Lessons offered by Latin American cash transfer programmes, Mexico's *Oportunidades* and Nicaragua's SPN. Implications for African countries

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1. Introduction

A new generation of programmes to combat poverty has been designed and put into practice in the last ten years. These programmes tend to be oriented towards mitigating the most negative consequences of poverty. Among the new generation programmes, the most outstanding are those offering cash transferences to the population. These transferences may be conditioned to specific concerns raised by interested members of the population. They try to foster the accumulation of human capital in children and youngsters as a way to break the cross-generational cycles of poverty. In Latin America, most of these programmes have at least two components: an educational component and another one related to health and nutrition.

The existing experiences in Latin American show important differences in the range of goals included in these programmes' strategies.[1] Some of them adopt an integral approach to social development, while others centre on reaching specific results inside a well defined population group. Variations also exist in different programme objectives such as the reduction of child labour and the creation of social protection networks during critical situations.

The best known examples in Latin America are: *Oportunidades* (previously PROGRESA) in Mexico, Social Protection Network in Nicaragua, *Bolsa Escola* and PETI (Infant Labour Erradication Programme) in Brazil, Family Assignment Programme (PRAF) in Honduras, Programme of Advancement through Health and Education in Jamaica, and *Chile Solidario* Programme (See Annex).

Cash transfer programmes in Latin America have been intensively studied and evaluated. This makes it possible to undertake a thorough systematization of the generated information in order to identify useful lessons for other developing countries starting their own programmes.

This paper describes the cases of Mexico–*Oportunidades* and Nicaragua Social Protection Network as well as cash transfer programmes in Malawi and Zambia. In its final section the paper discusses the possible implications of the Latin American experiences on the development of these kinds of programmes in African countries.

The document includes an annex (Annex 2) containing specific information about the existing programmes.

2. Mexico: *Oportunidades* Human Development Programme

2.1 Background

According to World Bank indicators Mexico is considered a middle income country with a per capita annual expenditure of US$8,540 and a population of 101 million people in 2002. However the distribution of income is highly unequal and 51% of the population is considered to be living under the poverty line. The income obtained by this part of the population is less than the one required to cover basic education, health, transportation and housing needs. Furthermore, 20.3% of the total population has a daily income of 1.5 USD per person.

The economic and social development of Mexico has been characterised by periods of growth and crisis. As in many other developing countries, Mexico has had a very modest growth in the last 20 years along with two major economic shocks. The welfare structure in education and health has been growing to become an important economic area. Governmental education expenditure represents 5.6% of GDP and governmental health expenditure 2.8% (See Annex). Despite the growth in welfare public expenditure and resources devoted to health and education, the concentration of income has developed a profile of deep inequities in the country. 42% of Mexico's total wealth is concentrated in the richest decile. This concentration of income is also mirrored by the distribution of public resources across the social structure. Historic budgeting makes public money to be preferably located in urban and middle class areas. The 50 million Mexicans that live in poverty have made claims for resources that are not easy to obtain through traditional expenditure patterns. Oportunidades has represented a new way to invest in the poor by channeling resources directly to families in order to promote their access to the available existing infrastructure.

2.2 Health needs of the very poor.

There are two distinctive traits in the Mexican population health profile: the double epidemiological burden and the existing inequality between the richest and the poorest populations in the country. The first one refers to the disease profile in which poverty-related problems such as infectious diseases and under-nutrition coincide with chronic illnesses showing an increasing trend.[2] The second issue reveals that the burden of disease in high-income groups shows a pattern similar to those in European industrialised countries while the pattern in empoverished groups is similar to those of the most underdeveloped countries.[3] Some examples are shown in table 1.

Table 1. Epidemiological profile of the poorest populations in Mexico

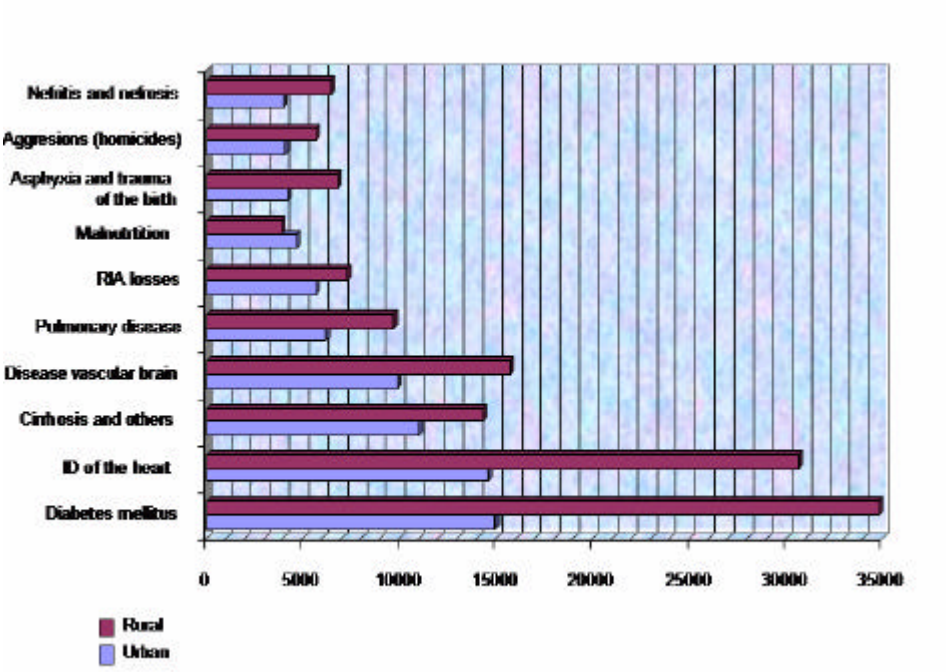
Health Indicador	High-income status	Low-income status
Life expectancy at birth	Baja California Sur and Nuevo Leon show figures that are similar to the ones reached by France (79)	Chiapas y Oaxaca show figures similar to the one of El Salvador (70).
Infant mortality (< 1 year). Average rate is 23 children death per every 1,000 born alive.	Below 20 children per 1,000 are Nuevo Leon, Federal District, Jalisco, Coahuila and Sonora which are similar to Chile, Costa Rica and Argentina.	Between 20 and 40 children death per 1,000 are Chiapas, Oaxaca, Guerrero and Puebla. These rates are similar to those of Brazil, Ecuador and Peru.
Probability of dying for adult population between 15 and 59 years	Nuevo Leon, Baja California Sur, Quintana Roo similar to European industrialised countries of the United States	Rural zones of Guerrero and Oaxaca: similar to those of El Salvador, Nicaragua, Honduras or Indonesia. Between 1992 y 1998 mortality in male adults in rural areas showed no change, while in urban areas decreased 17%. Among women this issue is still more dramatic as in the same period, mortality increased by 5% in rural areas and decreased by 12% in urban areas.
Caloric-proteic malnutrition. According to the 1999 National Nutrition Survey, there are around 2 million children below 5 years old with some degree of malnutrition.	In general, Northern states and the Federal District (Mexico City) show lower rates of malnutrition.	The retardation in growth of children in rural areas is almost three times more frequent than in urban areas, and four times higher in rural areas of poorest states as compared to the urban areas of Northern states. It is estimated that undernourished children loose between 12 and 15% of their intellectual capacity, have 8 to 12 times higher risk of contracting infectious diseases as compared to a well nourished child and have a higher risk to develop a chronic disease.

Other data reveal that:

1. The transmittable diseases that most contribute to the burden of disease in descending order are: respiratory infections, diarrheas, tuberculosis and sexually transmitted diseases. Diarrheas and respiratory infections still represent a significant proportion of the burden of disease in the Mexican population, particularly in rural areas. The risk of dying of diarrhea in the rural area is three times higher than that of the population living in urban areas.
2. In the year 2001 cardiac diseases, malignant tumors, diabetes, cirrhosis, and cerebro-vascular diseases concentrated more than half of the deaths occurred in the country. In the rural areas these same diseases concentrated 48% of deaths.
3. According to the 2000 National Health Survey, around 7.8% of the rural population over 20 years old has diabetes mellitus, a similar figure to that estimated for the urban areas. The prevalence of arterial hypertension in rural

areas is lower than that in the urban ones, but is not dismissable: around 17% of the population between 20 to 69 years presents this pathology.

Figure 1. Ten main causes of mortality according to rural or urban area in Mexico 2001



Mortality data base 1999, 2001, INEGI/Secretaría de Salud.

2.3 Purpose and requirements to obtain the subsidies

Oportunidades promotes specific inter-sector actions in education, health and nutrition. Its main objective is to help those families living in extreme poverty conditions. Its aim is to enhance the capabilities of their members and to broaden their alternatives to reach better levels of wellbeing by giving them better options in education, health and nutrition. It must also contribute to linking them with new development services and programmes to enhance their socio-economic conditions and their quality of life.[4] *Oportunidades* had its beginnings in 1997 with the *Progresa* Programme, which was developed as part of a radical change in the social policies of the Mexican Government. This change substituted traditional supply subventions with interventions on the demand side through direct cash transferences for the poorest families.[5]

In order to receive cash aid, the beneficiary families incorporated into the Programme are required to: 1) enrol all their children under 18 years old in elementary or secondary (high school) authorized schools and assure their regular attendance; 2) enrol youngsters up to 20 years old in the authorized medium high education institutions and

assure their regular attendance; 3) register in the corresponding health unit; 4) attend programmed visits of all of the families' members in order to receive the interventions available under the Basic Health Services Package; 5) the main beneficiary must attend monthly health education sessions; 6) promote and help the medium high education scholarship beneficiaries to attend health education sessions specially dedicated to them; and 7) use cash help to improve the family's wellbeing, particularly regarding children's nutrition and their school performance. Non-compliance with these activities means the immediate suspension of the cash aid.

2.4 Beneficiaries selection and subsidy type

The selection of the beneficiary families is made in three stages: 1) First the geographical zones presenting the highest levels of poverty are chosen with consideration given to measures of marginality level, which are based on criteria stated by the National Population Council (CONAPO). Once the zone has been selected, the access and services capabilities of the health units and elementary schools are verified; 2) beneficiaries are selected using a census based on a qualification system that reflects the poverty level of the family regarding a set of basic indicators. Those who are below the extreme poverty line are entitled to receive the benefits, and 3) a further filtering of the beneficiary families list is done in community meetings where proposals about families incorrectly left out or included are taken into consideration.

The subsidy is handed out directly to mothers through public and private institutions in order to enhance women's roles in the low income level households and to reduce the risk of deviation of the resources towards ends other than improving nutrition and improving the children's quality of life. It has been calculated that 70% of the money received is used to increase the availability of food in the household, in terms of quantity (calories) as well as quality (protein and micronutrients).[6]

2.5. Financing

The programme is totally financed by the federal budget and represents a total estimated cost of USD $2,200 million in 2004 (0.32 % of GNP in 2004).[7] The executor is the Ministry of Social Development (*SEDESOL*) in coordination with the Ministry of Health (*SSA*), as well as the subsidised branch of the Mexican Institute of Social Security (*IMSS*), as part of the health sector, and the Ministry of Education (*SEP*). It is estimated that the investment in the Programme will reach USD$ 3,280 million by 2005 and that it will benefit 5 million families.[8] (See Table 2)

2.6. Programme Operation.

1. Education Component.
Objective: to increase the transition to secondary education among low-income children, specially those inhabiting rural zones.

2. Health component
Objective: The Programme established specific strategies designed to improve health: a) to provide basic health services on a free basis; b) to avoid malnutrition among children starting from the gestation period, c) to improve nutrition through cash transferences, dietary supplements and education, and d) to improve hygiene habits through educational sessions for the beneficiary mothers.

3. Nutrition Component
Objective: to deliver direct cash aid to the beneficiary families in order to help them improve the quantity, the quality and diversity of their nutrition. The aim is to improve their nutrition status. Besides this, dietary supplements and nutritional education are provided to strengthen the children's nutrition as well as that of women who are pregnant or lactating.

4. Patrimony Component (*Oportunidades* Platform).
Objective: to offer development alternatives for the families. Through the links of this Programme with other social and human development programmes, this component constitutes a platform from where the scholarship recipients who have finished their studies can have an easier voluntary access to five different alternatives.

2.6.1. Interventions included in the health package.

Responding to the more prevalent health needs of poor populations, the *Oportunidades* basic health package includes 13 personal and non-personal interventions, encompassing health promotion interventions, disease prevention and treatment of the most common ailments. Among these interventions the package includes: immunizations, treatment of cases of diarrhea, treatment of acute respiratory infections, family antiparasitic treatment, prevention and treatment of tuberculosis, prevention and control of hypertension and diabetes mellitus, child nutritional and growth surveillance, detection and prevention of cervical cancer, prevention of accidents and initial treatment of injuries. It also considers different kinds of educational and community actions to improve health protection. By June 2004, 246,470 families were already receiving services through the new publicly-funded *Seguro Popular de Salud* which contains 91 interventions in its health package. More *Oportunidades* families are expected to receive services through the *Seguro Popular de Salud* in the following years.

2.6.2. Other interventions besides assistance interventions.

The health basic package also considers actions related to environmental improvement and community training for health self-care. All of them are provided at household and community level in order to maintain a clean environment and therefore to guarantee better health conditions for families. These actions are described next:

Table 2. Other interventions provided by *Oportunidades*.

Basic sanitation at household level.	It encompasses a series of effective activities to promote hygienic conditions in the environment where families and communities are living, as well as in the water and food consumed by them. It also includes the improvement of housing conditions.	Education for health, adequate handling of organic waste, control of dangerous fauna, disinfection of water at home, sanitary disposal of garbage.
Community training for health self-care	This activity is based on the participation of the community, the better use of common resources and the effort of auxiliaries, local agents, and representative trained committees to promote the link with the health sector, to offer information to the population about the available health resources, and about the better ways to control their health conditions.	Education for health; health promotion; support to health programmes; protection of food sources for self-consumption; health care in general and utilization of services.
Health education sessions.	These are carried out monthly and include 35 topics related to the Health Services Basic Package. Topics related to the epidemiological situation of the region are also included.	Educational talks.

2.7. Main Outcomes

Estimates point out that the programme reduces monetary poverty of the beneficiaries in a significant way. According to the poverty gap indicator, monetary poverty is reduced in 30% of beneficiaries, while the poverty severity indicator is reduced in 45%. These results suggest that the most important reductions of poverty are taking place among the poorest households.[9] (See Table 3)

2. 7.1 Impact on education

The most recent evaluations[10,11] show that:

- Between 2002 and 2004 there has been an increase of more than 27% in the number of scholarship beneficiaries with educational aid.
- The number of children who are scholarship beneficiaries enrolled in elementary school increased more than 28% between the 2001-2002 and 2003- 2004.
- During the same years, the number of enrolled scholarship beneficiaries in secondary school increased more than 42%.
- As for the scholarship beneficiaries in middle high level, *Oportunidades* has had a strong impact on the students' enrolment. The number of registered students increased more than 100% from 2001-2002 to 2003-2004.[12]
- 17% reduction of school drop outs in rural zones and almost 10% in urban zones, compared with 1997 figures.
- 13% reduction in the academic failure rate in rural zones and more than 20% in urban zones.
- The fact that youngsters in *Oportunidades* are deciding to continue their studies may greatly increase their chances to get better paid jobs once they finish their education, thus reducing their probabilities of staying in poverty levels.[9]

2.7.2 Impact on health

Regarding the health services utilization[13] it has been found that:

- The total consultation demand of the incorporated families has increased more than that of non incorporated families.
- Preventive consultations demand has increased more than fivefold between 1997 and 2001.
- The number of nutrition consultations has had a significantly more rapid increase in *Oportunidades* communities and it is directly related with the time they have been incorporated.
- *Oportunidades* has shown its efficacy in constantly increasing the demand for basic health services in the rural communities.

In relation to health[14] and nutrition[15] results show:

- The incorporation of the *Oportunidades* Programme in extreme poverty localities is related to an 11% reduction in maternal mortality as well as a 2% decrease in infant mortality.
- Concerning maternal mortality, the effect of *Oportunidades* is stronger in middle and very high marginality municipalities, whereas the same is true for infant mortality in very high marginality municipalities.

- A simulation exercise in 2003 has shown that the Programme has avoided 79 maternal deaths and 340 child deaths every year. These figures reflect an important change given the maternal and child mortality levels in the country.
- The improvement of nutrition and preventive health care in the zones where the Programme is operating has made it possible for the younger children to be less vulnerable to disease. Particularly, children between 0 and 5 years old show a 12% lower incidence of disease than those that are not participating in the Programme.[9]
- The analysis also shows that adults in beneficiary households are significantly healthier. This has been demonstrated by Gutierrez J, Bautista S, Gertler P, *et al*, [16] who show that in rural areas, there is a 20% average reduction in the days that 16-49 years old members of a family enrolled to Oportunidades report to be ill, compared to families that are not enrolled in the programme in the same localities.

2.7.3 Nutritional impact

Information suggests that *Oportunidades* has had an important impact in increasing the growth of children and in reducing the probability of child malnutrition in the crucial ages from 12 to 36 months.[17] These calculations imply an increase of about one sixth (16%) in average growth, which corresponds approximately to one centimetre per year for these children. There has also been a notable decline in the prevalence of childhood anaemia.

Oportunidades is generating a virtuous circle: better nutrition brings better health which, in turn, brings a better school performance.[7]

2.7.4 Cost-effectiveness evaluation

Few cost-effectiveness assessments have been carried out on *Progresa/Oportunidades*. One example is Coady and Parker (2001)[18] who carried out an evaluation of the Progresa's educational component. They considered two alternatives: a) extensive expansion of the school system (i.e. bringing education to the poor) and b) subsidizing investment in education to the poor (bringing the poor to the education system). For this purpose they compared Progresa communities with communities where schools were being constructed. Using statistical regressions on data collected before and after the program for randomly selected "control" and "treatment" households they estimated the relative impacts of the demand- and supply-side program components. They found that demand-side subsidies were substantially more cost-effective than supply-side expansions. The cost-effectiveness ratio of the extensive expansion of the school system is around 7.3 times higher than the subsidizing investment option. However, their results should be considered in the context of the programme's implementation. They do not disregard the possibility that other supply-side interventions could be more cost-effective than those currently existing.

2.8. Impact on gender equity.

One of the concrete actions promoted by *Oportunidades* to achieve gender equity is the granting of a higher subsidy rate for the education of women, both at secondary and high school levels. The granting of higher subsidies for the education of women has the objective of increasing their level of enrollment and decreasing their level of attrition particularly in rural and semi-urban areas. Some results of impact evaluations carried out in the educational component show that the effects of Oportunidades are higher for women (more than three times than men). This difference is statistically significant. Evidence indicates that:

1. At primary level. Oportunidades seems to have the capacity to reduce both educational attrition as well as failure, mainly in 3rd and 4th grades of primary school, and particularly for girls. As a result of the programme, the rate of attrition was reduced around 14% for boys and 17% for girls in 2000. The percentage for girls at 4th grade of primary school was 16.5%. Failure rates to pass from 3rd to 4th grade of primary school were reduced in 3.8% for boys and in 8.4% for girls, when their families were members of *Oportunidades* .
2. At secondary level, in semi-urban zones, the increase of female enrollment is significant.
3. At high school level in urban and semi-urban zones, female enrollment also experienced an 8% increase while male increase was only 4.9%.
4. In rural zones the impact of *Oportunidades* has increased the enrollment to secondary school in 23.2%, the effects on girls being outstandingly higher.
5. In the case of semi-urban zones, an increase of the average enrollment in 6.5% is observed as a consequence of being included in *Oportunidades*. It is worthwhile to point out that this effect is present mainly in the female population.

There is no information available that shows differences between boys and girls regarding health and nutritional impacts. However, other results obtained by evaluations have demonstrated that the characteristics of the programme´s design that give control of the monetary benefits to women, has allowed them to have higher decision power within the household. Women report a higher level of "empowerment", defined as the increase in self-confidence as well as the control of actions and over family resources.[19]

2.9. Interventions focused on adult population.

The health interventions package considers actions for all family members. Among these interventions we identify: family planning, ante-natal and post-natal care, antiparasitic treatment of family members, prevention and treatment of lung tuberculosis, prevention and control of hypertension and diabetes mellitus (pathologies that are highly prevalent in the Mexican population), prevention of accidents and initial treatment of lesions, and prevention and detection of cervical cancer. The application of these

activities requires the participation of the population according to the following procedures:

Table 3. Interventions addressed to adult population

Population Group	Age/condition	Frequency of attendance	Actions
Women	Pregnancy	5 ante-natal consultations	Nutritional advise, surveillance of pregnancy development, administration of iron and folic acid, immunizations, nutritional supplements provision, information, education and communication addressed to the couple to promote healthy behaviours regarding pregnancy, delivery and post-partum, prevention, detection and control of obstetric and perinatal risks, advise on family planning.
	In post-partum and lactation periods.	2 consultations: one right after delivery (7 days) and one at the lactation period (28 days)	Family planning, nutritional advise, new born care, encouragement of breast feeding, provision of nutritional supplement.
Adolescents and adults	Men and women between 20 and 49 years of age	Two consultations per month, one every 6 months.	Reproductive health and family planning, prevention of sexually transmitted diseases, education for general and mental health, HIV/AIDS prevention.
	Men and women 50 years old and beyond.	One consultation per year	Early detection of chronic diseases.

Some of the results achieved in the improvement of the health levels of these groups are:

1. The demand of total consultations by families incorporated into *Oportunidades* has increased more than that of non-enrolled families.
2. *Oportunidades* has shown its effectiveness by constantly increasing the demand of basic health services in rural communities.

The consumption of the basic package of services by adults is a requirement to receive cash benefits and this occurs in the largest majority of households. It has been suggested that a consequence of this utilization is making adults in beneficiary households significantly healthier than those that do not participate in the programme.[19] According to the data referred to above, the impact in the improvement of health in *Oportunidades* households, means that these households have seen a reduction by 6.2 days the number of days of reported illness for the group between 16 to 49 years old.[16]

A further issue that has to be considered is that there is no evidence showing that adults are working less because of the monetary benefits given by the programme, which means that *Oportunidades* is not creating dependency upon its benefits nor generating a reduction in self-sufficiency efforts in enrolled individuals. [19] Therefore, in general this information suggests that the improvements in health conditions in adults is related to the utilization of services provided by the programme.

2.10 Remarks:

Although the programme's operation is socially regarded as very successful, fair and transparent, it has generated problematic issues that somehow have prompted a response from the responsible institution, the Ministry of Social Development. Four main issues can be identified: a) demand is surpassing the capacity of institutions to provide educational and health services, b) beneficiaries are not getting enough information from the programme, c) there are no swift channels for the population to complain about the services they receive, d) there is a permanent risk of political mishandling at different levels of government. *Oportunidades* provides a subsidy to both Ministries, health and education, to repair old units, but no extra payment to personnel is considered. This subsidy is not enough to cope with the increasing demand created by *Oportunidades* beneficiaries on health care units and their personnel. Information gaps are not considered an important issue as top decision makers consider that communities are responsible for providing this information. This is also the case of complaints. In fact there are serious delays in the programme's response to the population's complaints. The final issue is important as Mexico has a long history of clientele politics conducted by governments. In order to guarantee the transparency of its operation money is not handled by authorities. Particularly in states where elections are to be held, the money is located in advance to avoid mishandlings.

3. Nicaragua: Social Protection Network (SPN)

3.1 Background

According to World Bank indicators Nicaragua is considered a low income country with a per capita annual expenditure of US$1,880 and a population of 5.3 million people in 2002. As in most Latin American countries, in Nicaragua the distribution of income is highly unequal and 45.9% of the population in 2001 was considered to be living under the poverty line which means a per capita daily income of less than USD 0.56. This group of population is defined under the criteria consumption aggregate index[1]. More than two thirds of rural inhabitants are poor. Similarly, more than 25% of those in rural areas are extremely poor.

[1] See table 2

3.2 Health needs of the very poor.

In Nicaragua the main cause of the population's poor health status is poverty. The epidemiological situation of the Nicaraguan population shows a combination of preventable and non-preventable health problems that are heterogeneously distributed throughout the population, according to socio-economic conditions. Although official statistics do not allow an accurate assessment, poverty is much higher in rural areas than in urban ones.[20]

Infectious diseases represented 14.5% of all causes of death in 1985, while they only represented 9% of all causes in 2002. However, transmittable diseases still represent the most important death cause for children under 5 years old.

Regarding mortality, among the most prevalent diseases in the group of children under 5 years old, we can identify diarrhoeal diseases, respiratory diseases (pneumonia), meningitis and inmuno-preventable diseases not covered by public vaccination campaigns. Prevalence of cervical cancer has increased reaching 13.9 cases per 100,000 women of reproductive age in 2002.

In Nicaragua poverty is measured by differences in food and non-food consumption levels of households. In order to show the impact of poverty on health, when health problems such as maternal and child mortality and under-nutrition are assessed, they tend to be more prevalent among those groups with lower consumption levels than those with higher consumption levels.[21]

According to the Life Level Measurement Survey (EMNV) 2001[22], 45.8% of the Nicaraguan population is living in poverty conditions, and one third of this group falls into the extreme poverty category. Poverty in Nicaragua is mainly concentrated in rural areas (five times higher than in urban areas) as well as in the periphery of the main cities. There is evidence that poverty is associated with precarious living conditions and limited access to basic services. This situation does not contribute to the healthy development of populations.

The main differences in the health determinants and population health care in Nicaragua include:

1. Population growth: Global Fertility Rate (GFR) is different between rural and urban areas, as well as between socio-economic groups when they are classified by levels of consumption. In fact, poor women, with low educational levels and living in rural areas, have a GFR of 4.4 while women living in urban areas and with higher educational levels have a GFR of 2.6.

2. Food consumption: In many rural areas, peasants and their families find it very difficult to cover their basic needs based on subsistence agriculture economy. This factor, associated to the lack of a national food security policy, promotes the existence of 20% of children under five years old with chronic under-nutrition (Demography and Health

Nicaraguan Survey –ENDESA - 2001)[23], and according to data produced by the Ministry of Health, 9% of new born children have a low birth weight. The same source shows that around 4% of women of reproductive age have nutritional problems, especially in municipalities catalogued as extremely poor.

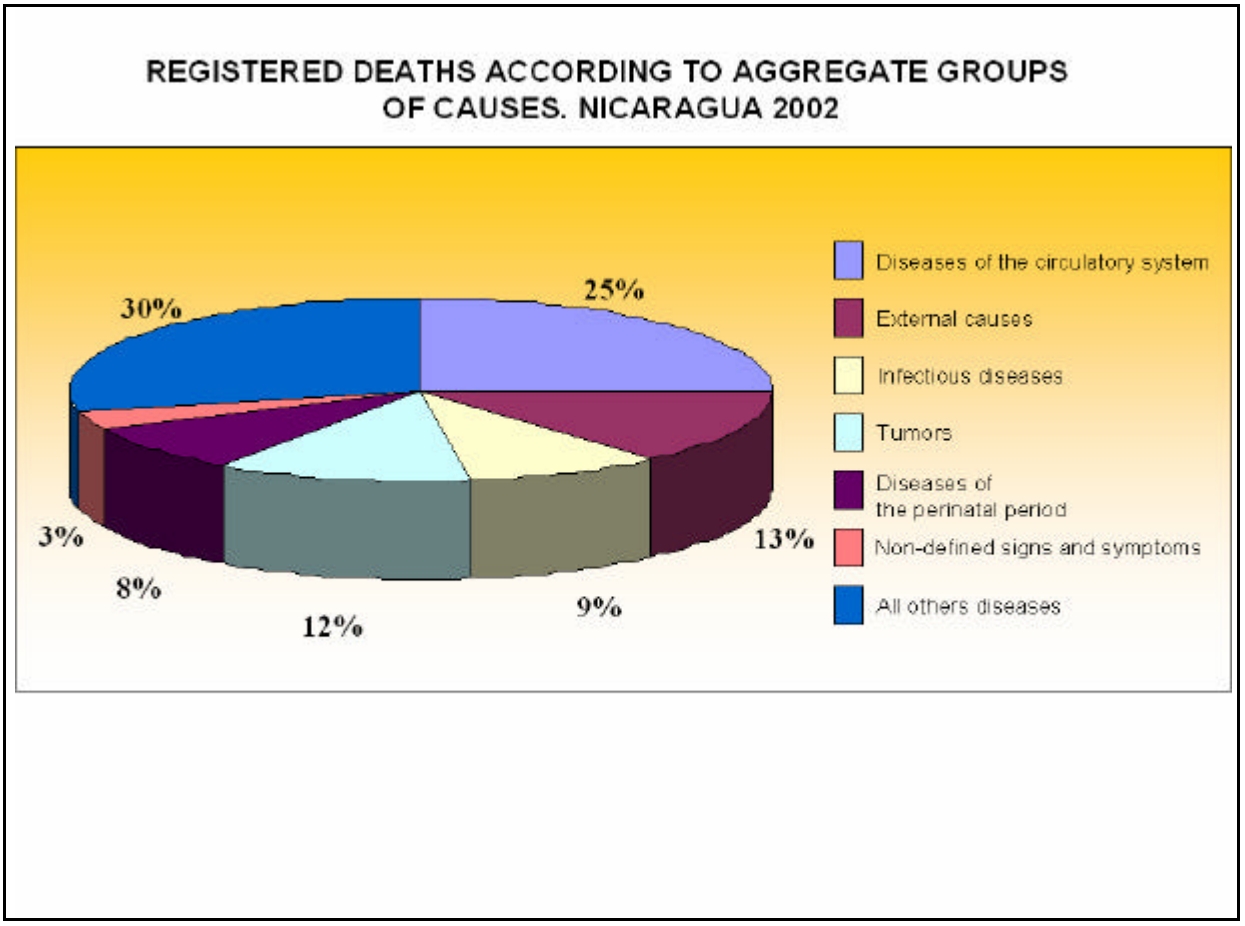
3. Immunizations: ENDESA-2001 shows that immunization coverage has an heterogeneous distribution across the population. Compared to urban areas, rural areas have a lower full-scheme coverage. By sex, inmunization levels are lower among girls.

4. Adolescent fertility: In rural areas adolescent fertility is 60% higher than in urban areas. Adolescents represent the age group with higher rates of maternal mortality. In this group, maternal mortality is associated with abortion and suicide.

5. Ante natal care: Among poor pregnant women, only 40% visited the health care unit and 43.3% received care from a professional. Unlike this group, 79.7% of pregnant women with higher consumption levels attended the health unit two times or more and 82.1% received care from a professional. Due to the existence of geographical, economic and cultural barriers the largest utilization of ante-natal care services is being made by women in urban areas vis a vis those women living in rural areas, amongst whom the highest levels of poverty are observed.

6. Delivery care: Among women belonging to the poorest 20% of the population the percentage of delivery care at a health unit was 70.4%. In contrast, among women belonging to the upper group of consumption this percentage was 97%. Also, only 27.1% of all deliveries in the first group were attended by a physician/gynecologist. This percentage was as high as 95.2% in the upper group. Therefore, the probability that a woman in the upper group receives care from a professional is more than three times higher than the probability that a woman belonging to the poorest group receives care.

Figure 2. Registered deaths according to aggregate groups of causes. Nicaragua 2002.



3.3 Objective and requirements to obtain the subsidies

The Social Protection Network (SPN) is a government promoted programme. Its aim is to promote a better quality of life level for households living in extreme poverty by investing in their human capital. The programme is part of the Reinforced Strategy for Economic Growth and Poverty Reduction ERCERP, which was approved by the International Monetary Fund (IMF) and the World Bank on August 2001.[24] SPN is based on and inspired by the lessons learned from the Education, Health and Nutrition Programme (PROGRESA) of Mexico. It is financed by the Interamerican Development Bank (IDB).

The programme has been designed in two phases. Phase I or "pilot phase" was meant to: a) establish the operative framework; b) increase care for children under 5 years old and to reduce drop outs in the first four years of elementary school; and c) evaluate the efficiency of this new approach with the use of pre-established indicators. This initial phase benefited approximately 10,000 families in 21 localities distributed along 6 municipalities.

The objectives of phase II are: a) to strengthen the initial operational framework of the Network; b) to supplement the income of families living in extreme poverty for as long as three years in order to increase expenditures on nutrition; c) to increase the care for children between 0 and 9 years old, for women in fertile age and for teenagers in general; and d) to reduce drop outs among students from 1st to 4th grade who are between 7 and 13 years old, in all the areas of the Programme.[25]

The SPN has four major elements: a) integration of education, health and nutrition in the family as its most important objective; b) the compliance with conditions on the part of the mother who receives assistance by attending training courses; c) direct transferences are conditional on results; and d) targeting.[26]

SPN is based on "contracts" established with the female head of the family receiving economic incentives against concrete results. The main conditions are to send children between 7 and 13 years to school and to maintain their attendance at school, to receive a basic infant-maternal health protocol, to attend training sessions on sexual and reproductive health, nutrition, children's care, lactation, environmental health and family hygiene and to use the received money to buy nutritious food, school materials and uniforms.

3.3.1. Selection of beneficiaries and type of subsidy

Targeting of the beneficiary population is done in three steps: a) municipalities selection; b) selection of the regions that shall receive attention inside the chosen municipalities; and c) selection of the beneficiary households inside a region.

The delivery of cash aid depends on the compliance of the family to the health care and nutritional package and education services.

The programme's aid is channeled through the "rights holder" of the family, that is, the mother or the person who is in charge of the decisions about food purchase and preparation, the children's health care and the person looking after children's attendance in school. This is a way to give the necessary recognition to women's importance, responsibility and position as agents of the family's development.

Cash aid is delivered bimonthly (except for the school provisions) to the rights holders of the beneficiary families in places that present minimal security risks. The Executive Unit of the Programme (UEP) is responsible of the payments, and specialized firms are contracted to do this. In order to receive the cash aid, the rights holder must present her identity card.

3.4. Financing

The Programme has been conceptualized as a multi-phase operation with a total cost estimated in US$ 32.22 million (US$ 29 million are financed by IDB). Each phase is financed through a different loan from the Bank (US$ 9 million and US$ 20 million each). Phase II will expand the Programme's coverage. The first phase was programmed to be executed in two years and the second one should be executed in three years.[24]

3.5 Benefits and Programme Operation.

The SPN Programme has two main components[27]:

3.5.1 Health, nutrition and nutrition security

- SPN provides each beneficiary household with a bimonthly cash transference called *nutrition bonus (NB).*
- This bonus is conditioned to the attendance to the bimonthly educational workshops as well as to the family's agreement to regularly send children under 5 years old to pre-established medical visits.
- SPN trains and contracts non-government health services providers (NGOs) to provide free primary care to beneficiaries.
- Workshops train mothers in the areas of hygiene, nutrition, reproductive health and lactation.
- Other services are also aimed at children such as growth monitoring and vaccination services, as well as provision of anti-parasite medicines, vitamins and iron (all delivered at the pre-established medical visits). Children under two years old receive monthly visits, while those above two years are visited every two months.

3.5.2. Interventions included in the health package

In order to reduce the effects of the epidemiological backlog[2] in the poorest communities, health actions considered in the programme are included in the health care package. Among those interventions included in Phase I of the project we can mention: diagnostic facilities, surveillance and growth promotion and development of children between 0 and 5 years old; vaccination of children between 0 and 5 years old; provision of antiparasitic drugs, ferrose sulfate and vitamin A; six annual training sessions for mothers on issues such as nutrition, hygiene and preventive health, and actions for the improvement of the nutritional condition of children.

[2] 'Epidemiological backlog' refers to the burden of disease usually related to low income countries (high rates of infectious diseases, poor reproductive health etc.), which remain within certain populations in countries that have already made the 'epidemiological transition' to a more pronounced high income disease profile (chronic diseases)

Phase II of the project (currently running) includes the following interventions: ante-natal care, post-natal care, family planning, vaccination of target groups, care provision to adolescents (including HIV-AIDS) and epidemiological surveillance.

3.5.3. Other interventions besides personal assistance

SPN includes actions on educational health as a complement to clinical care interventions. Some of the topics are sexual and reproductive health, nutrition, child care, maternal lactation, environmental health and personal and family hygiene. Phase II also includes modules for subsistence resources development such as animal hygiene and household economy (eg. raising of chicken and pork), among others.

3.5.4 Educational component

- SPN delivers bimonthly cash transferences to each beneficiary household known as the *school bonus*.
- This transference is conditional on the enrolment and regular attendance of the child at school.
- Additionally, the family receives an established sum of money for every eligible child, specially meant for school materials. This money is also conditional on the enrolment and regular attendance at school.
- There is also a transference for teachers and schools that is also known as the *supply bonus (SB).*

3.6 Main Outcomes

SPN supplemented per capita annual total household expenditures by 18 percent, on average. For beneficiary households, this increase compensated for the large income loss experienced by nonbeneficiaries, while producing a small overall increase in expenditures. Most of the increase in expenditures was spent on food.

According to different impact evaluations carried out by independent firms, the results of Phase I of the Programme were positive[26] and surpassed the expected goals.[17]

According to the evaluation report presented by the IDB[24], the attained goals and the lessons learned from Phase I are:

- *Institutional Strengthening (US$1.8 million).* The goals related to the institutional strengthening have been met. This is a proof of the satisfactory functioning of the institutional and executive scheme.
- *Health and nutrition security (US$ 4.4 million).* The health plan was provided under a new model based on the outsourcing to private providers in order to expand coverage of basic care. This scheme made it possible for rural families and isolated or dispersed communities to have immediate preventative care.

- *Education (US$2.4 million).* The satisfaction level of this component was measured using enrolment, school retention and school attendance indicators. SPN produced a significant average net impact in the increase of the enrolment in 21.7%.
- *Targeting and evaluation (US$0.7 million).* The results of targeting in Phase I were satisfactory even though the ambitious goals that had been established were not met.

The impact on education, health and nutrition security was:

3.6.1 Education:

- Enrolment. The Programme produced an important net average increase of 21.7% in the percentage of children of both sexes (7 - 13 years old) enrolled between 1st and 4th grades of elementary school.
- Impact on the enrolment by poverty level: There is an increase of 28.4% in children (7-13 years old) living in extreme poverty; 15% among poor children; and 9.8% among those who are not poor.
- School retention and attendance. The Programme produced a 9% increase in the proportion of children who continue attending school in 1st to 4th grades. This percentage was even larger in the case of children living in extreme poverty.
- Considering the significant increase in the enrolment for schools serving the beneficiary families, resources of the SB (per child per year) were not enough to respond to the increasing needs of financing of incentives for teachers and educational inputs.

3.6.2 Health and nutrition security

- Monitoring and Promotion of Growth and Development from 0 to 3 years. The net average impacts obtained are from two to three times more than expected.
- The Programme produced an increase of 48.5% in vaccinations of children between 12 and 23 months old who are beneficiaries of the Programme.
- The Programme also had significant impact concerning expenditures in food and in family food consumption. The net average impact of the Programme in the total per capita annual expenditure was 25%.
- An important increase of coverage of VPCD and of vaccination at the proper age was registered. The External Assistance Committee suggested a gradual reduction of the amount of NB for the new beneficiary families in Phase II. This will permit testing whether it is possible to reduce costs without reducing the impacts that have already been obtained.
- The health services protocol financed with the help of the SB and delivered by private providers selected in a competitive way, according to tariffs set together with SPN, have proven to be of very good quality.

3.6.3 Nutrition

- There appears to be an improvement in the quality of the food consumed by the family. It is in the group of extremely poor that the changes are more important in relation to the modification of the composition of the type of food consumed, with the introduction of food of a better nutritional quality.
- Before the launching of SPN, 41.9 % of children under 5 years old presented growth delay in the intervention area and 40.9 % in the control area. Two years after the programme's implementation the intervention area showed a statistically significant average decrease of 4.7%, while the control area showed practically no change.
- Before SPN started operating, low weight to age in the intervention area was of 15.3%. Two years later, low weight to age had been reduced in 4.9% while in the control area the situation was a little bit worse. The average impact of SPN was to diminish low weight to age in 6.4% reaching statistical significance.
- In conclusion, it can be said that SPN has had a statistically significant impact in the reduction of growth delay in boys and girls under 5 years old.

3.7. Impact on gender equity.

There is no evidence that the programme promotes gender equity by granting additional benefits to women in any of its components (education, health or food security). However, SPN strengthens beneficiary women directly by widening their knowledge and abilities to participate actively in the improvement of the nutrition and health conditions of their children.[28] Additionally the programme provides subsidies directly to women, motivated by the evidence that resources controlled by women can produce higher improvements in the wellbeing of their children and their families. There is no available disaggregated data by gender regarding the impact of the programme on education, health or food security.

3.8. Interventions focused on adult population.

Interventions included in the SPN services package are mainly focused on the infant population. However, at the project's Phase II ante-natal care services, post-partum care, family planning and health care for adolescents (including HIV/AIDS) are included. Additionally training workshops are offered for women in topics such as basic hygiene, nutrition, reproductive health and lactation.

3.9 Remarks:

The Nicaragua SPN programme has recently started its post-pilot stage. Therefore, so far, it is not possible to assess its real achievements. However, considering the results of the pilot stage, the impact on education, health and nutrition seems to be very promising. The Nicaraguan programme is based on the design of *Oportunidades* in

Mexico but it has also considered the particularities of its target populations. As has been shown, the reduction of the burden of disease in Nicaragua represents a formidable challenge as the poor endure the highest burden of the traditional infectious diseases but are also presenting with signs of increased rates in other diseases such as cervical cancer. A package of 13 interventions seems to be a very small one to cope with the potential demand. The package concentrates on the most salient problems giving a priority status to nutrition. Nevertheless, in the future, the programme should find a way to increase the number of interventions by integrating other programmes that provide services to the poor, as is done in Mexico. SPN does not have an explicit policy to promote gender equity. Granting cash benefits to women does not guarantee the reduction of gender inequities. The programme should foster the design of mechanisms to further reduce inequities, such as providing higher cash benefits to those families that send their daughters to school. Nicaragua is one of the poorest countries in the Latin American region and it is receiving external aid to support different projects. Most of these programmes could be interlinked to improve their capacity to respond to the educational and health demands of the poor.

4. Zambia: The Kalomo Project. Structure, Operation and Outcomes of the Pilot Scheme.

According to FAO,[29] 50% of the Zambian population falls under the food poverty line, equivalent to approximately 5.3 million people. Food poverty is defined as consuming on the average less than the minimum energy requirement, which according to FAO in Zambia is 1,800 Kcal per person per day.

The Kalomo Pilot Social Cash Transfer Scheme was designed to set up a social cash transfer scheme as a cost-effective approach to economically empower destitute and incapacitated households. An initial Pilot Scheme was financed by GTZ for a period of two years and was implemented by the Public Welfare Assistance Scheme (PWAS). In October 2004 the Zambian government and the African Development Bank signed an agreement to upgrade the programme (Zambia Child Welfare Programe – ZCWP) to include 9 districts over a period of 5 years. The new programme will start operations in January 2005 and will be based on the Kalomo Pilot Social Cash Transfer scheme.

4.1 The pilot scheme had the following objectives:

- Reduce extreme poverty, hunger and starvation in the 10% most destitute and incapacitated (non-viable) households in the pilot region (approximately 1,000 households)
- Focus mainly – but not exclusively - on households that are headed by the elderly and are caring for orphans and vulnerable children because breadwinners are chronically sick or have died due to HIV/AIDS or to other reasons

- Generate information on the feasibility, costs and benefits and all positive and negative impacts of a Social Cash Transfer Scheme as a component of a Social Protection Strategy for Zambia.

The Scheme started with a Test Phase, which was conducted from November 2003 to April 2004. In April the Test Phase was evaluated, the original Manual of Operations was improved and the Minister of Community Development and Social Services, officially launched the Scheme, on 4th May 2004.[30]

During the period May to November 2004 the Scheme was expanded to cover the whole pilot area which consists of two Agricultural Blocks (Kalomo Central and Kanchele). By the end of 2004 the Scheme already included 6 ACCs, 36 CWACs, 19 Pay Points and the Kalomo Branch of the Finance Bank and was paying monthly cash transfers to 1,027 households with a population of 3,856 persons.

Information on the structure of the beneficiary households is provided in Table 4. The table shows that 66% of the beneficiary households are female-headed, 54% are elderly-headed, 54% are effected by AIDS. 61% of the household members are children. Of them 71% are orphans.

4.2 Target Group and Level of Transfers

The target group is not individuals but households, which fulfill the following two criteria:

- Critically poor (chronic hunger; under nutrition; begging; in danger of starvation)
- Incapacitated (bread winners are sick or have died; household has no able-bodied person in the working age, just old, very young or sick persons; high dependency ratio)

Each household approved by the Scheme receives monthly ZMK 30,000 (US$ 6) in cash. The beneficiary households are, however, free to spend the money in any way they want.

The targeting and approval process is entirely done by PWAS structures, which did exist before the Social Cash Transfer Scheme started. The PWAS structures are a set of committees that work on a voluntary basis. At village level there are Community Welfare Assistance Committees (CWACs), which cover an area of 200 to 400 households. The members of the CWACs are elected or approved by the community.

The CWACs use a multi-stage participatory process to identify the 10% most needy and incapacitated households in their area[3]. They rank interviewed households according to the severity of their destitution giving the worst off household rank 1, the second worst

[3] The 10% limit is based on results of the National Household Survey carried out by PWAS in September/October 2003 and on a number of smaller surveys carried out before designing the Scheme.

off rank 2, and so on. After that, they present the ranking to a community meeting and discuss with the community until consensus is reached.

Payments to approved beneficiary households are channeled through the Kalomo Branch of the Finance Bank (beneficiaries living within 15 km of Kalomo Town open savings accounts to which their monies are transferred). ForpPayments to beneficiaries living more distant from town, 19 Pay Points are located at Rural Health Centers and Schools.

4.3 Effectiveness of Targeting and Delivery.

Recent assessments show that vertical effectiveness of targeting is very high. This means that the CWACs have been effective in selecting only those households which fulfil the criteria of critically poor and incapacitated.[31]

The horizontal effectiveness of targeting is not as good. This means that not all households in the pilot area, that fulfill the selection criteria, have been approved for the Scheme. This is not the fault of the CWACs but is a result of the limits set in every catchment area, which is 10% of families. In some villages more than 10% of the households fulfil the eligibility criteria but could not be approved.

The most important problem with regard to the payment system is the distance of up to 15 km, which the heads of the beneficiary households have to travel to access the transfers.

Impact of the Transfers on Target Group Level

- Heads of beneficiary households have understood the purpose of the transfers and make rational use of them.

- A number of beneficiaries using Pay Points have started saving by using the traditional “Chilimba” system where the cash obtained by 5 beneficiaries is given monthly to one family.

- 61% of the members of beneficiary households are children under 19 years of age. These children also benefit in terms of meeting their school equipment needs, such as books, pencils, clothing and soap.

- The fact that the transfers are in cash and that the transfers are regular and reliable is well regarded by the beneficiaries and the other stakeholders as the most important features of the Scheme. Beneficiaries are treated with respect and understanding.

- Quantitative data on the impact of the Scheme with regard to changes in the number of meals consumed, the nutritional status of children, school attendance and the health, the self-esteem, and the social position of different categories of household members differentiated by gender are collected by the monitoring and evaluation system but are not yet available.

- Impact results on an initial assessment applied to the programme will be made available in June 2005.

5. Malawi: Safety nets and cash transfer programmes.

In 1998, the government of Malawi and its partners in the international community concluded that the livelihood crisis among Malawi's poor needed urgently to be addressed with a comprehensive, institutionalised and long-term package of social assistance. Although a number of food and income transfer programmes were operational in Malawi at the time, these interventions were patchy in their coverage and uncoordinated across government ministries, donors and NGOs.[32]

Approximately 65.3% of the population (6.3 million people) by 2000 was considered poor and 28.2% of the total population was living under the absolute poverty line. Poverty in Malawi is defined by those whose consumption of basic needs (food and non-food) is below the minimum level estimated at MK 10.47 (approximately USD 0.3).[4] 28.2% of the total population was considered to be living in extreme poverty. This number was not expected to rise unless Malawi could achieve a GDP growth rate of at least 6% per annum, which seems highly unlikely given that growth has averaged 2.9% over the past 20 years.[33]

As with most African countries, Malawi has little history of cash transfers as part of welfare policy.[28] The extent of poverty makes it very difficult for schemes to rely purely on public funds in the context of a low tax base. Donor financing has traditionally concentrated on projects and programmes that aim to strengthen the productive sectors. Those people who have not been able to work have relied on informal coping systems and a whole set of uncoordinated in-kind transfers or work programmes.

Cash for work projects have been largely the initiative of MASAF (Malawi Social Action Fund), a quasi-governmental organisation. At present, MASAF is developing a new strand of projects, which will require sponsorship through NGOS and will be aimed at satisfying the expressed demand of many communities to cater for those unable to work in existing projects. In particular HIV/AIDS sufferers, their dependants and carers, those with disabilities, the vulnerable aged and single parent households will be targeted for support.

[4] Data for 1998. Exchange rate: MK 31.1 = 1 USD

In 1999, the National Safety Net Programme proposal identified four distinct sources of risk faced by the poor in Malawi:[34] 1) seasonal food shortages and food prices; 2) periodic droughts; 3) periodic macroeconomic shocks; 4) loss of breadwinners to AIDS.

5.1 Four specific targeted instruments were proposed

- Public works for landless, urban poor, and some female-headed households;
- A nation-wide targeted nutrition programme for malnourished children;
- An orphan support programme for AIDS orphans;
- Targeted cash transfes for the 'most vulnerable' – the disabled, elderly and infirm who were not in housholds.

The expanded public works programme was expected to employ 300,000 – 400,000 able-bodied poor Malawians and to cost US$12 million per annum. The nutrition programme would reach 1 million children and cost $7m per annum. The orphan support programme would assist 100,000 AIDS orphans and was costed at $3.9m per annum. Finally, 250,000 'most vulnerable' individuals would receive cash transfers at an annual cost of $4.3m. The total cost of the National Safety Net Programme would therefore amount to about $28m each year.[33]

The 2002 Malawi Poverty Reduction Strategy Paper considers safety nets to include productivity enhancing interventions for the transient poor (those within the poorest 30% of the population who are capable of moving out of poverty) and substantial welfare transfers to the chronically poor (the poorest 5 to 10 percent of the population). Both categories are considered to be provided by programmes that transfer cash to their beneficiaries. In the case of Welfare Support Interventions two types of welfare transfers are considered: a) targeted nutrition interventions for malnourished children and vulnerable pregnant and lactating mothers, and b) direct welfare transfers for the poor who cannot be supported by other welfare programmes.[35]

According to this document, the Targeted Welfare Transfer Programme will involve the direct transfer of cash or a cash proxy (retail voucher). Its implementation was planned to be carried out initially on a pilot basis. Once beneficiaries are identified, cash transfers will be made through District Assemblies. The value of transfer will be determined by resource availability and factors such as household monthly food requirements and minimum wages levels. The value of transfer is expected to be about US$83 per beneficiary per annum.

5.2 Two specific programmes lead by MASAF are

a) Cash for work. MASAF Public Works Programme, had, by September 1998, funded 379 projects. The vast majority of these were road rehabilitation and maintenance (339), with affoerestation, dam rehabilitation and valley tank rehabilitation making up the

balance. The programme claimed to have created 160,000 jobs (1.78 million person working days) with female participation just over 30%. Wages have accounted for about 70% of project costs. Worker selection was on the basis of self-selection (first come first served). Indications are that demand for work was greater than supply, which is borne out by other evaluations of the programme that claim that wage rates are significantly higher than the rural market wage.[34]

b) Sponsored Sub-Projects (MASAF). MASAF designed a new project stream in response to requests from communities for assistance to the most vulnerable members of communities. This would include poor female-headed households, AIDS/HIV affected households, people with disabilities, the landless and the orphans. It is envisaged that an initial $0.5 million will be aimed at such projects.

5.3 Problems with targeting and cash transfers

The most needy groups of the population would be those that normally benefit from cash transfers in countries with a social security system. In Malawi, these people are not only generally unregistered, but most also have little capacity for travelling to a bank or post office. Information for targeting is therefore the main constraint to such a scheme. At present it appears that targeting these people by using their immediate community's knowledge is the only viable option. [34]

Furthermore even if targeting was improved, Malawi has little capacity for the distribution of cash. Banks are confined to the main towns. The Post Office, with a wider geographical coverage, is plagued with security problems and lacks computerisation, which would be necessary for the smooth transfer of cash.

Initial observations indicate that the success of cash transfers will depend on the support of as wide a section of local communities as possible, but this has to be a perfectly well planned process to avoid creating perverse incentives in communities. Improvement in data and the coordination of different data sets to upgrade the capacity of the information system has also been recommended.[36]

6. Discussion

The following are lessons offered by Latin American cash transfer programmes, Mexico's *Oportunidades* and Nicaragua's SPN programmes, to African countries.

a) **How to target populations**. In both Mexico and Nicaragua targeting has required a sophisticated set of data about populations in order to arrive at an accurate selection of townships and households. Although this technically oriented approach is not perfect, in these two countries this has proved to be a necessary process to achieve fair targeting, particularly when the scope of the programme is

nationwide. Besides the issue of available information, in programmes such as *Oportunidades* and SPN, targeting the extreme poor is difficult. The design of the programmes does not allow for it. In order to be selected, families need to be close to both a school and a health centre. In both countries the large majority of the very poor are not close to these facilities so they cannot be included in the programme.

b) **Is conditionality needed to achieve effiectiveness**?. *Oportunidades* and Nicaragua´s SPN boast that conditionality is key to achieving effectiveness. There is not enough evidence to determine whether conditionality should or should not be part of a cash transfer programme. According to the programmes' managers in Mexico and Nicaragua, without conditionality the population would not be responding to the supply of services. This view in Mexico reflects an historical paternalistic understanding of poor populations. However, as Devereux[32] argues, information given to the population should be considered as a means to modify this view and trust families to be responsible of their wellbeing. The Kalomo project follows this view and does not require people to comply with any type of activity, nor to give account of what they do with their money. Assessing impact in this project will offer a good deal of evidence of the role of conditionality in cash transfer programmes.

c) **How to provide services when demand increases and budgets remain fixed**. In most countries, the coordination of the cash transfer programme with other public and private institutions depends on the capacity of the latter to provide services. The interaction among public institutions is not necessarily smooth. In the case of *Oportunidades* both ministries of education and health have independent budgets which have not been adjusted to the demand created by the new *Oportunidades* beneficiaries that are enrolled in the programme every year. Even though *Oportunidades* beneficiaries have been catered for by educational and health services, the increase in demand is produced by the conditionality issue that makes the same families be more demanding than in previous years. As a strategy to cope with increasing demand, after recognising the limitations of the public sector, SPN has also contracted NGOs, which provide services and which are available in many remote areas throughout the country.

d) **How to finance the programmes. Sustainability**. There are two basic options to finance programmes to combat poverty and the selection depends on the country´s capacity to raise taxes. *Oportunidades* is a programme that heavily depends on public funds, only a tiny part of the budget is related to donor resources. This is the best possible option for countries that intend to guarantee long-term sustainability. However, this option is not feasible for many countries. This is the case of Zambia and Malawi both of which rely completely on bank loans or aid from rich countries. There is always a risk that donors will change their position regarding ongoing programmes, according to the definition of international priorities and cycles. Nicaragua has had to rely on foreign support but it has been able to set up a highly structured and effective pilot programme

whose results are more than motivating for the future scaling up of the programme and it is already attracting the attention of more donors. Its challenge is to guarantee long-term sustainability by a combination of internal and external resources.

e) **What type of services to provide**. We have seen through country cases exposed in the present paper that poverty alleviation programmes can choose from a variety of services to be provided. Both *Oportunidades* and Nicaragua´s SPN focus their interventions on the relief of the most salient consequences of poverty but so far, not in its causes. Without reducing the merit of their achievements, it is questionable that a programme that promotes the accumulation of human capital through educational and health interventions could guarantee to this more educated and healthy population job opportunities in the future. In both cases, scaling up the programmes should necessarily mean the creation of job opportunities in the future. *Oportunidades* is moving already into that direction but still in a very narrow approach, unlike the new Chilean programme where pensions and job opportunities are right at the core of the programme. In the Malawi case it seems that efforts to educate the population, to combat poverty and provide health care are still to be aligned in a common effort to improve the efficient use of resources put into poverty alleviation.

f) **How to transfer cash. Advantages and disadvantages**. Most observers agree that transferring cash to families has more advantages than disadvantages: it is administratively easier to handle and it gives families the freedom to decide how to spend this money according to their priorities. However, using banks or other financial agencies to distribute the money entails potential problematic issues such as difficulties in access, as has been seen in Mexico, Nicaragua and Malawi, as well as discriminatory treatment. Distributing the money through community channels also entails risks but of a different matter.

g) **The role of evaluation**. Evaluation is the best way to understand the value of these types of programmes and to identify problematic issues in order to introduce adjustments. Both in Mexico and Nicaragua, programmes carried out a baseline assessment before the launching of the operation. This baseline has helped to contrast the changes produced by the programmes in terms of efficacy and impact. Indeed evaluations have shown that programmes have been successful in providing the intended services to populations, and in the case of Mexico, it has shown, at a large scale, that human capital investment has increased the capacity of children to remain at school, to improve their nutritional level, and in general, to enjoy better health. The Kalomo project in Zambia has carried out evaluations that show its capacity to cover populations according to predefined guidelines. Its technical and political importance has been made explicit by the fact that the government and an international donor decided to scale up the programme. This is not the case in Malawi where programmes still have not been evaluated. Evaluation entails a financial cost that has to be considered an intrinsic part of the programme and not a sideline process.

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Annex 1

Terms of Reference for a DFID Consultancy
Meeting the Health Needs of the Very Poor: The Impact of Cash Transfers on Health Outcomes

Purpose

The purpose of the work is to produce a paper for a workshop on Meeting the Health Needs of the Very Poor. The paper will examine available evidence on the impact of cash transfer programmes among the very poor on health and nutrition outcomes in a selection of countries and community settings.

Background

DFID, in collaboration with the Health Systems Resource Centre, is organising a workshop on *Meeting the Health Needs of the Very Poor* to be held in London on 14th and 15th of February 2005. The workshop will provide a forum for DFID advisers working in human development, social development and governance to consider the relationships between poverty and ill health as they affect the poorest and the policy options which could improve health outcomes for the poor. In particular the workshop will consider the role of social protection instruments in improving the health of the poorest; and the implications of scaling up poor people's access to improved health outcomes.

Scaling up poor peoples access to improved health outcomes will require a combination of health system investments along with investments outside the health sector. These may include demand side approaches and incentivization to utilise available services, as well as increasing service coverage and inclusiveness. Better use of health services is also correlated with increased income, which also impacts positively on other health outcomes.

Background papers for the workshop will consider demand side approaches and the role of social protection instruments in increasing the access of poor people to health services and improved health outcomes. A further paper will assess the potential of social assistance involving cash transfers to make a difference to the health and nutrition outcomes of the very poor.

Scope of Paper

The paper will compare several different types of cash transfer programme and explore the implications of different programme structures (recipients, conditionality etc) for the health and nutrition of the very poor. Suggested examples *include*: social pensions in South Africa and/ or Brazil, the Zambia cash transfer programme operated by GTZ, the conditional transfer programmes in S America, including Progresa and the equivalent programme in Nicaragua; Bolsa Familiar in Brazil and equivalent programme Honduras.
and safety net programmes, often associated with food security, in Africa (eg Burkina Faso, Malawi).

Some of these case studies may have been selected for a complementary DFID consultancy on social assistance. The consultant will work closely with RtVP and its advisers to ensure that the examples used in this study can inform the wider work undertaken by DFID on social assistance.

Activities
In consultation with DFID and DRC staff the consultant will select a number of case study examples on which to structure the paper representing different types of cash transfer programmes available to the very poor in a range of country examples. The consultant will:

- undertake a review of relevant material on these programmes, conducting a prior literature search in relevant journals in public health and development studies, including academic studies, grey material and programme evaluation documents where available, in order to present an analysis of the impacts of different kinds of transfer programmes (eg pensions/ child support grants/ family support to poor households as in GTZ Zambia) on health outcomes for different social categories e.g. children, the elderly, household heads, recipients , recipients' families, infants etc. A key area to be explored is whether conditionality tied to health service utilisation is a strong determinant of health impact, or whether the size of the transfer and its duration is paramount.

- produce a paper setting out the arguments in relation to examples as a review of the evidence at the workshop, although a first draft will be available by January 30th.

- Present key findings from the paper at the workshop in February.

- Make a revised version of the paper available after the workshop for dissemination via the DRC website.

Inputs: 12 days consultancy time, of which 10 are allowed for research and writing , and 2 days for preparation of slides and presentation at the workshop. The consultant will gave expertise in social policy analysis and a familiarity with the range of social transfer programmes in low income countries and broader issues around social protection, chronic poverty and health. He or she will have excellent writing and analytical skills.

Outputs:
The consultancy will produce:

- a workshop paper of no more than 6000 words (excluding notes and references) and power point presentation for the workshop.
- a revised paper for web dissemination

ANNEX 2
Detailed Information about Various Cash Transfer Programmes

Table 1. Cash Transfer Programmes in Latin America and the Caribbean

1.a. Objectives, Components and Target Population of

Program	Objectives	Components		Target population	
		Education	Health and Nutrition	Education	Health and Nutrition
***Bolsa Escola*, Brazil**	1. To increase the educational attainment of school-age poor children 2. To reduce current and future poverty	Cash transfer	-	Poor children, 6-15	-
PETI, Brazil	To eradicate the worst forms of child labor (i.e. those involving health risks), while increasing educational attainment and reducing poverty.	Cash transfer After-school program	-	Children 7-14	-
***Familias en Acción*, Colombia**	1. To increase the human capital investment among extreme poor families 2. To serve as a safety net	Bi-monthly school subsidy	1. Nutrition subsidy 2. Health education	Poor households with children 7-17 enrolled in school (2^{nd} - 11^{th} grade)	Poor households with children 0-6 not participating in other programs
PRAF II, Honduras	Increase the accumulation of human capital among the poorest families and thereby help to break the circle of poverty.	1. Demand incentives (educational voucher) 2. Supply incentives for primary schools	1. Demand incentives (nutrition and health voucher) 2. Supply incentives for health care centers 3. Nutrition training for mothers	Poor households with children 6-12 who have not yet completed 4^{th} grade of primary school	Poor households with pregnant women and/or children under three years of age.
PATH, Jamaica	1. Increase educational attainment, improve health outcomes, and thus reduce poverty. 2. Reduce current poverty 3. Reduce child labor 4. Serve as a safety net	Education grant	1. Health grant 2. Health education	Poor households with children 6-17	Poor households with children 0-5; pregnant and lactating women; elderly over 65; persons with disabilities; and destitute adults under 65.

Source: Rawlings L, Rubio G. Evaluating the Impact of Conditional Cash Transfer Programs: Lessons from Latin America. World Bank Policy Research. Working paper 3119, August 2003.

1.b. Conditionality and Transfer size

Programme	Conditionality		Transfer size	
	Education	Health and Nutrition	Education	Health and Nutrition
			Local Currency	Local Currency
***Bolsa Escola,* Brazil**	At least 85% school attendance in a 3-month period	-	US$6-19 per family	-
PETI, Brazil	At least 80% school attendance and participation in the after-school program *Jornada Ampliada*	-	Varies across states between US$11-17 per child per month.	-
***Familias en Acción,* Colombia** **PRAF II, Honduras**	At least 80% school attendance in a 2-month cycle School enrollment and maximum 7 days of school absence in a 3-month period.	Regular health care visits for child's growth and development monitoring Compliance with the required frequency of health center visits	Primary: US$6 per child per mont h Secondary: US$12 per child per month Educational voucher: US$58 per child per year Average supply incentive: US$4,000 / school/year	US$20 per family per month Health voucher: US$46.3 per family per year Avg. supply incentive US$6,020/facility/year
PATH, Jamaica	Minimum school attendance of 85% (maximum 9 days of school absence per term)	Compliance with the required number of health visits per year, which varies by beneficiary age/status	US$9/child/month	US$9 per eligible household member per month

Source: Rawlings L, Rubio G. Evaluating the Impact of Conditional Cash Transfer Programs: Lessons from Latin America. World Bank Policy Research. Working paper 3119, August 2003.

1.c. Selection criteria

Program	Selection criteria		
	Geographic	**Household level**	**Other**
***Bolsa Escola*, Brazil**	Participation at the municipal level is demand-driven; there is geographic targeting within municipalities	Eligible households must have a maximum income per capita of USD$35	Minimum residency requirement that varies between 1 to 5 years depending on the municipality. Some municipalities require beneficiary households to be female-headed.
PETI, Brazil	Municipalities with high incidence of child labor involving a health risk	Eligible households must have a per capita income below half the minimum wage US$65/month	-
***Familias en Acción*, Colombia**	1. Municipalities other than department capitals with less than 100,000 inhabitants 2. Municipalities not participating in other national programs with adequate supply of education and health services and a bank 3. Municipalities with available SISBEN database up-to-date	Level 1 families of the SISBEN (local information system that identifies poor and vulnerable households according to a Basic Unmet Needs Index and other income and earning potential information)	-
PRAF II, Honduras	Municipalities with the lowest average height for age z-scores	None	-
PATH, Jamaica	All parishes participate in the programme; funds are distributed across parishes depending on the poverty incidence	Household eligibility is determined by a scoring formula and a pre-determined cut off point	-

Source: Rawlings L, Rubio G. Evaluating the Impact of Conditional Cash Transfer Programs: Lessons from Latin America. World Bank Policy Research. Working paper 3119, August 2003.

1.d. Integral Programme for the alleviation of poverty. "*Chile Solidario*"

Name	Objective	Benefits offered by the Programme	Conditionality
Chile Solidario	To establish a system of social protection for families living in extreme poverty conditions. Started in 2002	**Component 1: PUENTE (Bridge) Programme** A. Psyco-social support Personalized care at home by a community workers, assigned to a family for a 24 month period. Support to reach minimum conditions of quality of life encompassing 7 strategies: identification, health, education, family dynamics, housing, work, income. B. Solidarity Support Moneraty support which decreases in the period of 24 months, related to the participation in the Bridge Programme and the accomplishment of the Family Contract. 1º Semester: US$ 17 monthly 2º Semester: US$ 13 monthly 3º Semester: US$ 9 monthly 4º Semester: US$ 6 monthly **Component 2: Guaranteed Monetary Subsidy** Money grants to 225.000 families living in extreme poverty integrated to the Chile Solidario system **. Family Unitary Subsidy (SUF)** granted to members under 18 years, subject to school attendance. **. Assistance Pension (PASIS)** for Elders or Disabled. **. Potable Water Consumption Subsidy (SAP)** at 100% for 15 m3 of consumption. These benefits are assigned in the 24 month period of intensive support and will continue as long as elegibility conditions remain. **Component 3: Preferential Access to Social Promotion and Social Prevision Labour Benefits Programmes.** Preferential access to social promotion programes include: * Education and training for work. * Improvement of housing conditions. * Support to the disabled. * Rehabilitation and prevention to reduce drug consumption. * Support and prevention against family violence.	Each family signs a contract to committ themselves to the Family Support Programme: The programme encompass responsibilities that families should fulfill. In each one of them, the family is considered to be responsible of its own development. Problematic issues are faced according to the seven pre-defined working dimensions.

Source: Gobierno de Chile Ministerio de Planificación y Cooperación. MIDEPLAN – Sistema de protección social Chile Solidario. Chile, December 2004. Consulted http://www.mideplan.cl/admin/docdescargas/centrodoc/centrodoc_170.pdf

1.e. Cash Transfer Programmes (CCTP) Mexico and Nicaragua.

Countries	Program Name	Executing Agency	Program Onset	Program Benefits	Cash Benedit	Public Annual Budget Programme and % del GDP
México	Program of Human Development. *Oportunidades*	Program of Human Development (*Oportunidades*) National Coordination belonging to the Ministry of Social Development (SEDESOL), in coordination with the Ministry of health (SSA), the Mexican Institute of Social Security (IMSS) and the Ministry of Public Education (SEP).	1997	Primary education scholarship for young people between 3rd grade of primary and 3rd of medium high education; monetary or in-kind support for school materials; Basic health package for all family members; Support for familiar feeding; Nutritional supplements for children between 4 and 23 months, undernourished children between 2 and 5 years and pregnant women or in breastfeeding period.	Feeding support US $15 a month per family. Education Scholarships (in USD): 3° primary: 10 4° primary: 11.5 5° primary: 15 6° primary: 20 Female secondary 1° secondary: 31 2° secondary: 34 3° secondary: 37.5 Male secondary 1° secondary: 29 2° secondary: 31 3° secondary: 32.5 Female High school 1° : 56.5 2° : 60 3° : 63.5 Male Higth School 1° : 49 2° : 52.5 3° : 55.5	Approx. US $ 1,860 million for 2002 (0.32% of GDP 2001)
Nicaragua	Social Protection Network	Emergency Social Investment Fund (FISE)	2000	Programme benefits: Phase I. In Education: Scholarship, school materials, and cash and in-kind supply incentive. Health and feeding Security of: Nourishing security bond and services. Phase II: nutrition bonus, training workshops, other services targeted to children.	1. Education: - School bond (BE), maximum amount up to US$90 per family every year, provided every two months to families who have at least a child registered between 1st to 4th degree and between 7 and 13 years of age. - School materials (ME), by a fixed amount of U.S. $25, given in cash, annually, by each registered child. - Supply Bond (BO). Annual amount of US $8.00 by student. It is provided bimonthly. These funds will be used 50% as incentive to the teacher and 50% for the purchase of materials for the school.	Approx. US $5 million for 2002 (0.021% GDP)

					2. Health and nourishing security: - Bond of nourishing security. Families Phase I: US$ 207 until completion of its period of elegilibility. Families Phase II: The annual value per family will be for the First year: US$168; second year: US$ 145; third year: US$ 126. The bond is given every three months directly to the beneficiaries of the Program. - Supply Bond (BO). Maximum value of US $ 90 annual by family. Includes payment of health services and qualification. The BO consists of the payment to the suppliers of the health services plan, according to an established tariff or per capita/service, or by family. The first option requires the establishment of a fixed menu and tariffs by service. In the second option a fixed amount by family settles down to cover the complete plan. Families should be registered to the nearest supplier.	

Source: TALLER SOBRE PROGRAMAS DE TRANSFERENCIAS CONDICIONADAS (PTCs): EXPERIENCIAS OPERATIVAS 2003, Ministerio de la familia Nicaragua. (Cash transfer condicional workshop)

Continuation of table 1.e.

Countries	Justification for the creation of the Programme	Demanded conditions to receive subsidies	Beneficiaries number	% of the total population	Coverage
México	The Program of Human Development *OPORTUNIDADES* is a program of the Federal Government which was created following the initial Program of Education, Health and Feeding (*PROGRESA*), on August 8, 1997 to take care of families living in extreme poverty conditions.	*OPORTUNIDADES* Programme has the following conditions: ➢ Education scholarship: on attendance of more of 85% of total classes ➢ To provide monetary nutritional support to families that must fulfill the commitment to attend appointments programmed by the health services units.	By the end of the 2001: 3,237,667 families and 3,315,481 scholarship holders.	3.38%	It covers beneficiaries living in rural areas and from year 2002 it also operates in urban areas.
Nicaragua	The Social Protection Network was created in an integrated interinstitutional frame that takes advantage of previous existing institutions and structures; it is a response to relief of extreme poverty of 20% of Nicaraguans having an average income inferior to the minimum caloric requirements equivalent to U.S. $ 0,55 by person per day.	➢ The Network demands the following conditions to transfer the benefits: ➢ Nourishing bond: families with children up to 5 years will have to complete a preventive health plan and to attend advanced training courses. ➢ Education bond: Not to miss more than 5 classes bimonthly by every registered children from 1 to 4 years. ➢ School materials: enrolment of all children at home between 7-13 years that have not completed the 4° year. ➢ Supply School Bond: enrolment and attendance. ➢ Supply Health Bond: improvement of nutritional status of children.	10,093 families, equivalent to 60.804 people; 7,761 children in health and 13,217 children in education	1.21%	The programme operates in rural areas.

Table 2. Definition of poverty and percentages of the population living in poverty.

Country	Definition of poverty	Population in poverty	Strategies to reduce poverty
Mexico	Categories of poverty 1. **Threshold of Nutritional Poverty**: households which income per person was less than the one considered as necessary to cover nutritional needs equivalent to 1.5 and 2.09 USD per day per person in rural and urban areas respectively. 2. **Threshold of Capacities Development**: households which income per person was less than the necessary to cope with nutritional needs (as defined in the previous group) plus the required income to pay health and educational expenses, equivalent to 1.8 and 2.4 USD a day per person in rural and urban areas, respectively. 3. **Threshold of Patrimonial Development**: households which income per person was less than the necessary to cover nutritional, basic consumption of health and educational services, dressing, housing and public transportation needs. In 2000 this income was equivalent to 2.8 and 4.1 USD a day in rural and urban areas, respectively.	Percentage of households and population: In 2002, 15.8% of households (20.3% of the total population) had an income below the reference values. In the year 2002, 21.1% of households at national level (31.9% of the total population) had an income below the reference values. In the year 2002, 44.1% of the country's households (51.7% of the total population) had an income below the reference values.	The results of the evaluation carried out by the Ministry of Social Development (SEDESOL) showed that in 2003, there was a reduction in the levels of poverty[5] between 2000 and 2002. This reduction is associated with the income obtained by poor populations in that period. A preliminar analisis points out the existence of at least 4 factors that contribute to the explanation of the increase in income: ➢ The expansion and better targeting of social programes. ➢ The increase in the purchasing power of salaries. ➢ The increase in the flow of money sent by Mexicans living outside the country. ➢ The reduction in the prices of some articles of basic consumption as a result of a period of economic stability. Expansion and targeting of *Oportunidades* Programme: ➢ In this period there was an important expansion of the programme as a consequence in the number of beneficiaries as well as the benefits provided (for example, educational support were expanded to higher

[5] The population in alimentary poverty condition at national level was reduced from 24.2 to 20.3% between 2000 and 2002. The population below the threshold of capacities development was reduced from 31.9 to 26.5% between 2000 and 2002. The population below the threshold of patrimonial development was reduced from 53.7 to 51.7% between 2000 and 2002.

			education levels). ➢ To provide cash transfers produced a positive effect directly in the household income level.
Nicaragua	Poverty in Nicaragua is defined by means of two indicators: **1. Consumption aggregate**. Total household consumption can be divided into two easily differentiated groups: food and non-food items. The Components of Total Consumption are: Food: Food consumed at home: purchased, own production, donations, gifts. Food consumed outside the home: restaurants, school, etc. Non-Food: Housing: annual value of house and basic services Health Education Consumer goods and services: transport, communications, personal goods, leisure, etc. Use value of durable goods. **2. Poverty Lines**. The extreme poverty line represents the cost of the minimum caloric requirement recommended for Nicaragua (2,199 Kcal/day) using the observed consumption food basket and prices of the households. The extreme poverty line was estimated at USD$ 178 per-capita/year.	Population living in poverty: 45.9% (2001) Population living in extreme poverty: 15.1% (2001). More than two thirds of rural inhabitants are poor in contrast with less than one-third in urban areas. Similarly, more than 25% of those in rural areas are extremely poor versus about 6% for urban residents.	Progress in poverty reduction between 1998 and 2001 reflect significant income gains for most Nicaraguan households as well as lower food prices. Income gains are the result of the record of broad-based growth witnessed in this period, associated with extraordinary levels of investment following Hurricane Mitch an in spite of drought and declining coffee prices. The decline in overall poverty is closely related to income gains concentrated in all but the highest decile of the population, which has resulted in a significant reduction in (consumption) inequality. Reductions in extreme poverty are largely associated with the decline in relative prices of key food staples (i.e., rice and beans) that constitute about one-third of the diet of the extremely poor. These findings indicate that the welfare levels of the extreme poor in Nicaragua are very sensitive to food price behavior.
Malawi	The poor are defined as those whose consumption of basic needs (both food and non-food) is below the minimum level estimated at the rural poverty lines are between USD 0.46 and USD 0.6, while the Urban poverty line is at USD1.5 per person per day. (adjusted to more recent July 2000 prices). The Situation Analysis of Poverty (1994) identified the following factors as key determinants of poverty: low agricultural productivity, rapid population growth, lack of off-farm employment opportunities, low levels of	65.3% of the population is poor (6.3 million people) and within this number of the poor, 28.2% of the total population are in dire poverty. Geographic Distribution of poverty: Poverty is more widespread in rural areas than urban areas. It is estimated that 66.5% of the rural population live in poverty as compared to 54.9% for urban areas. While as many as 90% of the population live in rural areas, 91.3%	

	education, poor health status, limited access to credit and limited or inequitable access to productive assets.	of the poor and 91.5 percent of the ultra poor also live in rural areas.	
Zambia	**Food poverty** is defined as consuming on the average less than the minimum energy requirement, which according to FAO in Zambia is 1,800 Kcal per person (adult equivalent) per day. categories of poverty: A. Moderate poverty: average energy consumption between 1,400 and 1,800 Kcal per person per day. B. Critical poverty: average energy consumption less than 1,400 Kcal. This distinction is important, because persons suffering extreme hunger over a period of time become physically weak, tend to sell or consume their productive assets (e.g. livestock, tools, seed), give up to invest in their future (like sending children to school), and die from infections which other people survive. For these reasons critically poor people are slow to respond to programmes, which demand a certain amount of effort and contributions (like credit and saving schemes). With regard to the causes of poverty, out of the one million households suffering from food poverty in Zambia, approximately 700,000 are poor because of conjunctural factors. They are considered as poor but viable. The other 300,000 are non-viable poor households. Conjunctural poverty is caused by unemployment or underemployment. It involves households with able-bodied adults who have no access to productive employment. If these households get access to credit, to employment, to programs such	According to FAO[6], 50 percent of the Zambian population falls under the food poverty line. This means that approximately 5.3 million people living in approximately one million households are food poor. It is estimated that in Zambia approximately 400,000 households (2 million people) suffer from moderate food poverty and about 600,000 (3 million people) from critical poverty.	

[6] FAO, The State of Food Insecurity in the World, Rome 2004

	as food for work or cash for work, they are able to escape from poverty. Poverty among the non-viable is structural as it is related to the structure of the households. These households have few or no able-bodied adult household members. In statistical terms they have a high dependency ratio, i.e. relation between the number of dependent household members (not able to perform productive work) and the number of household members able to perform productive work. AIDS affects many of the households suffering from structural poverty. The breadwinners have died leaving grandparents, who are too old to work, and orphans, who are too young. These households cannot react to self-help oriented or to labor-based projects or programs.		

Sources: Table 2

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Table 3. Country General Indicators. Malawi, Mexico, Nicaragua and Zambia

Indicador	Countries			
	Malawi	**Mexico**	**Nicaragua**	**Zambia**
Total Population [1/] (2002)	10.7 million	100.8 million	5.3 million	10.5 million
Life expectancy [1/] (2002)	37.5	73.6	68.7	26.9
Infant mortality rate (per 1000 live births) [1/] (2002)	113	24	32	102
Under 5 mortality rate (per 1000 children) [1/] (2002)	182	29	41	182
Literacy (% of ages 15 and above) [1/] (2002)	61.8	90.8	66.1	79.9
Literacy Female (% of ages 15 and above) [1/] (2002)	48.7	88.7	66.4	73.8
GNI Percápita (PPP US $) [1/] (2002)	540	8,540	1,880	770
Education Indicators				
➢ Total education expenditure as % of GDP [2/] (1998/1999)	4.1	5.1	5.0	1.9
➢ as % of total government expenditure [2/]	24.6	24.3	13	17.6
➢ Pupil / Teacher ratio, primary (headcounts) [2/]	63	27	37	45
Health Indicators				
➢ Total health expenditure as % of GDP (2001) [3/]	7.8	6.1	7.8	5.7
➢ General Government expenditure on health as % of total general government expenditure (2001) [3/]	12.3	16.7	17.9	13.5
➢ Physician (per 1000 people)	0.06 (1998) [4/]	12 [6/]	6.2 (1998) [7/]	0.1 (1998) [5/]
➢ Hospital Beds (per 1000 people)	1.3 (1998) [4/]	19 [6/]	3.3 (1998) [7/]	2.9 (1996) [5/]

Source: 1/ World Development Indicators database, august 2004
2/ UNESCO Institute for Statistics - Country Profile, 2004
3/ World Health Organization. http://www.who.int/countries/
4/ *PHNIP Country Health Statistical Report* Malawi. september 2002
5/ *PHNIP Country Health Statistical Report* Zambia. september 2002
6/ PAHO. Perfil del sistema de salud en Mexico, 2000
7/ PAHO. Perfil del sistema de salud en Nicaragua. 2000

Table 4. Federal spending in *Oportunidades* Programme

Concept	2000	2001	2002	2003	2004
Federal spending in the Human Development Programme *Oportunidades* (million USD)	958.6	1239.3	1700.3	2233.1	2532.4
% of GNP Programme *Oportunidades* 1/		0.32		0.58	
Annual Federal spending per beneficiary family in the Programme *Oportunidades*	387.1	382.8	401.0	526.6	506.4

Source: Statistical annex. 4th Presidential Report. 2004.
1/ Estimated by authors

Table 5. Coverage and benefits. 2000-2004 in Oportunidades Programme

Concept	2000	2001	2002	2003	2004
Number of Beneficiaries of the *Oportunidades* Programme					
Families (Thousands)	2476.4	3237.7	4240	4240	5000
Rural zones	2129.8	2524.5	3090.8	3010.6	3570.6
Semi-urban zones	341.6	599.4	616.1	747.4	697.7
Urban zones	5	113.8	533.1	482	731
Municipalities	2166	2317	2354	2360	2435
Localities	53232	67737	70520	70436	98866
***Oportunidades* benefits**					
Dietary supplements distributed (Millions of doses)	557.7	665.3	566.4	529.2	520.8
Families benefited with nutrition aid (thousands)	2476	3237.7	4240	4240	5000
Average monthly consultations (Thousands) :	1624.4	1836.4	2295.8	2661.5	2795.8
- Registered children under 5	1274.3	1656.8	2008.5	2004.4	2584.7
* In malnutrition control	1468.3	1525.7	1910.2	1943.6	2352.2
* With malnutrition	318.3	333	404.2	412.3	555.7
- Pregnant and lactating women					
* Registered	304.4	317.9	358.9	354.1	504.4
* Control	282.6	298.8	348.9	344.2	474.4

Source: Statistical annex. 4th Presidential Report. 2004.

Table 6. Number and Structure of Beneficiary households in The Kalomo Project

ACC Name	No of Households	Heads of Households		Elderly Headed Households Above 64 years		AIDS Affected Households		*No of Household Members including Household Head*		*Number of Household Members fit for work*	*Number of Children Under 19years*		*of them: Number of orphans*	
	Total	**1027**		**551**				**3856**			**2362**		**1685**	
	Gender	M	F	M	F	Yes	Not SURE	M	F		M	F	M	F
Choonga	169	73	96	36	38	105	64	263	307	10	176	162	147	134
Inkumbi	167	57	110	35	69	81	86	322	425	57	221	219	133	135
Siambala	201	65	136	34	86	92	109	352	393	26	266	197	186	129
Kanchele	185	42	143	22	82	98	87	247	361	7	191	195	136	135
Mukwela*	95	45	50	26	21	47	48	151	185	10	107	107	71	80
Bekilumasi◈	210	67	145	31	71	127	83	371	479	13	255	266	206	193
Grand Total for Scheme	**1027**	**349**	**680**	**184**	**367**	**550**	**477**	**1706**	**2150**	**123**	**1216**	**1146**	**879**	**806**

Source: Schubert 2004

* Includes estimates for Mukwela CWAC
◈ Includes estimates for Kinnertone and Mwata CWACs

Table 7. Main Characteristics. Malawi and Zambia Cash Transfer Programmes

Name of the Programme	Objective	Targeting	Coverage	Cash Transfer	Evaluation
Kalomo Project. Zambia	To set up a cash transfer scheme to economically empower destitute and incapacitated households	Community Welfare Assistance Committees select 10% of population by interviewing households and applying pre-defined criteria	1,027 households containing 3,856 persons	Banking system. Each household receives the equivalent to USD6 a month	High vertical effectiveness. Low horizontal effectiveness
Safety Nets. Malawi. (Cash for Work Programme)	Provide paid work in (non-agricultural) activities that foster local/regional development	Self-selection	160,000 workers (30% female)	In-site community participation	No specific evaluations found