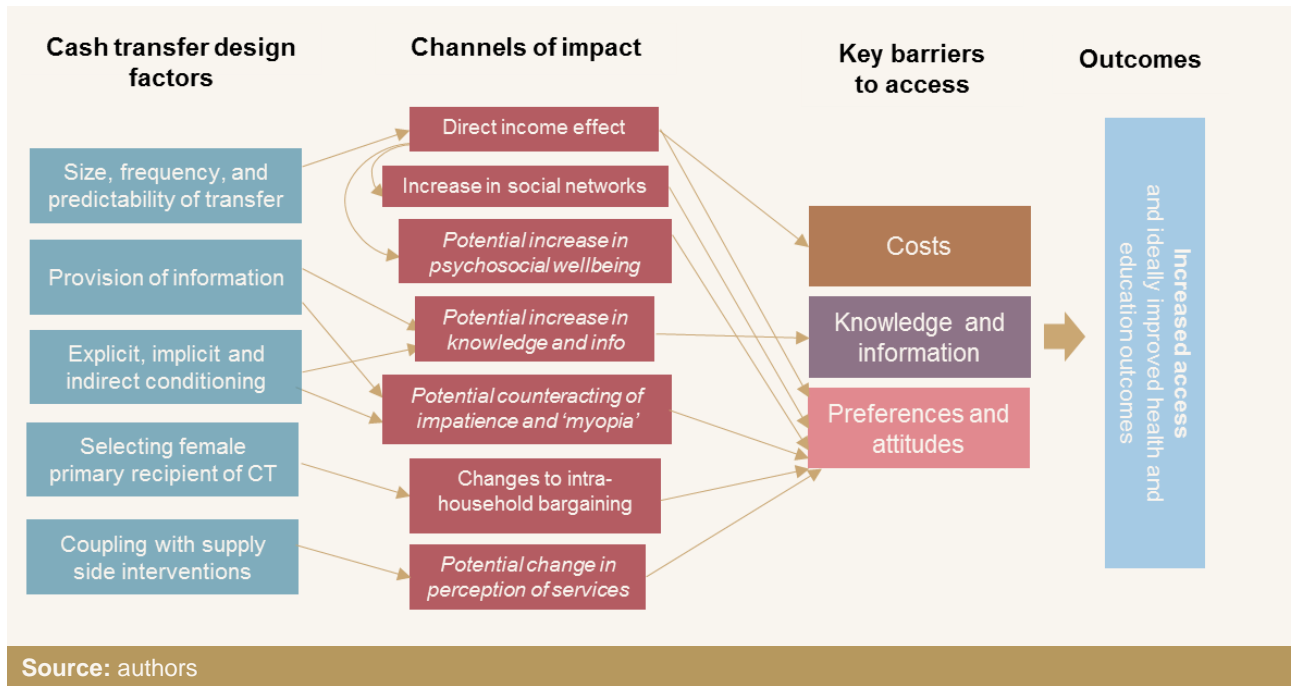
Key demand-side barriers	Specific barriers	Actual and potential CT impact	Operational factors affecting impact
Costs	Direct costs and prices	<i>Strong impact:</i> Lowers financial burden	<ul style="list-style-type: none"> Size, frequency, and predictability of transfer
	Indirect costs	<i>Strong impact:</i> Lowers financial burden <i>Can be designed to have further impact:</i> Pairing CTs with mobile clinics and immunization efforts, etc.	<ul style="list-style-type: none"> Size, frequency, and predictability of transfer Pairing with supply-side intervention
	Opportunity costs	<i>Strong impact:</i> Lowers financial burden	<ul style="list-style-type: none"> Size, frequency, and predictability of transfer
Household /individual preferences and attitudes	Asymmetric control over household resources and bargaining power	<i>Can be designed to have impact:</i> Can marginally affect bargaining power within the household	<ul style="list-style-type: none"> Making female caregiver primary recipient
	Impatience, myopia, etc.	<i>Can be designed to have impact:</i> Can act to correct preferences	<ul style="list-style-type: none"> Provision of information Explicit, implicit and indirect conditioning
	Lack of confidence and stigma (psychological barriers)	<i>Some impact:</i> Households receiving cash often re-enter contribution-based social networks and report lower levels of stigma (dressed better, clean) with impacts on confidence, status, etc.	<ul style="list-style-type: none"> N/A
	Demand responses to poor quality (low trust in services)	<i>Can be designed to have impact:</i> if quality of supply improves in tandem	<ul style="list-style-type: none"> Being coupled with supply-side interventions to improve coverage and quality
Knowledge and information	Lack of sufficient information regarding options and long-term benefits	<i>Can be designed to have impact:</i> provision of information regarding options and long-term benefits	<ul style="list-style-type: none"> Communication strategies, information provision, implicit endorsement

Source : authors

4.4 What design and operational aspects of CTs can help achieve impact?

How can a program be designed to maximize the impact on access to health and education? This section considers the advantages of CCTs versus unconditional CTs (UCTs); how different characteristics of payments can affect impact; the advantages of coupling CTs with some form of information and knowledge sharing; and how CTs can best be coupled with supply-side interventions. Figure 6 summarizes how these program design options affect demand-side barriers through the channels discussed in the previous section.

Figure 6: CTs and demand-side barriers – design factors and channels of impact



4.4.1 CCTs versus UCTs

There is an ongoing debate about whether or not conditions should be imposed on CTs (see e.g. Attanasio et al., 2005; De Braw and Hoddinott, 2007; Fiszbein and Schady, 2009; Baird et al., 2013; Barca and Pellerano, 2014; Attanasio et al., 2014). Some argue that CCTs have succeeded, notably in Latin America, by effectively incentivizing desired behavior, such as using schools and health services – particularly when demand-side barriers are rooted in weak information, preferences and power structures, rather than financial constraints alone.

Others, however, doubt whether conditionality itself played a central role in the achievements of CCTs in Latin America. UCTs, such as social non-contributory pensions, monetary subsidies to families and child benefits, have also effectively promoted expenditure in health and education (Case et al., 2005; Edmonds, 2006; Schady and Araujo, 2006; Benhassine et al., 2013). These researchers point out that conditionalities can be expensive and complex to administer (sometimes prohibitively so – in Kenya, for example, the initial intention to make the CT for Orphans and Vulnerable Children (OVC-CT) conditional was quickly reversed because of the administrative burden).

There are other ways to ‘condition’ behavior without imposing formal conditions.²⁴ UCTs often share three forms of behavioral conditioning that have been proven to be as effective as explicit conditions in influencing access to health and education services (see Box 5 for an example):

- **Conditioning on access:** CTs are targeted at households with socioeconomic characteristics that tend to lead to a particular pattern in the use of their transfers.²⁵
- **Implicit conditioning:** for instance, evidence shows that delivering transfers via electronic cards may increase a household’s propensity to save; paying child benefits to women leads to spending that is better aligned with their children’s best interests; and the name of the transfer scheme itself (e.g. Child Support Grant) nudges the recipient to use it in a certain way.²⁶
- **Indirect conditioning** or ‘soft conditionality’: through complementary policy actions, such as giving information to beneficiaries on the best use of the transfers, or using community-based case management systems to oversee how transfers are used.

Box 5: The Tayssir program in Morocco, an effective ‘labeled’ CT

In Morocco, a labeled CT (LCT) program was implemented by the Ministry of Education, and administered through schools by headmasters and teachers – even for children who were not currently in school. This implicit labeling of the CT as being for educational purposes had a significant ‘nudge’ effect on beneficiary households.

The impact evaluation showed that, over two years, the LCT: reduced the dropout rate by 76 per cent among those enrolled at baseline; increased re-entry by 82 per cent among those who had dropped out before the baseline; and cut the share of never-schooled by 31 per cent. These results were superior to those registered by the equivalent CCT, and were achieved at a significantly lower cost.

Interestingly, the LCT also influenced parents’ and children’s perceptions of those schools (which at follow-up were perceived to be of higher quality) and of the value of education (perceiving returns from secondary school as more than twice as large compared to a control group). These effects are confirmed by several studies (Jensen, 2010; Nguyen, 2008) that have shown that parents respond to interventions that increase the perceived returns to education by increasing participation and effort in school.

Source: Behnassine et al. (2014); Jensen (2010); Nguyen (2008)

4.4.2 Different characteristics of payments

How CTs are paid to households – the amount paid, the frequency of payment, the method (whether by paypoint, bank, cell phone etc.), and into which household member’s hands – can condition behavior and thereby affect access to health and education services.

Amount paid

Larger transfers are not necessarily associated with commensurately larger effects – after a certain threshold, diminishing marginal returns kick in (Bourguignon et al., 2003). Some evidence shows lump sum payments that are disproportionately large in proportion to household’s incomes and experience of handling money can be divisive within the household, and can be used unproductively (Farrington and Slater, 2009), or used primarily to invest in assets (OPM, 2014b). In

²⁴ This establishes a formal or explicit contract between the provider and the recipient, and beneficiaries are penalized in various ways (the most drastic of which is being expelled from the program) if they do not abide by the terms of the contract.

²⁵ An article by Esther Schuring which explores similar issues in a slightly different framework, calls this ‘ex ante conditionality’ (Schuring, 2010).

²⁶ This type of conditionality has been called ‘indirect conditionality’ by Schuring (influencing household behavior through the choice of implementation modalities) (Schuring, 2010). Similar claims have also been made by Schubert and Slater (2006).

Latin America some of the programs with the largest impact on health and education were the ones with the smallest transfer size (*Bono de Desarrollo Humano* (BDH) in Ecuador and *Chile Solidario*).

Of course, making transfer sizes too small can also reduce effectiveness. Best practice internationally is to set benefit levels in relation to the desired impacts. For example, the size of the education grant for *Oportunidades* in Mexico was set to cover children's incomes; in Honduras it was set to cover both the opportunity and direct costs, including the costs of books and uniforms (Grosh et al., 2008; Schady and Aurajo, 2009). A randomized controlled trial (RCT) of Cambodia's CESSP Scholarship Program found clear evidence of sharply diminishing marginal returns in relation to transfer size, which was set above the direct cost of schooling (Filmer and Schady, 2009 and 2011) .

In many SSA countries, where desired impacts are mostly focused on food security, transfer size is often set as a percentage of households' consumption expenditure or food poverty (see Box 6).

Box 6: How transfer sizes have been set in selected SSA countries

Several SSA programs have set their transfer size in terms of households' consumption or expenditures:

- Kenya's OVC-CT is equal to approximately 20 per cent of the household expenditure of poor Kenyan households
- Kenya's HSNP is between 30 per cent and 40 per cent of the food expenditures of beneficiary households
- Ghana's LEAP transfers are equal to 20 per cent of the bottom quintile's average household consumption

Others set transfer size in relation to poverty or food poverty:

- Ethiopia's Productive Safety Net Programme (PSNP) transfer equals approximately 10 per cent of the basket represented by the 2007/08 national poverty line
- Senegal's Child-Focused Social Cash Transfer (CF-SCT) equals about 14 per cent of the average food basket value in households with four adults
- Tanzania's Community-Based Conditional Cash Transfer (C-B CCT) provides benefits that equal half of the food poverty line for each child, and benefits that equal the food poverty line for the elderly

Source: World Bank (2012)

Other important considerations in determining the level of payments are how transfers will be adjusted to keep pace with inflation, and how the population of eligible beneficiaries is expected to evolve.

Frequency of payments

In theory, frequent payments should help households with consumption smoothing. However, a meta-analysis of evidence of impact on primary and secondary enrolment and attendance found larger effects in payments which were less frequent than monthly (Saavedra and Garcia, 2012).²⁷ Less frequent but higher payments are more likely to be used to cover lump sum costs, such as

²⁷ The authors sustain that this result is consistent with the idea that limited attention (Karlán et al., 2011) or limited self-control (Ashraf et al., 2006) can constrain families in regard to saving. However, it could also be argued that these effects are also linked to the recurrent cost of collecting the cash at a paypoint (time, transport, etc).

the cost of school uniforms, while smaller and more frequent payments get absorbed into a household's current expenditure budget.

With this in mind, some authors have argued for tying payments to households' seasonal needs – for example, periods in the agricultural production cycle (Sabates-Wheeler, Devereux, and Guenther, 2009) or in the school cycle (for example with a bonus paid at the beginning of the school year) (Barrera-Osorio et al., 2008; Schady and Aurajo, 2009).²⁸

While the literature on this topic is limited, it does demonstrate clearly the importance of regularity and predictability, to allow for household budgeting (Rutherford et al., 2009; Barca et al., 2010). Delayed and unreliable payments have been shown to lead to increased disinvestment and vulnerability (for example, OPM, 2014a; OPM, 2014b).

Payment modality

Modern technologies offer policy-makers an increasing range of options for transferring cash. Evidence shows there are benefits, where this is viable, in using bank accounts or mobile money, such as M-PESA in Kenya. This can trigger saving, in turn affecting investments in human capital accumulation.

Other benefits for the beneficiary include reduced stigma, increased flexibility, and reduced transaction costs for collecting the cash, and the advantages of entering a formal banking system. From a systems perspective, new technologies lower the possibility of fraud (Barca et al., 2010) and phones used for receiving money can also be used for providing text message reminders of scheduled health visits, such as for children's immunizations, as a small study in rural Western Kenya has shown (Wakadha et al., 2013).

An alternative form of payment modality that affects behavior is to pay in vouchers rather than cash, for example vouchers for school materials.

Main recipient of the payment

Many CT programs worldwide make their payments to women in the household, whether mothers or other female guardians. The theory is that women are more likely to spend the money on helping their children acquire human capital, although the literature is inconclusive in this regard. There is evidence of impact on the enrolment of girls in school (Baird et al., 2013; Schady and Aurajo, 2009); more expenditure on food and children's clothing and less on alcohol and tobacco (Doepke and Tertilt, 2011); and improvements in child nutrition and health (Yoong et al., 2012).

4.4.3 Different targeting mechanisms

Targeting design determines the types of household that will benefit from the cash support, in terms of both their demographic composition and their socioeconomic status. Targeting has implications not only for the cost-effectiveness and fiscal sustainability of CTs, but also the extent to which cash will be spent on health and education. In Latin America most programs are based on a poverty targeting approach, which identifies vulnerable households on the basis of income or proxies. However, reliable income measurement is more challenging in SSA, where targeting design options are the subject of intense debate and controversy.

²⁸ For instance, cash should not arrive at a time when labor demands on household members discourage them from retrieving transfers.

At one extreme, a universal coverage model was pursued most successfully by South Africa, with old-age pensions and child support grants: Everybody is eligible, though wealthier households are less likely to go through the applications process given the relatively low level of benefit. However, most countries in SSA seem unlikely to have sufficient resources and capacity to sustain universal models.

Some countries (Malawi, Lesotho, and Zambia) have introduced a poverty targeted approach, identifying the poorest of the poor through community assessment and externally verifiable asset information. This approach concentrates benefits on the most vulnerable households, but has high administrative costs.

Other countries (Mozambique, Kenya, Ghana, and Zambia in a more recent phase) have developed a categorical universalist approach, defining eligible categories in a narrow way, such as all households with little or no labor capacity or with high dependency ratios. However, as such households contain proportionally fewer children, there is a risk that the function of the CT targeted in such a way becomes purely protective, rather than increasing investment in human capital.

The focus of the debate about targeting has been on how to most effectively redistribute to the poorest households – but this can present trade-offs with the objective of increasing access to services and human capital accumulation. One option here would be to identify households that under-invest in their human capital, but this is not easy. Three main approaches have been adopted worldwide (Schady and Aurajo, 2009; De Janvry and Sadoulet, 2006):

- The most complex is that applied in Chile, where households are first means-tested and then must agree with a social worker a set of minimal conditions, including many related to their children, which constitute the ‘contract’ for program participation.
- Other countries have adopted forms of ‘narrow demographic targeting’ – relating to the age and sometimes gender of the children in the household, based on the assumption that certain age groups will most likely face challenges in regard to accessing school, for example. The age groups can be calculated on the basis of national data on attrition rates within schooling, identifying ages when children are most likely to drop out (the transition from primary to secondary).²⁹
- A similar approach is to base the targeting on characteristics that are good predictors of non-attendance, and lack of access to services more generally. Depending on the country context these could include gender, being from a minority ethnic group, or having illiterate parents.

The choice of targeting approach will depend on practical and political feasibility, and context. For example, where a large share of the poor experience similar human capital gaps, there are fewer trade-offs between redistributive and human capital goals than where the gaps are concentrated on a small proportion of the poor.

4.4.4 Communication strategies and ‘learning’ lessons

Lack of knowledge and information is a barrier to demand for health and education services – knowledge regarding the facilities available, the bureaucratic requirements to access them, and the long-term benefits of doing so (see details in Annex C). Popular strategies to tackle this barrier include targeted communication strategies and tailored training and learning sessions.

²⁹ Attanasio et al. (2005), for example, estimate that eliminating the transfers to children in sixth grade and below, and using those resources to increase the size of the transfer to children in the seventh grade and beyond, would almost double school participation among the older children, with no effect on school participation by the younger children.

Communication strategies can accompany CTs, coupling information about when, how and where to collect the cash with advice about suggested usage aimed at behavior change. For example, Nigeria's Kano CCT plans to use a communication campaign in program localities to combat cultural opposition to girls' education (World Bank, 2012). Methods include radio, posters, flyers, contests and theater shows at paypoints.

Informational sessions on parenting practices, including hygiene, nutrition and the importance of schooling, have been organized in several countries implementing CCTs. The most evaluated case is Mexico's *Oportunidades* program, where these sessions accompanied explicit conditionality. Duarte et al. (2004) conclude that the program improved knowledge and practices, and recommend basing the lessons on dialogue with beneficiaries about their existing knowledge, and tailoring materials to the target group. From several studies across SSA, it is clear that community committees set up to help vet the targeting and delivery of CT programs can and do play an information-providing role (OPM, 2014b).

With the use of mobile phones for CT delivery, opportunities also arise in terms of targeted SMS communication, such as simple reminders of upcoming check-ups or vaccination rounds (Wakadha et al., 2013).

4.4.5 Linking with supply-side interventions

No demand-side intervention can reach its potential if the supply of services is inadequate. As institutions such as schools and clinics can come under additional stress as a result of CTs, many programs couple roll-out with supply-side interventions in order to trigger virtuous cycles. Several approaches have been adopted in this regard.

In some cases, CTs have capitalized on potential synergies with successful supply-side interventions that are already being implemented. In other cases, the government has allocated additional resources to local health and education services as part of the design of the CT programs (Samson et al., 2010a).³⁰ Evidence from Mexico (Berhman et al., 2005) and from the review of several CTs carried out by Saavedra and Garcia (2012) shows that efforts aimed at concurrently improving the demand and supply of services has significant impacts on enrolment and other educational outcomes. Another approach is to implement CTs in coordination with ministries of health or education.

All depends on the country context. Where services were already widely available and of good quality, such as in Chile, CT implementers have simply focused on increasing beneficiaries' access to information about services and providers' information about beneficiaries' needs, to make sure they are not excluded. Where supply is so inadequate that the proper functioning of the program requires that new services be provided, initiatives have expanded public sector capacity to supply services in parallel with the CT. This was the case in Mexico, in Cambodia and in Bangladesh, among others (Schady and Aurajo, 2009).

³⁰ In Nicaragua, this took the form of direct bonuses paid to teachers, with a specific earmark for school materials. In Honduras, initial supply-side health measures included monetary transfers to primary health care teams which applied for grants that averaged US\$ 6,000 per year (ranging from US\$ 3,000 to US\$ 15,000, depending on the population served by the applicant health clinic). To improve education provision, initial support was given in the form of monetary grants applied for by legally registered parent-teacher associations associated with a given primary school. In Mexico, in tandem with *Oportunidades*, the government of Mexico took steps to improve the supply of schooling through a combination of interventions: rural primary schools and *telesecundarias* were rehabilitated in *Oportunidades* communities; grants were offered to parent associations to pay for minor classroom maintenance and repairs; and in some communities, secondary schools were constructed to help meet the supply requirements in line with *Oportunidades*. *Oportunidades* also included incentive grants paid to teachers (equivalent to a 29 per cent increase in the average teacher salary) tied to attendance and participation in extracurricular activities involving students and parents (Levy and Rodríguez 2004).

5 Policy implications

The wide range of issues discussed in this paper have significant policy implications, which are explored below.

Projected natural resources revenues in the sample countries are broadly in the range of the cost of a basic social protection package

Rough estimates and existing country data show that a basic social assistance package costs between 1 and 5 per cent of GDP, with exact estimates depending on the mix and types of scheme adopted and the demographic profile of the target population (these can be relatively easily simulated for any country). In many developing countries the range is closer to 1 to 2 per cent of GDP. In the newly natural resource-rich countries in Africa, the projected revenues are also broadly in this range – with the exception of Ghana.

Of course, it is unrealistic to posit that all new natural resources revenues be plowed into social protection systems – and it must be considered that CTs in particular require governments to enter into recurrent long-term commitments that can be politically very difficult to reverse, and therefore require assured fiscal space in future years. Still, new natural resources revenues could be used to help finance CT start-up costs, or mechanisms could be established to smooth revenues over time to ensure the country remains financially sustainable and economically stable after the natural resources are exhausted.

Social protection is one way to facilitate equitable growth in both the short and the long run, with benefits lasting for generations

Using natural resources revenues to finance social protection, and specifically social assistance schemes such as CTs, represents an important opportunity for countries that have made recent natural resources discoveries. This strategy may be optimal in countries wishing to tackle poverty and vulnerability in the short run concurrently with improving the human capital of their citizens, thereby reducing poverty and vulnerability in the long run.

CTs can be an effective policy tool not only for tackling poverty, vulnerability and food insecurity, but also for triggering other positive effects, including increasing the demand for health and education services. The channels through which this can happen are varied, and are not only monetary. For example, CTs can help to strengthen beneficiaries' social networks, trigger psycho-social wellbeing, improve intra-household relations and bargaining, and nudge changes in preferences and behavior – all with indirect positive effects on access to schooling and health services.

Overall, such benefits translate into further impacts in the long run: an increase in the employability and productivity of new generations through more pronounced human capital accumulation amongst the poor. There are also immediate indirect benefits of CTs on the growth of the local economy, through increased purchasing power of beneficiary households and multiplier effects.

Allocating natural resources revenues to social assistance initiatives can increase accountability and support existing policy processes

Investing natural resources revenues in social assistance would support existing government initiatives across Africa and build on the know-how and systems developed in recent years by

donors and governments alike. Moreover, the existing social contracts, social accountability frameworks (including grievance mechanisms and links to community committees) and M&E systems developed for the provision of social assistance would help to ensure the accountability in respect of natural resources revenues expenditure.

Such an approach would also be in line with the recommendations set out by the African Union, which has been advocating the development of strategies for 'introducing and extending public-financed, non-contributory cash transfers' (African Union, 2008).

Practical guidelines do exist regarding how to maximize impact on health and education using CTs

Evidence has shown that CTs (and other social assistance schemes) can be specifically designed to increase their impact on access to services. The most popular way to do so, especially in Latin America, has been to condition receipt of the transfer on desirable behaviors. However, CCTs can be expensive and complex to administer, and they are not necessarily the most appropriate option in many African countries. In fact, explicit conditionality is not the only way that behavior can be conditioned effectively. There are many other ways to maximize impacts on access to services.³¹ These include:

- Carefully designing the amount, frequency and modality of payment of the CT. For example:
 - Larger transfer size is not consistently associated with larger program effects on school enrolment or health access. Best practice has been to set the benefit level in relation to the desired impacts (though not too low, e.g. not below 20 per cent of household consumption).
 - The frequency of the payment should be set by balancing convenience for beneficiaries with costs for the program, without compromising the regularity and predictability of the CT. Programs in which transfer payment is bi-monthly or quarterly tend to report larger effects on health and education than those in which payment is monthly (partly as less frequent and higher payments can more easily be used to cover lump sum costs faced by households to access services). Best practice is applied by programs that have tied payments to households' seasonal needs or to the school cycle.
 - Where this is viable, transferring cash through bank accounts or mobile money (e.g. cell phone technology such as M-PESA in Kenya) can trigger saving behavior, which in turn can affect investments in human capital accumulation. Other benefits include reduced stigma for the beneficiary, increased flexibility, and reduced transaction costs in regard to collecting the cash, as well as the benefits of entering a formal banking system. From a systems perspective, new technologies can also lower the possibility of fraud.
 - Selecting women as the main recipients of payments can increase expenditure on food and children's clothing, and decrease the amount spent on alcohol and tobacco. Effects on schooling or access to healthcare of female vs male recipients have not been systematically documented, despite the theoretical literature endorsing this hypothesis.
- Tailoring the transfer's targeting approach by somehow identifying households that under-invest in their children's (or household's) human capital. However, the focus of targeting is primarily reaching the poorest households (redistribution), and this objective can present trade-offs with the objective of increasing access to services.

³¹ Note that these recommendations reflect only the policy objective of maximizing access to services. If another policy objective were selected (e.g. maximizing poverty impact) a different set of recommendations would hold.

- Implementing behavior change communications strategies and information sharing sessions alongside the CT. For example:
 - Communication strategies have been successfully carried out alongside the roll-out of CT systems in order to communicate about a wide range of implementation-related issues, including the suggested usage of the cash and the importance of spending on preventive healthcare and schooling (e.g. adopting behavior change strategies).
 - Informational sessions on parenting practices, including hygiene, nutrition and the importance of schooling, were successfully organized in several countries, with documented impacts on knowledge and practices.
- Coupling CTs with supply-side interventions, so as to trigger virtuous cycles, is international best practice. In some cases, CTs have capitalized on synergies with successful supply-side interventions already being implemented. For example, in Chile, Indonesia, Ghana and Mongolia, CT recipients are automatically linked to the free receipt of other public services (e.g., health insurance). In other cases, such as in Mexico, Nicaragua and Honduras, the government allocated additional resources to health and education as part of the design of these programs. Implementing CTs in coordination with different ministries (e.g. health or education) can also increase their effectiveness substantially.

Cross-ministerial collaboration and policy coordination is needed for effective social protection across Africa

A recent call for action by the WHO (2011) has recognized an urgent need for cross-ministerial collaboration when implementing social protection policies, and especially CT programs. Social development and social welfare ministries are often under-staffed, isolated from other ministries, lack sectoral technical know-how on how to enhance health and education outcomes, and are incapable of having sufficient bargaining power with regard to the center of government. Ministries of finance, health and education should therefore:

- Consider social protection and CTs as a concrete policy option in pursuit of health and education outcomes, with a particular focus on equity and tackling the social determinants of poor outcomes;
- Build cross-sector partnerships to help with the design, funding, implementation and evaluation of CT schemes in individual settings; and
- Offer technical assistance in relation to key aspects of scheme design and implementation (WHO, 2011).

Of course, such an intersectoral dialogue is facilitated by the recent push for the development of social protection floors and integrated systems for social protection, including the financing (by World Bank and other donors) of integrated systems for data and information management. It is also consistent with the message from this series of papers that effective human development based on new natural resources revenues calls for a far greater degree of cross-ministry collaboration than is common in SSA.

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Annex A Additional tables and information

Table 4: Experience with CTs of countries with recent natural resources discoveries

Country and programme	Program objectives	Number of households currently targeted	Coverage as per cent of poor households	Estimate of cost at scale (as per cent of GDP and government budget if possible)	Percentage of yearly budget that is government funded
Kenya HSNP	Reduce extreme poverty in Kenya, ending hunger and protecting assets	69,000 (soon to be 100,000 with HSNP 2)	1.1 per cent of total Kenyan households and 2.5 per cent of those living under the official poverty line ³² (at HSNP 2 coverage)	For Phase 1, funding was provided by DFID and AusAID, to a total of GBP 40.5 million (US\$ 65 million) between 2009 and 2013	No government contribution for Phase 1. Government is co-funding Phase 2 with progressive financial contributions ³³
Kenya CT-OVC	To provide regular cash transfers to households with orphans and vulnerable children, to encourage fostering and retention of orphans and vulnerable children in households within communities and to promote their human capital development	155,000; it is expected that the total beneficiary load will reach 240,000 households by early FY 14/15	2.8 per cent of total Kenyan households and 5.9 per cent of those living under the official poverty line (at expected coverage)	US\$ 32–35 million, or 0.1414 per cent of nominal GDP	Initial funding by UNICEF, then government funded (with World Bank funding) ³⁴
Uganda Social Assistance Grants for Empowerment (SAGE)	Reduce chronic poverty and improve life chances for poor men, women and children in Uganda	Aims to reach 95,000 households at pilot level (Apr 2011–Feb 2015)	1.3 per cent of total Ugandan population and 5.4 per cent of those living under the official poverty line	Overall funding of £39 million has been agreed for the program	During its initial five years, the program will be supported by international partners, in particular DFID, Irish Aid and UNICEF
Mozambique PSSB	To ensure that consumption by severely labor-constrained households does not fall to levels insufficient for survival	326,000 current beneficiary households (first semester 2014). No further significant expansion is anticipated	8 per cent of the total number of households in the country	0.3 per cent of GDP	11 per cent of all social assistance expenditure by Mozambican National Institute for Social Action (INAS) was externally funded in 2013. Expected to further reduce in 2014

³² Based on assumptions that the total population in Kenya is 44.35 million, that 47 per cent of the population lives under the official poverty line and that average household size is 5.1.

³³ A Memorandum of Understanding signed between the National Treasury and DFID on 20th February 2013 commits the government to progressively increase its financial contribution to the program, with KSh 312 million (\$3.5 million) paid in 2013/2014 and KSh 624 million to be paid in 2014/2015, increasing up to KSh 2,496 million in 2016/2017. Development partners (DFID and AusAID) are committing GBP 85.59 million for that period (HSNP website <http://www.hsnp.or.ke/>).

³⁴ See also World Bank (2015) for details.

Ghana LEAP	To supplement the subsistence needs of the extremely poor, connect beneficiaries to related services to improve their welfare, and encourage comprehensive social development	Started in 2008 and reached 70,000 beneficiaries in 2012. It is in the process of being scaled up to 100,000 households	Reaches around 1 per cent of all households and 5 per cent of those living under the official poverty line	0.1 to 0.2 per cent of government expenses (International Policy Centre for Inclusive Growth (IPC-IG), 2008b)	About 50 per cent. Every payment to beneficiaries by the government is matched by a subsequent payment by donors. This does not cover running costs etc.
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Source: authors' elaborations

Table 5: Pre-conditions needed for successful implementation of conditionality

	Dimension	When are CCTs useful?	When are UCTs and other policies more suitable?
Policy Design	Clarity of policy	Clear policy objectives, set of 'desirable' and easily targetable behaviors associated with this objective	Unclear policy objectives, focus on relieving poverty in a broader sense
	Linkage between desirable behaviors, publicly provided services, and objectives	Clear and strong linkage between final objective (e.g. human capital accumulation) desirable behavior encouraged (e.g. school attendance) and service provision system (e.g. public school system)	Unclear linkage between final objective (e.g. poverty reduction) and desirable behavior encouraged (e.g. productive investment). Unclear link between behavior and service provision system
	Consideration of other 'mild' forms of conditionality	Analysis of the relative effectiveness of the three mild forms of conditioning (conditionality relating to access, implicit and indirect conditioning) as opposed to explicit conditionalities and realization that they are ineffective for the policy objectives	Analysis of other forms of mild conditioning and realization that policy objectives can be reached through those alone (i.e. no need for explicit conditionality)
	Analysis of demand and supply of services	Detailed analysis of barriers to the demand for desirable goods and services, and of the quality and effectiveness of supply. Existence of demand-side barriers to desirable goods and services rooted in information, preferences and power structures	Lack of analysis or thorough understanding of country-level demand and supply of public services. Most demand-side barriers to desirable goods and services do not depend on information, preferences and power structures
	Ability to fine-tune policy	Effective usage of monitoring and evaluation to fine-tune CT design in response to specific individual sets of constraints so as to maximize results	No ability or political scope for fine-tuning of the programme so as to maximize results
Country Context	Supply of services	Developed supply of public services; equitable distribution of services; high quality and effectiveness of services	Undeveloped supply of services; inequitable distribution of services; low quality and effectiveness of services
	Capacity for scaling-up of public services provision	Existing capacity for scaling-up of public services provision (due to increased demand for services)	No capacity for scaling-up of public services provision

Dimension	When are CCTs useful?	When are UCTs and other policies more suitable?
Poverty levels	Households live at a subsistence level and are generally capable of satisfying their basic needs. Spending additional money on desirable behaviors is therefore less of a burden	Households live below a subsistence level and are not capable of satisfying their basic needs. Spending money on desirable behaviors is therefore an additional burden that detracts from the value of the benefit (effective exclusion of most vulnerable households)
Implementation infrastructure and monitoring costs constraints	Reasonable costs involved in monitoring explicit conditions. Presence of pre-existing infrastructure that can be used to decrease the costs of monitoring compliance	Budget constraints. No pre-existing infrastructure that can be used to decrease the costs of monitoring compliance
Beneficiaries' compliance burden	Low burden on beneficiaries in regard to monitoring their compliance (e.g. streamlined system for verifying attendance at schools, etc.). No severe budget constraints (CCTs are more expensive to implement)	High burden on beneficiaries in regard to monitoring their compliance (e.g. families having to provide certificates and incur travel costs to prove compliance)
Political feasibility	Middle class opposed to CCTs to poor households except if some form of co-responsibility is ensured	Weak middle class and strong focus on creating a safety net for the poorest households

Source: Barca and Pellerano (2014)

Table 6: Social insurance, labor market interventions and other types of social protection: potential impact on access to health and education

Type of social protection	Sub-typology	Description	Potential impact on access to health and education	Addresses: ³⁵			
				Poverty	Costs	Preferences	Knowledge
Social insurance: contributory programs (participants make regular payments to a scheme that will cover costs related to life-course events)	Contributory pensions; health, unemployment, or disaster insurance; and funeral assistance	Can be provided formally through a bank or employer, or informally through a community-based pooled fund. Social insurance is strongly linked to the formal labor market	Coverage mostly limited to formal workers, so no poverty focus. Health insurance has strong impacts on health	✗	✓	✓	✓
Labor market interventions: provide protection for poor people who are able to work, and aim to ensure basic	Active interventions	These aim to help the unemployed and the most vulnerable find jobs, through interventions such as job centers, training, and policies to promote small and medium-sized enterprises	If successful, can have secondary impacts on health and education, but less easy to trace	✓	✗	✗	✗
	Passive interventions	Include maternity benefits, injury compensation, and	Focuses on those already in work, so no strong poverty	✗	✗	✓	✗

³⁵ These columns should be read as answers to the following questions: Does this intervention address a. poverty and vulnerability? b. the cost barriers associated with accessing health and education? c. barriers linked to attitudes and preferences? d. barriers linked to knowledge and information?

standards and rights		sickness benefits for those already in work, financed by the employer. Passive interventions also include changes to legislation, for example establishing a minimum wage or safe working conditions	focus. Sickness benefits etc., have strong impacts on health				
Other types of social protection (not always included in standard definitions)	Subsidies	Can keep prices low for basic goods and services consumed by the poor	Often regressive (e.g. fuel subsidies); not fungible	✗	✗	✗	✗
	Social care and support	Highly complementary to social protection, addressing the interaction between social and economic vulnerability, through services such as home-based care and family support services	Costly and complex to administer, but can have large impact on access to health and education of vulnerable households (case management, etc.)	✓	✗	✓	✓

Source: authors

Annex B Evidence of impact of CTs on health and education

B.1 Impact on access to education

‘There is a significant diversity of evidence sources that indicate that both conditional and unconditional transfers tend to improve school enrolment and attendance’ (DFID, 2011).

The most recent systematic review of international evidence on the topic³⁶ suggests that both CCTs and UCTs have a significant effect on enrolment. Specifically, CCTs increase the likelihood of a child being enrolled in school by 41 per cent, and UCTs increase the likelihood by 23 per cent. Both results are strong, but conditionality increases the intensity of the effect. Specifically, the study concludes that the highest effects on enrolment are found for those CCTs that monitor compliance and penalize non-compliance (Baird et al., 2013).

A similar meta-analysis – which focuses on CCTs alone – concluded that all results are positive and statistically significant, with effects varying largely in size, and being higher for secondary than primary schooling.^{37,38} For example, findings from the study show that primary school enrolment rates increase by 6 percentage points and secondary school rates increase by 10 percentage points for children in families that receive CCTs. Attendance rates also increased for families receiving the transfer by 3 per cent for primary school and 12 per cent for secondary school (Saavedra and Garcia, 2012).

Interestingly, results from recent impact evaluations in SSA – where programs are mostly unconditional – have shown confirmation of these positive impacts on access to education, though with less clear-cut results than in the global evidence discussed above (partly as having an impact on education was not a primary objective of SSA programs). Box 7 discusses experiences in Kenya, Malawi, Lesotho, South Africa and Ghana.

The evidence is more limited and less conclusive in terms of whether CTs result in improvements in educational performance and skills acquired, showing that neither type of intervention has a significant effect on student test scores (DFID, 2011; Baird et. al, 2013). There are several possibilities why CTs have had a less conclusive impact on final outcomes (performance and test results), one in particular being that improved access has not been systematically supported by improved supply, leading to a weaker impact on education achievement and skills levels (World Bank, 2009).

³⁶ The study has a sample including 75 reports, with data from 35 studies, including five UCTs, 26 CCTs, and four studies that directly compare CCTs to UCTs.

³⁷ The study includes 42 references of CCT program evaluations in 15 developing countries

³⁸ Heterogeneity in reported effects is in excess of 70 per cent (Saavedra and Garcia 2012).

Box 7: Impacts on access to education in SSA

Kenya's CT-OVC evaluation found no program effects on attendance or enrolment for primary-age children (aged 6–12), with the exception of those most price-constrained, but a statistically significant positive impact for children aged 13–17 years of 7.8 percentage points.³⁹ Indicators of school progression and of lagging behind in schooling also showed a positive impact for secondary school children (Kenya CT-OVC evaluation team, 2012). Kenya's HSNP also had no significant impact on education enrolment or attendance rates, or on education expenditure by households. However, for those children already in school, the HSNP had a significant positive impact on school performance, with a statistically significant increase in the average highest class achieved for children aged 6–17, and in the proportion of children aged 10–17 passing Standard IV (OPM, 2013).

More positive results were found within the Mchinji (Malawi) Social CT Scheme, which reported a 4 percentage point increase in school enrolment among intervention households (Miller et al., 2010). The evaluation of the Lesotho Child Grant Programme likewise reported a large impact on the proportion of children (6–19) who are currently enrolled in school (5 percentage points overall) and on retention of children aged 13–17 in primary school (OPM, 2014b).⁴⁰ Similarly, a quasi-experimental evaluation of South Africa's Child Support Grant (CSG) reports a statistically significant impact of 7 percentage points on primary school enrolment, with children who were enrolled in the CSG at birth completing significantly more grades of schooling than children who were enrolled at age six, and achieving higher scores in math (Department of Social Development (DSD), South African Social Security Agency (SASSA) and UNICEF, 2012). In Ghana, the evaluation of the LEAP program also showed encouraging results, despite its inconsistent implementation. The program has increased school enrolment among secondary school aged children by 7 percentage points, and reduced grade repetition among both primary and secondary aged children. Among primary aged children LEAP has reduced absenteeism by 10 percentage points (Handa et al., 2013).

Overall, it should be noted that these results should be interpreted in the light of these programs' main objectives, which focused mainly on food security rather than human capital accumulation (World Bank, 2012).

Source: DSD, SASSA and UNICEF (2012); World Bank (2012); Handa et al. (2013); OPM (2013a); OPM (2014b)

B.2 Impact on access to health care

There is consistent evidence that a number of CT programs have increased utilization of health services (DFID, 2011).⁴¹ CTs provide the opportunity for families to overcome the economic barriers to accessing and using health services. The evidence for the effects of transfers on the use of preventive health services is generally stronger for children (DFID, 2011).

A systematic review of five CCT studies in Latin America and one in Malawi found increases in the use of health services for CT recipients. Specifically, the review reports a 27 per cent increase in individuals returning for voluntary HIV counseling, 2.1 more visits per day to health facilities, 11–20 per cent more children taken to the health center in the past month, 23–33 per cent more children under age four attending preventive health care visits (Pantoja, 2008; Lagarde et al., 2007).⁴² Similar results are presented in a review of financial incentives regarding coverage of child health interventions (Bassani et al., 2013) where 'the impact of CCT programs on preventive health care

³⁹ Among households living over 2 kilometers from a primary school the treatment effect on current enrolment was 19 percentage points higher, and 6 percentage points higher for each unit increase in the primary school cost index. These more nuanced results indicate that the program is having an important positive impact on schooling among households that are most price constrained (Kenya CT-OVC evaluation team, 2012)

⁴⁰ Interestingly, the CGP also had a very large and significant impact on the proportion of pupils aged 6–19 with uniforms and shoes (an increase by 26 percentage points) and the impact is particularly large for young children (6–12): boys and girls increase by 35 percentage points and 27 percentage points, respectively.

⁴¹ Relevant to health are also nutrition outcomes, which are beyond the scope of this paper but significant for many CTs (see, for example, DFID 2011).

⁴² As an example from the American continent, Mexico's *Progresas* evaluation found that the use of preventive services increased by 18 per cent, and a separate survey of households reported a 53 per cent increase in visits to public clinics, with no decrease in visits to private clinics, indicating that it was a net increase in access and patients were not transferring from private to public services (WHO, 2011).

use by children shows an average 14 per cent net increase among program participants compared to non-participants'. Both studies, however, found no clear-cut results for child immunizations.

Evidence from UCTs is less conclusive and is the object of study of a Cochrane Collaboration Review (2014). In Box 8, recent evidence from UCTs in SSA is reviewed, highlighting mixed effects on access to health services, but an important role of CTs in preventing distress sale of assets in the case of a health shock.

Box 8: Impacts on access to health in SSA

A recent impact evaluation carried out on the Child Support Grant in Lesotho showed no effects on access to health facilities for children, but a 5.2 per cent impact for adults, as well as a 37 percentage point increase in registration at birth amongst children aged 0–6 (as this was an enrolment requirement) (OPM, 2014a).

Similarly, an evaluation of the HSNP in the arid dry-lands of Northern Kenya reported no impact on access to facilities, but a small significant positive impact on health expenditure (OPM, 2013). Kenya's CT-OVC evaluation also provided no significant evidence of impact on child health indicators, though most indicators were 'moving in the right direction' (Ward et al., 2010).

In Ghana, though LEAP successfully helped to enroll children in the national health insurance scheme (with children 34 per cent more likely to be enrolled than in comparison households), no significant effects on health utilization were seen (Handa et al., 2013).

Nevertheless, qualitative evidence from Ghana did highlight increased ability to afford prescription medicines, and occasionally major operations, without distress sale of assets – as did evidence from Kenya and Lesotho (OPM, 2014). This insight is important: while any major health shock is met by hospitalization, the difference between households who receive and do not receive the CT in these impact evaluations was to be found in the capacity not to pursue negative coping strategies with detrimental effects on household welfare in the long term (impacts that are confirmed by quantitative evidence).

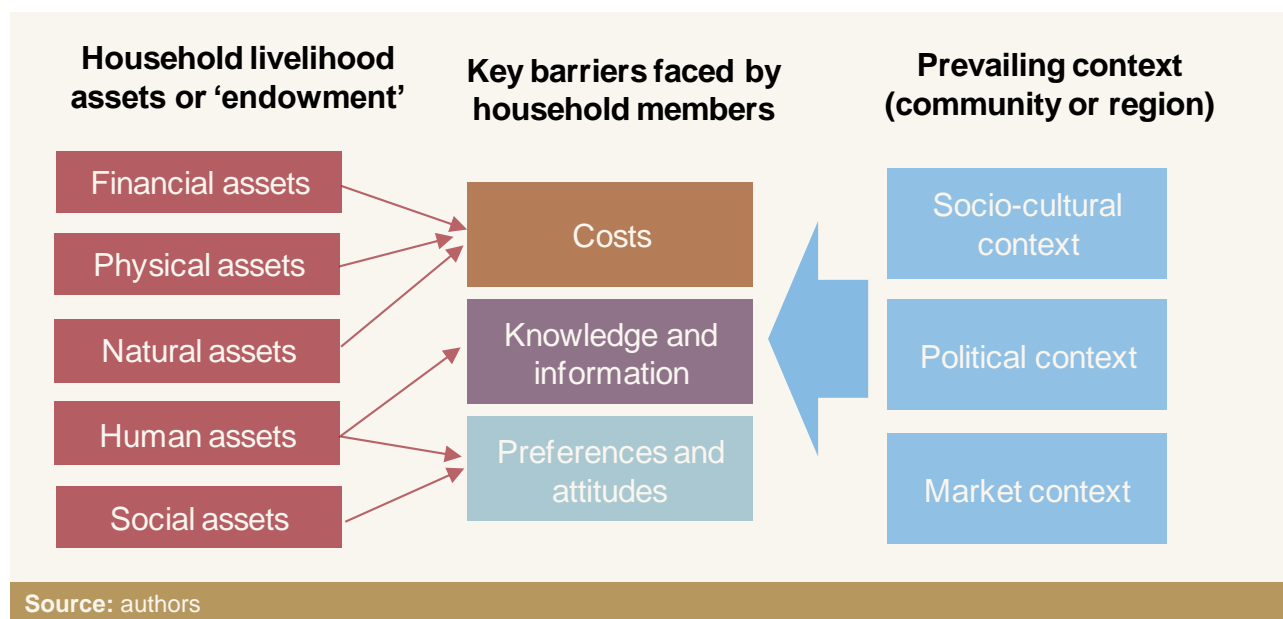
In an interesting new trend, moreover, CCTs in SSA that have been explicitly conditioned on attending preventive health care visits or other health outcomes have shown some positive results. An RCT of Burkina Faso's Nahouri CT Pilot Project (NCTPP) (Akresh et al., 2012), for example, showed a 49 per cent increase in visits to health clinics for children under five in the CCT branch compared to the control. In Tanzania, a CCT for the prevention of HIV and sexually transmitted infections (STIs) reported a 27 per cent lower STI prevalence rate than the comparison group for those receiving a high enough transfer after each round of negative testing (De Walque et al., 2012).

Source: Ward et al (2010); Akresh et al. (2012); De Walque et al. (2012); Handa et al. (2013); OPM (2013a); OPM (2014a)

Annex C Barriers to accessing health and education services

This annex provides more details about the specific barriers to access faced by households when accessing health and education services, as briefly summarized in Section 4.1. The linkage between the main barriers, household endowments and the prevailing context is summarized in Figure 7.

Figure 7: Links between main barriers to access, household endowments and context



C.1 Key barriers for household members

Three key barriers to access in health and education at the individual level have been identified; these are:

- Costs;
- Knowledge and information; and
- Preferences and attitudes.

The multiple costs faced by households when accessing health or education services pose a significant barrier to access. Users face direct costs and fees (official charges, enrolment fees, cost of medicines, cost of books and school uniforms, etc.), indirect costs due to travel or bribes, and opportunity costs in terms of the time they could have spent more productively.^{43,44,45} There is also strong empirical support for the proposition that the poor are more price sensitive than the better

⁴³ A study in Burkina Faso, for example, suggested that transport costs accounted for 28 per cent of the total costs of using hospital services (Sauerborn et al., 1994). A recent delivery survey in Bangladesh found travel costs were the second most expensive item (after medicines) in outpatient treatment (CIET Canada 2000) – both cited in Ensor and Cooper 2004.

⁴⁴ Bribes and unofficial payments for supposedly free health care are frequent around the world, but have been documented in particular in the former Soviet Union and eastern bloc. As an extreme example, in Armenia, in 1999, 91 per cent of users were paying informally for public health care (O'Donnell, 2007).

⁴⁵ 'Consuming health care, for example, can be time intensive. Both patients and relatives may have to give up long periods of work (or leisure) to receive treatment. This represents an important cost to individuals, particularly during peak periods of economic activity such as harvest time' (Ensor and Cooper, 2004b). Similarly, for education, the opportunity cost of sending children to work earlier is huge for the poorest households (OPM, 2010)

off, and that indirect prices and opportunity costs can play as much or more of a role than direct costs in deterring access to services (O'Donnell, 2007).

Preferences and attitudes are strongly linked to prevailing cultural norms (socio-cultural context), but are shaped by the particular background and beliefs of each household member.

- Many households present inequitable control over household resources. For example, spending on male household members is often preferred to spending on females (especially in cases where early marriage is the norm); or male members may be more likely to spend on agriculture than health or education.^{46, 47}
- Frequently, decision-making will be characterized by a tendency not to value the future as much as the present and to make 'non-optimal' decisions on that basis. In the realm of health, this will lead to under-investment in preventive cures and to the under-estimation of the impact of illness. In education, it similarly leads to an under-estimation of the benefits of secondary education for long-term earnings.
- Psychological barriers linked to lack of confidence, dignity and stigma can play a large role in undermining attitudes regarding engagement with public services, especially for schooling. This is linked to the perception by certain population groups that they are/will be excluded and treated differently than others (discrimination barriers to uptake).
- Strongly linked to the overall quality of services (a supply-side problem) are people's demand-side responses to poor quality of services, which diminishes their trust in the service itself and makes them less likely to access it.^{24, 25}

An important role is also played by the lack of knowledge and information about the long-term benefits of accessing health and education services, of the options available (different facilities, which facility is best, etc.) and how to negotiate access to them (overcome the bureaucracy, etc.). Linked to levels of education within the household (but not entirely dependent on those levels) this barrier goes beyond numeracy and literacy skills and depends on what specific messages have been communicated to the household and how these have been received.

C.2 Household livelihood assets or endowment

These three main barriers are all influenced by the household's endowment and livelihood assets, which affect its access to services in many different ways. In line with the 'livelihoods framework' (Chambers and Conway, 1992) our framework stresses the importance of a households' endowments in determining its choices, and eventually its livelihood outcomes.

- A household's overall financial assets (income and wealth) will influence its propensity to invest in human capital accumulation (health and education) rather than in food and basic survival (beyond specific budget constraints linked to costs). A multitude of studies have shown that, even where health care provision is free, higher income households have significantly higher access (O'Donnell, 2007).
- Increasing levels of human assets in the household (especially the education level of decision-makers) encourage access to health and schooling.²⁶ This is not only due to the acquisition of basic skills, such as literacy and numerical skills, but also to the 'understanding of institutions such as administrative and legal processes that give

⁴⁶ See, for example, Quisumbing and Maluccio 1999 and evidence from the Voices of the Poor study.

⁴⁷ Examples in the health sector include the unpredictability of opening hours, absenteeism of doctors, hostile staff, lack of medicines and equipment, and misdiagnosis (O'Donnell, 2007); in the education sector common problems cited are teacher absenteeism, lack of equipment and books, bad teaching, inadequate catering to needs (e.g. toilets), and perceived lack of safety (OPM 2010).

²⁵ In Ghana, for example, a decline in the quality of public health services was associated with a 40 per cent fall in utilization within five years (1979–1983) (cited in O'Donnell, 2007).

individuals control and confidence in utilizing information to improve their lifestyles and health/education status' (Ensor and Cooper, 2004).

- Social assets also take their toll on participation in community decision-making and friendship networks: the more a household is connected to a community network and feels dignified, the more likely it will be resilient to shocks, proactively engaged with public services and free from the stress and social exclusion that has detrimental effects on health and education (Wilkinson and Marmot, 2003; Sabates-Wheeler, Adato and Devereux, forthcoming).
- Natural assets (ownership, use, and disposal of land) and physical assets (entitlement to, use and ownership of productive and non-productive assets) will strongly influence livelihood choices and a household's ability to generate income and cope with shocks, with strong secondary impacts on investments in human capital accumulation.

C.3 Prevailing context (community or region)

Even more distant, but still important in determining barriers to access, is the prevailing socio-cultural, political and market context within the community and region – this frames demand-side barriers and contributes to defining and mediating individual and household-level practices and attitudes.

- The socio-cultural context determines how women are valued and treated within the society (the restrictions of purdah, for example, will affect women's behavior). It may also dictate overall attitudes toward the value of 'modern' over 'traditional' practices. In the health sector, this will lead to preferences for traditional therapies (witch doctors and traditional healers, etc.). In the education sector, it could mean that early marriage or child labor to 'learn the family trade' are seen as a priority over schooling.
- The political context defines access to resources, community power dynamics and overall levels of voice and accountability.
- The market context, on the other hand, can determine the ability to borrow resources to invest in human capital, or the reward to higher investment in human capital (higher demand or salary for skilled workers).