

**CONDITIONAL CASH TRANSFERS AS A MEANS OF
ADDRESSING POVERTY IN SOUTH AFRICA**

by

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ABSTRACT

In this thesis the feasibility of making social transfers conditional in South Africa is examined with specific focus on the Child Support Grant. Currently, there are more than 8.7 million children receiving Child Support Grants, which is impacting positively on poverty alleviation. Yet, social outcomes, especially in health and education are poor. The conditionality of transfers will compel the parents/guardians of these children to ensure that the children regularly attend school and also utilise the health services. Conditional cash transfers, by their nature, attempt to address the low demand for these services, which are available but are not being utilised.

The National Income Dynamic Study (NIDS) is employed to test empirically whether it will be feasible to institute conditionality to the CSG. The methodology adopted is to determine if there is any statistically significant difference (education and health outcomes) between the recipients of the CSG with non-recipients of the CSG. Moreover, the population (as extrapolated from the sample) is separated into four groups, namely, children that qualify and receive the grant (QR), children that qualify and do not receive the grant (QNR), children that do not qualify and receive the grant (NQR) and children that do not qualify and do not receive the grant (NQNR). Subsequently, educational and health outcomes are compared between these groups to determine if there is any statistically significant difference between them.

The results demonstrate that school attendance is high among children, and there is no significant difference in school attendance between the recipients and non-recipients of the CSG; as well as between the QR, QNR, NQR and NQNR. Moreover, there is no substantial difference in education outcomes (grade repetition) between the recipients and non-recipients of the CSG; as well as between the four groups. Similar results are found for health where there is no statistically significant difference between the groups regarding utilisation of health services as well as health outcomes.

Therefore, conditionality of the CSG would not be feasible, as it does not address the causes of poor health and education outcomes, which are mainly due to supply-side deficiencies. Government should rather strengthen current poverty alleviation policies which seem to be impacting positively on poverty reduction.

Key words: conditional cash transfers, Growth, Employment and Redistribution (GEAR), globalisation, poverty, poverty line, social assistance, Reconstruction and Development Programme (RDP), social insurance, social security, unemployment

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LIST OF ACRONYMS

ADB	Asian Development Bank
ANC	African National Congress
AMPS	All Media Product Survey
ART	Anti-Retroviral Treatment
BDH	Bono de Desarrollo Humano (Ecuador)
BIG	Basic Income Grant
CDC	Centre for Disease Control and Prevention
CESSP	Cambodia Education Sector Support Project (Cambodia)
CCOD	Compensation Commissioner for Occupational Diseases
CCT	Conditional Cash Transfers
CI	Children's Institute
CRIN	Children's Right Information Network
CDG	Care Dependency Grant
CSG	Child Support Grant
DG	Disability Grant
DOSD	Department of Social Development
DPT	Diphtheria, Pertussis (whooping cough) and Tetanus
DRC	Dutch Reform Church
ENE	Estimates of National Expenditure
EPRI	Economic Policy Research Institute
EPWP	Expanded Public Works Programme
GHS	General Household Survey
FA	Familias en Acción (Colombia)
FBI	Full Basic Income
FCG	Foster Care Grant
FCND	Food Consumption and Nutrition Division
FSSAP	Female Secondary School Assistance Program (Bangladesh)
FTE	Full Time Equivalent
GDP	Gross Domestic Product
GNI	Gross National Income
GEAR	Growth, Employment and Redistribution
GIA	Grant-in-aid
HDI	Human Development Index
Ho	Null Hypothesis

HSRC	Human Science Research Council
HST	Health Systems Trust
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant of Economic, Social and Cultural Rights
IDS	Institute of Development Studies
IFAD	International Fund for Agriculture Development
IFPRI	International Food Policy Research Institute
IHME	Institute for Health Metrics and Evaluation
ILO	International Labour Organization
IMF	International Monetary Fund
IPC	International Poverty Centre
ISSA	International Social Security Association
ISSR	International Social Security Review
IRR	Income Replacement Rate
JPFR	Japan Fund for Poverty Reduction Girls Scholarship Program (Cambodia)
LICUS	Low Income Countries Under Stress
LIS	Luxemburg Income Study
MDG	Millennium Development Goals
MPRA	Munich Personal RePEc Archive
MRGI	Minorities Rights Group International
NGO	Non-Governmental Organisations
NHI	National Health Insurance
NIDS	National Income Dynamic Study
NP	National Party
NQR	Children who do not qualify and receive the Child Support Grant
NQNR	Children who do not qualify and do not receive the Child Support
NSNP	National School Nutrition Programme
ODI	Overseas Development Institute
OECD	Organisation for Economic Co-operation and Development
OLS	Ordinary Least Squares
OAP	Old Age Pension
OPG	Older Person's Grant (previously known as State Old Age Pension)
PACES	Programa de Ampliación de Cobertura de la Educación Secundaria (Colombia)

PBI	Partial Basic Income
PSI	Policy Studies Institute
PETI	Programa de Erradicaçao do Trabalho Infantil (Brazil)
PPP	Pantawid Pamilyang Pilipino (Philippines)
PRAF	Programa de Asignación Familiar (Honduras)
PSNP	Primary School Nutrition Programme
QR	Children who qualify and receive the Child Support Grant
QNR	Children who qualify and do not receive the Child Support Grant
RAF	Road Accident Fund
RDP	Reconstruction and Development Programme
PATH	Programme for Advancement through Health and Education (Jamaica)
PRAF	Programa de Asignación Familiar (Honduras)
RPS	Red de Protección Social (Nicaragua)
SACC	South African Council of Churches
SALDRU	South African Labour and Development Research Unit
SAP	Structural Adjustment Programmes
SARS	South African Revenue Services
SASSA	South African Social Security Agency
SMG	State Maintenance Grant
SIU	Special Investigating Unit
TAC	Treatment Action Campaign
TB	Tuberculosis
TEVS	Targeted Educational Voucher Scheme
TSLS	Two Staged Least Squares
UCT	Unconditional Cash Transfer
UDHR	Universal Declaration of Human Rights
UIF	Unemployment Insurance Fund
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
UNODC	United Nations Office on Drugs and Crime
UNPO	Unrepresented Nations and Peoples Organisation
UNRISD	United Nations Research Institute for Social Development
WEF	World Economic Forum

WHO	World Health Organisation
WTO	World Trade Organization
WVR	War Veteran's Grant

Chapter 1: General introduction

1.1 Introduction

Social grants are at the forefront of the government of South Africa's campaign to combat poverty. Consequently, the number of recipients has increased from 2.4 million in 1996/97 to nearly 14 million in 2009/10, with social assistance expenditure representing 3.5 per cent of GDP (Budget Review, 2010:105; South African Social Security Agency [SASSA] Annual Report, 2008/09:5).

The grants are well targeted and benefit the neediest in society, especially in lifting them out of poverty. Van der Berg, Louw and Du Toit (2007:23) using the All Media Products Survey (AMPS) data between 1993 and 2006, find that the head count rate (P_0)¹ has decreased from 50.1 per cent in 1993 to 44.4 per cent in 2006. This is further confirmed in the Development Indicators (2010:27) where it is again highlighted that both the depth (P_1)² and severity (P_2)³ of poverty has decreased from 24 per cent and 14 per cent in 1994, to 19 per cent and 11 per cent in 2007 respectively.

1.2 Poverty and conditional cash transfers – The research problem

Although these social assistance initiatives impact on short-term poverty, the lack of improvement in the social indicators and human capital in areas of health and education have long-term implications of enabling people to be self-sustaining and decrease their dependency on social assistance.

The infant mortality rates (Development Indicators, 2010:37) have improved marginally from 55 per 1 000 live births in 2001 to 44.7 in 2010. Although the immunisation coverage has increased dramatically in the last ten years, the 'successful treatment rate' of TB has decreased from 73 in 1994 to 71 in 2008 (Development Indicators, 2010:39). Similarly, maternal deaths per live 1 000 births

¹ Head Count Ratio: Percentage of poor in the total population

² Poverty gap Index: Reflects the depth of poverty

³ Squared poverty Gap Index: Sensitive to the depth and severity of poverty

(maternal mortality ratio) has increased dramatically, from 80.7 in 1997 to 160.5 in 2003 (Development Indicators, 2010:40).

Equally disturbing are the educational outcomes. A World Economic Forum (WEF) Global Competitive Index Report ranked South Africa's quality of primary school education at 125th out of 139 countries, affirming the poor quality of education children are receiving (WEF, 2010:303). Moreover, education expenditure is the largest single item in the national budget every year. An estimated amount of R189.58 billion has been spent on education for the 2010/11 financial year, which is the largest expenditure item in the budget (Budget Review, 2011:xii).

The poor health and education outputs bring into focus whether South Africa should consider making the grants conditional. That is, should policymakers rather institute **conditional cash transfers (CCTs) as an instrument to alleviate poverty and promote human development in South Africa.**

The underlying precept of CCTs is the linking of cash to behaviour by providing money to poor families contingent upon certain verifiable actions, generally minimum investment in children's human capital such as regular school attendance or basic preventative health care (De la Brière and Rawlings, 2006:6). The focus on education and health to improve human capital investment is an important concern of South African policymakers.

The experiences of other countries may not provide a template to design an efficient and effective CCT programme for South Africa, but these countries could provide the government with a roadmap on how to design such a system should we need to implement it in South Africa; or alternatively, if South Africa should even consider implementing CCTs as a means to improve educational and health outcomes and subsequently long-term poverty. This is the question that will be addressed in this study, that is, **CCTs as a means to address poverty in South Africa.**

1.3 Research methodology

Education (school attendance) and health (immunisation or health centre visits) are most often the conditions that are attached to CCT programmes. Consequently, the international literature is thoroughly examined to ascertain whether there is an increase in demand for education and health services after the implementation of conditionality. More importantly, the international literature is scrutinised to determine whether conditionality improves actual education and health outcomes.

Once the international literature is thoroughly explored, the study aims to determine analytically if conditionality would be feasible and efficient in South Africa. This is done by attempting to compare the demand for education and health services by recipients of cash transfers with that of non-recipients of cash transfers.

The National Income Dynamic Study (NIDS), which was conducted by the Southern African Labour and Development Research Unit (SALDRU) is the dataset that was selected for the empirical analysis for this study. The NIDS endeavours to provide data for a set for households and individuals which can be used for policy and social research. There are other cross-section studies (General Household Surveys [GHS], Income and Expenditure Surveys [IES]) which are regularly conducted in South Africa to provide valuable information on households/individuals at any given time, but they do not provide information about the same person or household at different times.

The NIDS survey does represent the latest information on individuals and households that is necessary for the analysis and is compared with other sources and cross referenced with data from the South African Social Security Agency (SASSA) during the ensuing analysis. Whilst the NIDS shares common characteristics with GHS on population, gender, and even school attendance, which is also relevant to this study; the NIDS does provide variables which are distinctive for this study, specifically, variables on pass rates and grade repetition which are useful when making comparisons between grant recipients and non-recipients, and which are notably absent from other datasets. Furthermore, the GHS survey has variables such as school attendance which are also found in the NIDS data, but lacks information on expenditure (such as amount spent on food, beverages, transport costs etc.), which

is found in the Income and Expenditure Survey (IES). But variables such as school attendance are not found in the IES.

More importantly, many of these surveys refer to the households as the recipient of the grants, which the NIDS also does, but the NIDS is unique as it identifies the individual beneficiaries (especially children) as well. This is an important distinction which allows for comparison between recipients and non-recipients, which forms the backbone of much of the analysis of this study. For the purpose of this study, the NIDS data is the most representative information needed to conduct the analysis.

The National Income Dynamic Study (NIDS) is instituted to demonstrate analytically whether it will be feasible to attach conditionality to the CSG. The analysis is performed with STATA 10 statistical software.

The methodology employed is to determine if there is any significant difference (education and health outcomes) between the recipients of the CSG and the non-recipients of the CSG. Moreover, the population (as extrapolated from the sample) is separated into four groups, namely, children that qualify and receive the grant (QR), children that qualify and do not receive the grant (QNR), children that do not qualify and receive the grant (NQR) and children that do not qualify and do not receive the grant (NQNR). Consequently, educational and health outcomes of the different groups are compared.

1.4 Structure of the study

The study is arranged into four sections. Section A examines the need for social security; section B which evaluates social security in South Africa; section C explores conditional cash transfers and finally section D evaluates the applicability and analysis of CCT in South Africa.

In Chapter 2 of section A the meaning of social security is discussed, as social security does not only exist to alleviate poverty. The chapter commences by formulating a working definition of social security. The sub-components (social assistance and social insurance) of social security are formulated to facilitate the discussion of the need for social security.

In Chapter 3 the need for social security is evaluated from a global perspective, that is, needs for social security that are universal. These inter alia include social security as human right, and why it is important for social stability. The next need for social security that is deliberated is the prevention of deprivation and the need to assist the most vulnerable in society. The following need that is examined is the need to mitigate inter-generational poverty. The last subject investigated in this chapter is the fact that social security promotes economic activity.

In Chapter 4 the need of social security is scrutinised through the lens of developing countries. The needs that are reviewed are different from those of developed countries. However, citizens in developed countries may also experience similar needs for social security, but they are more severe in developing countries. Therefore, the need of social security to alleviate poverty is addressed. But poverty is multidimensional and there are different indices to measure it. Consequently, the definition of poverty is determined, after which a deliberation on its various components and its measurability is deliberated. Next, the underlying causes of poverty are evaluated.

The next need for social security that is examined is the need to compensate for the lack of market opportunities, with specific attention being paid to unemployment and informal workers. The last aspect of social security that is examined is the need to mitigate the adverse effects of globalisation.

Chapter 5 commences by exploring the informal social security arrangements that began prior to 1994. This is followed by a short discussion of the advancement of social security during the colonial period in South Africa. The chronological advancement of social security is examined in five periods, namely; 1910-1933 (3.4), 1934-1947 (3.5), 1948-1970 (3.6), 1971-1980 (3.7) and 1981-1993 (3.8).

In Chapter 6 the social security development in post-apartheid South Africa is evaluated. The economic policy choices (Reconstruction and Development Programme [RDP]; Growth, Employment and Redistribution [(GEAR)]) of the African National Congress (ANC) impacted on social security strategy choices by the government. Hence, the economic strategy post 1994 is deliberated to appreciate the social security decisions that were made. The present social security dispensation that prevails in South Africa is subsequently evaluated in this chapter. The Expanded

Public Works Programme (EPWP) that has been introduced to alleviate poverty, also receives attention. There is also deliberation on whether the debate on the Basic Income Grant should be resuscitated.

There are various reasons why the CCTs are implemented which have been covered in section A; which attest to their popularity. Section C focuses on CCTs.

In Chapter 7 the economic rationale for instituting CCTs is investigated. The chapter commences by exploring the definition of CCTs which is followed by an examination of the characteristics of CCTs, namely; focus on the neediest, focus on female poverty, the disbursement is conditional, but not conditional on how it is spent, and supply-side support.

In Chapter 8 the international evidence pertaining to CCTs is scrutinised. The impact of CCTs on school enrolment and school attendance is deliberated as well as the impact of CCTs on actual education outcomes. School vouchers as an alternative policy instrument to improve educational outputs, are also discussed. In the second part of the chapter the effect of CCTs on health, nutrition and infant and child mortality is discussed. In the last section the administration of CCT which policymakers need to be cognisant of when implementing the CCT, is examined.

The international evidence provides a backdrop to determine the necessity of instituting conditionality to social transfers in South Africa. In Section D the focus is on the applicability and analysis of CCTs in South Africa.

Chapter 9 examines social grants (excluding Child Support Grant) and conditionality. The chapter commences by describing the NIDS dataset that was employed in this study and the extrapolation of the sample to the population. This is followed by an analytical exploration of which grants will **not** be suitable for conditionality. The study assumes that all transfers are suitable for conditionality and systematically purges the social transfers that are not suitable for conditionality.

In Chapter 10 considers the Child Support Grant and conditionality. The underlying principle is to compare education and health outcomes between recipients and non-recipient of the CSG. A comparison is also made between the four groups (QR, QNR,

NQR and NQNR) to determine if there is any statistically significant difference between the four groups regarding health and education outcomes. In the last part of chapter 10 other significant factors that must be considered before implementing a CCT, are discussed. Even though there are myriads of factors that need to be scrutinised, the focus of this chapter is specifically on administration and monitoring challenges, fraud and corruption, dependency and political considerations. These factors are discussed within the context of the current CSG.

In Chapter 11 an overall synopsis of the thesis is presented, as well as conclusions and recommendations and the salient points of each of the preceding chapters are identified. The chapter concludes with recommendations.

1.5 Limitation of the study and areas of future research

The recipients and non-recipients of CSG as well as the four groups (QR, QNR, NQR AND NQNR) are compared with each other. This forms the foundation for deliberation on the need for conditionality.

The study uses the NIDS data, which is a first panel dataset to be developed for South Africa. However, the NIDS data does not permit comparisons of the same people over different periods. That means that it is impossible to compare education and health outcomes of the same people/households before they received the social transfers (especially the CSG), and after they received them. The future 'waves' of the NIDS will provide critical information to compare the education outcomes as well as the nutrition status over time and should be a focus area of future research.

Furthermore, whilst this study proves that there is correlation between the outcomes, for example, school attendance among all children, the study does not isolate causation of social transfers to school attendance as well as causation between the demarcated groups and health outcomes. It is not demonstrated in the study whether CSG impacts directly on education and health outcomes. There may be other factors that contribute to the education and health outcomes, which need to be controlled for before conclusive causal links between grants and education and health outcomes can be established. The control of variables will have to be econometrically demonstrated to not only determine if CSG impacts on education and health outcomes; but also, how much does CSG contribute to education and

health outcomes. This is an area of potential future research which can further contribute to the dialogue on conditionality of social transfers in South Africa.

The focus of this study is to determine if there is any statistically significant difference between the children who receive the CSG and those who do not; as well as between the four groups. In this way, we can infer whether the education and health outcomes are due to the lack of demand, or supply-side deficiencies which need to be remedied. Therefore, the results are statistically significant and deserve consideration in any discourse of conditionality of social transfers in South Africa.

Besides the social transfers to the most needy in society, government is also conducting the Expanded Public Works Programmes (EPWP) which primarily targets people (e.g. youth) who cannot access the social transfers. Consequently, future research on the impact of this programme on household poverty and welfare would be informative, as current research indicates that current social transfers are impacting positively on poverty.

Moreover, in this study the Basic Income Grant (BIG) that was on government agenda in the past but has fallen out of favour with the present government will be briefly reviewed. Further research on the cost as well as the benefits could form the foundation for robust discussion to augment present social transfers.

Notwithstanding the limitations, the key findings of this study do provide substantive information to determine whether conditionality is an appropriate policy choice for government.

Section A: The need for social security

Chapter 2: Understanding social security

2.1 Introduction

Social security encapsulates a wide range of strategies that policymakers implement to not only help the poor, but for various other economic, social and even political reasons. Conditional cash transfers are an element of social security which governments can employ to attain desired poverty alleviation goals. Therefore, it is imperative to ascertain the meaning of social security to appreciate the need for conditionality to social transfers.

The chapter deals with definitional foundations for social security for this study. A working definition is formulated to appreciate the need for social security in the context of this study. Social security has various components (social insurance and social assistance) which are also evaluated in this chapter.

2.2 Definition of social security

Section 27(1)(c) of the South African Constitution (Constitution of the Republic of South Africa, 1996:13) states that "everyone has the right to have access to social security, including, if they are unable to support themselves and their dependents, appropriate social assistance". However, the Constitution (Constitution of the Republic of South Africa, 1996) is silent on what is meant by social security or social assistance. Van Rensburg and Lamarche (2005:209) note that the terms social security or social assistance are not clearly defined in South Africa and are very often used interchangeably with one another and other terms such as social protection, social welfare and social insurance.

There is also no consistency in the definition used by organisations (e.g. International Labour Organization [ILO], Non-Governmental Organisations [NGO], World Bank, donors) where the concept is very often rooted in the ideology or philosophy of the organisation.

The International Social Security Association (ISSA) notes that social security can include social insurance programmes, social assistance programmes, universal programmes, mutual benefit schemes, national provident funds, and other arrangements including market-oriented approaches, that, in accordance with national law or practice, form part of a country's social security system (ISSA, 2009).

Furthermore, the definition in the Constitution of South Africa is similar to the definition of social protection which is often used in the literature. Van Rensburg and Lamache (2005:211) note that the Commission of Inquiry into a Comprehensive System of Social Security for South Africa (Taylor Committee) defined social protection as:

Comprehensive social protection is broader than the traditional concept of social security and incorporates all developmental strategies and programmes designed to ensure, collectively, at least a minimum standard of living for all citizens. It embraces the traditional measures of social insurance, social assistance, but it goes beyond that to focus on causality through integrated policy approach including many of the developmental initiatives undertaken by the state.

Conway, De Haan and Norton (2000:5) describe social protection as public actions taken in response to the level of vulnerability, risk and deprivation which are deemed socially unacceptable within a given polity or society.

The definition of social protection is the broadest and covers nearly everything to do with the poor. Consequently, following on the definition above it can be inferred that social security is part of social protection. Barrientos and Hulme (2008:3) note that social protection can be broadly classified into three main headings, namely, social insurance, social assistance and labour market regulation. It is worthwhile noting that labour market regulation does not refer to unemployment, as unemployment insurance falls within the jurisdiction of social insurance.

Whilst in this study the focus is primarily on social security, issues cited within the ambit of social protection will be relevant to social security as they relate to the social security element of social protection. For example, the ILO defines social protection as "entitlements of benefits that society provides to individuals and households through public and collective measures – to protect against low or

declining living standards out of a number of basic risks and needs” (Conway et al, 2000:26). It can be intimated that this definition, although referring to social protection contains aspects that are relevant to social security.

Van Ginneken (2003:280) argues that social security comprises of social insurance and tax financed social benefits which are usually targeted to the needy and are most often awarded on the basis of a means test. Within the European Union, social security is defined as social insurance and social assistance arrangements that protect the population against becoming poor (Dethier, 2007:1).

Consequently, Samson, Kaniki, MacQuene, Van Niekerk and Adams (2008:1) note that the South African social security system comprises of mainly two components, namely, social insurance and social assistance. Hence, social security, for the purposes of this thesis includes social insurance and social assistance.

2.2.1 Social insurance

Social insurance are programmes to compensate against a contingency that may occur to an individual. Social insurance requires compulsory payments by workers and/or their employers to ensure certain benefits are conferred on to employees should any of these contingencies materialise. Social insurance is based on the principle that individuals or households who are exposed to the same risk mitigate these risks by contributing to a pool of resources. Barrientos and Hulme (2008:3) claim that social insurance consists of programmes that provide protection against contingencies that may transpire from events in life such as maternity, or from work-related contingencies such as unemployment or sickness.

Social insurance differs from private insurance in that social insurance is usually compulsory; as non-insurance would create external costs (such as adverse selection and moral hazard) [Van Ginneken, 2003:280]. Furthermore, social insurance is not designed as an instrument for income distribution, rather as a means to provide income when the event (e.g. unemployment) is realised. Feldstein (2005:3) asserts that social insurance is different from welfare (social assistance) in that welfare programmes are means tested.

Van Ginneken (2003:80) affirms that the distinction between social insurance and social assistance is that social insurance's main purpose is to make provisions for various contingencies to prevent the household descending into debt and make household expenditure more predictable. Social assistance exists to help low income households to reduce household expenditure on basic items.

2.2.2 Social assistance

Social assistance are transfers to the poor and vulnerable to support and to assist in poverty alleviation. They are often means tested to determine if the beneficiaries qualify for the transfer. Luiz (1995:580) avers that social assistance is granted on the basis of an income test (also asset test) without a contribution test. The benefit is either in cash or in-kind, whilst social insurance disbursements are mostly in cash. Hence, social assistance entails public actions that are designed to transfer resources to eligible groups due to deprivation (which may be defined by low income or in terms of other dimensions of poverty e.g. social or nutritional status) [Norton, Conway and Foster, 2001:10].

In South Africa the onus is on the recipient (or the parent/guardian) to prove that the recipient is in 'need'. Therefore, social assistance is needs based assistance with no compulsory contribution to the scheme.

The social assistance (e.g. Child Support Grant [CSG]) and social insurance schemes (e.g. Unemployment Insurance Fund [UIF]) that are operational in South Africa are discussed in section 6.4. Suffice to add that there is a need for social security in South Africa; and that it consists of primarily two components, namely social insurance and social assistance.

2.3 Summary and conclusion

The purpose of this chapter was to determine the meaning for social security to serve as a context for understanding conditional cash transfers. There are various interpretations of social security and the meaning is often used interchangeably with other terminology such as social protection. For the purpose of this study, and as is common in academic literature, social security is described as being composed of two components, namely social insurance and social assistance. Social insurance

refers to programmes that employers and employees are compelled to join to protect against contingencies (e.g. illness, unemployment) that may occur in life. Social assistance entails cash or in-kind transfers to the poor in society and is financed from the fiscus with no contribution made by the beneficiaries.

Social security exists to assist people when they are most in need and are unable to help themselves or their families. This is discussed in the following chapter.

Chapter 3: Social security - A global perspective

3.1 Introduction

The programmes and strategies that are implemented to alleviate poverty are often mistakenly thought to be the exclusive objective of social security. Whilst poverty strategies are one component of social security, they are by no means the only constituent. Even when governments are inefficient, there is still a need for them to provide social security as it can offer income maintenance, poverty reduction and promote economic stability and social justice (Van der Merwe, 2000:716).

Nevertheless, there is a common misunderstanding that social security exists only to assist the poor. Social security has been implemented to not only assist the poor, but all citizens, who may find themselves in circumstances that could render them poor. In the United Nations Research Institute for Social Development (UNRISD) [2008:3] report it is contended that countries that were successful in alleviating poverty did not target social security exclusively to the poor; but also invested in pensions, child benefits and unemployment insurance that was also available to the non-poor, for situations that may give rise to poverty.

Consequently, in this chapter the aim is to determine the need for social security from a global perspective. Whilst there are numerous direct and indirect reasons for social security, the elements that were selected for deliberation in this chapter were chosen for the following two reasons. Firstly, the needs that are discussed here are the ones that policymakers have principally focussed on in social security as an instrument to achieve outcomes, for example, poverty reduction, income maintenance, etc. Secondly, the needs are also the most pertinent ones that have received scholastic discussion within the academic literature.

Section 3.2 commences by evaluating social security as a human right, the denial of which could lead to social instability. In section 3.3 the need for social security to prevent deprivation and assist the most vulnerable groups in society is deliberated. In section 3.4 how social security can mitigate inter-generational poverty is considered, whilst in section 3.5 how social security can promote economic activity is demonstrated.

3.2 Social security as a human right

The moral imperative of human rights is to ensure that humans are entitled to live a decent life because they are human. Nickel (1987:561) defines human rights as “basic moral guarantees that people in all countries and cultures allegedly have simply because they are people”. Human rights “are predicated on the intrinsic value and worth of all human beings and are considered to be universal, vested equally in all persons regardless of their gender, race, nationality, economic status, or social position”(Chapman, 1993:21).

This principle of human rights is grounded in natural law which often has a theological foundation. Munro (2008:31) argues that natural law has a quasi-theological character and is based on a few axioms or articles of faith. Munro (2008) further notes that a good affirmation of natural law is the American Declaration of Independence which states: “We hold these truths to be self-evident, that all men are created equal, that they were endowed by their creator with certain unalienable rights” (Munro, 2008:31).

The other foundation for human rights is constitutional and international law. Although not mutually exclusive from natural law, this school of thought espouses that human rights are not about charity or morality, but are legal obligatory responsibilities of the state. This legal interpretation of rights implies that human rights exist because most states have ratified human right treaties and/or because their constitution grants these rights to their people (Munro, 2008:31).

These rights find expression in the Universal Declaration of Human Rights (UDHR), which was adopted in 1948. Articles 22 and 25 have reference to elements of social security as well as social protection:

Article 22: Everyone, as a member of society, has the right to social security and is entitled to realization, through national effort and international co-operation and in accordance with the organization and resources of each State, of the economic, social and cultural rights indispensable for his dignity and the free development of his personality.

Article 25: (1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, and housing and

medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

(2) Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

The UDHR was augmented by the International Covenant of Economic, Social and Cultural Rights (ICESCR) in 1966 to strengthen countries obligations to socio-economic rights. Article 9 of the ICESCR underlines everyone's right to 'social security, including social insurance'. Consequently, the UDHR (general assembly resolution) together with the ICESCR (international treaty) and the International Covenant on Civil and Political Rights (ICCPR) [international treaty] is informally referred to as the International Bill of Human Rights. The Bill of Rights provides the impetus for social insurance and assistance forming part of the right to social security (Riedel, 2007:75).

Consequently, human rights as expressed by the International Bill of Rights are entrenched in the constitution of many nations. Van Ginneken (2009:230) argues that when human rights, particularly economic and social rights are recognised as a legal right they become claimable and operational. Moreover, human rights grant citizens a legitimate claim on the resources to realise these rights; and for the state to mobilise resources for essential redistributive purposes (Schrecker, 2010:156).

But very often, the content (as in the South African Constitution) of social security that the government is responsible for, is not clearly defined. However this does not pardon authorities from investing in social security as the benefit accrues to not only the poor, but society as a whole (section 7.4). Some governments are acutely aware of the long-term benefits and accordingly expend significant part of their budgets on social security. Townsend (2007:vii) notes that Organisation for Economic Co-operation and Development (OECD) countries spends an average of 12.6 per cent of their GDP on social security cash transfers and altogether more than 20.9 per cent on public social services and social security, excluding education.

3.2.1 Social stability

Whilst the citizenry may be unaware that social security is a human right, people will not always quietly accept the destitute conditions, especially if they perceive that the authorities have the means to improve their lives and those of their children. The rights of the poor cannot lie dormant indefinitely, and policymakers are vigilant of social instability that can erupt if the basic wants of the poor are ignored for too long. Dethier (2007:1) maintains that social security does not only provide for a harmonious and cohesive society, but also results in gains in efficiency which are not always measurable and tangible.

The lack of social security to mitigate the risks of poverty and to provide for circumstances that give rise to poverty, may lead to people turning to crime and increase of social tensions in society. Van der Merwe (2000:719) notes that social security may not altogether stop, but can reduce the risk of political upheaval, unrest and even crime.

Social security exists to protect against hardships which are likely to occur through a sudden change in circumstances. People shouldn't have to sell their possessions and live in destitution or even deprive themselves of basic necessities just because they have become old, disabled or even unemployed (Spicker, 1993:105).

This becomes especially clear when the poor are criminalised for not being able to pay for basic services such as water and electricity and have to resort to stealing them to provide for their families. Social security is necessary for a more equitable society which is necessary for peace, stability and social cohesion through social justice (ILO, 2008a:1). The ILO articulates these sentiments and it is therefore pertinent to quote them at length:

Poverty and gross inequalities and their intense social tensions are more likely to result in violent conflict, ultimately destabilising governments and regions causing waves of migration, and may make people more susceptible to terrorist appeals and other forms of criminality. Social security assists in preventing and alleviating poverty by making the outcomes of economic forces more equitable thereby enhancing peace, stability and social cohesion. Providing social security is one of the most effective policies that a state can implement to gain legitimacy and to provide stability in post-conflict situation (ILO, 2008a:2)

Social security need not only be seen as a safety net for those who cannot meet their basic needs; but for everyone, as everybody at some time or another was a child, sick or will be old. The Asian Development Bank (ADB) [2010] asserts that social protection reduces risk for the whole population (and not only the poor) from falling into, sliding back or remaining in poverty.

Therefore, social security is not only a human right that all citizens are entitled to because they are human but also a safety net to alleviate the plight of the poor. And the right to social security is entrenched in international law and constitutions which concomitantly obliges government to fulfil.

3.3 Prevention of deprivation and assistance of the vulnerable

Poverty (section 4.2) is not only about the lack of income, but also about deprivation. Sivakumar and Sarvalingam (2010:4) describe poverty being not only about insufficient income or consumption, but also insufficient outcomes pertaining to health, nutrition, literacy and deficient social relations.

Consequently, social security exists not only to remedy income poverty but also to protect against deprivation and vulnerability of the individual and the family. However, income based poverty measures focus exclusively on deprivation of one variable (income) [Anand and Sen, 1997:5].

Poverty is a consequence of people being deprived of these services, whilst vulnerability is often a source of this deprivation. Spicker (1993:16) believes that poverty should not be defined in terms of inadequate resources and consumption, but rather the lack of welfare that results from them.

The lack of schools for children can be defined as an element of poverty and can easily be factored into a poverty index. But if there is a school with no water, sanitation or the child has no transport to the school, it can be inferred that the welfare of the child is being disregarded.

However it can also be argued that if schooling facilities are provided and the child is not attending, the child is not suffering from poverty. So it boils down to a value

judgement on the relative welfare of the people because what counts as deprivation is a value judgement that can be defined in different ways (Dreze and Sen, 1991:5).

There are many ways of characterising deprivation for theoretical discussions and the list of conditions that can lead to deprivation is wide and varied. Baratz and Grigsby (1971) *in* Spicker (1993:11) list a catalogue of factors which do not describe people as poor, but are elements which, if they are deprived of, will place them in circumstances that can render them poor. These include the following:

1. Severe lack of physical comfort
 - a) shelter which does not provide adequate protection from elements, is poorly lighted or ventilated, overcrowded or filthy
 - b) hunger
 - c) highly unpleasant neighbourhood (excessive noise, litter, traffic)
 - d) highly unpleasant environment on job (extreme temperatures and odours, limited workspace etc.)
 - e) clothing wardrobe which does not provide adequate protection from the elements

2. Severe lack of health
 - a) high probability of short life-span
 - b) frequent illness
 - c) chronic illness
 - d) permanent physical or mental illness

3. Severe lack of safety and security
 - a) unsafe housing
 - b) unsafe neighbourhood
 - c) lack of protection against major loss of assets
 - a) unsafe working environment
 - b) unsafe air or water
 - c) lack of protection against major decline of real income

4. Severe lack of welfare values
 - a) personally unacceptable ratio of earned to total income
 - b) personally stigmatising form of financial dependency
 - c) inability to perform a socially valued function (e.g. paid work)
 - d) lack of good quality education
 - e) non-possession of symbols of medium-high social status

- f) highly unfavourable self-conception
 - g) low aspirations for, or hopelessness about, potentiality for upward socio-economic mobility
 - h) severe family instability (e.g. broken homes)
5. Severe lack of defence values
- a) severe restrictions on economic and social opportunity and activity (especially discrimination)
 - b) exclusion from participation in political process
 - c) victim of injustice in law enforcement process
 - d) non-possession of socially valued skill
 - e) socially stigmatising form of financial dependency (Spicker, 1993:11-13).

The directory of factors noted by Baratz and Grigsby is quite comprehensive and it is highly unlikely that all components can be factored into the poverty measure. Furthermore, some components (personally stigmatising form of financial dependency) are vague and will be difficult to substantiate empirically. Other factors (non-possession of symbols of medium-high status) cannot really be seen as pertinent to the formulation of social policy.

Although most of these factors cannot be empirically measured, they are important to the well-being of people. Furthermore, the deprivation that occurs because of some of these factors is often the foundation of or a consequence of poverty.

Therefore, these issues should not be discounted in any debate about poverty and deprivation; since the basic tenet of social security is to use social policy instruments (e.g. social assistance and social insurance) to prevent deprivation and vulnerability.

3.3.1 Vulnerability and vulnerable groups

Whilst poverty (and deprivation) focuses primarily on resources or the lack thereof; poverty is also about opportunities, power relations and lifestyles (Spicker, 1993:58). This can result in certain segments being more vulnerable and therefore more prone to poverty. The vulnerable groups in society are those that are most discriminated against, stigmatised and socially marginalised. And very often these are women, religious minorities and refugees who languish in poverty. They are also

the people who usually bear the brunt of natural disasters (floods) and manmade calamities such as war.

Vulnerability is when certain segments of the population are more susceptible to falling into poverty. Catastrophic events (such as death of a breadwinner) with a lack of insurance to mitigate any contingencies, can result in a household descending into poverty. There are a host of causes of vulnerability and they can be temporary in nature; but they can lead to many poor households sinking into deeper poverty as they have to go into debt (if they can access credit) or sell off their assets. Rowson (2007) notes that during periods of economic crisis or when there is a death of a household wage earner, assets may not be replaced, making the poor more vulnerable and pushing them even deeper into poverty.

Although there is no wish to deny that other segments suffer, the groups (e.g. women) that were selected are the ones that are the most marginalised in society, and the impact of preferential social expenditure on them will have a greater impact on society. Numerous studies (Ainsworth, Beegle and Nyamete [1996:117] Handa [2000:184], and Osili and Long [2008:73]) have shown that schooling for females is responsible for lower fertility rates and better health outcomes.

Therefore, these groups are targeted by policymakers as they bear most of the consequences of poverty and are most in need of social security. Social security targeted at these segments of the population can create a more equitable society.

3.3.1.1 Women

Whilst most women are not poor, most poor are women. The United Nations Development Fund for Women (UNIFEM, 2010) note that by some estimates 70 per cent of the world's poor are women and are often paid less than men with the average wage gap in 2008 being 17 per cent. In a study of poverty between men and women in America, Elmelech and Lu (2004:14) found that women of the same racial/ethnic origin are more likely to be poor, although White women are less likely to be poor than any of the minority status men. Gornick (2004:213) in a review of two decades of analysis of the Luxemburg Income Study (LIS) data, find that in several countries, post-tax and transfer poverty is more prevalent among women

than men, mothers compared to fathers, and female-headed households relative to male-headed households; solo mothers everywhere have a higher risk of low income.

In addition Munnell (2004:2) notes that women's lifetime earnings are lower than those of men for three main reasons. Firstly, they earn lower wages. In the USA, women who are employed full time earn 25 per cent less than men. Secondly, women are more likely to work part-time, which reduces their take home wage. A quarter of all women work part-time compared to ten per cent of all men. Moreover, women are more likely to work part-time when they have young children. Thirdly, women spend fewer years in the labour force compared to men (Munnell 2004:2).

Also, their poor earning capacity often results in women not saving (or inadequately saving) for their later years. Moore (2004:8) argues that as a woman gets older her capacities, and the responsibilities as well as opportunities available to her change, all of which can impact on the well-being of the woman. The time devoted to unpaid work decreases time available to earn income, reduces the experience that would be gained if fully employed (male equivalent), and broken service reduces their long-term earning potential.

And when women do earn as much as men or even more than men, they are not necessarily 'better off' within the household. Chen, Conconi and Perroni (2007:21) find that the higher relative wages of married women only increases the 'double burden' as it increases their market effort and decreases their leisure time. Double burden is a term coined to describe the situation where a woman is employed fulltime in the labour market together with unpaid home and child responsibilities within the household.

Moreover, poverty alleviation strategies that are targeted at women may not always reach them. The resources received by women in the household may be used by them for the children within the household. The benefits may be mitigated by the low contribution to the household by a husband, or the man may sequester the resources that the woman receives.

3.3.1.2 Minorities

Even when countries do not have high aggregate levels of poverty, certain classes of citizens may be poor or more prone to poverty. These minority groups are often discriminated against; and can be excluded (or not fully participate) in the economy and may consequently require special interventions to assist them. Minorities Rights Group International [MRGI] (2010) define minorities as

Disadvantaged ethnic, national, religious, linguistic or cultural groups who are smaller in number than the rest of the population and who may wish to maintain and develop their identity.

Minorities have less access to social services (health and education) which often manifests in sickness and higher incidence of mortality and morbidity. In the United Kingdom, a report by the Policy Studies Institute (PSI) [1997] found that Pakistanis, Bangladeshis and Caribbeans (minorities) have the poorest health of anyone in Britain, highlighting the fact that health services were failing to meet the needs of ethnic minorities. Phillips and Bowling (2003:269) argue that the focus of studies is too often on the over-representation of minorities as being arrested and incarcerated and ignore discrimination against minorities by the criminal justice processing system.

Although minority children may be provided equal access to education, they may still be at a disadvantage as they face particular challenges. The Unrepresented Nations and Peoples Organisation [UNPO] (2010) notes that these challenges include lack of educational instruction in their mother tongue, school fees which are prohibitive as they are often the poorest segment of the population, discrimination by teachers and administrators and a curriculum that is often not reflective of (and sometimes in conflict with) their culture.

The difficulties experienced by minorities in Britain are also felt by minorities in the United States. Gradin (2008:2) contends that in the United States, minorities (Blacks and Hispanics) which comprise half of all poor Americans, share common elements of poverty and deprivation; they have less education, less health insurance and a larger risk of being prisoners, unemployed or underemployed. Furthermore, Boehm and Schlottmann (2007:128) using the American Housing Survey, find that African-

American households and Hispanic households pay more for their home financing than White households.

Hence, one must be cognisant of the vulnerability of minorities in society, even when poverty levels are declining as all segments of society may not be equally benefitting.

3.3.1.3 Rural inhabitants

Poverty is more pervasive in rural areas and people living in these areas may need more protection. Rural citizens' access to social services is lower when compared to that of urban dwellers. The International Fund for Agriculture Development (IFAD) [2002:9] avers that the rural poor have inefficient schools, health care, roads, land and institutional and market access. Although rural poverty has declined between 1970-1985, the rural-urban gap in income, poverty, nutrition and education has not decreased (IFAD, 2002:9). Rural inhabitants are usually situated further from markets and ports and have inferior infrastructure such as road transport electricity and water quality.

Whilst rural poverty is commonly associated with developing nations, rural poverty is also felt in developed countries. Jensen (2006:2) asserts that approximately 7.3 million rural Americans were poor in 2005, or 15.1 per cent of the rural population. In contrast, 12.5 per cent of individuals in urban areas were poor (Jensen, 2006:2). The IFAD (2010) finds that rural poverty is practically non-existent in the European Union and Northern Europe, but is a growing threat in Eastern Europe and Southern Europe. In the United Kingdom there is less overall exclusion and poverty in rural areas, with the exception of the proportion of older people who receive help from social services, which is lower than in urban areas (Harrop and Palmer, 2002:4).

Therefore the rural population experiences greater poverty and social exclusion and this should be noted in all social service delivery arrangements.

3.3.1.4 Disabled

Even though there is no consensus on the definition of disability, there is widespread agreement in academic literature that disability is both a cause and consequence of poverty. People who are poor may not have the means to visit a health professional when they have a debilitating illness leading to disability. Disabled people will lack the capacity to generate income to care for themselves. There is a case of social security to compensate for a disadvantage, especially if the person is born mentally handicapped or physically disabled.

Despite there being no agreement on the definition and little comparable information on disability, the World Health Organisation (WHO) [2010a], finds that an estimated 10 per cent of the world's population - approximately 650 million people, of which 200 million are children, are disabled. Furthermore, disabled individuals have lower education and income levels and are less likely to have savings and assets (WHO, 2010a:2).

Although disability can affect all age groups, the incidence and severity of disability increases with age. Elwan (1999:8) notes that the proportion of disabled people is estimated to reach 80 per cent in people 85 years and older. Furthermore, disabled people who live in rural areas have limited access to training and employment opportunities; and subsequently have lower incomes than non-disabled individuals (Murray, 2009).

The motivation for social security is not only to assist the person or those who have to care for them, but also from a humanity perspective as it is 'undesirable' to be disabled (Spicker, 1993:105). At a social level, remedying the disadvantage is often represented in terms of equality or social justice.

3.3.1.5 Youth and children

The children and youth are dependent on their parents/guardians for their needs during the critical development years of their life. Often parents do not make the best choices (e.g. no education, poor nourishment) in the interest of the child which places them at a disadvantage later in life. Wüst (2010:2) argues that the prenatal investment is one of the most important investments in child health as these investments lay the foundation for later investments and outcomes. Furthermore,

infants born in poor health (as measured by low birth weights and low APGAR⁴) have lower survival rates and may experience health and social difficulties later in life (Conley, 2003 *in* Oreopoulos, Walld, and Roos, 2006:1).

Sometimes the parents are unable to provide for their own well-being and do not have sufficient resources to provide for their children and even neglect their children. Children who are born to parents who are malnourished themselves, or whose mothers indulge in narcotics or alcohol whilst pregnant, are at a disadvantage. The growth and development of the foetus, especially of the brain and the immune system takes place during the foetal and early childhood periods. The Centre for Disease Control and Prevention (CDC) [2004] notes that women who drink during pregnancy have a higher probability of giving birth to a child with Foetal Alcohol Syndrome; which manifests as neuro-behavioural and developmental abnormalities. It is therefore critical that the pregnant mother and the new-born child are healthy as this is necessary for the future cognitive and physical development of the child.

Compulsory visits by the parent to the clinic will mitigate the risk of the parent causing harm to the child. Furthermore, parents who neglect the well-being of the child by neglecting to have the child vaccinated regularly, will not only place the child's life at risk, but also other children with whom they come into contact. Immunisation not only prevents suffering and disability of the child, it also reduces contagion, decreases strain on the health systems, and consequently saves money that can be used for other health services (WHO, 2005). Hence, it is imperative that the child be vaccinated and that his/her progress be checked regularly.

Several children have lost their parents because of the AIDS pandemic (AIDS Orphans) and require special protection and even foster care. Many children have become de-facto heads of households and look after their much younger siblings because the parent has died or is terminally ill and needs full time care, which the state cannot provide. This leaves them with little time and resources to take care of their immediate needs, and even less to provide for their futures. The Children's Right Information Network (CRIN) [2005:2] contends that children in child-headed

⁴ A test administered immediately after birth to assess the health of the newborn. It evaluates five criteria (Appearance, Pulse, Grimace, Activity, Respiration), each scored from zero to two, and summing up the five values. The score ranges from zero to ten.

households are confronted by a myriad of extreme circumstances. These include “no immediate adult to protect them, feed them, guide them, love them and laugh with them, leaving them at risk of hunger and neglect and of being exploited physically and of being sexually abused and worse” (CRIN, 2005:2). This also denies them the enjoyment of their childhood and makes it impossible for them to provide for the future.

Similarly (section 7.4.1.5) educational services that are available may not be seen as important by the parent; but the positive impacts on the child, society and even the parent may necessitate that the state to prioritise intervention so that the child receives the education. Currie (2008:3) finds that parents with more education earn higher income and children in higher income families are likely to have more education than other children.

Notwithstanding the transition challenges such as employment, starting a family and marriage and even furthering their education; some children will be trapped in the vicious cycle of poverty when they get older. Moore (2004:2) argues that the youth face many challenges simultaneously in their lives. These changes are in their personal relationships, work environments and in their living arrangements (Moore, 2004:9). The United Nations World Youth Report-2005 (2005:iii) finds that almost half the world’s population is under the age of 25; with 200 million youths (15-24) living in poverty, 130 million illiterate, 88 million unemployed and 10 million living with HIV/AIDS.

Providing social services and investing in these children can break the cycle of deprivation so that children from disadvantaged homes can earn a decent livelihood as youths and adults, and live a better life than they did as children.

The youth are in the early stages of their careers where they may find it difficult to save and subsequently acquire assets. Any setback can have a long-term impact on their lives. Young couples may defer saving and consumption as they have to provide for the education and health needs of their children, when the quality provided by the state is inadequate. Wheeler-Brooks and Scanlon (2009:763) contend that young people are aware of the importance of savings, but most young people do not have much to save due to employment disruption and the fact that they perceive their

expenditure needs as fixed. In a survey conducted by the *Financial Times*, it was found that only 4 per cent of 20-somethings have actually started saving for retirements via pensions and individual savings accounts (Law, 2009).

Youths who have not received a tertiary education may struggle to find gainful employment. 'O Higgins (1997:83) find that youth unemployment is higher than adult unemployment in industrialised countries as they possess few marketable skills, and almost no career oriented work experience, face severe difficulties in finding meaningful employment, as evidenced by their chronically high unemployment rates and concentration in low-paying jobs.

The youth do not often receive unemployment benefits as they have not worked long enough (or not at all) to contribute to the unemployment insurance funds and are therefore not entitled to any benefits (Westcott, 1970:87). Social security targeted at the youth can assist the youth realise their full potential, contribute to society and arrest the transmission the poverty that they might have been born into.

3.4 Mitigate intergeneration poverty

Whilst it is not always easy for governments (due to fiscal constraints) to address the social challenges in the short-term they can attempt to rectify social inequalities in the long-run. The concept of intergenerational transmission of poverty highlights the association of processes that may result in adulthood and chronic poverty, rather than outcomes or experiences during a specific time (Harper, Marcus and Moore, 2003: 536).

Moore (2004:15) reports that in the United States, people who have been in poverty for more than four years have a 90 per cent probability of remaining poor the rest of their lives. When an individual or household falls below a 'critical level' it can become increasingly difficult to move from survival to improvement strategies.

The transmission of poverty entails the transmission of poverty from the older family members to the younger generation (mostly children). Moore (2004:12) argues that the transfer can be both positive (cash) as well as negative (bonded labour, poor nutrition). Jenkins and Siedler (2007:ii) contend that research has shown that when compared to children from affluent families; children from low income families on

average, have lower birth weight, higher risk of infant mortality, more behaviour problems, less successful in school, do worse in labour markets and have inferior health. Bird (2007:13) argues that having uneducated parents is strongly associated with household poverty and increased risk of malnourishment and disease from poor sanitation and health practices. Bhargava, Mathur, and Rajagopa (2005) *in* Bird (2007:13) found that in Rajasthan, less educated parents did not prioritise education for girls. Handa, Simler, and Garrower (2004) *in* Bird (2007:13) find that children who had educated mothers in Mozambique are more likely to go to school and stay in school.

Hence, parents may not make the best choices for their children and place them at a disadvantage later in life and society may subsequently endure the consequence of these decisions. There is a responsibility on the state to act and provide strategies and policies for people to assist in making correct decisions (saving choices) and preventing them from making poor decisions (stop children from school).

Even if the incumbent government cannot alleviate poverty of households, there is a strong case to be made for preventing the transmission of poverty across to the next generation. Firstly, when the children of the household become citizens they will not be dependent on the state, which will free resources to assist other people, who could not be reached; or assist the others with more than what they were currently receiving.

Secondly, the citizen that is no longer dependent on the state can now contribute through taxes to the fiscal purse for government and social priorities. Thirdly, the person will be able to take care of his own children and therefore relieve the state from committing resources for that household.

Although the focus of intergeneration poverty is often from the older generation to the younger one, the transmission of poverty from younger to older people must not be forgotten. Bird (2007:23) notes that the transfers made from one generation (younger) to the next can be made due to an implicit contract that link children to the adult. The child is dependent on the adult for food, health education with the expectation that they are obliged to care of the adult when they are older. Moreover, the adult views the arrangement as an investment for their old age or as security for

support in the twilight years. However, many families are unable to provide for their elderly family members who have no resources or expect to be looked after by the younger generation. The inability of families to provide care and support to the elderly results in the elderly becoming more vulnerable (Malhotra and Kabeer, 2002:7).

Although it may be perceived to be paternalistic for the state to know what is best for the individual, the state can justify its decision on behalf of individuals as the benefits (or the consequences) not only accrue to the individual but also to the state. It could also be too late when the individual does realise that he/she has taken an erroneous course of action. Hence, the need for the mitigation of the transmission of poverty cannot be stressed enough.

3.5 Promotes economic activity

The government should not disburse social security only on humanitarian grounds, or because it is politically convenient to do so, but because it is economically beneficial to society.

Social security has fiscal implications for the country. Sen (1999:130) warns that it is not sufficient to see entitlement to basic social provisions (medical attention, education, income security) as an inalienable right of citizens, but that – given the limitation of economic resources – there are serious choices to be made. Resources have to be optimally employed to attain the best social outcomes with the country's finite resources.

Not all resources can be used for social policy, since resources have to be employed to generate economic growth, which can provide the resources to deliver social protection to the neediest in society. Although economic growth has indeed occurred in many parts of the world, poverty and inequality has persisted. There is growing evidence that economic growth has benefited higher income groups the most. The rich have more resources and are able to invest more and receive larger returns (Li and Zou, 1998 *in* Chittooran, 2009:8).

Social transfers are instruments to achieve equity in society by allowing redistribution of wealth from wealthier citizens to lower income individuals. Mahler

and Jesuit (2006:491) find in their study that relative to taxes, social transfers have a greater impact on redistribution.

The benefits of economic growth (when it does occur) does not always 'trickle down' to the poorest in society; and when it does, it is painfully slow, and therefore public policies are necessary to encourage redistribution (ILO, 2007a:3; Leliveld, 1994). Ravillion (2004:8) finds that economic growth is not typically pro-poor, and that changes in inequality at the country level have zero correlation with rates of economic growth.

Prasad (2008:3) finds that in 64 countries that spent on social transfers, inequality tended to be lower. Moreover, inequality is relatively higher in the United States where expenditure on social transfers is limited whilst countries that spend more on social transfers (Austria, Belgium, France, Germany and Sweden) have relatively lower income inequality (Prasad, 2004:3).

The calls to scale back on social security grow louder during the downturn in economic activity when there is a greater demand for social security and more demand for taxes to fund these needs. Poor economic activity is often a pre-text to scale back on social services, when there is usually some other (e.g. external financial crises) cause for the economic decline. Furthermore, when economic downturns do occur, social services are easy targets for policymakers, and this does find favour within certain segments of society.

Very often the crisis in social security is not because of the structure of social security, but the attrition of the economic foundation necessary for its functionality. In fact, social security has partly mitigated the social and economic impact of the erosion of the economic base (Spicker, 1993:111).

The WHO (2009:6) notes that the poor suffer disproportionately during economic downturns as an increased number of people are pushed into poverty. The social transfers prevent people from falling deeper into poverty, ensure that they have access to health and education services and reduce the likelihood of social unrest; but importantly they also make a contribution to limiting the fall in aggregate demand (WHO, 2009:7).

The ILO (2008a:1) contends that "social security serve as cash injections to local economies and have a positive impact on their development". The OECD (2009a:23) notes that social transfers promotes pro-poor growth, by increasing economic efficiency through improved resource allocation and taking advantage of economic capacity. By raising the income of the poor they increase the domestic demand which in turn encourages growth by expanding domestic markets.

Regular transfers to the poor provide the stimulus for economic growth (rate of increase of per capita income), which creates employment and raises income (Wahenga, 2007). Cash transfers enable poor households to participate in the local economy and demand goods and services, which stimulates local producers and service providers to increase production, which will, in turn, result in higher employment. Wahenga (2007) avers that this local multiplier effect can revitalise local economies, and when replicated across the country, it can be an impetus for larger economic growth.

This argument is the one that Keynes believed was important to stimulate the economy in times of an economic downturn. Social security according to Keynesian thinking viewed social security as automatic stabilisers. The countercyclical nature of social security expenditure is its inbuilt feature as a source of automatic stabiliser of individual incomes and aggregate demand (Hagemejer, 2009:2).

Keynesian thinking advocates that the worse the condition of the economy, the more money should be pumped into the economy by government. More money will stimulate the demand for goods which can increase economic output. Social security not only assists the most destitute during this time, but it also provides a means to increase economic output. Due to the working of the income multiplier, the government will be able to increase the national income by changing aggregate demand, by increasing government expenditure (social transfers) or reduce taxes (Calitz, 2002:262). Social transfers increase consumption and the subsequent increase in nutrition leads to higher labour productivity (Barrientos and Scott, 2008:11).

Alternatively, when economic activity takes off, social spending will decrease as there will be less unemployment and more resources to fund other government priorities. Hence, it is imperative that governments should not always lament the costs of social security as excessive which can impede growth.

However, the government may not be able to afford the increased demand for social security, especially during the economic downturn. The additional funding must either come from existing reserves (e.g. contingency reserves), reallocation of public spending, increased contributions and taxes or from an increase in public financing deficit (Hagemeyer, 2009). Consequently the country will be restricted in expanding social security. This is likely to occur if the cause of the economic downturn is a financial crisis where lenders demand fiscal austerity. Therefore, the multiplier effect for consumption expenditure must be evaluated in the context of the prevailing macro-economic environment. The benefits of increased social transfers will be negated by the tax increases (or increase in public finance deficit). The impact of the multiplier may therefore be limited. It is noteworthy that developing countries may even find it difficult to afford comprehensive social security programmes.

But social expenditure also contributes to increasing human capital which in the long-term will benefit economic growth. The WHO (2001:34) finds that a 10 per cent increase in life expectancy leads to a 0.3-0.4 percentage point increase in per capita income.

Besides providing households with resources to satisfy (and/or supplement) their consumption needs, social transfers can also be a means of investing in productive capacity and entrepreneurial initiatives. Whilst the transfer may be too small to be used for commencing an entrepreneurial activity, the regular remittance of the social transfer could serve as collateral or a proxy for creditworthiness. Brooks (2009:62) notes that in Brazil, pensioners in the informal sector are able to access loans from banks by showing their pension cards. Consequently, the availability of credit enables households to invest in productive capacity as well as human capital, enabling households to move to higher income levels and better opportunities (Brooks, 2009:62).

Gertler, Martinez and Rubio-Codina (2006:1) in a study of rural households that participate in the *Oportunidades* (social assistance programme in Mexico), find that transfers to these households result in increased investment in micro-enterprise and agricultural activities. They further note that the investments improve the household's ability to generate income and that there is an estimated return of 17.6 per cent (Gertler et al, 2006:1).

The OECD (2009a:24) asserts that social protection enables the poor to protect themselves and their assets against shocks allowing them to conserve their income-generating potential. Furthermore, social protection prevents households from resorting to desperate measures (selling assets) when the household experiences a shock. Social transfers prevent distress sales and allow for capital investment in productive activities, enabling the beneficiaries the chance to protect and improve their economic situation (Vincent and Cull, 2009:9).

Often high-income generating activities are linked to higher risk. The poor household may be reluctant to invest in these opportunities as they are afraid of risks and are not insured against the risk of not succeeding. Therefore, the poor may engage in low-risk low income generating activities. Social transfers enable the poor to manage these risks and provide the opportunity for income generation. Risk management could allow for smoothing consumption, reducing uncertainty, and fostering a more efficient allocation of resources (Gentilini, 2009:151).

Savings will be minimal in poor households, with the social transfer (however small) providing some funds to save for emergencies, as well as to mitigate risks. There is strong evidence that recipients save a small fraction of their transfers, even when the transfer is small. This is motivated by the need to purchase more expensive items, accumulate assets (increase access to credit) and insurance against future shocks (Brooks, 2009:63).

Hence, social security increases or permits continuation in investment in human capital (health and education), assist in raising the productivity of the poor and enable them to participate in the economy (OECD, 2009a:23).

3.6 Summary and conclusion

In this chapter the need for social security was evaluated from a global perspective where social security exists not only to alleviate poverty but for other reasons as well. Social security is a human right that entitles people to a decent standard of living because they are human. Furthermore, most countries are legally obliged to provide social security as they have ratified international agreements (e.g. International Bill of Human Rights) that bestow social security rights on their citizens. These social security obligations are enacted in many constitutions which compel authorities to provide social security. However, very often the social security obligations are not specifically defined in the constitutions. But this does not absolve governments from the responsibility of providing social security, as the refusal to provide social security could lead to social instability, especially if the citizens believe that the government has the means to provide social security.

Social security permits the poor to maintain a basic standard of living and also serve as a social guarantee to all citizens that they will be 'covered' should they ever find themselves in poverty. Social security should not only be there for poverty alleviation, but also for poverty prevention. Social security must mitigate deprivation and the vulnerability of people. Some segments of the population are more vulnerable and subsequently more prone to deprivation than the rest of the population. These include women, minorities, rural citizens, the disabled, children and the youth.

Women are over-represented among the poor and social security expenditure on women has benefits for both women and society. In some societies, minority groups have higher levels of poverty and have less access to social services than the rest of the population. Hence, there is a justification for social security to be targeted to this group to provide them with opportunities.

Although rural poverty is not pervasive in developed countries it does prevail in developing countries. The rural population that experiences higher levels of poverty should receive preferential social security disbursements to ensure that their standard of living is equivalent to that of their urban counterparts.

The disabled not only require social security to compensate for their disability, but also on humanitarian grounds.

Children may be at a disadvantage as the parents may not always make the best choices (e.g. no education, poor nourishment) which may place them at a disadvantage later in life. And even if the parents can make the correct choices for their children, they may not have the resources to do so. Social security allows parents to invest in their children and provide them with opportunities that they would not otherwise have had.

The youth may be unable to save and acquire wealth in the early phases of their careers. Social security can help the youth realise their full potential, contribute to society and prevent them falling into poverty.

Even when governments target the marginalised, some households remain anchored in poverty from one generation to the next. Whilst government is unable to alleviate the current levels of poverty that prevail in society, it can try to redress social inequalities in the long-term. The government can use social security to prevent the transmission of poverty from one generation to the next, and thus create a more equitable society.

Nonetheless, social security is not only dispensed for humanitarian reasons or for political expediency, but has economic merits as well. Social security (especially social assistance) enables income redistribution to achieve a more egalitarian society. Besides providing households with the means to satisfy their consumption needs, social security provides a means for saving and investments. Social security enables the poor to participate in the economy by demanding goods and services which is a stimulus for economic growth.

Therefore, one must be guarded against calls to scale-back on social security, especially when there is decrease in economic output, as social security may appear 'unaffordable'. Keynesian economic thought dictates that the lower the economic activity, more money (via social transfers) should be pumped into the economy. The additional funds in the economy will stimulate the demand for goods and services which will increase economic output. In contrast, when economic activity increases,

social spending will decrease (due to lower unemployment) which will release more resources for other government priorities. Social transfers act as automatic stabilisers. But the government may not always have the funds to increase social spending during the economic downturn, and any increase in borrowing/taxes may negate the multiplier effect of the social transfers.

The need for social security in developed countries are also needs for social security in developing nations; but the needs are all the more greater and there are other needs which impact more on developing nation. These issues will be spotlighted on Chapter 4 where the focus is on the need for social security in developing countries.

Chapter 4: Social security in developing countries

4.1 Introduction

The need for social security is universal as the circumstances that underlie the need for social security affects both developed and developing nations. Poverty, disability/mental incapacity and unemployment are problems that afflict both developed and developing nations. But whilst the needs are common to most countries, there are needs that are unique to developing countries. And even when the needs for social security are similar, they may be altogether greater in developing countries.

Many developing countries (e.g. Bolivia, Kenya, Ghana, Mexico) had to restrain government expenditure (usually social spending in areas of health and education) as per conditions stipulated in their Structural Adjustment Programme (SAP) from the World Bank and IMF. The impact of this is felt mostly by the poor within developing countries. The International Social Security Review [ISSR] (1992) finds that the reduction in government expenditure frequently results in the reduction of services (such as health and education) to the poor. Furthermore, the loans from IMF and World Bank call for the imposition of 'user-fees' for government services like schools, and health clinics which often results in denial of access to these services (ISSR, 1992).

Hence, in this chapter the need for social security with specific focus on developing countries, is explored. These conditions underscore the need for social security that differs from that of developed nations. That is not to deny that those needs (lack of access to education and health services) do not exist in the developed countries, but rather to emphasise why the needs are all the more greater in developing countries.

In section 4.2 the first need for social security, which is to alleviate poverty, is discussed. An understanding of the concept of poverty is discussed with particular emphasis on absolute and relative poverty. Also the theory of the poverty line is analysed as it is often the yardstick that is used to determine if someone is poor or

not. This is followed by a study of the underlying causes of poverty, namely, lack of income, education, health and lack of services (water and sanitation)

In section 4.3 there is a deliberation on the need for social security to compensate for the lack of labour market opportunities. The labour-leisure model is adopted to analyse the impact of social security (unemployment benefits) on unemployment theoretically. There is also a discussion of the lack of social security for informal workers.

In section 4.4 the impact of globalisation is discussed and the need it creates for social security, especially for those who have not benefitted from globalisation.

4.2 Poverty alleviation

People benefit unequally from market forces in both developed and developing countries, but the impact on the poor in developing countries is more pronounced. Furthermore, natural disasters (earthquakes, floods) and man-made calamities (wars) impact negatively on the neediest in societies. A slump in economic activity or a natural disaster can mean adversity and suffering to some in the developed world, but can lead to a lifetime of destitution and even death in many developing countries (sub-Saharan Africa). Burgess and Stern (1989:40) argue that whilst deprivation may be common and unpleasant in developed countries, it is more dire and severe in developing countries. The dichotomy in access to basic services is vividly enunciated by the 2006 UNDP report on the inequity in distribution of water and sanitation.

In rich countries clean water is now available at the twist of a tap. Private and hygienic sanitation is taken for granted. Concern over water shortages may occasionally surface in some countries. Children in rich countries do not die for want of a glass of clean water. Young girls are not kept home from school to make long journeys to collect water from streams and rivers. And waterborne infectious disease is a subject for history books, not hospital wards and morgues (UNDP, 2006:5).

In a review of the Millennium Development Goals (MDGs) after the financial crises in 2009/10, the International Monetary Fund (IMF) notes that progress on MDGs related to human development (child mortality, hunger and nutrition, HIV/AIDs, gender equality beyond primary education) has been much slower, most notably in

sub-Saharan Africa (IMF, 2010). Lay (2010:26), employing regression analysis, finds that the average MDG progress is likely to be too slow to meet most social sector targets in most developing countries.

The Millennium Development Goals (MDGs) [Appendix 1] are eight time-bound goals that leaders committed to in 2000 to be attained by 2015. There are objectives for tackling many dimensions of poverty, which are monitored through 21 targets and 60 indicators. These include goals and targets on income, poverty, hunger, maternal and child mortality, disease, inadequate shelter and gender (United Nations Development Programme [UNDP], 2010a). The Overseas Development Institute (ODI) [2008:2] notes that MDG 5, - Improve maternal health; is unlikely to be achieved, as more than 900 women die for every 100 000 live births in sub-Saharan Africa compared to just 8 per 100 000 in industrialised countries.

Social security in developed nations is well developed and receives government support. It is usually in place to provide for the unemployed, disabled and the elderly. This contrasts with the situation in many developing countries, where social security only covers small sections of the population and even then, it is not as comprehensive as that which is available in developed nations. The circumstances that confront the poor in developing countries are dissimilar and very often call for a different type of response.

There are various reasons for this state of affairs. Firstly, the primary reason is that the financial resources per capita are much lower in developing countries. The World Bank delineates economies as per their Gross National Income (GNI) per capita [2009]. Accordingly, a country with a GNI per capita of \$995 or less are classified as a low income country; lower middle income countries are countries with a GNI per capita of \$996 - \$3 945; upper middle income countries, \$3 946 - \$12 195; and high income countries, \$12 196 or more (World Bank, 2010).

Secondly, many low income countries may have neither the institutional capacity to implement nor the administrative competence to manage social security. The World Bank (2002:iii) notes that Low Income Countries under Stress (LICUS) are characterised by very weak policies, institutions and governance.

Bonfiglioli (2003:78) argues that institutional weakness is a major constraint in developing countries and the notion of institutions is critical in any debate regarding development. Institutional capacity refers "to the administrative bodies, systems, and mechanisms of government, both local arrangements and the intergovernmental mechanisms that help to manage and support decentralization" (Bonfiglioli, 2003:79).

Thirdly, the poor or the people who need social security are often the most marginalised in society, those who do not have a 'voice' (are powerless) to articulate their plight. This is more so in developing countries. Many developing countries are non-democratic and the citizenry does not have a voice to initiate change not only for social security, but also for other aspects in their lives. These people cannot exert pressure as they are denied both the political mechanism and as well as legal recourse to highlight their plight. The powerlessness of the poor translates into the lack of a voice in decision-making and public policy choices; lack of basic political freedoms; social exclusion and lack of social rights; and the limited ability to access and influence state institutions and/or social processes (Bonfiglioli, 2003:60).

This usually translates to extreme poverty and large inequalities in which millions accept their fate in developing countries. The ILO (2008a) affirms that the current levels of poverty and inequality are unacceptable. At the turn of the century, half the world's population lived on less than the \$2 per day poverty line. According to the UN the richest 10 per cent of the adult population receive 85 per cent of the global wealth and in contrast the poorest 5 per cent barely receives 1 per cent (ILO, 2008a:1).

It is often affirmed that social security is there to assist the poor and the most destitute of society. Whilst not all social security developed as a reaction to poverty, the response to poverty has been a notable motivation for social security and is generally the underlying precept in designing benefits. For example, the pensions that are given to the elderly should be sufficient to sustain the individual/family so that they do not descend into poverty. If not for any other reason, extreme poverty is an unambiguous motive for the implementation of social security in developing countries.

But the poor are not always easy to define, and the indicators used to measure poverty in one country may not necessarily be the same indicators as used in another country. Hence, a poor person in one country may not necessarily be classified as poor in another country. And when we contend that social security should exist to alleviate poverty; what are we actually implying that social security needs to rectify?

Hence, it would be instructive to obtain a working definition of poverty. Or more specifically, to delineate who are the poor who need social security. While the definition of poverty has been debated at much length and there can be no agreement on a comprehensive definition; there will be an attempt to understand the concept of poverty from the viewpoint of when poverty engenders a need for social security. There is likely to be a variety of interpretations of poverty which affects our measuring of poverty and this should be recognised and declared in the method that is used (Atkinson, 1989:26). Nevertheless, any endeavour to delineate poverty requires some value judgement of what represents a good quality of life (Kingdon and Knight, 2003:2).

4.2.1 Definition of poverty

The elimination or reduction of poverty is a policy imperative most governments cite as a reason for economic growth. Almost every development policy in official dialogue (World Bank, donors) is assessed by its impact on poverty; although there is debate on what poverty means (Laderchi, Saith and Stewart, 2003:243). The definition of poverty will identify what and who gets measured. This is critical as policy prescripts (welfare benefits) have fiscal implications and impacts on society as a whole. Noble, Ratcliffe and Wright (2004:2) argue that "the concept and definition of poverty in a society is like a mirror-image of the ideals of that society: in conceptualising and defining what is unacceptable in a society we are also saying a great deal about the way we would like things to be".

The measurement of poverty has historically been measured by income that was necessary to provide for the nutritional needs of an individual. Maxwell (1999:2) notes that Booth in London and Rowntree in York published in 1901 a poverty standard for families based on nutritional requirement. The definition (and its objective) has evolved in subsequent decades to be more encompassing. In the

1960s the main focus was on level of income as denoted in indicators such as GDP per capita. The objective moved beyond income to a set of basic needs that must be fulfilled for the individual to survive in society. There was a paradigm shift to a multidimensional approach as underscored by the capabilities approach which was spearheaded by Amartya Sen (1999:119).

A multidimensional approach attempts to capture the many elements of poverty that a person should experience if they are classified as poor. There may not be consensus, but often the multidimensionality is captured in a single index such as the Human Development Index (HDI). The HDI is a composite index that is used by the United Nations to rank countries in terms of their human development. The index is composed not only of GDP per capita (standard of living), but also of life expectancy (longevity) and education. The index varies from 0 to 1, with countries below 0.5 classified as being in the low Human Development group, between 0.5 and 0.8 as in the medium Human Development group and countries with an index of greater than 0.8 as in the high Human Development group. Whilst not optimal, the index does provide some measure (better than no measure).

And when there is a multidimensional index, there is sometimes debate about which dimensions matter the most and which dimensions should be left out, as well as about what weighting should be attached to which dimension. But there are some aspects of poverty that cannot easily be captured in an index and quantified. Psychological suffering, mental anguish and feelings of despair and hopelessness that arise from poverty cannot easily be empirically tested nor scientifically measured.

Grusky and Kanbur (2006:12) note that "economists have not reached consensus on the dimensions that matter nor on how they may decide what matters". The issue is not that researchers do not select the dimensions; the issue is that they do not explain the reasons for the dimensions that they chose (Alkire, 2007:2).

But this should not dissuade governments from attempting to measure poverty. The emotive issues are a consequence of poverty and a manifestation of lack of some component (e.g. income, food/nutrition, education, sanitation) that needs to be addressed by government. The quantification of poverty lends some objective rigour to policy discussions and choices.

Poverty in academic discourse is often related to some measure of basic goods that are necessary for an acceptable standard of living. Fields (2000:73) defines poverty as “the inability of an individual or a family to command sufficient resources to satisfy basic needs”. Nowadays a basket of ‘basic needs’ is defined and costed after which we classify the recipient as poor if his/her income (or consumption which could also be the chosen measure of economic well-being) is below the cut-off amount. This cut-off amount is the poverty line.

The poverty line is a measure of the minimum requirement that is necessary to sustain an essential standard of living. Income that is sufficient to purchase the basic food (caloric) and other essential goods and services necessary for survival. The poverty line has to be adjusted as the cost of goods that form its components (inflation) rises over time.

4.2.1.1 Absolute and relative poverty

In development discourse and academic deliberation, a distinction is made between absolute and relative poverty. The poverty line (or other measure) is used as the threshold to discern between the two types of poverty.

Absolute poverty measures (counts) the number of people below a certain threshold, for example, the actual number of people that earn less than \$1.5 per day. The use of such a measure enables comparisons between different groups of people or different countries or regions. Such comparisons will be meaningful once the consumption or incomes are adjusted for purchasing power parity (PPP). This measure does not relate to income distributions (income equality) and if the overall income of the country rises, absolute poverty will decrease. This type of poverty has become synonymous with subsistence poverty as people below this level have difficulty meeting basic subsistence (Noble, Ratcliffe and Wright, 2004:6).

In contrast, relative poverty can remain the same or worsen even when overall income rises in a country. Relative poverty usually compares a certain segment of the population with the rest of the population to classify them as poor for some threshold. For example, 10 per cent of the lowest income earners can be classified as poor. Hence, even if their income rises together with that of the rest of society and by the same factor, they will still be classified as poor. Accordingly, the phrase ‘poor

will always be with us' has its ideological roots in relative poverty. Consequently, income inequality can be studied with the relative poverty measure.

Irrespective of whether absolute or relative poverty is measured, there must be a threshold or a benchmark which distinguishes the poor from the non-poor. Most often this is the poverty line.

4.2.1.2 Poverty line

The \$1 per person per day was the benchmark that the World Bank set in 1990 as the international poverty line. This amount represents the minimum amount that is required for a person to meet his/her physical needs. A person is considered to be living in absolute poverty if their income falls below this level. This benchmark was subsequently changed to \$1.25 per day in 2005 (equivalent to \$1.00 a day in 1996 US prices), the new international poverty line following a review of the line by Ravallion, Chen and Sangraula (2008:23). Consequently the \$1.25 poverty line is used by World Bank as the benchmark for poverty alleviation. The MDG's target of eradicating extreme poverty and hunger is to 'halve between 1990 and 2015, the proportion of people whose income is less than \$1 a day' indicating that \$1 is still the official poverty line that is used by the United Nations, with the caveat that indicators based on national poverty lines should be used for monitoring country poverty trends, where available (United Nations, 2003).

However, poverty lines do have some limitations. The complex dimensions (life expectancy, maternal mortality ratio, and literacy levels) of poverty cannot be captured in the poverty line, and the consequences thereof may not be factored into policy choices that are instituted to prevent and/or remedy poverty.

Poverty lines do not actually indicate the actual consumption of the household, but the income that is required for a minimum standard of living. Household consumption patterns may differ widely from those which are measured.

The other disadvantages of the poverty line include:

1. Poverty lines in different countries differ in design and content (World Development Report, 2001:25).

2. Poverty lines do not factor in that there are different living standards across a country. Food prices may vary between urban and rural areas (World Development Report, 2001:205).
3. They do not reveal who are chronically poor or who have become poor due to a 'temporary shock' (World Development Report, 2001:29).
4. It does not reveal the distribution of income within a household (World Development Report, 2001:27).
5. The people below the poverty line are all treated the same. The poverty line reveals little on the depth and severity of poverty. Someone who is far from the line is treated in the same way as someone who is just below. They will usually receive the same benefits, even though the person at the bottom is 'poorer' (World Development Report, 2001:18).
6. A person just above the poverty line maybe poor but will not receive any benefits (World Development Report, 2001:18).
7. The \$1 and \$2 benchmarks are usually used as indicators for comparison of countries, but may not be an appropriate measure for a specific country (World Development Report, 2001:26).

This may necessitate a broader characterisation of poverty with a set of indications to describe poverty and there are other poverty measures which policymakers employ when determining and defining the poor. But the poverty line, its disadvantage notwithstanding, does provide a headcount of those individuals/families who are poor.

Leibbrandt and Woolard (2006) *in* National Treasury (2007a:1) affirm that whilst the poverty line may not be a perfect index to compartmentalise household vulnerability, it does serve as a useful comparative analytical tool to track the relative well-being of households over time. And while there is some arbitrariness in determining what is adequate, the poverty line still provides a useful benchmark (Rosen, 2002:137). The poverty line identifies those who are poor and compares different groups, for example, men and women, and also makes comparisons over time permissible.

Poverty is a multifaceted phenomenon and poverty lines may be complex to formulate, but the poverty line does reduce components to understandable requisites that can be conveyed to persons less astute in economic and social theory.

Moreover, the underlying precepts of poverty still have to be addressed in order to make society functional. The factors underlying the causes of poverty have to be rectified and social security should be in place to correct these factors. That is, the causes of poverty have to be remedied.

4.2.2 Remedy the underlying foundations of poverty

The causes of poverty (as alluded to earlier) are wide and varied and can be comprehensive. The issues discussed here focus on the main underlying causes which social security has been instrumental to alleviate.

Whilst issues listed below are not an exhaustive register, the list does attempt to capture the conditions that poor people may find themselves in. Spicker (1993:111) argues that most of these conditions are closely associated with poverty and that whilst the lack of these services may not necessarily define the poor, the provision of these services/goods is likely to improve the lives of the poor.

The need for housing, health, sanitation and water are social issues, that, if not provided, impact negatively on the lives of the poor. But the inability of the poor to access these services stems from not only the inability of government to provide for these services, but primarily from their lack of income to provide for these social necessities.

The inability of the poor to acquire social services for themselves also impacts on their long-term income generating ability. For example, the lack of education opportunities restricts their income earning potential in life. It must also be added that these factors are not mutually exclusive and are dependent on one another. If the poor have free education opportunities, but no health care when they are ill, they may not even be healthy enough to exploit the benefits of education that are provided. Furthermore, resources will be used to cure them and little will be left for the ancillary costs (transport, school uniforms) of education, thereby resulting in none of the services being utilised.

4.2.2.1 Lack of income

Lack of income most often afflicts the needy and destitute in society. Lack of income disempowers the poor from making choices that they feel are in their (and their

families') best interests. Provision of income provides the poor with the resources to invest in rectifying or improving what they feel is the underlying cause of their poverty. Hence, from an economic perspective, direct cash transfers are described as most efficient as they provide a means for the poor to help themselves as they deem fit.

In their studies [Neves, Samson, Van Niekerk, Hlatshwayo and Du Toit (2009:16); Samson, Lee, Ndebele, Mac Quene, Van Niekerk, Gandhi, Harigaya, and Abrahams, (2004:1); Harvey (2007:2)] have shown that cash transfers have impacted positively on peoples' lives, especially in developing countries and helped in the alleviation of poverty.

The lack of income or the little income that the poor have leaves little resources left over to provide for other social services. The inadequate housing and sanitation constrains poor households with meagre resources to provide these basic necessities and they are prone to the consequences such as diseases. Furthermore, there will be few resources to remedy the consequences such as the ill health that may result from the poor health conditions. Similarly, poor households will not be able to invest in other social services (education for their children) which can have positive impacts on their lives.

4.2.2.2 Education

Social security is important to harness the educational potential as it delivers benefits not only to the individual but to the whole of society in terms of poverty reduction and economic development. Economic theory makes the case for education to be subsidised as the positive externalities are conferred on society; since the marginal social benefits from additional education exceed the marginal private benefits (Black and Siebrits, 2002:28).

The importance of education and its positive consequence has made it a MDG. Specifically, MDG 2: Achieve universal primary education with a target - Ensure that by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling. The importance of female education is also underscored with the MDG 3: Promote gender equality and empower women with a target -

Eliminate disparity in primary and secondary education, preferably by 2005, and at all levels of education, no later than 2015.

An educated individual will have a higher earning potential as the person will have an increased productive capacity. The knowledge and skills acquired through education will provide better opportunities for economic and social progress in society. Education provides the means to better paying and safer jobs; to understand the instruction on a bottle of medicine; to follow prices and keep accounts and to extend one's social network and obtain respect in one's household and community (Harper et al 2003: 545). Therefore, it is in the interest of not only the child but also of society to invest in education for the child.

The World Bank (2009a) research has established that a year of schooling increases individual wages for both men and women by a worldwide average of about 10 per cent with the gains in poorer countries being even greater. The variation in average returns to schooling between developed and developing countries are about 11 per cent for developing countries to about 7.5 per cent for OECD countries (Patrinos, Ridao-Cano and Sakellariou, 2006:2). Leigh and Ryan (2005:iii) find that the Australian rate of return to education, once corrected for ability bias, is approximately 10 per cent which is similar to the rate of return in Britain, Canada, Netherlands, Norway and the United States.

Education to girls yields numerous immediate and long-term benefits. In a study of 14 sub-Saharan African countries, Ainsworth et al (1996:117) find a strong negative (non-linear) correlation between female schooling and cumulative fertility in virtually all of the countries, in both urban and rural areas. Consequently, education of females leads to a decrease in child mortality. The World Bank (2009a) study estimated that one year of schooling reduces fertility rate by 10 per cent.

An educated female (and male) will have better personal health as they will have learnt about health issues and the higher earnings will also bestow sufficient resources to look after themselves. Specifically, it impacts positively on their reproductive health. Females who attend school will have higher immunisation rates as they will have to be immunised to attend school and also may receive part of the immunisation regimen at school. Also immunised mothers can identify with the

positive benefits of immunisation. The United Nations Millennium Project (2010:1) found that educated mothers immunise their children 50 per cent more often than mothers who are not educated. The children of a woman with five years of primary school education has a survival rate 40 per cent higher than children of women with no education (United Nations Millennium Project, 2010:2).

A girl's education can reduce the spread of HIV/AIDS as she is informed about the causes, consequences and prevention of the disease. AIDS spreads twice as quickly among uneducated girls than among girls that have even limited schooling (United Nations Millennium Project, 2010). An education contributes to economic freedom, family planning knowledge and the prevention of early marriage, which can all contribute to females not contracting the disease.

Females who are empowered with education are likely to delay marriage, use contraception, delay childbearing and have fewer and healthier children than women who have little or no education. Educated women can learn about and use contraception more effectively than uneducated women, reducing the number of unanticipated pregnancies (Ainsworth et al, 1996:87). Education also impacts on fertility by increasing the opportunity cost of childbearing and rearing among educated women; education lowers fertility through improvement in child health and reduced rates in mortality thereby resulting in fewer births to yield the desired family size (Osili and Long, 2008:57).

Furthermore, educated women will be more knowledgeable to provide nutritional foods and professional medical care (make certain that the child is immunised) for their children. Their children will be healthier and better nourished and have lower mortality rates than a woman with no formal education. It is estimated that an additional year of schooling for 1 000 women helps prevent two maternal deaths (World Bank, 2009a).

A child whose mother is educated is more likely to have educational opportunities and education accomplishments. Studies in numerous countries have revealed that an additional year of formal education completed by a mother translates into her children staying in school for an additional one-third to one-half year (World Bank, 2009a). In a study of 175 countries between 1970 and 2009 on the effect of

increased female education on child mortality, Gakidou, Cowling, Lozano, and Murray (2010:959) find that of the 8.2 million fewer deaths in children younger than 5 years, they estimate that 4.2 million (51.2 per cent) could be attributed to increased educational attainment in women of reproductive age. The Institute for Health Metrics and Evaluation (IHME) at the University of Washington find that 51 per cent of the reduction of mortality in children under age 5 (from 16 million to 7.8 million annually) can be linked to increased education among women of reproductive age (IHME, 2010).

Therefore, education gives the poor (especially females) an opportunity to escape poverty and subsequently prevents the transmission of poverty across generations. Broad based quality education can result in economic growth, higher national productivity and promote democracy and social cohesion (World Bank, 2009a).

The education opportunities can be undermined by lack of complimenting social services. A child who is chronically ill and does not receive proper healthcare will not be able to fully utilise and benefit from the free education opportunities. A child who does not have electricity at home to do his/her homework will not benefit from education that is available. The lack of other supporting social strategies underscores the need for comprehensive social security so that resources (budgeted for education) are frugally spent to maximise the benefits from education.

4.2.2.3 Health

The causality between poverty and health runs in both directions. Ill health limits people's productivity, earning potential and the nutrition to sustain themselves and their family, resulting in them descending into poverty. Poverty (lack of proper sanitation and clean drinking water) not only can create the environment to get ill; but denies one the resources to treat oneself when one does get sick. Ill-health can be a catalyst for poverty spirals and in turn poverty can create and perpetuate poor health status (Grant, 2005:3).

Besides its inherent value to the individual, improving and protecting health is also central to overall human development and to the reduction of poverty (WHO, 2003:20). The importance of health in the international development domain has

also been highlighted by three MDGs being related directly (MDGs 4, 5 and 6) and one (MDG 8) indirectly to improving health. These are:

MDG 4: Reduce child mortality

Target 4.A - Reduce by two thirds, between 1990 and 2015, the under-5 mortality rate

MDG 5: Improve maternal health

Target 5.A - Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio

Target 5.B - Achieve, by 2015, universal access to reproductive health

MDG 6: Combat HIV/AIDS, malaria and other diseases

Target 6.A - Have halted by 2015 and begun to reverse the spread of HIV/AIDS

Target 6.B - Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it

Target 6.C - Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases

MDG 8: Develop a global partnership for development

Target 8.E - In cooperation with pharmaceutical companies, provide access to affordable, essential drugs in developing countries

The strong focus of health in human development is underpinned by the belief that better health improves the quality of life of citizens and reduces the burden of disease which will in turn increase productivity and growth in the country (National Commission on Macroeconomics and Health, 2005:31).

The WHO (2003:21) notes five pathways through which health can contribute to development. These are

1. Higher labour productivity. Healthier workers are more productive, earn higher wages, and miss fewer days of work than those who are ill. This increases output, reduces turnover in the workforce, and increases enterprise profitability and agricultural production.
2. Higher rates of domestic and foreign investment. Increased labour productivity in turn creates incentives for investment. In addition, controlling endemic and epidemic diseases, such as HIV/AIDS, is likely to encourage foreign investment, both by increasing growth opportunities for them and by reducing health risks for their personnel.

3. Improved human capital. Healthy children have better cognitive potential. As health improves, rates of absenteeism and early school drop-outs fall, and children learn better, leading to growth in the human capital base.
4. Higher rates of national savings. Healthy people have more resources to devote to savings, and people who live longer save for retirement. These savings in turn provide funds for capital investment.
5. Demographic changes. Improvements in both health and education contribute to lower rates of fertility and mortality. After a delay, fertility falls faster than mortality, slowing population growth and reducing the "dependency ratio" (the ratio of active workers to dependants). This "demographic dividend" has been shown to be an important source of growth in per capita income for low-income countries.

The diseases that afflict the poor in developing and low-income countries are mainly preventable and treatable. Poverty related diseases (infectious and parasitic diseases, respiratory diseases, prenatal and maternal conditions, nutritional deficiencies and tropical diseases) result in higher mortality in low-income countries than high income countries (Stevens, 2004:6). It is estimated that 88 per cent of child diarrhoeas, 91 per cent of malaria and up to 100 per cent of childhood illness, such as measles and tetanus, can be prevented among children using existing treatments (Stevens, 2004:6).

The WHO (2001:2) contends that the main causes of avoidable deaths in low-income countries are HIV/AIDS, malaria, tuberculosis (TB), childhood infectious diseases, maternal and perinatal conditions, lack of micronutrients and tobacco related diseases.

Preventable diseases are most common among the poor and if treated and avoided will lead to improved, healthier and more productive lives. This is most evident with the HIV/AIDS pandemic that is most prevalent in the developing world. The WHO (2009:7) notes that 33 million people were living with HIV/AIDS in 2008, with sub-Saharan Africa being the most affected region, accounting for two-thirds of people living worldwide with HIV.

HIV/AIDS has become a challenge and a demand on fiscal resources in many developing countries. Expenditure on HIV/AIDS is crowding out other health expenditure as well as other government priorities, with many of the poorest nations relying on aid agencies and donor support to assist in combatting the disease. The lack of resources to fund current treatment leaves little resources for prevention strategies which is crucial in halting the spread of the disease. England (2007:334) notes that although HIV contributed 17.6 per cent of the burden of disease in 2001 it received 40 per cent of all health aid in 2004.

In fact, HIV/AIDS can be viewed separately as a need for social security as there are many other elements associated with the prevention and treatment, for example orphans that are left behind to care for, as well as child-headed households, and nutrition that needs to be given to individuals. Social security therefore has to be formulated to stem the tide of this disease.

Some poor households have a predilection for sickness and need consistent medical assistance as the communicable diseases (e.g. cholera) are more prevalent among the poor. Moreover, they are most prone to under-nourishment, and they lack proper sanitation and clean water, which is a catalyst for ill health.

Whilst the communicable diseases are more prevalent in developing nations, non-communicable diseases are also beginning to pose a public health risk. These mainly relate to heart disease, cancer, pulmonary disease and hypertension which are largely preventable if the risk factors such as smoking, excessive alcohol and physical inactivity are controlled and monitored. The rise in income in many developing countries has seen an increase in non-communicable diseases. It is worthy to note that 90 per cent of the population dying of non-communicable diseases live in developing countries (WHO, 2004).

Boutayeb and Boutayeb (2005:1) find that by 2020, it is predicted non-communicable diseases will be causing seven out of every ten deaths in developing countries. Many of the non-communicable diseases can be prevented by tackling associated risk factors. The incidence of non-communicable diseases has rapidly increased and is impacting on productivity thereby impacting on family resources

that they are becoming a major threat to social and economic development in developing countries (WHO, 2010b).

The readily availability of 'fast foods' and its relative inexpensiveness has resulted in a dramatic rise in the incidence of non-communicable diseases (heart attacks, strokes) as a leading cause of death among the poor. The WHO (2010b) notes that the developing world is now consuming more processed foods that are high in fat, sugar and salt than ever before. Sen (2010:1) notes that causality of poverty and non-communicable diseases also work in the opposite direction. Besides bearing the higher risk for non-communicable diseases, once they develop the non-communicable diseases, the poor face higher health and economic impacts, that is, the poor have less access to medical care allowing non-communicable diseases to progress to advanced stages resulting in higher morbidity, mortality and disability (Sen, 2010:2).

The cost of treatment and the opportunity cost are extremely high, rendering health services in some developing countries relatively too expensive for most of the poor in society. Patients may sometimes delay assistance until the very last when the condition has worsened where medical treatment is much more expensive than it would have been had it been sought earlier. Poorer people often delay treatment (and therefore payment) for as long as possible or until a critical point is reached, at which point the problem may have developed and be harder to treat quickly (Grant, 2005:13).

And if medical attention is critical, the household may have to go into debt, or sell off productive assets. Houses can be mortgaged, and possessions can be sold and households anchored in destitution if the illness is protracted. Whilst many households may forgo education for themselves and their children, many households will have to sell possessions and go into debt to pay medical expenses for the members of households, leaving the household (and even future generations) trapped in poverty.

Pryer, Rogers, and Rahman, (2003) in a qualitative study of coping strategies utilised by adults in response to illnesses in Dhaka note the sequential coping strategies that families employ to settle medical debts. The process begins by " borrowing money;

followed by diversifying income sources, women going to work; expenditure reduction; use of savings, selling assets; merging households; moving families to rural areas and finally, begging” (Pryer et al, 2003:21).

Even if the asset (land) is not sold, it could remain unproductive and underutilised if the person responsible for farming is ill, solidifying the impoverishment of the household. Health is a proximal cause and consequence of poverty. But many of the health issues stem from the lack of proper or decent water and sanitation which is a cause of poor health, and more fundamentally which should be seen as a basic human right.

4.2.2.4 Lack of basic services e.g. water and sanitation

The lack of clean water and adequate sanitation are inextricably linked to poverty and consequently find expression in the MDGs. Specifically, MDG 7-Ensure environmental sustainability, with a target - Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation. The WHO (2010c) notes that 2.6 billion people lack a simple ‘improved’ latrine and only 1.1 billion people have to access to any type of improved source of drinking water. Furthermore, 1.6 million people die every year from diarrhoeal diseases attributable to lack of access to safe drinking water and sanitation and 90 per cent of these are children under 5, mostly in developing countries (WHO, 2010c).

The lack of these services result in health diseases which the poor have to bear; and poverty (lack of income) limits or even restricts access to these basic services. Furthermore, it is the poor that cannot afford these services when rendered by government, and it is therefore the poor who are often denied these basic services altogether or are provided with limited services. Water Aid (2009) found that improved access to water and sanitation reduces poverty both directly and indirectly; and therefore, any poverty reduction strategies must include water and sanitation interventions if authorities want to attain any long-term success.

In developing countries, the benefits from water and sanitation, human rights notwithstanding, are numerous. Firstly, people will not be contracting water borne disease and will not have to seek and pay for medical treatment. They will be much healthier and more productive. The UNDP notes that “water and sanitation are

among the most powerful preventive medicines available to governments to reduce infectious disease. Investment in this area is to killer diseases (like diarrhoea) what immunisation is to measles - a life-saver" (UNDP, 2006:6). In a study of 70 countries over the period 1980-2008, Günther and Fink (2011:30) find that advanced water and sanitation technologies reduce the chances of suffering from diarrhoeas among children under 5 by 7.3 and 12.9 per cent respectively. Hence, water and sanitation is a necessary condition for other forms of development.

Secondly, the provision of piped water to households will save time so that the households can engage in other economic activities, such as agricultural activities, manufacturing activities and/or other sales services that may increase the income of the poor. Furthermore, children will not have to spend many hours fetching water and could make time to attend school.

Thirdly, readily available water can be used for farming, both crop and livestock farming, which will increase economic activity. The accessibility and availability of water establishes the choice of productive water use alternatives available to the poor, for example, agriculture, livestock and fisheries (ODI, 2002). Readily available water for subsistence farming and livestock can assist poor families with food security and even surplus yield which could be sold and consequently provide food security.

The benefits of sanitation and clean water to the poor and society as a whole are numerous, making a strong case for the government to provide water and sanitation as a basic social service to the neediest in society.

4.3 Compensating for the lack of labour market opportunities

Unemployment is the one argument that is used by both proponents and opponents of the need for social security. This debate stems from the question of whether social security should at all be linked to the labour market or should be seen first as a fundamental right.

The labour market dynamic has changed globally and the need (or not) for social security for the unemployed generates fierce debate. In some developing countries

(e.g. South Africa), economic growth has not generated sufficient jobs for the growing labour force. Borat (2008:27) notes that the labour force in South Africa has grown at a faster rate than employment resulting in employment expansion being relatively mild. Many countries have pursued policies that focus on capital intensive and hi-tech industries, where the need for scarce and specialised skills are demanded thereby rendering much of the workforce unemployable in the formal economy (ILO, 2002:29).

The consequences of the new dynamics in labour markets have also impacted on the way authorities adopt strategies to protect vulnerable workers. Among the mechanisms used to manage the unemployment risk are according to Rabalino (2004:2):

1. Risk reducing instruments – stable macro economy and investing in human capital
2. Risk mitigation instruments - saving and insurance
3. Risk coping mechanisms - unemployment assistance, public works and retraining

The poor and marginalised have neither the means nor the knowledge to mitigate the risk of the labour market and often find themselves unemployed.

4.3.1 Unemployment

Unemployment benefits (social insurance) as well as social assistance protects the family/household from falling into poverty when there is an end to their income. Unemployment protection enables the households to continue contributing to future human capital investment, by continuing the education of their dependants, and providing for their health needs. Social protection provides the means to build human capital, promote investment and foster participation in the economy (OECD, 2009b:9).

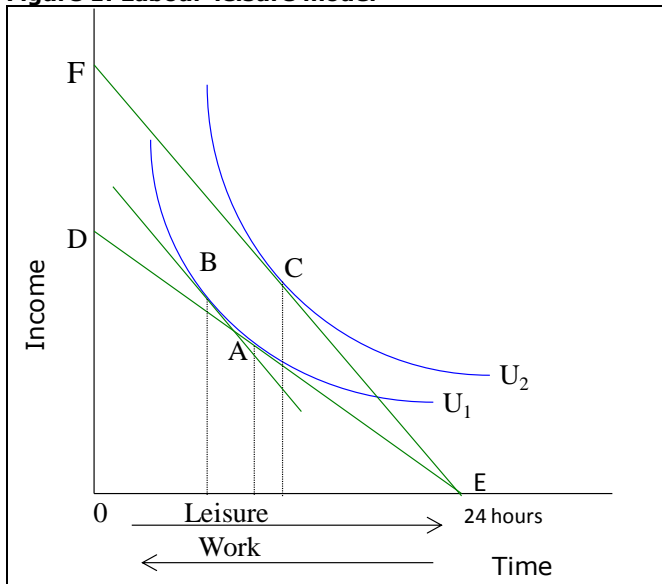
The absence of social security to protect workers has a devastating impact on families and individuals to cope with the loss of a job and labour market risks. Accordingly, in the absence of social security, there would be less risk mitigation (protection), less investment in human capital, and fewer opportunities to make society more inclusive and economies more productive (McKinnon, 2007:154).

The opponents of social security (specifically social insurance) contend that it is the availability of money for the able-bodied workers that discourage them from seeking employment. The availability of unemployment benefits can lengthen unemployment spells, by making leisure more attractive; or it can alternatively shorten unemployment by providing resources for job searches. This can be illustrated by the simple labour-leisure model.

4.3.1.1 Labour-leisure model

An individual has 24 hours in a day and can choose one of only two options, namely work (labour) and leisure. The individual chooses a combination of hours of work and hours of leisure that maximises the individual's utility as represented by a budget constraint that is tangent to an indifference curve as demonstrated in Figure 1 below.

Figure 1: Labour-leisure model



Source: Own illustration

The graph illustrates time (work and leisure) on the x-axis and the income earned per day on the Y-axis. The current wage rate will determine the mix of leisure and work that maximises the individual's utility (indifference curve U_1) where the individual will be on his budget constraint (DE). If he chooses only to work he will earn the maximum income of (D). If he chooses not to work at all he will have no income and 24 hours of leisure (E). With the current wage rate, the individual maximises his utility at point (A).

An increase in the wage rate increases the person's income to the new budget constraint (EF). The higher wage rate has increased the opportunity cost of leisure time and the individual spends less time on leisure and more on work. As the wage rate increases the opportunity cost of leisure becomes more costly – this is referred to as the substitution effect. The individual moves higher up (B) on the same indifference curve U_1 .

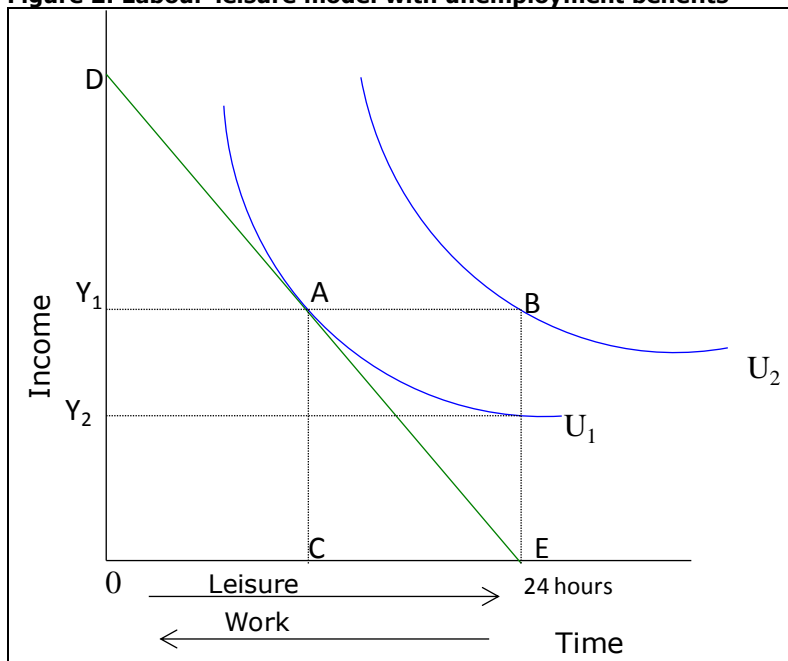
As the wage rate increases, the individual's income will also rise. This results in the person consuming more 'normal' goods. If leisure is a 'normal' then the individual consumes more leisure and less work – this is known as the income effect.

Hence, the individual moves to a higher indifference curve U_2 , consuming more leisure (C). The net effect is that the income effect is larger than the substitution effect, resulting in the person consuming more leisure and earning more as well.

It must be noted that leisure is assumed to be a normal good, and an increase in the wage rate will result in the labour supplied to either increase or decrease depending on which effect (income or substitution) is larger. If the substitution effect is larger than the income effect, then the increase in the wage rate will result in an increase in labour supplied. Conversely, if the income effect is larger than the substitution effect, an increase in the wage rate will lead to a decrease in the labour supply.

The neoclassical model provides an underpinning for unemployment benefits. The response will depend on the value (amount and duration) of the benefit as demonstrated in Figure 2 below.

Figure 2: Labour-leisure model with unemployment benefits



Source: Own illustration

If the benefit is equal to the wage (Y_1) then the individual will only consume leisure and move to a higher indifference curve U_2 and be better off. But if the benefit (Y_2) is lower than the wage, then the person will once again only consume leisure, but remain on the same indifference curve. This neoclassical theoretical demonstration is the underlying motivation for the argument that unemployment benefits discourage people from being employed and extends periods of unemployment.

Numerous studies of the impact of unemployment, albeit ambiguous, have noted the unemployment insurance does extend unemployment; and the greater the benefits and the longer that they are received, the longer is the unemployment. Layard, Nickell, and Jackman (1991) find that the elasticity of duration of unemployment in relation to benefits ranges from 0.2 to 0.9, depending on the state of the labour market and country (Vodopivec, 2009:7). Katz and Meyer (1990:39) find for the United States that a one week increase in potential benefits duration increases the average duration on the unemployment durations of the unemployment beneficiaries by approximately 0.16 to 0.2 weeks. In Austria, Lalive and Zweimuller (2004:2610) note that unemployment benefits increased expected unemployment by approximately 9 weeks.

But these studies pertain mainly to developed countries, where the labour markets are more developed and have stronger administrative capacity compared to those of developing countries. Vodopivec (2009:10) asserts that whilst unemployment in the developed economies is mostly a 'discreet event', unemployment in developing countries (due to the large informal sector) is largely continuous.

Vodopivec (2009:4) notes that whilst unemployment insurance covers most workers in developed and transition countries, only part of the workforce in developing countries is covered due mainly to the large workforce. In contrast to developed countries where benefits can extend from six months to indefinite, benefits, when they are available range from 6 months to 24 months in developing and transition economies (Vodopivec, 2009:4). The labour disincentives are applicable to developed countries which are associated with comparatively generous benefits; and are less of a concern in developing countries where benefit levels are relatively low (Neves et al, 2009:29).

The recipients of unemployment benefits are often perceived to be a drain on fiscal resources which could otherwise be more productively employed. Proponents of this argument proclaim that economic weaknesses that prevail in these countries are due to labour market rigidities and the consequences of elaborate job and income protection arrangements that raise the cost of labour (International Social Security Review,1997:3). Vodopivec (2009:3) notes that the main weaknesses of unemployment insurance is that it creates a disincentive to be re-employed and wage pressures, and contributes to overall unemployment.

Another line of thought postulates that unemployment benefits are a cause of unemployment. The argument goes that once people have benefits (insurance) for sickness, accidents and unemployment etc, these incidents tend to occur more frequently among the insured. Euzkby (2007:5) argues that certain contingencies (sickness, accidents, unemployment, etc.) occur more frequently when the persons affected are insured against the financial prejudice to which those contingencies give rise.

When this argument is extended to unemployment, the intimation is that unemployment benefits are responsible for the 'voluntary' unemployment that exists

in developed countries. These benefits impact on the economic behaviour of the individual. The benefits that provide a minimum means of subsistence reduce the incentive for the individual to find new employment (income effect); and secondly the benefits reduce the cost of leisure relative to working and thereby encouraging the substitution of leisure for employment (substitution effect).

Furthermore, in countries where a period of employment is necessary to qualify for benefits; unemployment assistance encourages certain individuals to enter the employment market in order to meet the qualifying conditions for receipt of unemployment benefits and then they leave their jobs (Euzkby, 2007:7).

According to the International Social Security Review (1997) employment protection is often used as a scapegoat to explain or justify the high level of open unemployment in industrialised countries. The provision of employment benefits does have economic merits as an economic regulator, and it also maintains social peace which is not easily quantified. Spicker (1993:111) reiterates that social security for unemployment is important not only for the effect it has on unemployed people but because it acts as an economic regulator, increasing expenditure at times of reduced economic activity and so bolstering demand.

Moreover, the issues of unemployment are more cyclical in developed countries as compared to in developing countries where they are more structural. The unemployment benefits in developed countries are comparatively more generous than those of developing countries. Also unemployment levels are not as high as those experienced in developing countries (International Social Security Review, 1997:4).

Whilst conventional social security arrangements were formulated against risks in the formal economy, the economic activities of the poor are usually confined to the informal sector. The rural and non-formal components of present-day labour markets in many countries create distinctive challenges for conventional social security.

Consequently, the divergence between conventional social security arrangements practice and labour market realities has resulted in a low percentage of the world's

population having access to social security coverage: less than one in every five persons has adequate social security protection (Van Ginneken, 2003:290).

4.3.2 Informal sector

Unemployment benefits, when available, usually cover the employed in developing countries. However, most economic activity of the poor takes place in the informal sector where the workers do not qualify for any unemployment benefits.

4.3.2.1 Definition of informal workers

Informal workers are a diverse group which consists largely of self-employed (own micro-enterprises) and workers in family businesses which fall under the 'non-wage employment' category. The ILO defines informal sector employment as "...all persons who, during a given reference period were employed in at least one informal sector enterprise" (ILO, 2004:3). The informal workers referred to here are those that fall under the 'wage-employment category' and these include the regular workers, casual workers, sub-contract workers and home base workers (Blunch, Canagarajah and Raju, 2001:3).

4.3.2.1.1 Social security for informal workers

The informal sector plays a critical role in economic growth and development in developing countries. It has been found that the informal sector is the most important source of employment in developing countries as the formal sector has struggled to generate sufficient and adequate jobs (Blunch et al, 2001:10). Scheinder (2002:1) finds that the average size of the informal economies (as a per cent of Gross National Income) in 2000 was 41 per cent in developing countries and 18 per cent in developed countries.

Whilst the activities and types of work performed by informal workers are diverse; they do share one common characteristic, in that they are not recognised under legal and regulatory frameworks and consequently have little or no social protection (ILO, 2002:3). Although the informal sector has grown in both relative and absolute terms in the developing world, wages continue to be very low. Wages tend to be lower relative to the formal sector and sometimes even lower than the prescribed minimum wage.

This has resulted in poverty being more prevalent among informal workers, and most of the poor being informally employed. Furthermore, the informal workers do not have the institutional capacity (e.g. trade unions) to enact change on their behalf. The ILO (2002:71) notes that informal workers are excluded from or under-represented in social dialogue institutions and processes almost everywhere in the world.

Sethuraman (1997) found in Latin American urban areas, that the majority of the working poor are in the informal sector (e.g. 66.2 per cent in Bolivia, 66.4 per cent in Brazil, 87.1 per cent in Panama, 57.4 per cent in Venezuela). He also shows that the incidence of extreme poverty is higher in the informal sector relative to the formal sector.

Furthermore, the majority of working women are in the informal sector, especially in developing countries. Chen (2002:3) finds that the informal sector accounts for over 95 per cent of women outside agriculture in Benin, Chad and Mali, whilst in India and Indonesia, the informal sector accounts for nine out of ten women working outside agriculture.

Hence, the needs of women cannot solely be met through recognised labour market legislation as their needs sometimes extend beyond government's prescribed labour policy domain and enforcement.

But not all informal workers are poor and need social security, and the term 'informal workers' can be loosely defined. Hence, it must be stressed that the link between poverty and informal workers does not apply across the whole sector. The ILO (2000:3) asserts that although many informal workers are poor, empirical evidence has shown that the informal sector does not equate to poverty; as in many cases workers earn incomes above the minimum wage in the formal sector in the economy. The self-employed, particularly micro-enterprise owners, are found to have average earnings several times the minimum wage, inferring a lower likelihood of poverty among them (Blunch et al, 2001:15).

Therefore, whilst it may be incorrect to declare that poverty is a defining characteristic of the informal sector, it can be inferred that most of the poor who

work are found in the informal sector, and this makes the case for some kind of social security (Blunch, et al, 2001:15).

This is all the more evident in the globalised economy where firms (and consequently workers) are competing, and the calls for cost savings grow louder. Wages are being set by the lowest common denominator in the pursuance of higher returns, and workers' benefits are being systematically eroded. The impact of globalisation calls for a closer inspection and need for social security as not all people benefit from globalisation.

4.4 To mitigate the adverse side effects of globalisation

Globalisation has produced large wealth for many nations and people. The rise in income has improved the livelihood of millions of people. Millions of people in developing countries now have the chance to escape poverty and destitution by joining the global workforce (Economist, 2007).

However, not all people have benefited equally, with some not benefiting at all. In fact, many groups have become marginalised in the global village, leaving people to live in grinding poverty surrounded by unbelievable wealth. This is more evident in developing countries where a select few have benefited from globalisation with the majority of the poor still anchored in poverty. Cornia and Court (2001:6) find that income inequality has risen sharply in many countries (especially sub-Saharan Africa) since the mid-early 1980s, which is not mainly attributable to the 'traditional causes' such as land concentration, urban bias and inequality of education. The 'new causes' that result in globalisation are linked to the excessive liberal economic policy regimes and hastened economic reforms that are instituted (Cornia and Court, 2001:6).

But not all developing countries have followed this path. In fact, some developing countries have harnessed globalisation to achieve a more egalitarian society. Social security has been the cornerstone of the economic development of the East Asian Tigers (Hong Kong, Singapore, South-Korea and Taiwan). The South-Korean experience has made social security central to their economic strategy in taking the majority of the population out of poverty. The social policies of South-Korea, Taiwan

and Singapore, proved to be the most effective policy instruments during the period of rapid economic growth (Cook and Kwon, 2007:2).

But what do we mean by globalisation? An understanding of the concept is imperative if one is to appreciate its consequences fully.

4.4.1 Definition of globalisation

A common thread that runs through most definitions of globalisation is the removal of borders whether they be political, social, geographic or economic (Asher and Nandy, 2006:1). Deacon (2000:1) argues that the current phase of globalisation consists of the following broad trends:

- a. Advances in transportation, information and communication. The global reach of these new forms of communication including the internet and television.
- b. A strong tendency towards unilateral, bilateral, regional, and global economic liberalisation. Trade policies aimed at reducing barriers to trade.
- c. The movement of people for trade and labour purposes.
- d. Rebalancing the state-market mix in favour of the market
- e. More foreign direct investment.

In essence, globalisation is the gradual integration of economies and societies, catalysed by new technologies, new economic partnerships and new economic relationships combined with national and international policies involving a wide range of stakeholders including governments, business, labour and civil society (Gunter and Van der Hoeven, 2004:7).

These processes and related phenomena have resulted in economic activity becoming more global, which has impacted on the lives of most people in the world. And while there is common agreement on what globalisation means; there is fierce debate regarding its impact on people generally and specifically on the poor.

4.4.2 Impact of globalisation

Globalisation has increased the economic insecurity of lower and middle income countries as jobs have become less secure than in the past. Globalisation has also increased inequality between countries as the developed nations have enjoyed the

benefits more than developing countries have (although there may be exceptions). The IMF (2008) notes that even though the per capita income has increased across all regions (even the poorest segments of the population); income inequality has risen in most regions and countries. There have also been greater inequalities within countries, as interest groups aligned to the political elites and who are knowledgeable have benefited the most (Van der Merwe, 2000:725).

Globalisation has many critics who lament the adverse social consequences that mostly afflict the poor. Whilst not an exhaustive directory of the negative impacts of globalisation, the UNDP does point out the prominent arguments that often voiced against globalisation (UNDP, 1999). These include:

1. Globalisation has resulted in more inequality. There is strong evidence that globalisation has increased inequality between and within countries. Until 150 years ago there was relatively equality between major parts of the world. Today the richest 20 per cent of the world's population receives 83 per cent of the world's income, use 70 per cent of the world's energy, 75 per cent of the world's metal, 60 per cent of the world's food, while producing 75 per cent of the world's environmental pollution. In contrast, the poorest 60 per cent of the world's population receive 5.6 per cent of the world's income (Kirkbride. 2001:33). Weller, Scott and Hersh (2001:1) also note that whilst in 1980, the median income in the richest 10 per cent of countries was 77 times greater than in the poorest 10 per cent; by 1999, that gap had grown to 122 times.
2. The taxation capabilities of countries (especially developing countries) are restricted by tax competition, tax havens and the transfer price mechanisms of multinational corporations. Lao-Araya (2003:3) contends that multinational corporations often manipulate transfer prices among subsidiaries in various tax jurisdictions to minimise overall corporate tax liabilities. The sovereignty of a government is undermined by policies that contradict international norms, institutions and rating agencies. Multinational companies can easily move between countries if economic, labour and tax policies are not conducive to them doing business and do not suit their purposes. This has impacted on government's ability to function optimally within the economy. Tanzi (2010:10) notes the following disadvantages of tax competition:
 - a. Public spending may often be inflexible or rigid downwards, and can result in increased fiscal deficits and high public debt.

- b. When governments are forced to cut expenditure due to decreased revenue collection, there is no guarantee that they will cut the inefficient public expenditure.
 - c. The shift of tax burden from mobile factors (such as financial assets and skilled labour) to immobile factors may render the system inequitable and increase call for redistributive policies.
 - d. The increased taxes earned from income tax in the formal economy may stimulate growth of an informal economy to avoid tax within an economy (Tanzi, 2010:10).
- 3. High income and highly skilled individuals are increasingly becoming mobile over national frontiers, with developing countries losing trained professionals to developed nations. This further erodes the tax base in developing countries and the scope for social security.
- 4. Even in circumstances where globalisation may have increased the revenue and tax base, this has not translated into more jobs. In fact, the 'jobless growth' has created the need for protection for those who do not have the skills to participate in the global economy, and more importantly the need for social security to enable the citizens to educate themselves and make themselves technically capable of participating in the economy. The ILO (2008b:3) notes that although the economic expansion from 1990 has resulted in robust employment growth; these trends mask the pertinent distributional challenges which are:
 - a. Employment growth has varied considerably within each region with significant numbers of women remaining excluded from the world of work.
 - b. Labour's share of income has been declining.
 - c. In the majority of cases, this period of expansion has gone hand in hand with wider income inequalities.
- 5. Globalisation has resulted in people sometimes being exploited and obliged to participate in (and be victims of) criminal activities (e.g. human trafficking, drugs, prostitution). In this context the informal economy of drugs, prostitution, arms dealing and illegal trade flourishes. Organised crime has now become diversified, gone global and has reached macroeconomic proportions: illicit goods are now sourced from one country trafficked through another and marketed in a third (United Nations Office On Drugs and Crime [UNODC], 2010: ii).
- 6. Multinationals use capital, technology and management practices of their host country and sometimes without being held accountable in the country within

- which they operate. The liberalisation of trade has enabled employers to threaten to close plants or relocate operations or outsource production abroad where regulations are less stringent and difficult to enforce; resulting in governments sanctioning the lowering of wages and subsequent living standards of employees in a bid to attract investment (Weller et al , 2001:3).
7. Some countries' currencies are at the mercy of currency speculators who wreak havoc in their financial markets for profit. Weller et al (2001:122) employing univariate and multivariate analysis robustly demonstrate that financial liberalisation has increased the risks of experiencing banking and currency crises.
 8. Governments find it difficult to pursue industrial strategies that they believe are in the best interests of their economy. World Trade Organization (WTO) agreements limit their autonomy in this sphere. The introduction of structural change and shifting of employment due to trade liberalisation has resulted in a decrease in real wages and declining working conditions and living standards (Weller et al, 2001:3).
 9. The loans that are granted to developing countries from the IMF and World Bank have policy consequences that are beneficial to developed countries. Kirkbride (2001:34) argues that the Structural Adjustment Programmes [SAPs]⁵ of the IMF and the World Bank ensure that Third World countries pay off their debt, but at the expense of increasing poverty, exploiting local workforces, reducing social services and reducing their ability to build strong economies.
 10. Consequently, many developing countries are heavily in debt, limiting their capacity to provide social services such as education and health.
 11. Globalisation has resulted in many countries selling off state assets in order to attract capital, with little regard for the labour, environmental and social ramifications (Deacon, 2000:6).

⁵ SAPs were policies that governments had to implement as a condition of receiving loans from the IMF and World Bank. The conditions included elimination of trade barriers, privatisation of state assets and deregulation.

From the arguments listed above, it can be deduced that globalisation has not only not benefited many sectors of the population, but has also been detrimental to their welfare, thereby strengthening the case for social security. Deacon (2000) believes that the social consequences of globalisation dictate the need for more (and not less) social protection, fortifying the call for government intervention within the economy.

The prevailing inequality will require social redistribution, and social security for all citizens. Chang (2003:47) believes that interventions can be justified theoretically as welfare economics or 'market failure' sees the intervention of the state as necessary because of the inability of decentralised agents in the pursuance of self-interest to produce outcomes which would fill the 'efficiency' outcomes of a competitive equilibrium. The state as the 'powerful guardian' has the right and obligation to correct the inequitable social outcomes of globalisation through taxes, subsidies, and the reallocation of property rights.

However, this argument is refuted by the pro-globalists who assert that social protection is not under threat in the global economy, if anything social security systems have been strengthened. De Grauwe and Polan (2005:118) find no evidence of a race to the bottom concerning social security in the industrialised world. On the contrary, they find that that the rich countries that spend most on social needs rank highest on average, in terms of competitiveness.

The evidence provided by the authors may be correct for industrialised nations; but it does not apply to developing countries which suffer the negative impact of globalisation more severely (Kirkbride, 2001:33; Lao-Araya, 2003:3; Tanzi, 2010:10; UNDP, 1999; Weller et al, 2001:3);. Developed countries have benefited more from globalisation, in terms of tax revenue and more skilled migration from developing countries and will therefore have better social security. Therefore, the need for social security to mitigate the risk of globalisation for developing countries stills prevails. Tanzi (2004:534) asserts that there will be strong pressure to replace the more rudimentary systems of social protection with a more formal system of social protection, which will lead to increase levels of public spending and subsequent increases in taxes.

Moreover, social security is an indispensable institution of any market economy. There is no successful market economy that does not have a fairly extensive security system. Market economies with missing or weak institutions, including institutions of social protection/security are not able to ensure sustainable economic growth and social development in a globalising world (ILO 2008a:2). Consequently, expenditure by government on social security does not hold back countries in their pursuance of economic growth and development, on the contrary social expenditure promotes and augments competitiveness.

Social security should be a long-term strategy of government to obtain economic development, maintain social stability and not be a reflex to forces of globalisation. If not, globalisation will be resisted as wealth that is generated is not benefiting everyone; and the costs of keeping people excluded will be higher.

The ILO (2003) argues that maintaining 80 per cent of the world's population without basic social protection translates into continuing poverty, increasing inequality and the growing likelihood of conflicts.

4.5 Summary and conclusion

In this chapter the need for social security in developing countries, was examined. Whilst the needs that confront developing countries are also experienced in developed countries, they are more acute in the developing world. The first need that is analysed is the need to alleviate poverty.

But poverty has many meanings and is multidimensional, which is not always easy to capture in a single measure. Whilst there is no consensus on the ideal measure of poverty, political and academic discourse often acknowledges poverty to be related to the inability of a person to command sufficient resources to satisfy his/her basic needs and sustain an essential standard of living. Consequently, the poverty line (e.g. \$1 per person per day) is the yardstick that represents the minimum amount that is required for a person to meet his/her basic needs. Notwithstanding their limitations, poverty lines do serve as a measure to examine the well-being of people empirically.

Social security in developing countries exists to not only directly compensate the poor, but also to remedy the underlying foundations of poverty. The main causes of poverty in developing countries that are evaluated are the lack of income, education, health and the lack of basic services (water and sanitation).

The lack of income is the primary reason why people are trapped in poverty. They are unable to satisfy their basic needs as well as those of their families. Social security assists the poor to satisfy their basic needs and empowers them to make decisions which they feel best address the poverty they are enduring.

Therefore the investment in education of the poor is vital for the reduction of long-term poverty and economic development. Consequently, the importance and positive benefits of education, especially female education are underscored in the Millennium Development Goals (MDGs). Education of children endows children with skills and knowledge that provides them with better opportunities in society. Furthermore, the education of girls results in lower fertility and an increase in reproductive health when they become adults. Education of females is also correlated with an increase in immunisation rates and a subsequent decrease in child mortality. Social security is vital to grant children access to educational opportunities which their parents might not otherwise be able to afford.

Similarly, social security empowers the poor to live healthy lives. The poor are often ill due to the lack of decent nutrition and are afflicted by preventable and treatable diseases. Social security allows the poor to eat nutritious foods to remain healthy and productive, as well as the resources to seek medical attention should they get ill.

Often, the illnesses that plague the poor are the result of poor sanitation and the lack of clean water and this is most prevalent among the poorest in society. The lack of adequate sanitation and lack of safe clean drinking water is responsible for preventable and communicable diseases such as diarrhoea, which negatively impacts on children's health. Social security enables poor households to have access to water and sanitation and mitigates the negative consequences of inadequate sanitation and clean water.

Social security is also necessary when people become unemployed. However, the critics of social security argue that it is social security itself, especially the generous unemployment benefits, that cause high unemployment. This is theoretically demonstrated by employing the labour-leisure model. Numerous studies have indicated that generous unemployment benefits are associated with extended unemployment. But these studies are more applicable to developed countries where unemployment is a 'discreet' event whilst in developing countries unemployment can be structural and benefits are not as generous. Unemployment in developing countries has resulted in more people working in the informal sector where there are no unemployment benefits. Hence, social security is necessary to compensate and protect this vulnerable group as most of the poor are found in the informal sector.

Globalisation has improved the lives of millions of people and was a contributing factor in many developing countries to create a more equitable society. However, this has not homogeneously occurred in all countries. Whilst the overall income of some developing countries has increased, the wealth of a few has risen exorbitantly juxtaposed by the poor living in grinding poverty. Consequently, globalisation has increased inequality, increased the mobility of skilled workers to developed countries, limited countries sovereign authority to tax corporations and rendered some countries currency vulnerable to speculation. Hence, globalisation has increased the need for social security for those that are excluded from the benefits that accrue to a selected few.

The need for social security in South Africa is not divergent from that of other developing nations (as well as developed countries). In fact, in some cases (high unemployment) the need is more acute. But South Africa has a relatively well-developed social security system that has evolved over the past centuries to provide for the poorest in society.

The next section takes up the issue of the social security arrangements in South Africa and how it developed over time and what social assistance is presently available to mitigate both poverty and the consequences of poverty.

Section B: Social security in South Africa

Chapter 5: Social security pre-1994

5.1 Introduction

The need for social security in South Africa is comparable to that of other developing countries (referred to in the previous chapter), as the circumstances that underpin the need for social security are universal. However, not all developing countries (even those at similar levels of development) have similar social security systems. The economic, political and cultural climate of the colonial past resonates in many of the present day social security arrangements. Triegaardt (2007:2) notes that social security systems in developing countries were influenced by European and British social security systems. And South Africa is no exception to this.

It is informative to look at the evolution of social security in South Africa to better understand the social security of present day South Africa. The aim in this chapter is to unravel the history of social security in South Africa. The chapter commences by exploring the informal social security arrangement that took root prior to 1994. This is followed by a brief synopsis of the evolution of social security during the colonial period in South Africa. The historical development of social security is examined in five periods, namely; 1910-1933, 1934-1947, 1948-1970, 1971-1980 and 1981-1993. Post-apartheid social security is scrutinised in the next chapter.

5.2 Informal social security arrangements

The social security arrangements under apartheid and the lack of social services (as well as opportunities) led to many African households relying on informal social security arrangements for survival. The rural Africans were excluded from most social assistance (especially pensions) in the belief that the African way of life will cater for their needs. The urban Africans were excluded as it was not possible to distinguish between the rural and the urban Africans, irrespective of their needs (Van der Berg, 1997:487).

The limited formal social security for the Black (especially the African) majority was alleviated by the reliance on traditional and informal social protection arrangements. These informal social security arrangements have ensured the survival of Africans in destitute circumstances. The traditional social protection arrangements were flexible and geared to resolving both the immediate as well as the future needs of households in the community.

This is not to say that these informal and traditional systems no longer exist; but to note that they took root prior to 1994 in response to the destitute conditions that many Africans found themselves in, as well as part of the traditional lifestyle. These informal arrangements have endured to some extent in post 1994. Informal social security continues to prevail as the need still exists (perhaps even more so) as many people (Black and White) find the present formal social security disbursements to be inadequate.

Triegaardt (2007:7) avers that these traditional systems were based on personal reciprocity, social solidarity, social networks of trust and direct face to face interaction between individuals, households and communities and were relevant to poverty alleviation, especially in rural areas. Visser (2004:1) adds that in pre-colonial times the welfare needs of individuals were met through the wider African society and communalism, co-operation and the mutual support of individuals with the social group being highly developed.

The informal arrangements that were established (and still prevail today) include the mutual aid societies, saving clubs, burial societies, stokvels and food co-operatives which have contributed to poverty alleviation. The extended family was instrumental as a social security institution which was based on a culture of ubuntu. Kasante (2000:31) observes that traditional social security systems in the region are kinship-based and follow the principles of solidarity and reciprocity. They operate by mobilising resources within the extended family to support members in need by giving them money or other materials.

This system makes it obligatory for individuals to support their relatives who are exposed to contingencies. Traditionally there are societal sanctions for those who fail to meet their obligations, although this is becoming less and less effective; as the

role of the extended family has been declining with increasing urbanisation and industrialisation. The informal social security has also been a response to the weakening of the extended family support (Kasante, 2000:37).

Although informal security arrangements permitted women greater independence to form social networks; the traditional systems of social security system often prejudiced women for the benefit of other members of the extended family. Women because of their social status (and absent spouses who had gone to the mines) sometimes assumed greater responsibilities and were not legally entitled to assets. (Kasante, 2000:36).

Hence, informal social security is seen not as separate but concurrent with the formal social security that prevailed in South Africa. Furthermore, informal social security post 1994 still exists, even though formal social security has been extended to the indigent. The formal social security provision may still be inadequate to meet the demands of the poor. There is ample evidence (section 6.4.2.5) that pensions provide income support for grandchildren. Aids orphans are sometimes placed in the care of grandparents, thereby placing pressure on the cash transfer that the grandparents receive.

Many of the poor may still not be reached by the formal social security arrangements, as they may not be 'poor enough' by the formal definition to qualify for any assistance, and are still reliant on the informal social security arrangements.

Therefore, informal and traditional modes of reciprocity of mutual assistance should not be ignored or absent in any discussion of social security. While they cannot replace social insurance and social assistance, it must be remembered that they continue to contribute to the alleviation of poverty (Triegaardt, 2007:8).

5.3 Colonial period

In the pre-colonial period there were no formal social security arrangements and social security was based on informal social arrangements. The seventeenth and eighteenth centuries of European settlement was a period of scarce social security with little poverty relief. The state played a very limited role and the church was the

main establishment which cared for the poor and destitute (Van der Berg, 1997:485).

The Dutch system of poverty relief was transferred to the Cape Colony but soon took on a racial dimension in terms of the social services that were provided to the needy. Patel (1992:34-35) notes that the foundations of racial discrimination, the denigration of indigenous ways, paternalism in the social services and the distorted nature of social welfare policies favouring Whites as a welfare elite were laid during colonial times.

The creation of the South African social security system was the result of a rivalry between the two prevailing economic ideologies of the period. The liberal laissez-faire position which was grounded in Victorian principles, did not favour social security. In other European countries it was felt that the most destitute should be assisted. The laissez-faire position enjoyed stronger support when South Africa was under the British rule, specifically from the predominantly English business class.

British occupation in the early nineteenth century brought pre-Victorian views on the distinction between the deserving and the non-deserving poor and strengthened the racial bias in the provision of social services that remained dominant for two hundred years (Van Der Berg, 1997:485).

European influence was prevalent in the Old Boer Republics and in the pre-British Cape Colony, and came to the fore again under the Afrikaner nationalist rule. The consequences of the Anglo-Boer war elicited sympathetic response from the Afrikaner community particularly the church. The church, with the Afrikaans women organisations and the Dutch Reformed Church (DRC) provided assistance and aid to poor Whites at the local community level (Kruger, 1992; Visser, 2004:2).

The establishment of organised welfare services took place after the British occupation of the Cape Colony in 1806; with the emphasis of care pertaining mainly to children, the disabled and support of the poor. The welfare provisions of the colonial authorities focused almost exclusively on Whites. The Dutch East India Company assisted the needy by raising money through the DRC, which founded the first orphanage in 1814 (Visser, 2004:2). The first pension was introduced in the old

Transvaal Republic in 1882, but was not legislated and cannot therefore be seen as social insurance (Van der Berg, 1997:485).

5.4 1910-1933

Social security evolution during this period was mainly reactionary to the social consequences of the economic climate. There were significantly innovative programmes introduced in South Africa, that were piecemeal and uncoordinated, with the most benefits accruing to Whites. Kruger (1992:159) notes that Indians and Africans were mainly barred from any social security as the White government was unwilling to use fiscal resources to provide for services for Africans.

Social insurance by the state was first formalised in 1911, when state support for workers was instituted for miners with phthisis and silicosis and there was compensation for injuries sustained at work. This resulted in the first Workers Compensation Act in 1914 (Ehrlich, 1992:3).

Social assistance began with the promulgation of the Children's Protection Act in 1913 which provided maintenance grants for children (Samson et al, 2008:3). Most of these grants went to White children and very few to African children and virtually none going to rural African children (Kruger, 1992:161). The rural African children were expected to be cared for in the reserves by their guardians or chiefs (Pollak, 1981:165).

The Children's Protection Act was amended in 1921 and was replaced by the Children's Act of 1937 when its coverage was extended, but the maintenance grants still accrued disproportionately to White beneficiaries. The first school feeding scheme which was partly funded by parents and provided meals in the winter, was only started in 1916 by the Transvaal Provincial Council (Bhorat 1995: 596).

Until the 1920s relief to the poor was the main focus of the social security programmes. Social insurance first took root in the early 1920s. The first known unemployment insurance began in the printing and newspaper industry in 1919 following negotiations between management and labour with the state playing no part (Meth and Piper, 1984:4). Occupational insurance became formalised after the

1920s, and was based on contributions by both the employer and the employee, where there was a defined benefit upon retirement (Visser, 2004:2).

In 1922 an industrial confrontation between the mining houses and organised labour took place in the Witwatersrand. Although the workers lost the industrial battle, the clash was instrumental in the formation of a partnership between organised labour and their Afrikaner Nationalist allies (Visser, 2004:2).

Prior to 1924, the South African Party government had already implemented the Industrial Coalition Act to protect White wages from being undercut by cheaper non-White wages. State interventions were implemented to create employment opportunities for Whites and in 1924 a Department of Labour was created with the task of creating work opportunities for Whites.

The Wage Act of 1925 protected the White wage against competition from Blacks in the labour market under the so called 'civilised labour policies'. Visser (2004:3) argues that the Act aimed at fixing White wage at a rate that may be described as the 'White survival line' to prevent Whites from sinking socially and economically below such a line.

In 1926 the government introduced the Mines and Works Amendment Act which was aimed at protecting White mineworkers from losing their jobs, thus preserving jobs for Whites. During this period, the social welfare of the non-Whites was disregarded, whilst sympathy for the White poverty grew during the depression in the 1920s.

The Military Pension began in 1919, whilst the Old Age Pension Act came into being in 1928 and enabled White and Coloured males over the age of 65 and all females over the age of 60 to receive pensions. The Act excluded Indians and Africans. The pensions for Whites were R5 per month, whilst those for Coloureds was R3 per month (Pollak, 1981:157).

In 1928 at the behest of the DRC, the Carnegie Corporation of New York conducted an investigation into the causes of White poverty in South Africa and the ways it could be reduced. The 1932 report of the Carnegie Commission of Enquiry had a dramatic impact on South African social welfare. The report provided the momentum

for the creation of the Department of Social Welfare in 1933, which focussed primarily on Whites who received more and a higher standard of service than the other population groups.

The White population dependent on social pensions remained relatively small as occupational retirement proved its superiority for the more affluent. The end of the 1920s saw the Old Age Pension become the main modality of support for the poor. Welfare provision now began to be channelled institutionally through the state and in this era the seed of the segregated social policy was sown.

Whilst no definitive hypothesis can be rendered for the legislative changes that resulted in the social security changes of this period, a few arguments related to an improvement in the economy, can be postulated. Bromberger (1982:173) affirms that the South African economy grew from 1933, largely driven by the new gold boom of that era. The real GDP grew at 5 per cent during the 1930s, which provided the stimulus for further diversion, the economic impact of which continued (albeit interrupted by the war) into the following years (Bromberger, 1982:173).

5.5 1934-1947

The economic trajectory of the 1930s continued into the 1950s which underpinned social security changes of this period. The real output of manufacturing (which began to dominate the South African economy) during 1936-1952 more than trebled with manufacturing employment growing at 6 per cent per annum (Bromberger, 1982:173).

In the late 1930s and 1940s the social security system was extended more broadly, but with racially differentiated benefits levels. In 1936 and 1937 grants for the blind and the disabled were introduced respectively, but only for Whites and Coloureds. The Old Age Pensions paid to the blind and the disabled were extended to Indians and Africans in 1944 (Bromberger, 1982:173).

The Unemployment Act of 1937 covered 88 000 workers but excluded agricultural, domestic and mining workers and African workers earning less than £78 per annum (Meth and Piper, 1984:7). Consequently, the government's industrial legislation provided social assistance and unemployment insurance thereby entrenching White

labour privileges, and by 1939, for the most part the poor White problem was all but eliminated (Visser, 2004:3).

Pensions for War Veterans were instituted in 1941 when the War Veterans Pension Act was passed but excluded Africans who served in WW1. Also in 1941, inflationary adjustments were added to protect pensions from rising prices, but differentiation in disbursements between the race groups continued.

In 1943 all school children were to be given one free meal per day under the direction of the Department of Social Welfare. Discrimination became formally established when African schools were placed under the Union Education Department in 1945. White, Coloured and Indian school feeding schemes remained under the provincial administrations and were bolstered by a subsidy from central authorities. Moll (1985:5) contends that school feeding schemes were discontinued in 1949 and subsequently for all race groups.

The Old Age Pension was extended by Smuts to Blacks in 1944 with the benefit level at one tenth of that of Whites. Kruger (1992:173) contends that the sentiment of that period was reflected in the Social Security Committee of 1944 which foresaw an array of social services which were means tested irrespective of race. The Social Security Committee took its inspiration from the Beveridge Report in the United Kingdom during WWII which it used as framework for a future social safety net (Dixon and Schenrell, 1989:311). It aimed to improve the limited achievements made by Blacks in welfare provision and repeal the losses that occurred.

In 1946 exclusion of Africans from the Insurance Bill was favoured by the National Party to ensure a reserve of cheap labour. The Chamber of Mines wanted a stable urban workforce and opted for universal transfers (Meth and Piper 1984:10). In the end the Act removed the £78 restriction but still excluded agricultural, domestic and mining workers (Bhorat, 1995:596). Unemployment insurance was still denied to most working Africans.

By the end of this period the Disability Grant Act of 1947 extended disability grants to all racial groups, and family allowances were introduced for low income families in 1947, but these excluded Black people.

By 1947 the maximum pension for Whites was five times that of Africans, and the pensions of Coloured and Indians were half that of Whites (Bhorat, 1995:597).

5.6 1948-1970

The United Party of Smuts was defeated by the Nationalists in 1948. The National Party's (NP) agenda before the 1948 election inter alia included addressing the poverty of the poor White Afrikaner and rectifying the injustices of the past by implementing a comprehensive welfare policy for Afrikaner upliftment (Terreblanche, 2003:299). The Nationalist government introduced affirmative action styles of legislation which reflected aspects of social insurance and social assistance, which attempted to address the 'Poor White Problem'. Terreblanche (2003:304) notes that the NP used its fiscal powers to increase social spending for Afrikaner upliftment.

The Nationalist victory instituted legislation and institutions to shield White workers from the expanding African workforce, and the limited gains made to the achievement of an equitable social safety net were destroyed (Bhorat, 1995:597). Legislated increases in pensions for White South Africans and a decline in pensions for Black South Africans distorted the system regressively, while bureaucracy-based discrimination deepened the prevailing inequalities (Samson et al, 2008:5).

The separation of welfare services according to race groups served to perpetuate and entrench discrimination in the quality of services. Consequently social security benefits were paid to Whites at a level higher than that paid to other groups.

Visser (2004:4) adds that the state welfare expenditure was an important tool of the government of the day to maintain political support; as was evident during election campaigns when salary increases and social benefits for state employees were improved.

Pollak (1991:159) contends that the argument of the day was that Africans needed to be provided for under a system more in keeping with their indigenous practices and customs. African pensions were disbursed to the Native Trust for disbursement. Kruger (1992:172) argues that the Nationalist logic was that White taxes were paying for Black pensions and therefore had to be reduced to reflect the taxation capacity of Blacks.

The Nationalist Party government revoked the 1946 Unemployment Insurance Act as 74 per cent of benefits were accruing predominantly to Africans (Meth and Piper, 1984:17). The Unemployment Insurance Amendment Act of 1949 set a minimum income level of £182 for Africans to qualify for benefits. This was adjusted to £278 per annum in 1957. This resulted in unemployment benefits paid to Blacks falling significantly from £122 600 in 1949 to £1 439 in 1957 (Bhorat, 1995:598). The new threshold of £278 was much higher than what most African workers were earning, and subsequently excluded most of them from qualifying for benefits. Hence, benefits (which were claimed by Africans) decreased significantly after the law was passed in 1957.

Furthermore, the NP government's apartheid policies aimed at instituting separate development, including social welfare. Not only did the Nationalist government institute a policy of separate development in general, but specifically in social welfare disempowering Blacks for the next 46 years (Brown and Neku, 2005:3). From 1951, the different race groups had their own Departments of Social Welfare to administer the social welfare responsibilities for their respective race groups. This separation of social welfare services translated into better social welfare services for Whites than for non-Whites. Accordingly, social security benefits paid to White recipients were higher than those paid to other race groups (Visser, 2004:4).

By 1954 most unemployment benefits were being disbursed to unemployed Whites. Coloured and Indian workers who were still unemployed after drawing benefits for 13 weeks were obliged to accept alternative employment provided by the state or relinquish further benefits (Bhorat, 1995:598). However, positive benefits were introduced in 1952. Maternity benefits were added in 1953 and death benefits were introduced in 1957.

The 1956 Pensions Funds Act was a milestone in regulating pension funds but excluded lower skilled workers, which meant that most Black workers were largely excluded (Visser, 2004:4). By 1958 Blacks already constituted 60 per cent of the 347 000 social old age pensioners, although they only received 19 per cent of old age expenditure (Van der Berg, 1997:487). Between 1966 and 1971 the absolute gap between African and White pensions increased.

The Industrial Conciliation Act of 1956 was promulgated by the apartheid government as a tool to preserve employment for Whites, and enforced job reservation and racial separation in trade unions. This was regarded as another attempt to provide a measure of insurance for White labour against unemployment (Visser, 2004:4). By the end of the decade income inequality between the richest 20 per cent of the population (mainly White) and the poorest (mostly Black) had widened. Bromberger (1982:165) found that in 1970 the top 20 per cent of income recipients took 77 per cent of aggregate personal income, whilst the bottom 40 per cent received just less than 4 per cent.

Although Blacks were greatly disadvantaged by the social security arrangements of the day, their aspirations for social welfare were indeed in place. Their desire for social security found expression in the Freedom Charter that was adopted by the Congress of the People (a group of anti-apartheid movements consisting of the African National Congress, South African Indian Congress, South African Democratic Congress and the South African People's Organisation) which made rudimentary references to social security such as unemployment benefits, health insurance, old age pensions, disability grants and child and family grants (Visser, 2004:4).

5.7 1971-1980

The surge in industrialisation in the 1960s and the 1970s increased the demand for cheap labour. In the 1960s and the early 1970s rapid industrialisation brought Black workers into industry and occupational retirement insurance was extended to the less skilled workforce, and consequently to more Black workers (Van der Berg, 1997:485).

Another inequitable feature of the pension system was the maximum free income allowance that was given to the aged. This declined by 54 per cent (real) [remained the same in nominal terms] between 1954 and 1969 for Africans; whilst it grew by 231 per cent (nominal) for Whites (Bhorat, 1995:599).

From 1957 to 1981, total benefits paid by the Unemployment Insurance Fund were greater than contributions to the fund. This growing deficit brought about a tightening up of the unemployment legislation. Illness and maternity benefits declined steadily and responsibility for these was passed onto labour and

management. In 1966 the 'alternative suitable employment' clause reduced the period of insurance benefits from 13 to 6 weeks.

The 1970s marked the commencement of economic stagnation. There was increasing Black unemployment coupled with a scarcity of skills. The Afrikaner capitalist class began to realise that the economy could not rely solely on White workers to sustain economic growth. Job reservation laws were subsequently repealed.

Moreover, the non-racial unions were gaining momentum, whilst White labour movements were waning and their memberships were falling. The focal point of the unions in the 1970s was mainly around wage concerns and political issues. Trade unions were able to register after the 1973 Durban strikes. Bhorat (1995:600) argues that it was at this time that social services began to be based on need and not on race. The real income gap that increasingly widened until 1974, began closing from 1975.

The labour law reforms following the Wiehahn Commission of Enquiry in 1977 and 1979, allowed for the formal recognition of Black trade unions (Adler and Webster, 2001). From the beginning of this period the gap in Old Age Pensions between the Whites and other race groups began to narrow, as noted in Table 1 below.

Table 1: Old Age Pension, by race between 1972-93

Year	Pensions as a percentage of White pensions		Difference between monthly pensions for Whites and other race groups (in 1990 rands) [per month]	
	Coloured/Indian	African	Coloured/Indian	African
1972	50	15.9	197	331
1973	50	16.9	206	342
1974	51.7	19.8	217	360
1975	53.2	23.4	208	340
1980	56.8	30.1	185	299
1985/6	63.8	43.9	129	206
1990/1	81.5	63.4	51	101
1991/2	86.2	73.9	36	69
1992/3	92.2	84.9	27	52

Source: Bhorat (1995:600)

It can be observed from Table 1 above, that in 1972, Coloured and Indian pensions were 50 per cent of that of Whites, whilst African were only 15.9 per cent of that of

Whites. The difference between White pension and other race groups is greatest in 1974 (rands per month), after which the gaps begins to narrow dramatically until 1992/3. It is notable that the narrowing of the gap was achieved by increasing the pension of the other race groups, with a consequent decline in real pensions of the White group. Van der Berg (2001:254-5) notes that it would have been fiscally impossible to achieve parity at White benefit levels, and White benefits were accordingly reduced. The real values of White pensions declined by 40 per cent after 1978, whilst those of Blacks increased fivefold in real terms from 1970 (Van der Berg, 2002a:31).

Black trade unions were legalised, a few discriminatory labour market practices were softened, and the government made some effort to erode the racial basis of social security benefits. In 1977 the Unemployment Insurance Act restored the period of paid unemployment to 13 weeks. Racial differentiation of payments was abandoned.

This led to an improvement in the real wage of African workers in the formal sectors. During 1960-1970, the average real wage rates increase of Whites and Blacks were 3.9 per cent and 3.7 per cent respectively, with the absolute gap between Black and White average wages being similar (Nattrass, 1977:252). However, between 1970-1975, the rate of growth of Black real wages increased to 6.6 per cent per annum, whilst the rate of growth of White wages fell to 1 per cent (Nattrass, 1977:252).

The maintenance grants for Coloured, Whites and Indians stopped at 18, whilst those of African stopped at 16; which reduced the number of mothers that were eligible, but the maximum and free grants were favourable to White families (Bhorat, 1995: 600).

5.8 1981-1993

The trend emerging from the 1970s was that racial differentials in social security were being narrowed. Kruger (1992:178) finds that after 1972, there was a trend towards re-incorporation and reduced inequality in social security. The government's distributional stance altered as the strain between the incorporation and separation of Blacks played itself out in the political arena (Van der Berg, 1997:487).

The period of the early eighties was characterised by economic stagnation and creeping unemployment which took root in the 1970s. The annual real economic growth rate declined from 5.5 per cent per annum during the 1960-1974 period to 1.9 per cent per annum between 1974 and 1985 (Van der Berg, 1989:187). Furthermore, the number of jobs created in the formal sector decreased from 157 000 to 64 000 per annum during this period, at a time when the need for new jobs was growing due to the large number of workers entering the labour market (Van der Berg, 1989:187). Consequently, the government was experiencing fiscal constraints due to the economic downturn as well as international sanctions which limited budgetary allocations for social security. It became apparent to the Nationalist government that a competitive economy was not possible in the apartheid fiscal paradigm (Bhorat, 1995:600).

Social security became an issue in 1981, when the government tried to enforce preservation of pension rights when people changed jobs. The 1981 Preservation of Pension Interests Bill, which was meant to preserve pension rights when employees withdrew from a fund, was met with fierce resistance by the unions. The unions interpreted this as a move by the government to disallow Black people the right to their own money as they believed the state was the rightful source of pensions. The bill was rescinded with unions subsequently participating in the retirement benefits of their members (Visser, 2004:4). The victory was symbolic of the empowerment of Black workers.

The state began to commit to equalising benefits. The differential gap continued to narrow in the 1980s (late apartheid period) when the PW Botha-headed government attempted to legitimise the apartheid systems by attempting to get support from Africans, Indians and Coloureds, by decreasing 'real increase' in social assistance to Whites.

Both coverage and benefits levels improved. The fiscal cost of incorporating these relatively small groups into a welfare society was manageable. The far greater fiscal challenge only came later, once the principle of moving to parity in social spending levels was reluctantly accepted in the late 1970s (Van der Berg, 1997:487).

However, overall expenditure by government began to scale back as an economic recession began to impose budgetary constraints, resulting in a reduction of social services expenditure (Patel, 1992:43). This prohibited increasing Black benefits to those of White levels. Hence, deracialisation of benefits was achieved by decreasing where resistance was the least, that is, the elderly and the disabled poor Whites who were seen as most politically expendable. Therefore, pension equalisation occurred through enhancing Black pension benefits (by 7.3 per cent per in real terms from 1970 to 1993) and seriously eroding real White pensions (Van der Berg, 1997:487).

By 1978, after their numbers had grown by 5 per cent a year over two decades, Blacks made up 70 per cent of the 770 00 pensioners and received 43 per cent of pensions. By 1990, this latter portion increased to 67 per cent. The pension paid in the Bantustans increased by 23 per cent from 1989/90 to 1990/91 (Bhorat, 1995:601). But the poor administration resulted in inefficient delivery to the African poor.

By the late 1980s the racial gap began to narrow slightly. In 1950, 61 per cent of the welfare budget was spent on Whites, 14 per cent on Coloured and Indians and 25 per cent on Africans. By 1990, Whites accounted for only 23 per cent of welfare spending, whilst Coloureds received 24 per cent and Africans 52 per cent (Van der Walt, 2000:71).

African Old Age Pensions as a percentage of Whites increased from 16 per cent in 1972 to 85 per cent in 1993 (Bhorat, 1995:600). Although Whites had the largest per capita income in 1990, social transfers to Whites were only 0.8 per cent of estimated personal income compared to 6.5 per cent of Coloured and 6.5 per cent for Blacks (Van der Berg, 2002a:12).

5.9 Summary and conclusion

The primary objective in this chapter was to examine social security arrangements in South Africa preceding 1994. The historical path of South Africa is mirrored in the social security evolution of the country.

The chapter commenced by evaluating the informal social security arrangements that were founded prior to 1994 and their importance in poverty alleviation, especially for

groups of people who were denied or under-represented in social security. The informal social security was reliant on reciprocal social protection arrangements that satisfied the immediate and future needs of many traditional households in a community. The informal social security continues to be relevant as formal social security may not reach everyone who is in need; and may be insufficient for many who do receive it.

In the pre-colonial period there was no formal social security in South Africa, with poverty relief mainly being provided by the Dutch Reformed Church. The foundation of social security within the colonial period was the consequence of divergent influences of European and the British thought on social security during this era.

Social security was implemented primarily to protect Whites against any unforeseen circumstances, resulting in a rare situation of a semi-industrial state with the social security of a modern welfare state (Visser, 2004:1).

Consequently, the historical course of social security was described in five stages from 1910 to 1993. These are 1910-1933, 1934-1947, 1948-1970, 1970-1981 and 1981-1993.

Social security changes were informed by the political climate and economic circumstances which dictated social security choices during these periods.

It cannot be denied that the per capita expenditure of social security among African people was lower than that of other race groups. But this must be seen in the context of the period that this occurred. Fiscal incidence studies have illuminated the discrepancies between the race groups and have also provided insight as to the reasons why this occurred. It is worth noting factors that were at play during this time that resulted in the wage gap between Africans and Whites, for example, the 'Poor White Problem' led to the government implementing policies to improve the lives of mainly the Afrikaners vis-à-vis the Black population.

The justification for the lower social expenditure on Africans by earlier governments was that Africans contributed less in the way of direct taxes, and therefore were not entitled to the same level of benefits as those that contribute to taxes. The Native

Economic Commission noted that the R8.3 million of benefits that went to Blacks in 1929/1930 exceeded the R6.6 million they paid in taxes (Van der Berg, 2001:249). Similar results were found in 1950s by the Tomlinson Commission that concluded that in 1951, Blacks' benefits from social services of R50.3 million plus R32 million in non-assignable services; which contrasted with the direct taxes of R4.million and R15.4 million in other taxes resulted in a transfer of R63.3 million to Blacks (Van der Berg, 2001:249).

Another justification for the discrepancy was that the need for social protection was greater among Whites than Blacks, as Blacks had familial arrangements and settings providing care for each other. Batson (1944:283) argued at the time that the European needs a greater measure of relief than the Native for a smaller degree of privation and Blacks did not contribute as much as Whites to the industrial output.

The ensuing years also showed similar trends where Blacks relative to their taxes paid, received more in social services (McGrath, 1984:72; Van der Berg, 1989:197). However, from the mid-1970s social security gaps (especially social assistance) began to narrow. Consequently, the rise in government expenditure ratio with greater emphasis on social spending saw the real social spending on Blacks grow by 10 per cent per annum from 1975 to 1993 (Van der Berg, 2001:258).

The expansion of the social security to other race groups that took place prior to 1994 placed South Africa (a semi-industrial state) with the trappings of a welfare state (Van der Berg, 1997:484). The unique South African historical context largely framed the social security arrangement that greeted the new ANC government that took office in 1994. When the new administration took office in 1994, the elimination of racial disparities in social expenditure had long begun, and had mostly been eliminated (Van der Berg, 2001:258).

Chapter 6: Post-apartheid social security

6.1 Introduction

The first democratically elected government of South Africa inherited a fragmented social security system that was skewed in favour of the White minority, although changes to reduce the gap had already started in the 1970s (Samson et al, 2008:4). The period subsequent to apartheid was an era of high inequality and poverty that was unusual for a middle income country (Adato, Carter and May, 2006:226).

The newly elected ANC government had a mandate to reduce poverty, racial disparities and inequalities in income and social services. But the government soon realised that it would be fiscally challenging to equalise social assistance at the levels of the White population. The extension of social assistance (e.g. State Maintenance Grant) to racial parity and maintaining benefits for minorities could not be universalised in a fiscally sustainable manner.

Furthermore, the global political stage in the 1990s was changing with the fall of the Soviet Union. Hart (2006:13) notes that the early 1990s coincided with "the zenith of market triumphalism with the death of post-war 'developmentalism'".

Also, there was stagnation of the South African economy. Cassim (2006:57) notes that the decade was characterised by low growth, low investment and marginal improvement in employment. Naidoo (2006:110) a senior official in the National Treasury, noted that the South African economy was on its knees as this period (1994) was also followed by the after-effects of the 1992 droughts, a global economic recession, political strife, economic policy uncertainty at home, a large budget deficit, almost no foreign exchange reserves, high interest rates and inflation of about 15 per cent.

Also there was an explosion of HIV/AIDS after 1994 which put a strain on social spending and limited resources for other social priorities.

Social policy (as well as other economic choices) was made against a backdrop of the economy of low growth and liberalisation (Cassim, 2006:57). The new government was in a fiscally tight space with a mandate to deliver services to the previously disenfranchised majority. Moreover, expectations were high that the lives of the poor would improve soon. But the economic resources and capacity were not in place to appease the expectant majority. The implementation of social security within South Africa must therefore be appraised within the context of international developments that were taking place at the time, as well as the fiscal challenges that confronted the government of the day.

Moreover, the African National Congress (ANC) government looked at the USA and Europe for policies and programmes that were used to kick start the economy. These policies were largely demand driven and involved large infrastructure spending, increased public spending, increased public investments, increased public-sector employment and higher social security spending (Naidoo, 2006:111). Over the successive years social security changed in South Africa, with the changes being influenced by the government's economic policies of the day.

In this chapter social security development in post-apartheid South Africa is evaluated. The economic path greatly influenced social security strategy pursued by the government. It is imperative to understand the context of the economic climate that impacted on social security in the new political dispensation to better appreciate the social security choices. Hence, the economic strategy post 1994 is discussed at length. In section 6.2 the Reconstruction and Development Programme (RDP) as the economic policy that was the guiding strategy of the new government, is discussed. This is then followed by the analysis of the Growth, Employment and Redistribution (GEAR) [section 6.3] and its influence on the social security trajectory in South Africa.

In section 6.4 the current social security arrangements South Africa are investigated and in section 6.5 the Expanded Publics Works Programme (EPWP) as a means to address poverty alleviation is addressed. Lastly in section 6.6 the Basic Income Grant (BIG) and whether it should be reconsidered by government is deliberated on. The chapter concludes with a summary.

6.2 Reconstruction and Development Programme (RDP)

A super trade union confederation, the Congress of the South African Trade Unions (COSATU) was established at the height of political turmoil in the 1980s with a strong tradition of support for the ANC. The community-based unions which entered COSATU brought with them a strong tradition of support for the ANC (Visser, 2004:6). After the unbanning of political organisations in 1990, the ANC, COSATU and the South African Communist Party (SACP) formed the Tripartite Alliance in negotiation with the National Party led government. COSATU's intervention was influential in securing an election success for the ANC (Terreblanche, 2003:108).

The tripartite alliance movement saw the coalition as a means to ensure that policies to be adopted by the ANC government would be working class friendly. Visser (2004:6) argues that COSATU wanted to make certain that the newly elected government would implement labour-friendly policies in South Africa.

Visser (2004:6) adds that prior to South Africa's first democratic election in April 1994, the ANC agreed in principle to adopt COSATU's Reconstruction and Development Programme (RDP), a programme that contained elements of social security, in return for COSATU's support in the elections. The RDP formed the basis of the ANC's election manifesto. Marais (2001:239) notes that the RDP was also an ideological reference point that appears to verify the political continuity between the Freedom Charter and the realism of post-apartheid South Africa.

The RDP battle cry was growth through redistribution, which aimed at meeting the basic needs of people, such as jobs, social welfare and education - it was the guiding government policy in the first couple of years of the Government of National Unity. The new government focused on satisfying the basic needs of the masses, eradicating poverty, investing in human capital as well as reforming the social welfare system in the country.

One of the strategies to meet the basic needs of the poor was the establishment of a social security system to assist the poor, disabled and vulnerable in society. During the short lifespan of the RDP, no significant gains were made to social security, particularly social assistance. Policies that were initiated during this time reached fruition in later years. For example, the government immediately recognised that

that the current State Maintenance Grant (SMG) was not reaching the majority of the poor and needed to be reformed. Consequently, the Lund Committee on Child and Family Support (from now on referred to as the Lund Committee [1996]) was established to review and make recommendations regarding the SMG. The SMG, just before the end of apartheid, was R430 per month for the mother and R135 per child. This changed in the 1997/8 budget when the grant to mothers was abolished and children only received R75 per month. By then, the RDP had officially been replaced by the Growth, Employment and Redistribution (GEAR) strategy as the economic policy of government. Although changes may have transpired in later years, some social security initiatives (Child Support Grant) have their heritage rooted within this period.

Nevertheless, Visser (2004:7) notes that social security was extended to cater for the aged, the disabled, foster parents and many others who were too poor to meet their basic social requirements. The government also started providing free health care for pregnant women and children under the age of six; and free meals were provided to between 3.5 to 5 million school children (Heymans, 1995:57).

Whilst the RDP proposed an increase in social services to the poor (such as a million houses, the provision of water and electricity, increased employment and health and education), it seemed too ambitious and expectations seemed too high. The RDP did not spell out a detailed programme for attaining its main aims. It was too broadly formulated and ended up as a wish list for too many people (Terreblanche, 2003:109).

The government had difficulty meeting the ambitions and satisfying the targets of the RDP. The lack of skilled staff with the implementation skills, the huge backlogs, incompetence of provincial administration, and bureaucratic and political infighting resulted in dissatisfaction with the RDP. Terreblanche (1999:4) states that the one possible interpretation for the government's sudden abandonment of the RDP in 1996 was that government realised then that they did not have the capacity (manpower, administrative, governmental and state) to implement fundamental reconstruction of the economy which was necessary for the RDP. Visser (2004:7) notes that by March 1996 only R5 billion of R15 billion allocated for reconstruction and development had been spent.

This was compounded by the economic realities that were prevailing at the time. Economic growth rate was around 2.5 per cent against the hoped for 4-6 per cent that was necessary to mobilise resources to meet the goals of the RDP. As economic realities began to dominate political discourse, the government decided to re-think the RDP, and that the focus should be shifted to economic growth.

This was noted in the White Paper on Reconstruction and Development in 1994 which differed significantly from the original RDP policy where the emphasis was on macroeconomic management of the economy with limited fiscal space to implement poverty alleviation strategies and poverty reduction (Terreblance, 2003:109).

The economy strategy had to be revised and although the social objectives were noble, the economic growth necessary to generate the fiscal resources was not taking place.

6.3 Growth, Employment and Redistribution (GEAR)

GEAR attempted to address the misgivings of the RDP, in order to stimulate economic growth. There was a shift from the demand driven neo-Keynesian Reconstruction and Development Programme (RDP) to the supply-side/new classical paradigm, the Growth, Employment and Redistribution (GEAR) [Terreblanche, 1999:5].

The difference between RDP and GEAR was that whilst RDP expected the state to conduct a people-oriented development policy; GEAR saw economic salvation in a high growth rate that translated to a sharp increase in private capital accumulation. Visser (2004:9) eloquently articulates that the difference between the RDP and GEAR was that whilst RDP emphasised "growth through redistribution" GEAR emphasised "redistribution through growth". The GEAR argument was that growth had to come first and welfare second, whilst the RDP argued that immediate redistribution programmes would boost economic growth by enhancing productivity and consumer demand.

The government's task in this was to refrain from economic intervention and to concentrate on the necessary adjustments that would create an optimal climate for

private investment (Terreblanche, 1999:5). The poverty problem would be resolved through higher growth rates and the alleged 'trickle-down' effect.

The prescripts of GEAR included reducing the current account deficit, the lowering of tariff barriers to be more competitive, liberalisation of the exchange control, and the introduction of inflation targeting. Furthermore, government spending had to be limited and the budget deficit should not exceed 3 per cent of GDP. GEAR also intimated a cut back in government expenditure with a resultant reduction in social spending. The implication of GEAR from a social security perspective was that social welfare realities had to take a back seat to macroeconomic imperatives which would deliver the resources for social needs. The focus on reducing the budget deficit meant social expenditure would not increase as envisaged by RDP and reallocation had to take place within the existing budgets.

Although some of the targets set in GEAR between 1996–2000 were realised, many macroeconomic objectives fell far short. In the period 1996-2001, the economy grew by only 2.7 per cent a year instead of the 6 per cent as originally envisaged, with a resultant loss of 1 million jobs as opposed to a target of an additional 1.3 million jobs that were to be created (Terreblanche, 2003:117). This was compounded by the 'jobless growth' South Africa experienced in both the public and private sector. South Africa's unemployment rose from 16 per cent in 1995 to 30 per cent in 2002, and when one uses the expanded definition of unemployment; then unemployment was at 43 per cent (Visser, 2004:14).

Suffice to add that GEAR did not make any significant impact on poverty alleviation. In fact, during the GEAR era poverty and inequality became more entrenched. Welfare spending fell from 9.6 per cent of the total budget in 1998/99 to 9.3 per cent in 2000/01; and health spending from 12.2 per cent to 11.7 per cent (Van der Walt, 2000:74). The redistributive impact of social transfers were insufficient to make a difference to the lives of those trapped in the cycle of poverty. GEAR actually set no redistributive targets.

Social welfare expenditure had been declining in real terms even before the adoption of GEAR. In the 1996/7 budget, spending on grants increased by 7.4 per cent, and poverty alleviation by 1.6 per cent and health only increased by 0.5 per cent, which

were all below inflation, representing a real decline in spending (Van der Walt, 2000:72). There were also open budget cuts. Subsidies to old age homes were cut by R50 million, and expenditure on primary school feeding scheme programmes declined from R623 million to R500 million (Van der Walt, 2000:72).

The State Maintenance Grant in the late apartheid period was R430 per month for the mother and R135 per month per child up to the aged 18 for 2 children. This grant (section 6.4.2.8) was extended to all children but only up to the age of 6 with an amount of R75 per month; and the grant to mothers were abolished. Van der Walt (2000:73) adds that while the government insisted (unconvincingly) that this amount was sufficient to feed and clothe a child, social advocacy groups estimated that the new schedule effectively meant a cut of R2.5 billion on child welfare services.

This led to calls from many quarters (including the other partners of the alliance) being critical of GEAR. The ANC led government had unilaterally set priorities and budgets that would be committed to social priorities. In contrast to RDP, GEAR was not the result of consultation with COSATU and SACP of the tripartite alliance. This led to disagreement within the alliance, as GEAR's central objective was that the private sector should lead the economic development, with the state playing a lesser role.

COSATU felt that GEAR was responsible for the hardships endured by the poor. COSATU's President, John Gomomo, (1997) complained about the lack of job creation and redistribution and that social spending had been severely cut as a result of GEAR; whilst COSATU's first Vice-President, Connie September (1998), complained that COSATU members had to carry the burden (by means of taxes) of providing a social security net for the unemployed which in fact was the responsibility of the state. However, COSATU and SACP did not explicitly call for the government to abandon the policy at its 6th National Congress. This is indicative of the relative strength of the ANC vis-à-vis the other partners in the alliance.

After consultation with various stakeholders a draft White Paper on Social Welfare was published in 1995 (and adopted by cabinet in 1997) which was in line with the social developmental approach. Midgley (2001:267) argued that the new South

African government restored the social development approach and moved it into a position of prominence. The White Paper indicated that there should be an improvement in welfare spending and argued that the state should be the last resort for social assistance. Van der Walt (2000:72) indicates that the White Paper favoured the phasing out of benefits in favour of 'development programmes' to train the poor to support themselves. The White Paper even intimated, that where possible, the aged should be removed and looked after by community structures (Van der Walt, 2000:72).

According to GEAR and the White paper on Social Welfare – social welfare spending can only increase by increasing economic growth which will result in higher tax revenue for the state. The government was aware that the social security system that was in place was not reaching many of the most destitute, and instituted a commission of inquiry to have a look at the overall social security system in South Africa and make recommendations. In 2002, the Committee of Inquiry into a Comprehensive Social Security for South Africa (Taylor Committee) was formed. It was headed by Professor Vivien Taylor, who was assisted by many experts in the field of social security policy. The main recommendations put forward to change the system included:

- a. Simplifying the foster care procedure to make it easier for people to claim it (Taylor, 2002: 59).
- b. Increasing the Child Support Grant (Taylor, 2002: 61).
- c. Paying an old age pension to men and women when they turn 60 years (Taylor, 2002:98).
- d. Revising the criteria for care dependency grants to include children with moderate and mild disabilities as well as severe chronic illnesses (Taylor, 2002:105).
- e. Revising the criteria for paying people a disability grant (Taylor, 2002:106)
- f. Paying a basic income grant of R100 per person per month (Taylor, 2002:134).

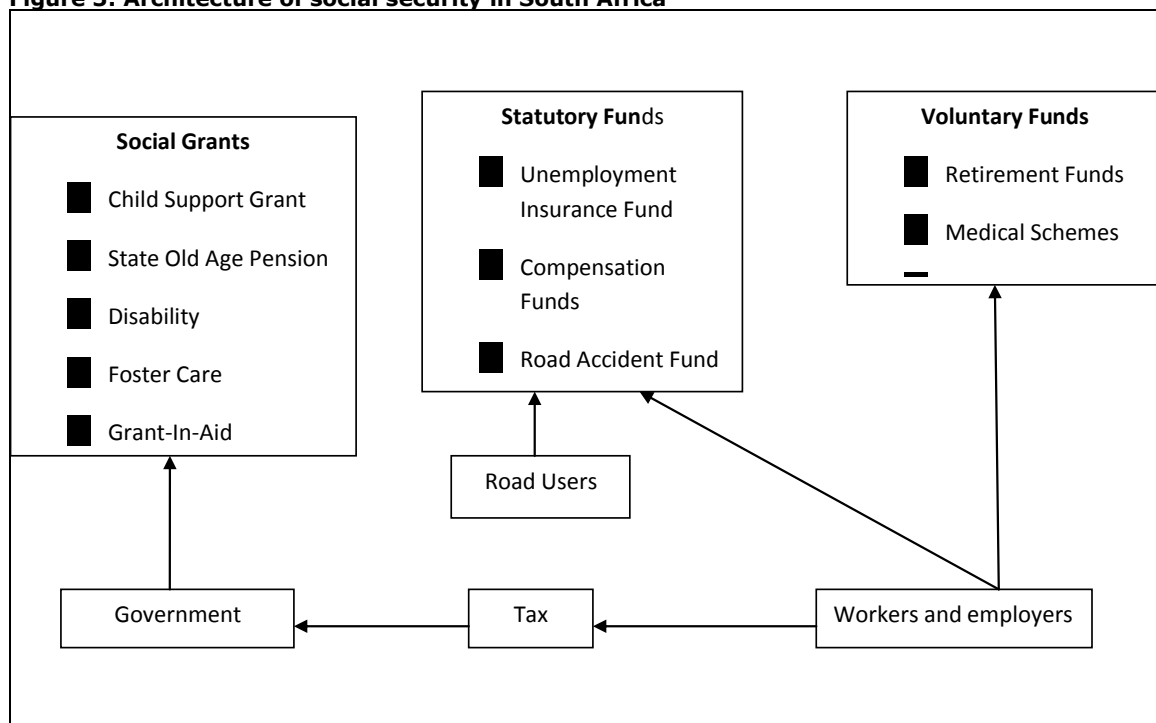
The 2004 ANC election manifesto reflected a turnaround in respect to government's socio-economic policy, as it indicated that the RDP would serve as its guiding strategy for the next ten years. The 2004 election heralded a series of shifts in policy on certain fronts from GEAR; which included an increase in government spending, expanding the social security net (although not Basic Income Grant [BIG]) and the

expansion of the Expanded Public Works Programme [EPWP] (Hart, 2006:26). President Mbeki launched the EPWP in May 2004 and in an address to Parliament, he stated that the government would improve social security to alleviate poverty. Mbeki also committed the government to step-up other social security programmes such as school nutrition programmes and increase the provision of free basic services (Mbeki, 2004). It would appear that Mbeki relented to the criticism from the alliance partners and began to re-embrace the RDP principles.

6.4 Current social security arrangements in South Africa

The prior discussion on the RDP and GEAR provided some insight as to the economic foundation for social security choices post 1994. The social security (for the purposes of this study) will be separated into social insurance and social assistance (section 2.2). The present social security architecture can be illustrated in Figure 3 below.

Figure 3: Architecture of social security in South Africa



Source: National Treasury, Budget Review (2010:102)

Social assistance is disbursed directly from government and is funded by taxes. Consequently, the main beneficiaries of social assistance are the elderly, the disabled and children, which is funded by the fiscus and is non-contributory; in contrast to social insurance which is contributory, and often compulsory.

6.4.1 Social insurance in South Africa

Social insurance comprises of statutory funds which are funded by road users (in the form of fuel levies) for the Road Accident Fund, and employees and employers from the salary bill for Unemployment Insurance as well as Compensation Funds. The contributions to these schemes are mandatory for most workers and employers. Social insurance for health (medical insurance) and retirement (pensions) [voluntary funds] can be voluntarily obtained from the private sector if citizens want more than what is provided by the state. People are not compelled to join, but most companies encourage membership by their workers, as there are tax incentives to participate (Budget Review, 2010:102). The number of recipients of social insurance in South Africa can be observed in Table 2 below.

Table 2: Social insurance arrangements in South Africa

	2006/07	2007/08	2008/09	2009/10
Unemployment Insurance Fund				
<i>Recipients per month</i>	154 546	140 086	164 301	207 967
Compensation Fund				
<i>Claims registered</i>	213 246	209 830	203 711	234 266
Road Accident Fund				
<i>Claims registered</i>	170 418	267 133	294 771	196 405
Medical Schemes				
<i>Members</i>	2 985 350	3 233 490	3 388 582	3 463 642
<i>Dependents</i>	4 141 993	4 371 746	4 486 244	4 636 935
Pensions and Provident Funds				
<i>Active Members</i>	7 370 436	7 273 897		
<i>Pensioners</i>	1 971 682	2 138 272		

Source: National Treasury, Budget Review (2010:103). Pension and provident numbers could be incorrect due to 'double counting'. Active members are estimated to be between 5 - 6.5 million

Many low income earners cannot afford the private medical insurance and retirement funds, resulting in low coverage by the private sector with many people dependent on the state. Nevertheless, the social insurance is an integral part of the social security arrangement in South Africa, which is deliberated below.

6.4.1.1 Unemployment Insurance Fund (UIF)

The unemployment insurance fund is an insurance scheme which was established to insure the contributors against the loss of earnings. The UIF contributes to poverty alleviation by providing short-term unemployment insurance to all that qualify for unemployed-related benefits (Estimates of National Expenditure [ENE], 2009:335). The UIF is an integral element of social security in South Africa as it prevents people from falling into destitution when they lose their jobs, by providing (albeit limited) a safety net until they find another job or come back from maternity leave.

UIF contributions are funded by both the employer (1 per cent) and the employee (1 per cent) in the private sector who works more than 24 hours a month. The contributions have a threshold of R97 188 per annum (R8 099 per month) [2010] and if a worker earns more than the threshold, the contributions are capped at 1 per cent of the threshold.

The UIF has recently been extended to include informal workers such as domestic and farm labourers who were previously exempt or did not qualify for UIF. Samon et al (2008:24) note that this exceedingly susceptible segment of the labour force can now gain unemployment, illness, maternity, death, and adoption benefits which they were previously denied. These efforts to extend coverage have been successful to some extent. According to Labour Minister Mdladlana (1998 -2010), the fund has paid out "more than R65 million to nearly 74 000 beneficiaries" including more than 500 000 domestic workers registered with the fund as of 2003 (Samson et al, 2008:25).

Presently, the recipient receives one day insurance for every six days that they have worked, and begin receiving benefits after 14 days of unemployment. The recipients are those who have contributed to the fund. There are different categories of unemployment benefits, namely; maternity, sickness, adoption, death and unemployment. This entitles recipients to benefits for a maximum period of 283 days after the loss of their jobs. The Income Replacement Rate (IRR) for this period varies from approximately 38 per cent for high income workers to a maximum of around 58 per cent for low income earners. The actual benefit is determined by a formula on a sliding scale which favours the lower income contributors. For example, a person

earning R150 per month will receive an IRR/UIF benefit of R87.96 (58.64 per cent); whereas a person earning R8 099 per month will receive an IRR/UIF benefit of R3 077.62 (38 per cent). Furthermore, a person earning R10 000 will only receive R3 077.62 as they would have only contributed for R8 099, although this translates into an IRR of 30.78 per cent.

This arrangement of the UIF has enabled it to remain solvent for the past years, despite the high unemployment levels in the country. In 2006/07, the revenue of the UIF was R9.5 billion, with expenditure of R3.6 billion; whilst in 2009/10 the revenue was estimated at R13.4 billion with an expenditure of R8.2 billion (Budget Review, 2010:107).

The total number of workers registered under the fund has risen from 4 million in April 2003 to around 6.5 million in 2005. The number of workers receiving benefits was 527 890 in 2007/08 for a total benefit pay-out of R2.9 billion (ENE, 2009:336). By providing the unemployed with a basic income, the UIF has helped many thousands of workers weather employment shocks. In addition, for the employed, it reduces the fear of losing work, thereby bolstering their bargaining position with their employer in terms of hours and fair wages. However, the UIF benefits only reach 5 per cent of the 5.2 million unemployed people in South Africa, highlighting the need to address the structural unemployment in the country (Budget Review, 2010:107).

6.4.1.2 Compensation funds

Compensation funds offer medical care and income replacement to workers who are injured at work or who develop occupation related illnesses, as well as survivor benefits to families of employees who were injured or killed, or disabled due to occupation related employment. Revenue for these funds is generated by mandated levies imposed on employers. Presently, there are four main compensation funds. These are:

1. *Compensation Fund* - This is administered by the Department of Labour and covers workers affected by occupational injuries and diseases, excluding the mining and construction industries. The fund is financially stable with a surplus of R6.5 billion and reserves of R13.9 billion in 31 March 2009 (Budget Review, 2010:109).

2. *Compensation Commissioner for Occupational Diseases (CCOD)* - This is under the authority of the Department of Health and provides compensation to miners and former miners who have contracted lung diseases due to their occupation. The CCOD spent R1 billion in 2008/09 to reimburse 5 227 claimants (Budget Review, 2010:109). However, significant backlogs still persist and administrative challenges continue to plague the organisation (Budget Review, 2010:109).
3. *Rand Mutual Association* - This organisation provides compensation to miners injured in the mining industry. The association dispensed R157 million to cover 22 263 claims in 2009 (Budget Review, 2010:102).
4. *Federated Employers Mutual Assurance (FEMA)* - This covers injuries suffered by employees in the construction industry. Payments are granted for reasonable medical expenses, temporary and permanent disability and pensions to the family when a worker dies. The FEMA registered 10 279 accidents with a resultant pay-out of R98.5 million; plus R37.5 million of pensions in 2009 (FEMA Annual Report, 2009:35).

These funds operate in isolation to one another and there is an opportunity to obtain efficiency gains if they are consolidated. For example, administrative costs could be lowered from economies of scale gains. Consequently, the government is aiming to achieve synchrony between the compensation funds as well as with other social security arrangements (Road Accident Fund [RAF]) in respect of financing and administration (Budget Review, 2010:109).

6.4.1.3 Road Accident Fund (RAF)

The objective of the RAF is to compensate victims for loss of income, and to pay general damages, and medical and funeral expenses to victims of road accidents arising from negligent or wrongful driving of another driver. The driver was previously indemnified against any liability for loss or damage wrongfully caused. The RAF is financed through a dedicated levy on fuel that is collected by the South African Revenue Services (SARS). The RAF had unlimited liability with consequently all damages proven being paid. The RAF had an accumulated deficit of R27.8 billion in 2007/08 (ENE, 2009:824). This dire financial position is due to the high accident rate and the payment of huge medical expenses, especially to those who utilise the private hospital system (Taylor, 2002:109).

Consequently, claims far exceed the revenue generated from the levies. Another criticism has been that the National Treasury does not raise the fuel levy in accordance with the escalation of medical costs (Olivier, 1999: xxvi). Other problematic areas include:

- a. Attorneys delaying claims, running up costs and overstating medical claims.
- b. Assessors are lodging fraudulent claims and false accounts.
- c. The legislation is seen to be complex and virtually incomprehensible to the average person (Olivier, 1999: xxvi).

The RAF Act was amended in 2005 and these amendments came into effect in August 2008. Among the amendments were the following:

- I. Damages for loss of income are capped at a maximum amount of R160 000 per year.
- II. Future medical expenses payable by the RAF will be paid according to tariffs based on health services in the public health sector.
- III. General damages (for pain and suffering, disablement, disfigurement, loss of amenities of life) are excluded in all cases save for injuries classified as serious.
- IV. A serious injury is an injury which results in 30 per cent or more of total body impairment. If an injury does not result in 30 per cent or more total body impairment, the injury may be assessed as serious if the injury results in serious long-term impairment or loss of a body function (Kapleus, 2008).

It is anticipated that these amendments will reduce the liability of the RAF, but the delays in the promulgation of the RAF reforms has resulted in backlogs of claims that need to be settled (Budget Review, 2010:110). Consequently, R5.2 billion was added from the fiscus between 2005/06 and 2008/09, as well as increases of 17c and 8c in the fuel levies in 2009/10 and 2010/11 respectively, to strengthen the liquidity and solvency of the RAF (Budget Review, 2010:110).

Moreover, further proposals have been drafted for a no-fault accident benefit scheme by the Department of Transport to reduce the increasing liabilities of the RAF (Budget Review, 2010:110).

6.4.1.4 Retirement funds

South Africa does not have a national or public pension scheme, but occupational and private pensions (and provident) funds are in place for retirement provision (Olivier, 1999:61). People, who have not participated in these funds and have not accumulated sufficient private savings, are reliant on the state Old Age Pension.

The South African private pensions sector, is founded on a well-established legal framework, sophisticated institutions and deep financial markets that cover mostly the formally employed or self-employed (National Treasury, 2007b:2) There are different forms of private retirement funding in South Africa, which are:

1. *Pension funds*: "These are funds established for the purpose of providing annuities (normally in the form of monthly pensions) for employees on their retirement from employment. In terms of income tax legislation, not more than one-third of the annuity payable may be commuted in a lump sum – accordingly, at least two-thirds of the benefit must be paid as a pension for the rest of the pensioner's life"(Olivier, 1999:61). These funds are based on defined benefits.
2. *Provident funds*: "These are funds established solely for the purpose of providing benefits for employees on retirement or solely for the purpose of providing benefits to a deceased member's dependants or for a combination of both. The benefits may be paid by way of a lump sum. No employee contribution is tax deductible" (Olivier, 1999, p.62). These funds are based on defined contributions.
3. *Umbrella funds*: "These are either pension or provident funds that a group of employers can join. These multiple employer funds are typically sponsored by a financial services company. Essentially employees working for different employers or organisations are consequently fully funded" (Van der Heever, 2007:3).
4. *Segregated funds*: This is when the investments of a pension scheme are managed by an insurance company independent of other funds under its control (Van der Heever, 2007:3).
5. *Retirement annuity*: This is a personal pension that is taken out by an individual with a private life assurance company. Contributions are made to the fund and are not available to the member until they reach the age of 55. The person can only withdraw prior to 55 if they are disabled (Van der Heever, 2007:3).
6. *Preservation funds*: When an employee leaves his/her occupation, he/she may not be able to transfer his/her pension to the pension fund of the new employer. This option enables them to place their 'retirement saving' somewhere until such time they can use a more appropriate vehicle. The rules of the ex-employer fund dictate the rules applicable in the preservation fund (Van der Heever, 2007:3).

The private pension environment is diverse consisting of more than 11 271 private pension funds including occupational funds, provident funds and retirement annuity funds as of 31 December 2008 (Financial Service Board [FSB] Annual Report, 2010:63). The total number of members in retirement funds for this period is 10 496 541, of which 8 557 228 were active members and 1 939 313 were pensioners, deferred pensioners and dependants (FSB Annual Report, 2010:63). It must be noted that there will be some double counting as people may belong to more than one fund.

Most (60 per cent) of these funds have less than 100 members, with the government employee's pension fund having approximately 1 million members as the largest pension fund (Budget Review, 2010:111). Although the coverage rate of formal employees of about 60 per cent is relatively high compared to countries with compulsory participation, the aggregate figure masks the limited access of lower paid employees or the self-employed employees to cost-effective retirement vehicles (National Treasury, 2007b:5). According to data from the 2006 Labour Force Survey, only 51 per cent of workers contribute to an occupational pension scheme (Budget Review, 2010:111).

Moreover, all workers are not covered and those workers that are covered, are not adequately covered to sustain their livelihood after retirement. It is further estimated that in South Africa, more than 50 per cent of people who retire with a funded pension, receive a retirement income of less than 28 per cent of their pre-retirement income (National Treasury, 2007b:5).

Another contributing factor is that numerous individuals 'surrender' their policies before they reach maturity. Also people may use the accumulated benefits when they switch employment rather than placing the money in a preservation fund if they cannot carry over the pension to the new employer.

The inaccessibility of social insurance to the poor also results in too many households being reliant on social assistance (Child Support Grant and Old Age Pensions) as the sole means of support. The net result is that many South Africans reach retirement age without a funded pension benefit and are solely dependent on the state Old Age Pension as means of support in their old age.

The tax-incentivised private pensions sector favours higher-income individuals relative to low-income individuals. The low income earners are further penalised if they save as the means test for the state old age grant implies that they will forfeit some of their private pension. This creates a disincentive to save for their old age as they will lose the social benefits provided by government. Ironically, fiscal support for saving and income protection for the poor diminishes as their income rises, while the tax incentive for higher-income groups rises in value as lifetime income increases.

The current retirement funding framework strengthens the division between the rich and poor instead of bridging the gap between the two. This has provided the impetus for government to reform the pension industry so that it encapsulates more workers. Therefore, the intention of the Retirement Reform Project of the National Treasury is to expand on the positive aspects of the current system and thereby develop a more equitable framework in which saving, risk pooling, self-reliance and social solidarity are more anchored (National Treasury, 2007b:3).

Currently, no formal public pronouncements have been made on the outcome of the Retirement Reform Project of the National Treasury. Suffice to add that National Treasury will engage with the public in 2011 on the possibility of mandatory preservation of funds upon the change of jobs or in the event of divorce (Budget Review, 2011:107).

6.4.1.5 Medical insurance

The South African health care system consists of a well-resourced private sector in comparison to an under-resourced public sector. Most citizens in South Africa are dependent on the public health facilities for their health needs, as the cost of private health care is prohibitively high. Large cost increases and the exclusion of low income earners characterises private sector schemes. There are presently 7.9 million people who are covered by medical schemes with more than 40 million having no medical insurance (Budget Review, 2010:112). Yet, only 40 per cent of health care expenditure flows via the public sector financing intermediaries (primarily the national, provincial and local departments of health) whilst 60 per cent flows via private intermediaries (McIntyre and Thiede, 2007:36).

Consequently, more resources (human and financial) are in the private sector that services mainly the medically insured, whilst the overburdened state health facilities cater for the rest of the population. Furthermore, there has been limited growth in public health sector funding in the decade after 1994, whilst expenditure in the private sector continued to increase at rates far exceeding the inflation rate (McIntyre and Thiede, 2007:38, 41). This has been the primary reason for the stagnation in private medical coverage over these years as it has become largely unaffordable for most people.

These disparities manifest in the inequality of the services that are received by patients in public health facilities compared to the services received at the private health centres. Among the differences are:

- a. a pharmacist in the public sector serves 12 times as many patients as the private sector
- b. a general practitioner in the public sector serves 7 times more people than those in the private sector
- c. 80 per cent of specialist doctors work in the private sector and almost exclusively serve medical scheme members (i.e. less than 15 per cent of the population) [McIntyre and Thiede, 2007:36].

Not only does the public health sector suffer from a shortage of skilled personnel, but also infrastructure backlogs. Hospital and clinic visits associated with HIV/AIDS are approaching 30 million a year (Budget Review, 2010:112).

Government is acutely mindful of the inequity in health care in South Africa and has initiated reforms to improve health care delivery to South Africans. The proposals include the National Health Insurance (NHI) together with a 10 point strategy to revitalise the health sector (Budget Review, 2010:112). Consequently, a Ministerial NHI task team has been constituted to advise the Minister of Health on the formulation and rollout of the NHI. The process is still under discussions and is currently being formulated.

6.4.2 Social assistance in South Africa

The present social assistance framework consists primarily of social grants that are targeted to the disabled, the elderly and children who were born on or after 31

December 1993. Those children born after this date and younger than 18 will qualify for the grant. The eligibility criteria for qualification for the grant as well as the current value (2010/11) are reflected in Table 3 below.

Table 3: Social assistance arrangements in South Africa

Grant	Amount (2010/11) [R per month]	Eligibility Criteria	Means Test
Children's Grant			
Child Support Grant	250	Children born on or after 31 December 1993, and under 18 years old.	Applicable
Foster Care Grant	710	Children under the age of 18 who have been fostered as their parents are unable to care for them; or are absent, unfit or deceased. Can be extended beyond the age of 18 if the child is still attending school or special school	Non - applicable
Care Dependency Grant	1 080	Children under the age of 18 years who are in need of regular care or support services, given their disability	Applicable
Adult's Grant (18 years or older)			
Disability Grant	1 010	Adults under 60 years old and who are in need. Applicants must have a disability which leaves them unfit to support themselves	Applicable
Old Age Pension	1 010	Adults 60 years and older who are in need.	Applicable
War Veteran's Grant	1 030	Adults 60 years and older who are in need and who served in a World War and/or the Korean War.	Applicable
Grant-in-aid	250	Adults of any age who are in receipt of a Disability Grant, War Veterans' Grant or Older Person's Grant and are in need of regular attendance by another person.	Non - applicable

Source: National Treasury (Budget Review, 2010:103); Blacksash (2010:133)

Furthermore, most grant beneficiaries (or their caregivers) have to be judged in 'need' in terms of a means test to qualify for the grants.

6.4.2.1 Means test for qualification for social grants in South Africa

The means test is applied to justify the 'need' for the household, besides any other criteria (e.g. age) that the recipient must fulfil. Means tests usually impose a pecuniary limit on the income of the family or the recipient for the person to qualify for the benefit, whether it is a cash transfer or/and in-kind transfer. Tabor (2002:4) notes that means tests establish eligibility against some standard criteria to qualify for the cash.

Table 4: Means test for social assistance

	2010/11
Child grants	Rand (per annum)
Child Support Grant	
Income: single caregiver (and dependent children)	30 000
Income: married caregiver (and spouse and dependent children)	60 000
Care Dependency Grant	
Income : single caregiver	129 600
Income: married caregiver (and spouse and dependent children)	259 200
Foster Care Grant	
No means test	
Adults grants	
Disability Grant/ Old Age Pension/War Veteran's grant	
Assets: single person (and dependent children)	518 400
Assets: married couple (and dependent children)	1 036 800
Income: single person (and dependent children)	31 296
Income: married couple (and dependent children)	62 592

Source: Blacksash (2010:137)

The means test for adults to qualify for social assistance consists of the assets of the individual and his/her spouse as well as his/her income or the combined income of both spouses. The means test is exclusive to other criteria (e.g. age, disability) that determine whether the person/household is in need.

Consequently, a single adults' assets must be less than R518 400 per annum, for him/her to qualify for the Disability Grant/Old Age Pension/War Veteran's Grant. There is an income threshold of R31 296 per annum for single persons and R62 592 per annum for married persons above which a person will not receive the grant. Below this threshold, recipients receive the grant on a sliding scale, where their benefits increase inversely to their income up to a 'floor' of R2 608 per month where the individual will only receive R100 grant a month. Conversely, an individual whose income is less than and equal to R648 per month will receive the full benefit.

In the following sections the main social security transfers that are disbursed in South Africa will be discussed. The Grant-in-aid is disbursed to people who are in receipt of the Old Age Pension, Disability Grant or the War Veteran's Grant and requires full time care by someone else, with the value of the grant being R250 per month. There were 53 237 recipients of the Grant-in-aid (GIA) by March 2009 (Development Indicators, 2010:27). Expenditure on this grant has increased from R67 million in 2006/07 to R95 million in 2009/10 (ENE, 2010:362). Since this grant is not a stand-alone grant, but one which augments the other grants, it is not discussed separately. The grants that GIA supplement, namely Old Age Pension and the Disability Grant are the ones that are discussed in depth, and not the GIA. Hence, the GIA can be seen to be contributing to the objectives and outcomes of these grants.

6.4.2.2 South African Social Security Agency (SASSA)

Until 2008, funding for social grants was transferred to provinces as part of their equitable share allocation and was subsequently disbursed through contracted private parties, with delivery varying across the provinces. A government committee reviewed the social security system and identified numerous problems associated with provincial deliverance of social grants. Among the problems identified were the delays in processing and approving applications, difficulty in accessing payments once they were approved and a significant amount of fraud. Furthermore, the decentralised arrangement restricted negotiating power of government as well as achieving economies of scale efficiencies.

These factors were instrumental in the government setting up a national government agency, the South African Social Security Agency (SASSA) to manage the social grants; under the stewardship of the Department of Social Development. The SASSA was set up to improve service delivery of social assistance (grants) to the poor. It was envisaged that the establishment of the SASSA as an entity (independent of the Department of Social Development) focussing exclusively on social transfers will lead to improvement and administration of the social grants as well as a decrease in fraud and leakage in the system (ENE, 2006:390). The funding arrangement was revised from a conditional grant that was paid to provincial departments from the National Department of Social Development (DOSD) to a grant that is paid directly from the DOSD to SASSA in 2005. The management of SASSA is overseen by the DOSD, and

the Minister of Social Development has executive authority over the institution. The number of grants recipients can be observed in Table 5 below.

Table 5: Number of grant recipients, 1996/97 - 2009/10

	Old Age Pension	War Veterans Grant	Disability Grants	Foster Care Grant	Care Dependency Grant	Child Support Grant	Total
1996/97	1 637 934	13 473	711 629	42 999	2 707		2 408 742
1997/98	1 697 725	10 525	660 528	43 520	8 172		2 420 470
1998/99	1 812 695	9 197	633 778	46 496	16 835	21 997	2 540 998
1999/00	1 848 726	7 908	607 537	49 843	22 789	150 366	2 687 169
2000/01	1 900 406	5 617	655 822	66 967	33 574	1 111 612	3 773 998
2001/02	1 903 042	5 336	694 232	67 817	34 978	1 277 396	3 982 801
2002/03	1 943 348	4 638	840 424	83 574	42 355	1 998 936	4 913 275
2003/04	2 050 572	3 996	1 228 231	120 571	76 494	2 996 723	6 476 587
2004/05	2 124 984	2 963	1 293 280	195 454	86 917	4 165 545	7 869 143
2005/06	2 146 344	2 817	1 315 143	317 434	90 112	7 075 266	10 947 116
2006/07	2 195 018	2 340	1 422 808	400 503	98 631	7 863 841	11 983 141
2007/08	2 229 550	1 924	1 408 456	454 199	102 292	8 189 975	12 386 396
2008/09	2 390 543	1 500	1 286 883	474 759	107 065	8 765 354	13 026 104
2009/10	2 534 082	1 248	1 310 761	569 215	119 307	9 424 281	13 958 894
Average annual growth (%)	3.4%	-16.7%	4.8%	22.0%	33.8%	73.5%	14.5%

Source: SASSA (Annual Report 2008/09:18); National Treasury (Budget Review, 2010:105)

The number of grant recipients has increased from 2 408 742 to almost 14 million recipients in 2009/10 highlighting the government's commitment of alleviating poverty, which are deliberated in detail below.

6.4.2.3 War Veterans Grant (WVG)

The WVG is meant for South African citizens who fought in the First or Second World War or the Korean War. This grant is not meant for people who fought in the apartheid struggle. The Special Pensions Act makes provision for people who made significant sacrifices in fighting for a democratic South Africa. These people were unable to save for their old age or prevented from saving for their old age. The Act also specifies that their survivors may receive a pension or a lump sum in the event of the death of these individuals (Blacksash, 2010:112).

The current amount (2010/11) of the WVG is R1 100. Furthermore, the recipient of the WVG must not be maintained or cared for in a state institution and must not be in receipt of another social grant for himself/herself.

6.4.2.4 Disability Grant (DG)

A Disability Grant is intended for people who are physically or mentally disabled, unable to support themselves and unfit to work. The grant is permanent if your disability continues for more than a year, and is temporary if the disability exists for more than 6 months but for less than a year. The value of the grant is set at the level of the OAP which is currently at R1 080 per month. It only applies to people over the age of 18 and younger than 59 and is converted to an OAP after the person turns 60. Besides the age criteria, the individual must be judged in need in terms of the means test (like the OAP). The applicant must also submit a medical assessment confirming their disability.

However, there is also the condition that the recipient forfeits that grant once they get better. This has led to many TB patients absconding from treatment centres for fear of losing their benefits. Lamani (2007) notes that the absconding of patients with extensively drug-resistant tuberculosis (XDR-TB), a virulent and virtually untreatable form of TB, from hospitals, is reportedly causing alarm in South Africa.

The Treatment Action Campaign (TAC) [2008] argues that the current practice of cancelling the Disability Grant of drug-resistant tuberculosis (DR-TB) patients who are isolated in specialised DR-TB hospitals for prolonged periods of time and not providing social assistance to those living with chronic illnesses, is unconstitutional. The patients do not get better, become more resistant to treatment, and infect others in the process. Furthermore, these patients can only use state health facilities as they do not have the income to be cared for by the private sector. Hence, there is a need for a review of the relevance of this condition, as it creates a perverse incentive for the patients not to get better.

The number of recipients of the Disability Grant has grown steadily from 711 629 in 1996/97 to 1 310 761 at an average annual growth of 4.8 per cent, as can be seen in Table 5. Given the high prevalence of HIV/AIDS in South Africa and the high disease burden, it is to be expected that the number of DG recipients will grow. Furthermore, people who are HIV positive can qualify for a DG if their CD4 count is below 200. But people fear losing the grant if they get better, creating a perverse incentive for not getting better or going on to anti-retrovirals (ARVs). Many infected

individuals have to make the 'dreadful decision' of choosing to take ARVs and getting better or losing the grant and eventually dying. (Richter, 2007).

There is a need for government to review the conditions for the grant as well the conditions for exiting the grant as it creates an incentive for the patient not to get better.

6.4.2.5 Old Age Pension (OAP)

The Old Age Pension which was initially set at 65 for men and 60 women has been amended. The government in 2008 instituted policies to progressively equalise the qualifying age at 60. The complete equalisation of men and women will occur at age 60. The present value of the OAP is R1 080 per month (2010/11) for both men and women. The number of recipients of the OAP has increased at an average annual rate of 3.4 per cent from 1 637 934 in 1996/97 to 2 534 082 in 2009/10. The expenditure for 2009/10 on the OAP was R30 billion compared to the CSG which was R27.2 billion (Budget Review, 2010:106).

The Old Age Pension is subject to a means test which determines the benefits one obtains from the grant. Non-grant income is taxed at 50 per cent creating a perverse incentive to not declare any non-grant income or to transfer the income to non-qualifying members of the household before retirement.

Woolard (2003) examined the impact on poverty of the various types of grants and compared the per capita income with and without the pensions of the poorest 40 per cent of the population and the poorest 20 per cent (ultra-poor). She found that in the absence of the OAP, 55.9 per cent of the elderly would be in poverty, and 38.2 per cent would be in ultra-poverty. Assuming that all who qualified for the grant registered for the grant, she concludes that poverty among the elderly declines by 22.9 per cent and poverty among the ultra-poverty reduces to 2.5 per cent (Woolard, 2003:6). Pauw and Mncube (2007:33) find the result unsurprising as the pension is means tested and is targeted to the poor pensioners.

The OAPs assist more than the intended beneficiaries and contribute significantly to overall poverty alleviation in poor households. Old Age Pensions are sufficient to keep many of the poorest households out of the poorest quintile with households

that receive OAPs more likely to be in the second and third quintile rather than the poorest quintiles (Woolard, Harttgen and Klasen, 2010:20).

Maitra and Ray (2003:34-35) show that the households that receive private transfers and those that receive public pensions both have higher expenditure shares on food and education, and lower expenditure shares on alcohol, tobacco and entertainment than other households do. Case and Deaton (1996:27) find that female-headed households that receive a pension spend less on alcohol and tobacco than male-headed households that receive a pension. Samson et al (2008:6) note that the Old Age Pension was initially intended to provide a social safety net for the aged poor, who were vulnerable in the household because of “a decline in job opportunities, increased vulnerability to health conditions, limited mobility, discrimination in access to credit and financial markets, and changes in household composition and status”.

The Old Age Pension is instrumental in increasing household income of children in poor households as a large proportion of the elderly in South Africa live in multi-generational households (Woolard et al, 2010:21). In many South African households, the grandparents’ pensions provide financial support for their grandchildren who are left in their care as one or both parents are deceased. Samson et al (2004:69) find that those children who live in three generational African households with pensioners are 3.1 per cent more likely to attend school than those in three generation African households that do not receive a pension. Duflo (2000:21) finds that households including women eligible for an Old Age Pension reported significantly better weight-for-height indicators for girls, while there was no significant difference for boys or in households with eligible men.

All these studies indicate the effectiveness of the OAP to not only mitigate poverty of the elderly but of the poor population at large. Case and Deaton (1996:12) find that the Old Age Pension is well targeted to the poorest households and households with children.

In summation, there is substantive evidence to indicate that pensions improve the health of both beneficiaries and other household members; and women who receive pensions are more inclined to allocate these transfers in ways that benefit other household members, especially children (Woolard et al, 2010:24). Hence, transfers

of pensions to poor households are significant contributors to poverty alleviation in South Africa, which policymakers must be mindful of when considering conditionality of social transfers.

6.4.2.6 Care Dependency Grant (CDG)

These are for disabled children who need special care. The disability must be assessed by a medical doctor in a government hospital. The grant is paid to the natural parent, foster parent as well as the adoptive parent. The value of the grant is R1 080. A child who is fostered and disabled will qualify for both grants if the child is in need of special care. Among the conditions is a means test, the child must also live in adequate housing, receive the necessary medical and dental care and regularly attend school. A further condition is that the child must be tested at the age of 6 years to ascertain whether he or she needs special schooling.

The number of recipients of the CDG has increased from 2 707 in 1996/97 to 119 309 at an average annual rate of 33.8 per cent. Whilst the increase may appear large, it must be seen in the context of the low numbers who were initially accessing the grant.

It is notable that a CDG beneficiary does not receive a GIA unlike a DG recipient who can if they are deemed to need someone to look after them. However, it is probable that family members will have to look after these children and may have to stay at home with these children (Blacksash, 2010:82). Hence, there may be a need to review the GIA accessibility to CDG caregivers as well.

6.4.2.7 Foster Care Grant (FCG)

The FCG is intended for children who are placed in the care of a guardian due to their biological parents not being able to take care of them. The FCG is also available to refugees who adopt South African children. The foster parent is not the biological parent of the child. Foster parents are not restricted by the means test to qualify for the grant.

But there is a requirement that the child should not be receiving maintenance from the parent and that the child should not be receiving an income. There are other

conditions that the foster parent must satisfy, which include providing adequate food and shelter for the child, and making sure that the child receives the necessary medical and dental attention, as well as that the child regularly attends school. These also 'soft' conditions with no punitive measures for non-compliance.

The grant is not meant to mitigate poverty and therefore there is no means test that is applicable. But there is a large difference in the values between FCG (R710 in 2010/11) and CSG (R250 in 2010/11) which creates a perverse incentive for caregivers to apply for the FCG instead of the CSG if they have the opportunity to do so (Woolard et al, 2010:10). Furthermore, people could foster children within their extended family in order to receive the larger payment that accompanies the grant. This could be more pronounced after the age of 15 as that is when the CSG falls away, which was the age criteria for qualification for the CSG prior to extension to 18 years.

The Blacksash (Blacksash, 2010:72) refutes these arguments by noting that social workers determine whether a child needs to be fostered and if the potential foster parents are 'fit and proper' and willing and able to take care of the child, before the child is fostered. The fact that the child is looked after by the family may not necessarily be for the money, as the foster parent (grandparent/uncle) may be best suited as a family member to look after the child. It must be remembered that these foster children are not being looked after because of their poverty, but primarily because their parents are unable to look after them. Simkins and Dlamini, (1992) *in* (DOSD, 2006:37) note that the placement of children with relatives is a well-established practice among Black families. Also children in rural areas have traditionally been left in the care of their grandmothers to enable their parents to seek employment in cities (Vorster, 2006 *in* DOSD, 2006:37).

But there is no denying the strong growth in FCG beneficiaries in the last 10 years, as can be observed in Table 5. The number of recipients of foster grants increased from 42 999 in 1996/97 to 569 215 in 2009/10, at an average annual growth rate of 22 per cent; highlighting the increasing accessibility and demand for this grant. There could be various reasons for the strong growth for in FCG.

Firstly, there is an increasing number of children who are orphaned due to the death of their parents due to HIV/AIDS. The Health Systems Trust (employing the Actuarial Society of South Africa Aids Model) reveals that the number of maternal AIDS orphans younger than 18 years old, increased from 1 018 548 in 2006 to 1 674 359 in 2010. The FCG is increasingly being accessed to provide support to the guardians of children who have lost their biological parents due to the AIDS epidemic (Pendlebury, Lake and Smith, 2009:80).

Secondly, many children are cared for by their extended families or the community to enable their parents to seek employment in cities (Vorster, 2006 in DOSD, 2006:37). Thirdly, the process of approval of FCGs could have become more efficient and/or the increased uptake could be due to greater public awareness due to heightened media campaigns (Naicker, *in* DOSD, 2006:37).

6.4.2.8 State Maintenance Grant (SMG)

The SMG was the antecedent for the Child Support Grant (CSG). The state maintenance grant consisted of two components: a monthly parent allowance of R430 (same as the old age grant and disability grant at the time) and R135 per child to a maximum of two children.

This grant was inherited from the previous dispensation and did not cover most children, especially African children. The SMG for single parents of children under 16 was racially skewed. In contrast to the Old Age Pensions where the recipients were mostly African, the recipients of the SMG were mostly non-African children. Indian and Coloureds received a disproportionately higher number of the benefits than African children. White beneficiaries were 15 per 1 000 White children, Coloureds were 48 per 1 000 Coloured children and Indians were 49 per 1 000 Indian children (Makino, 2004:12). This was in contrast to 2 beneficiaries for every

1 000 African children (Health Systems Trust, 1997). The grant was seen as not impacting on widespread poverty and was limited in its action in reaching the neediest in society.

The Lund Committee was established in 1996 to look into revising the grant to reach more children. The Lund Committee (1996) asserted that extension of the SMG to reach racial parity will cost in the region of R5-R20 billion in contrast to the R1 billion that was currently being spent on the SMG. The Lund Committee (1996) concluded that it would be impossible to eliminate discrimination without reducing benefit levels and recommended the phasing out of the SMG and the phasing in of the CSG which was set at R70 without a parent allowance and set at a much lower age limit between 4 and 9.

The Lund Committee (1996) noted that given the fiscal constraints, it was realised that if the CSG was to be extended to more households or children that qualify, it had to be drastically reduced. Furthermore, it would not be able to cover all children. It was also going to impact on those households that had become dependent on the SMG.

Cabinet accepted the main recommendations and announced its intention to introduce a new child benefit of R75 for children up to the age of 6 with the phasing out of the SMG (Makino, 2004:13). This was met with strong opposition from civil societies and some academics. This led to the government holding public hearings where civil society organisations raised their concerns and recommended a minimum child allowance of R135 (Makino, 2004:13).

The country was now a democratic dispensation where disparities in social assistance were unacceptable, but extending the grant to all at the present levels was also not acceptable within the framework of GEAR. Makino (2004:13) adds that GEAR had a strong influence in the final recommendation of the Lund Committee as the recommendation reflected the underlying theme of the GEAR policy.

There was criticism from some quarters on the impact of the decisions of the Lund Committee would have on families that depended on the grant. But government, aware of the potential impact, decided to phase out the SMG. The government

relented to some pressure and set the CSG at R100 per child paid to the primary caregiver of children between 0-6 from April 1998 intending to reach 3 million children in 5 years. The 0-6 year olds were targeted as they were regarded as the most vulnerable to poverty, illness and development, and that nutritional feeding schemes would subsequently assist the child once they began attending school (Rosa and Guthrie, 2002:2).

The SMG was to be phased out over three years, and the CSG commenced on 1 April 1998. This meant that the beneficiary of SMGs would receive a final payment of R175 in March 2001, after which no more payments were to be made. In ensuing years, coverage has extended by the CSG to cover more children, but not to the levels of the SMG. Makino (2004:14) notes that in the history of social assistance in South Africa since 1928, the CSG benefit reform was the first and so far the only case of a drastic decrease in benefit levels of social grants. The cut down was to achieve parity, but some lost almost 90 per cent of state maintenance grants.

6.4.2.8.1 Child Support Grant (CSG)

The CSG came into effect on the 1 April 1998, and was provided at R100 per child for children under the age of 7.

The means test for the grant on inception in 1998 was based on household income, and the applicant had to meet the following criteria:

- a. Lived in a formal urban area and whose household income did not exceed R800 per month
- b. Lived in an informal urban settlement or rural area and whose monthly household income exceeded R1 100

6.4.2.8.1.1 Present conditionality of Child Support Grant (CSG)

There were certain conditions attached at inception to qualify for the grant, but none for subsequent monitoring of the grant. Although not explicitly conveyed as such, a child had to have a 'road to health card' which compelled the child to have all the necessary vaccinations. However, there was no follow up once the child was registered for the grant or an audit to determine if the child continued to receive vaccinations.

A further condition was that the applicant (who received the grant on behalf of the child) for the CSG was to participate in income-generating projects and should not decline to participate if there was a project available (Kola, Braehmer, Kanyane, Morake and Kimmie, 2000:12).

Leatt and Budlender (2006:7) note that in some areas in South Africa the conditions were 'illegally' being implemented. Goldblatt, Rosa and Hall (2006) reviewed the work done by the Gender Research Programme of the University of Witwatersrand and the Children's Institute of the University of Cape Town which focussed on the implementation of the CSG. They find evidence of unlawful application of conditionalities. Specifically they found that:

- a. Officials required clinic cards (in North West) or proof that the applicant is pursuing a maintenance claim against the father of the child.
- b. In Gauteng, some offices also required that the child be brought along when application is made, so that the child can be photographed. This is allegedly to prevent fraud.
- c. Other unlawful requirements include 'brown cards' from Department of Labour proving that the applicant had registered as a work seeker, or proof of the child's school attendance.
- d. In North West and Eastern Cape, applicants sometimes had to obtain proof from the traditional authorities, for example in respect of their (customary) marriage or residence. Obtaining this proof often required payment that applicants could ill afford (Goldblatt et al, 2006:25)

However, in June 1999 the 'conditions' concerning immunisation and job creation projects were scrapped and the means test was applicable to personal income rather than household income (Kola, et al, 2000:11). The immunisation requisite was removed as it discriminated against children who could not easily access these services (Leatt and Budlender, 2006:4). Furthermore, there was no continuous monitoring, and therefore a child that entered the programme when he or she was born but did not receive all the vaccinations, could obtain the grant. The child would not have to provide proof of completing the immunisation schedule. This was unfair to the child who applied for the grant and did complete the full schedule of vaccinations.

However, there have been discussions regarding introducing conditions. Chapter 6 of the new regulations of the Social Assistance Act that was gazetted in 2006 makes mention of such conditions. The conditions that are proposed for the receipt of the grant include:

- a. The child must have accommodation, be fed and clothed.
- b. The parent/guardian must ensure that the child receives immunisation and other health services.
- c. The child, if of school-going age, must attend school regularly.
- d. The recipient must use the grant for the benefit of the child.

The conditions, unlike the previous conditions which were for the qualification for the grant, will apply once they receive the grant. No policy prescriptions of how these conditions will be monitored are set, nor is there any mention of the disciplinary actions (punitive steps) for non-compliance with the regulations. These conditionalities of formal school enrolment and school attendance have been formally stated by the National Treasury (Budget Review, 2010:104). Specifically, from 01 January 2010:

Caregivers need to ensure that children for whom they are in receipt of a grant are enrolled and attending school. Regular proof of school enrolment needs to be submitted to the Department of Social Development, along with reports from the school. Upon receipt of any information regarding a child not attending school the Department of Social Development will send a social worker to investigate and put in place steps to ensure that the child attends school. While punitive measures such as stopping the grant are not envisaged, these provisions will allow government to improve school attendance and provide the necessary support to households where needed (Budget Review, 2010:104).

It is worthy to note that the conditionality is 'soft' as there is no punitive action or sanctions (e.g. stop the grant) if there is non-compliance. Moreover, there is no specific description of 'regular school attendance' and what criteria are used to distinguish between regular and non-regular school attendance. Woolard et al (2010:25) also note that the current shortage of social workers together with their present workload will make it difficult for them to monitor and intervene on behalf of the Department of Social Development.

It is notable, that no reports of sanction for non-compliance of conditionality have been recorded nor of the CSG being annulled because of non-compliance.

6.4.2.8.1.2 Impact of Child Support Grant (CSG)

Despite the implementation challenges, the CSG (as well other social transfers) have been instrumental in alleviating poverty in South Africa. When the CSG was first implemented it was poorly targeted and there was low uptake, with only 21 997 beneficiaries in 1998/99. The conditions and the confusion surrounding the implementation led to a slow uptake of the grants. This changed in the following years once eligible people began accessing the grant and when the 'conditionalities' were relaxed. By 2001/02 there were 1 277 936 children who were receiving the grant, but this was still far lower than the number of children who qualified for the grant.

In 2002 following President Mbeki's State of the Nation Address where he indicated a concerted effort by government to register those who were eligible for the grant, the National Treasury asserted that there was a 45 per cent increase in the size of the grant (Samson et al, 2008:22). It can be noted that there was a huge increase in CSG beneficiaries from 1 277 936 in 2001/02 to 1 999 936 beneficiaries in 2002/03.

The increase from 1 999 936 beneficiaries in 2002/03 to almost 3 million recipients in 2003/04 can be attributed to the phased extension of the CSG to children under the age of 14 that was announced in the State of the Nation Address in 2003 and began in that financial year. Subsequent years saw strong growth in CSG numbers as can be noticed in Table 5 above. In April 2009, the CSG was extended to children under the age of 15; and in October 2009, Cabinet approved the phased extension of the CSG to 18 over the next five years, commencing in April 2010.

Studies (Samson et al, 2004, Leatt and Budlender, 2006; Woolard, 2003 and Woolard, 2009) have shown that welfare transfers have made an impact on poverty. The CSG specifically has improved the lives of children. Current studies of the impact of conditional grants specifically demonstrate that the grant has had positive results in improving consumption choices of the poor. Hence, the poverty situation (especially among children) would have been much worse had they not been accessing the CSG.

Woolard (2003) assesses the impact of the Child Support Grant. She assumes that all children who are eligible for the grant access the grant and also assumes that the grant is pooled with other household financial resources (including pensions). Poverty is then estimated to decline from 33.1 per cent to 28.9 per cent, with the reduction of the percentage of children in poverty from 42.7 per cent to 34.3 per cent and with ultra-poverty falling from 13.1 per cent to 4.2 per cent (Woolard, 2003:9).

Samson et al (2004) of the Economic Policy Research Institute (EPRI) was commissioned to evaluate the impact of South Africa's social security in 2003. Using micro simulation modelling they evaluated the impact of grants on access to housing, electricity, water, schooling and health. Samson et al (2004:57) mention 2 ways in which social grants assist in improving education. Firstly, the grant can be used for costs such as books and transport. Secondly, the grants offset the opportunity cost of attending school. Also parents pay school fees which might improve the quality of education. However, this seems unlikely as the parents are already poor, and legislation already excludes parents who receive the CSG from paying school fees. The models of Samson et al (2004:69) reveal that a R100 increase in the grant will lead to a 3.8 per cent increase in full time school attendance.

Leatt and Budlender (2006:8) conclude that households in the lowest income brackets, who are most eligible for social transfers, are more likely to spend on education, which increases the impact of grants on school enrolment. Hence, it can be inferred that the current social security arrangement is improving access and utilisation of education services.

6.4.2.8.1.3 Child poverty

In spite of the large uptake of the grants there is still widespread poverty, which is impacting on children, and child poverty is still pervasive in South Africa. Although South Africa is a middle income country with a GDP per capita of \$5 600 (World Bank, 2008) it still has one of the highest levels of child poverty. Leatt and Budlender (2006:2) note that according to the 2005 household survey, 66 per cent of children in South Africa live in poor households, with 10 million of the 18 million children living in households that earn less than R800 in reported income per month.

An analysis of child poverty was undertaken for the Institute for Democracy in Africa (IDASA) by Ingrid Woolard. Using a R430 per month poverty line, she found that 75 per cent (13 million) children were living below the poverty line (Coetzee and Streak 2004:3). Furthermore, the plight of children is exacerbated by the large number of children living in households where there is no formal wage income. Budlender (2005:16) finds that only 42 per cent of 18 million children had an employed parent living with them in June 2004 whilst 59 per cent had an employed adult (parent or someone else) living with them.

Van der Berg and Bredenkamp (2002:2) demonstrating poverty analysis by cumulative density functions; conclude that whether one sets the poverty line at R3 000 or R1 500, the proportion of young children (0-6) in poverty is greater than the proportion of pension-aged people.

Moreover there has been no material improvement in social indicators (infant and child mortality) of poor children. Infant mortality (under 1 year) rates have declined marginally from 52 deaths per 100 000 live births in 2004 to 43 death per 100 000 live births in 2010 as per the Actuarial Society SA Model (ASSA) [Development indicators, 2010:37]; strengthening the case to make CSG (which is already in place) conditional, especially if health indicators do not improve significantly.

6.5 Expanded Public Works Programme (EPWP)

In 2002 the Taylor Committee (2002) proposed a Basic Income Grant as a way of extending social protection to the poor, but received an indifferent response from the government of the day. The government felt that the public works programmes would be better suited to remedy the structural unemployment and consequently mitigate poverty. Government was not oblivious to the plight of the unskilled youth who are mostly afflicted by unemployment and lack skills; and had implemented the Expanded Public Works Programme (EPWP).

The stubbornly high unemployment levels led to the government launching the Expanded Public Works Programme (EPWP) in 2004 to provide temporary work which would contribute to income and poverty relief. It was further envisaged that the

EPWP would assist the unemployed to gain skills while they work and improve their ability to earn an income.

The training component is considered to be central as the significant majority (70 per cent) of the unemployed youth have never been employed, and 69 per cent of all unemployed have never had a job before (Hemson, 2007:4).

The initial goal of Phase 1 was to create one million work opportunities of which at least 40 per cent of beneficiaries will be women, 30 per cent youth, and 2 per cent will be people with disabilities (Department of Public Works, 2010). It is important to observe that the EPWP achieved a couple of the targets that it set out to achieve. Most notable is that by 2008, the target of one million work opportunities was in sight of being achieved, and the targeted proportion of work opportunities for the youth and women (not disabled) were reached (Hemson, 2008:1). But the success of the EPWP has been hollow as it failed in critical areas. Hemson (2008:1) noted that the main shortcomings included:

- a. Decent work: minimum standards for length of a job are not being reached.
- b. Training: only 19 per cent of training targeted has been met.
- c. Actual spending: only 59 per cent of the funds allocated over 3 years have been spent.
- d. Wages: overheads and other costs are rising while wages are static.
- e. Earnings: earnings per job are declining over time.

Nevertheless, government has viewed the progress of the programmes as a success and has initiated Phase 2 which was launched in 2009 with the objective of creating two million full time equivalent (FTE) jobs as a means to halve poverty by 2010 (Department of Public Works, 2010).

There is no guarantee that the EPWP will have the intended impact of lowering poverty. Given the wide scale poverty and the targets of the EPWP, it is unlikely that the EPWP will have a significant impact on poverty in the short-term (McCord, 2002:26). The programme is plagued by multiple objectives and employs an implementation model which offers a single short-term period of employment and is therefore unlikely to have a significant social protection and employment impact in an economy that has obstinately high levels of unemployment and poverty (McCord,

2007:7). McCord (2007:8) also argues that the EPWP is not appropriate for South Africa as skills development in the absence of unmet labour demands for the skills being taught is fruitless.

Although the social security system is relatively well developed for a developing country, there are still significant areas for improvement as certain segments of the population who need assistance, are excluded. A more inclusive social security system is required to offer some sort of relief for the poor that find themselves excluded from any social security structures. This has led to calls for some type of guarantee of social security for all South Africans so that they have at least some type of social protection.

6.6 Basic Income Grant (BIG)

While the impact of social security on alleviation of poverty in South Africa is well documented, there are many segments of the population who are still marginalised, specifically, the unemployed, the informally employed, and many households who are just above the poverty line and do not qualify for any social assistance. The South African Council of Churches (SACC) [2001] notes that more than 13.8 million people in the poorest 40 per cent of households do not qualify for any social security transfers. Furthermore, many poor households do not have members receiving UIF, a state Old Age Pension, a Disability Grant, or any children qualifying for a State Maintenance Grant (SACC, 2001).

Consequently, some civil society groups argue that the constitution provides the legal mandate for government to provide for all its citizens, and the present situation violates the premise of social security for all the country's citizenry. This has been the impetus for proponents to call for the introduction of a Basic Income Grant (BIG) for all citizens. This is not the first time that BIG has been on the political agenda. The call for a BIG has been lying dormant for the past few years. It received a great deal of attention when it was first proposed by COSATU at the Presidential Job Summit in 1998 (Nattrass and Seekings, 2002:2). The BIG was one of the recommendations of the Taylor Committee for the alleviation of poverty.

6.6.1 Characteristics of a BIG

Essentially, the BIG will provide all households with a minimum level of income to enable the nation's poorest households to better meet their basic needs, to stimulate equitable economic development, to promote family and community stability, and to affirm and support the inherent dignity of all people (SACC, 2001). The main characteristics of the grant will inter alia include (SACC, 2001):

- a. *Universal Coverage*: The Basic Income Grant is intended for all citizens from birth to death and will not be subject to a means test. This would alleviate the administrative burden and also remove the stigma associated with welfare relief. Furthermore, a universal grant would be administratively easier to manage. There will be no need for a means test which will reduce administrative cost (the means test) and could counter corruptive practices. The BIG would remove the perverse incentive of people not looking for a job as they fear they may lose the grant should they find a job or should their financial situation improve
- b. *No substitute for existing grants*: The Basic Income Grant is meant to widen the net to include those households that cannot be reached by the present social security dispensation. The idea is not to have the present beneficiaries benefits reduced. The other grants would not be lowered to the value of the BIG, but by the value of the BIG. For example, if the BIG is set at R100, then the OAP would decline by that amount and the person will also receive the BIG. The net effect will be that the pensioners will receive the same amount as previously.
- c. *Delivery Mechanisms*: Payments of the grant can be managed by the SASSA. Disbursements of the grants could follow the same avenues as is presently the case with the current grants. Payments could be made through the post office, banks and other contractors that deliver social security payments to the rural areas.
- d. *Value*: Proponents have recommended a variety of amounts, usually in the range of R100 to R200. The final figure should be decided after extensive consultation with stakeholders and careful analysis of the fiscal implications.

But the BIG proposed in South Africa is a Partial Basic Income (PBI) in the sense that the proposed benefit level (R100 per month) is not sufficient to cover the basic needs, unlike a Full Basic Income (FBI) which does cover all the basic needs (Makino, 2004:4).

Moreover the BIG proposed in South Africa is in sharp contrast to the dole in the UK or a FBI, in that it does not cover all the basic needs, and would therefore not be a disincentive for work; and would not create dependency, especially if it is universal (Makino, 2004). The BIG has no means test unlike the 'dole system' which administers the orthodox means test to target the unemployed, unemployable and the poor (Samson, Babson, Haarmann, Haarmann, Khathi, Mac Quene and Van Niekerk, 2002:14). But it does have a fiscal impact which needs careful consideration before implementation.

6.6.2 Fiscal implications of a BIG

There is variance in costing calculation that has been proposed for BIG, which to some extent is determined by the underlying assumption to calculate the costs to the state. If one assumes that the population in South Africa is 50 million and a BIG of R100 per month; a simplistic projection would imply a cost of R5 billion per month or R60 billion per annum. South Africa's GDP for 2010/11 is estimated at R2.7 trillion (Estimates of National Expenditure, 2011:x). Consequently, the BIG will translate into 2.25 per cent of GDP in 2010/11.

Similar logic was employed by Van der Berg (2002b:4) when using a population of 45 million to calculate the BIG to be R54 billion without administrative costs. Assuming a R20 per month per beneficiary would increase the cost by another R10.8 billion resulting in a cost of R65 billion in 2002 (Van der Berg, 2002b:4). It is worthy to note that these figures were extensively quoted by the National Treasury and the Minister of Finance to lament the unaffordability of the BIG. The Minister of Finance told parliament after the release of Taylor Report, that BIG would cost more than R60 billion (Basic Income Grant [BIG] Financing Reference Group, 2004:37)

Naidoo (2002:37) using a R100 per month per person, calculated the cost to be R48 billion per annum but added that the cost can be reduced to R15 billion per annum once the government claims back the taxes. The majority of the cost of a Basic Income Grant should be recovered through progressive taxation. Hence, the rich would not necessarily benefit as the tax system will be reworked to ensure that the wealthy pay back the cost of the grant (Naidoo, 2002:2).

The recuperation of the BIG transfers by taxes is also a feature of the cost calculation by Samson et al (2002:26). Assuming a population of 44.9 million in 2001 of which 8.4 million are already eligible for social security programmes which will be excluded, a R100 per month per person will translate into a cost of R43.8 billion per annum (Samson et al, 2002:26). Micro-simulations of tax rates and income threshold through which most of the BIG will be recovered, yields a net cost of R23 billion per annum (Samson et al, 2002:26).

Hence, irrespective of the methodology employed, the cost of the BIG will have to be funded from government resources. There will have to be measures to raise more fiscal resources to fund the BIG without sacrificing other social expenditure. But Archer (2002:22) cautions that unless and until a range of questions are answered, the BIG could end up being a high risk bit of social engineering using exceptionally large quantities of resources.

But there is a cost for not acting as well, as the delay in implementation of the BIG will lead to more social costs in the long-run. Naidoo (2002:4) notes that delaying necessary spending to save money is false economy, because the cost gets higher once the damage is done. Furthermore, the impact of BIG alluded to above (decreasing the poverty gap and removing people out of poverty) provides justification for the BIG.

Criticism from many quarters (such as the National Treasury) regarding the disadvantages (such as the fiscal implications) have relegated BIG to a back seat in the policy agenda and government discourse. Although the National Treasury proclaimed no official position on BIG, Treasury representatives concluded that a BIG would require huge fiscal adjustments in overall spending levels and the ability to fund competing priorities such as health and education (Basic Income Group [BIG] Financing Reference Group, 2004:23). It must also not be forgotten that this was a period when the GEAR policy (referred to earlier) was at full throttle.

Matisonn and Seeking (2002:16) note that the government considered the administration more of a challenge than the financing of the BIG. However, the present administration of grants by the SASSA does provide ample evidence that they are capable of administering the grant. Besides administration should be less

cumbersome as the grant is universal and avoids the costs of registering, monitoring and evaluation of the grants and the conducting of the means test.

6.6.3 The need for a BIG

The purpose of the BIG is to help people improve their living standards, afford basic necessities, and ultimately improve health in communities and lessen the load on the health system. Furthermore, the grant would provide poor people with the income support to access government services, thereby improving the effectiveness of service delivery programmes and social policies (Taylor, 2002:62). The Taylor Committee (2002) noted that the full take up of the current social transfers will reduce the poverty gap by 37 per cent (0.8 million people) whilst the implementation of the BIG would reduce the poverty gap by 74 per cent (6.3 million people) [Taylor, 2002:63].

Another need for the BIG is the many people who are living with HIV/AIDS and who do not qualify for the disability grant, and are unemployed. Their medical and nutritional requirements cannot be sustained and they become more dependent on the state which could be more costly. The BIG will remove the perverse incentive for people (who receive the disability grant) not to get better and will provide some means (albeit limited) to cope with the malaise. The problem with allowing HIV positive people to keep their disability grant, even when their health has been restored (if that is another policy option) is a moral dilemma: why should the HIV positive individual be privileged over other people who may be equally in need and HIV negative? (Nattrass, 2005:15). Furthermore, the BIG will remove the criteria of which HIV patients should qualify and not qualify for the disability grant, as everyone will receive the BIG.

A key focus will be at the political agenda for the BIG. The universality of the grant makes political sense because the poorest of the poor are unable to mobilise and voice their grievances. SACC (2001) argues that BIG serves as a symbol of the solidarity of all South Africans in a national drive to eliminate poverty.

But the National Treasury was against the introduction as the former Minister of Finance, Trevor Manuel, felt that BIG was fiscally unsustainable. The then government head of policy co-ordination within the Presidency, Joel Netshitenzhe

commented that people should enjoy the dignity and reward of work and only the disabled or the ill should receive 'hand-outs' (Makino, 2004:21).

In August 2003 the Minister of Agriculture, Thoko Didiza, remarked that BIG should be carefully considered as it may create dependency. She further intimated that BIG should be linked to EPWP, so that the grant would not be seen as a 'mere hand out' (Makino, 2004:22). The ANC General Secretary, Kgalema Mothalane, said that the ANC disapproved of BIG as they felt that "we should assist the indigents in reclaiming their dignity rather than a dole system" (Makino, 2004:23).

Naidoo (2002:4) sarcastically notes that, in all probability, the poorest are already dependent on others, including abusive partners and spouses. Poverty, after all, creates the worst kind of dependencies. We are all dependent, after all. A man is dependent on his wife. A student is dependent on her teacher. Most of all, businesses and the rich in this country are heavily dependent on explicit and implicit state subsidies (Naidoo, 2002:4). It appears that the government's argument for not wanting BIG is more ideological than fiscal (Makino, 2004:21).

There have been calls for the EPWP (section 6.5) as a policy imperative to reduce poverty rather than the BIG as that creates employment as well as empowers people with skills. The weakness of this argument is that the EPWP will not achieve the same outcomes as the BIG (BIG Financing Reference Group, 2004:33). And even if EPWP is providing some income relief to poor households, not all poverty issues (child-headed households) can be addressed with public works programmes. Whilst one accepts that the EPWP is important, it cannot be seen as a serious strategy to mitigate mass poverty (Naidoo, 2002:2).

It has been clearly demonstrated by the Taylor committee (2002) that the EPWP and BIG cannot be pitted against one another as they are complementary, in that they have harmonising roles to play as part of a comprehensive social protection package (BIG Financing Reference Group, 2004:33).

It is believed that the union calls are not altogether altruistic and that their members could be net losers if it is implemented. Matisonn and Seekings (2002:21) contend

that the higher costs that may be borne by their members will provide justification at the bargaining chambers for demanding higher wages.

6.7 Summary and conclusion

In this chapter the focus was on social security in post-apartheid South Africa. In section 6.2 the RDP (which was the guiding policy for the ANC prior to coming into office) and its impact on social security was discussed. The RDP was working class friendly and advocated social security initiatives which it was hoped would alleviate poverty. However, the RDP was too ambitious and most of the targets were not realised and were soon abandoned in favour of GEAR.

The focus on GEAR was to stimulate economic growth which would realise the resources to improve the plight of the poor. This resulted in a real reduction in social expenditure which had little impact on poverty alleviation. This led to fierce debate within the tripartite alliance and an outcry from civil society which felt that it was the poor who were bearing the brunt of the neoliberal GEAR policy. In 2004, it appeared that the ANC had relented to the growing criticisms of GEAR and re-adopted the RDP philosophy as the guiding policy for the next ten years. Hence, the economic policy choices provide the backdrop of current social security arrangements in South Africa.

In section 6.4 the current social security framework in South Africa was examined. Social insurance in South Africa, comprises of the UIF, Compensation Funds, RAF, pensions and medical insurance.

The UIF provides temporary relief for unemployed people who have contributed to the scheme. The compensation funds (Compensation Fund, Compensation Commissioner of Occupation Disease, Rand Mutual, and Federated Employers Mutual Assurance) collectively cover all formally employed people affected by occupation injuries and diseases. The RAF exists to compensate people who are involved in motor car accidents. The RAF has consistently been in deficit and reforms have been initiated to improve its solvency.

The South African pension sector is sophisticated and well developed, consisting of over 11 000 private pension funds with more than 10 million (including double counting) members. Nevertheless, these funds have low coverage with many South

Africans reaching retirement with no or inadequate pensions. Consequently, many retirees are dependent on the state Old Age Pension. Furthermore, the means test may create a perverse incentive for low income earners not to save for their old age, with tax incentives favouring the high income earners relative to low income workers.

Private medical insurance only covers approximately 25 per cent of the population thereby constraining the public health sector. Most resources (e.g. doctors) and financing in South Africa is concentrated in the private sector. Consequently, the Minister of Health initiated strategies to improve the public health sector and the improve health coverage by establishing a NHI.

Social assistance in South Africa consists of the War Veterans Grant, the Disability Grant and Old Age Pensions which are meant for adults; whilst the Child Support Grant, Care Dependency Grant and Foster Grant are meant for children.

People who want to access the grants (except the Foster Grant and Grant-in-aid) have to be judged in need to receive the grant. The means test is utilised to determine if a person is in 'need' to qualify for the grant. Social grants are administered by SASSA which was founded to expedite social transfers in South Africa.

The War Veterans Grant has been declining over the years as the number of beneficiaries has been decreasing. The Disability Grant is for physically or mentally disabled adults who are unable to work or support themselves. It is noted that the poor HIV/AIDS patients are penalised for getting better as they fear they will lose the grant.

The Old Age Pension in South Africa is meant for adults who are older than 60 years of age. The Old Age Pension contributes to poverty alleviation in poor households, especially in three generation households. Moreover, pension in the hands of females were more beneficial (spend less on tobacco and alcohol) relative to male pensions.

The Care Dependency Grants are paid to parents who have children who need special care. The disbursement of the Foster Care is larger than the CSG, and may create an

incentive for extended family members to foster their relatives' children. There is also an indication of strong growth of the FCG over the years. But this is due to its easier accessibility to those who qualify and also the increasing number of orphans, especially those whose parents have died because of HIV/AIDS.

The State Maintenance Grant (SMG) was the predecessor to the CSG. Although benefits were generous, the SMG only covered a limited number of children, mostly excluding African children. The Lund Committee (2006) was established to make recommendations and reform the SMG. They proposed the CSG which came into existence in April 1998. The CSG initially had conditions attached, namely that the child receive all the necessary vaccinations, as well as the caregivers making themselves available for participation in income generating projects. These conditions (although not explicitly administered), were in part responsible for the slow take up rate, which improved in later years, once these conditions were lifted. Nevertheless, school enrolment and school attendance was attached as a condition (with no punitive measures for non-compliance) in January 2010.

The CSG has a positive impact on child welfare and even on poverty levels in the households. The CSG provides the household with the resources for better education and health. Although CSG has had positive impact on child welfare, child poverty still prevails in South Africa.

The EPWP is another initiative by the government to alleviate poverty, as the present security arrangement does not reach the unemployed poor. The impact has been limited with some experts arguing that the EPWP should be seen as complementary to other poverty alleviation strategies and not as a primary initiative to improve mass poverty.

In section 6.6 whether the government should introduce the BIG (which received a lot of attention in the late 1990s) was discussed. The BIG would be universal (not a substitute for the present grants) and not means tested. The fiscal implication of a BIG varies depending on the methodology of the costing approach employed.

Civil societies have called for the introduction of an unconditional BIG to provide some assistance to the most needy in society, but their pleas have met with very

little support from the government. In fact, the government is in favour of using conditional cash transfers to improve the lives of the poor. When delivering the 2008 National Budget, the previous Minister of Finance, Trevor Manuel (Budget Speech, 2008:09) indicated that the state was keen to implement CCTs to improve the lives of the poor. In essence, he felt that there would be better outcomes (education and health) for the money that government was spending on these services. CCTs are popular in many countries and they do have their merits as well as their challenges, which are discussed in section C.

Section C: Conditional Cash Transfers (CCTs)

Chapter 7: The economics of conditional cash transfers

7.1 Introduction

Social security policies have been instrumental in alleviating poverty (income poverty) in South Africa and many other developing countries. The poor are indeed targeted to receive social services such as health and education which are usually free for the poorest in society. Van der Berg (2009:16) notes that in 2006, the poorest 40 per cent of the population received more than 50 per cent of the value of social spending. The poorest 40 per cent received 57 per cent of the spending on public clinics, 49 per cent of the spending on education and 45 per cent of the spending on public hospitals (Van der Berg, 2009:16). Yet, the social outcomes for health (life expectancy) and education (literacy and numeracy) have not improved significantly despite the increased welfare spending on the poor. In fact, life expectancy has declined from 54.9 years in 2001 to 50.4 in 2010 (Actuarial Society SA Model); whilst the number of higher-grade mathematics passes has declined from 29 475 in 1994 to 25 145 in 2007 (Development Indicators, 2010:36 and 47).

Furthermore, poverty has become entrenched within families passing from one generation to the next despite the free health and education opportunities available to the poor, which policymakers expected would mitigate long-term poverty. Caldés and Maluccio (2005:166) argue that a major cause of intergenerational poverty is the inability of poor households to invest in the human capital of their children. The supply-side interventions alone which increase the availability of health and education services are often ineffective as resource constraints confronting poor households preclude them from bearing the private costs associated with utilising those services.

This had been the impetus for many countries to link the cash transfers to the poor on condition that they make use of these services in the hope that this will lift them out of poverty. The CCT is contingent on some action by the recipient that will improve his/her long-term situation.

But CCTs are wider in their definition and their application. Their implementation has occurred in different countries under different circumstances and the results have varied. The chapter commences (section 7.2) by scrutinising the definition of conditionality cash transfers, (specifically on the various interpretations of 'conditionality').

This is followed by section 7.3 where the characteristics of CCT are discussed, the main ones being CCT's focus on the neediest, female poverty and how the transfer is conditional, but not conditional on how the money is spent. The last characteristic; that receives attention is supply-side support which does occur in some CCT programmes.

In section 7.4 the economic rationale underlying CCTs, is analysed. The specific elements that are evaluated are CCTs ability to mitigate inconsistent decision-making, low participation, fungibility, the need for CCT because of imperfect credit and capital markets and the need to mitigate the principal-agent inefficiencies. The next economic principle that is examined is CCT as a conduit for the promotion of equity.

In the next chapter the international evidence regarding conditional cash transfers is evaluated.

7.2 Definition of CCTs

Although not explicitly mentioned, most social assistance to the poor is conditional. The fact that they have to be poor to qualify for assistance is conditional, that is, the person will qualify on condition that they are poor. Social insurance is also conditional as it is contingent on the risk (illness, unemployment, disability) being realised before any benefits are disbursed to the claimant. Therefore, most transfers are to some extent conditional on some factor. Schubert and Slater (2004:3) aver that although not always transparent, there is more often than not some form of conditionality in every cash transfer.

Some transfers do not necessarily depend on income, but are conditional on some other factor, such as age (pensions), disability or geography. But many of these social assistance transfers are also conditional in that the recipients undergo some

form of means test besides the explicit conditions of age or gender. Goldblatt (2005:247) refers to the notion of an identity document as conditionality, whilst Budlender and Woolard (2006:4) mention the requirement of obtaining immunisations and signing up for a development programme as a condition. But some of these conditions are merely an administrative compliance by the recipients. Lund, Noble, Barnes and Wright (2008:13) discuss the conditions that define a conditional transfer and how it differs from an unconditional transfer.

An unconditional transfer is one where the constitution or other legislation defines a right which becomes an entitlement for a person with certain characteristics who meets certain qualifications. When conditionality is introduced, the applicant meeting certain requirements to get the benefit must in addition conduct him or herself in certain ways in order to continue receiving it. Some things which are not conditionalities, however, act to exclude some who are eligible, and there are sometimes blurred lines between conditionalities and other requirements.

Lund et al (2008:13) comprehensively explain the underlying differences between the CCT and UCT; and is therefore appraised at length.

- a. Firstly, age and disability are characteristics of a person that are necessary to qualify for a grant and are not conditionalities.
- b. Secondly, identity documents or birth certificates are administrative requirements and also not conditionalities. The proof of socio-economic status or income is necessary for the means test. This is also not a condition but a mechanism for exclusion.
- c. Thirdly, there are requirements in the regulations called 'conditions' such as the child must be fed or clothed and stating how the grant has to be spent on the child. These 'conditions' cannot easily be monitored and they are not adequately spelt out in detail on how exactly they should be spent on the child.
- d. Fourthly, there are requirements created that attempt to regulate conduct such as immunisation or providing proof of having tried to obtain private support from the other spouse/partner (usually the father). These requirements begin to look like conditions but are not, but rather once off conditions of entitlement.
- e. Fifth, there is a category, which the authors regard as true conditionalities, and those are where the beneficiaries have to constantly do something (regular attendance of school) in order to continue receiving the grants. And any contraventions of the condition lead to punitive measures, which is usually a temporary halt of the transfer.

It is notable that the application of above five criteria as a foundation for conditionality excludes all of the current social transfers in South Africa as a CCT; but conditionality which is employed in this study pertains to the fifth criteria.

CCTs are in some ways, not unlike other transfers; but the main difference is that the recipient has to take some action in order to qualify for the cash transfer. De la Brière and Rawlings (2006:6) assert that the underlying precept of CCTs is the linking of cash to behaviour by providing money to poor families contingent upon certain verifiable actions, generally minimum investments in children's human capital such as regular school attendance or basic preventative health care. The behaviour that needs to be undertaken is pre-determined and usually very specific.

The conditions depend very much on what the specific country perceives as the underlying cause of poverty, as well as the area that needs investment to improve the socio-economic status of the poor. In most implementing countries, CCTs are part of a bigger strategy of social assistance in poverty reduction and assisting the most destitute in society.

Not all countries that implement CCTs define poverty in the same manner. In fact, some post-socialist countries (e.g. Lithuania) use CCTs as a means to assist the poor mitigate the costs of heat, electricity and water (Tabor, 2002:18). The cash transfer can also be reliant on the recipient participating in some work programme such as the Expanded Public Works Programme (EPWP).

7.3 Characteristics of CCTs

Besides the conditionality facet of CCT, they do share other characteristics which are common to cash transfers. Most CCTs are usually (although not exclusively) demand driven where they stimulate demand for social services such as health and education. It is assumed that the services (health and education) are provided and that the poor (for whatever reason) are not accessing them. Furthermore, it is assumed by the policymakers that if the poor make use of these services, this will ease the burden on the parents, improve the lives of the children and have long-term benefits for the state.

7.3.1 Focus on the neediest

Much of the poverty that prevails in developing countries is transmitted from ones' parents, which makes it morally unacceptable. Bourguignon, Ferreira and Walton (2007:37) argue that the differences that occur as a result of circumstances over which individuals have no control such as race, family or background are often regarded as an inequality of opportunity, and make the case for cash transfers as a suitable instrument for compensating families who suffer from the inherited disadvantage. The CCTs (as with many social assistance initiatives) are programmes that are meant for the poor. They are mainly targeted to the poorest households to not only mitigate current poverty, but to prevent poverty from being transmitted to the next generation.

7.3.2 Focus on female poverty

Studies (see section 6.4.2.5) have shown that investing in women yields longer-term benefits for the household than if the money went to the male head of the household. Females will spend more on households and their children relative to males. A growing body of literature in recent years has drawn attention to the existence of considerable disparity in resource allocation inside the household, especially along gender lines (Dasgupta, 2001:1712). A study by Quisumbing and Maluccio (2000:53-58) revealed that women tend to increase the share spent on education. This is despite the fact that women have fewer resources than males within households.

Simister and Piesse (2003:166) reveal that many studies in Africa demonstrate that when females in households have control over resources, significantly less is spent on alcohol and more on nutrition. Children benefit from female pensions as was demonstrated by Duflo who found "...that pensions received by a woman led to a sizeable increase in the height of girls, showing that cash transfers can have an important effect on a child's health" (Duflo, 2000:21).

Fiszbein and Schady (2009:9) assert that mother's priorities are usually aligned with those of her children, specifically her daughters. Consequently, many CCT programmes are biased toward women or girl children or the female head of the household. This has been the underlying motivation for granting the cash transfer to the mother instead of the father in many CCT programmes.

CCTs are usually implemented in societies that have large gender disparities. When there are limited resources and only certain children can go to school and develop their earning potential; it is usually the male child that is chosen. The United Nations Children's Fund (UNICEF) [2007] finds that in South Asia, out of the 42 million children not attending school in the region, 24 million are girls which they attribute to gender discrimination, compounded by the caste system, class, religious and ethnic divisions that prevail in the region. Hence, the investment in girls' schooling may be lower even if returns on education for girls are the same or even higher than for boys. The main barriers to female schooling in South Asia are not only costs, but also parental pressure to marry once the girls reach puberty (Heijnen-Maathuis, 2008:11). These parents believe that girls are more costly as they have to pay dowries and that boys are more likely to look after their parents. CCTs are implemented to reduce the gender difference in access to education in these countries as well as to compel these parents to allow girls to attend school to reduce the disparities that prevail in the region.

7.3.3 The disbursement is conditional, but not conditional on how it is spent

An important distinction between a CCT and an in-kind transfer is that whilst the CCT transfer is conditional, that is, the beneficiary has to fulfil some condition (attend school); there is no condition regarding on what and how the transfer is spent. The beneficiaries can spend the monies as they see fit. The expenditure of the grant isn't conditional unlike in-kind transfers and vouchers where they have to be spent on specific purposes and/or redeemed at certain places only.

7.3.4 Supply-side support

The underlying principle for conditionality is that the services are available and the poor are not accessing them. However, the institution of conditionality may lead to an increase in demand for these services which the authorities may not be able to manage. There is sometimes supply-side support where a portion of the CCT budget is kept aside for improving the educational supplies and building schools and health centres. Son (2008:3) notes some CCT programmes do have a supply-side component, such as what has been implemented in South America. Specifically, the *Red de Proteccion Social* (RPS) in Nicaragua and the *Programma de Asistencia*

Familiar (PRAF) in Honduras have invested in infrastructure. Rawlings and Rubio (2003:5) show that some countries (such as Nicaragua) have strengthened the supply of health and education, where teachers receive a modest bonus per participating child, half of which goes to provide school provisions. Mexico sets aside resources for medicines that result from the demand that arises from the programme (Rawlings and Rubio, 2003:36).

7.4 The economic rationale of CCTs

There is little doubt that governments should assist the poor (irrespective of how they are defined), but there is often voluble debate about what form this assistance should take. Moreover, the debate sometimes extends to whether cash is the best tool to assist the poor. The proponents of CCTs assert that CCTs are better than other transfers (as well as cash) in satisfying the two main objectives in alleviating poverty, that is, to reduce current consumption poverty and promote the accumulation of human capital, and secondly to help break the vicious cycle of destitution whereby poverty is transmitted across generations (Schady, 2006:3). Another argument rendered by the proponents of CCTs is that they are more redistributive, especially when there is asymmetric information. That is, they are more equitable.

Governments have finite resources to expend not only on social services, but on other government priorities. In countries with a low tax base, governments may choose to invest in other programmes that will stimulate growth rather than spend on social assistance. Scarce public resources may yield better returns for the country if invested in infrastructure (roads, ports, schools and clinic) which can result in long-term gains for the country and the population. As mentioned in the previous chapter (section 6.2), this was the impetus for abandoning the RDP in favour of GEAR in order generate more growth which will translate into more revenue which will result in more funds available for social expenditure.

But economic growth may take many years to be realised whilst millions of people languish in poverty. Moreover, there is no assurance that economic growth is going to occur, that it is going to be high and sustainable enough to mitigate poverty; and more importantly, that it is going to be translated into better social outcomes (economic development). Hence, a need exists for some form of protection for the

most vulnerable in society. Van der Berg (2002a:1) argues that whilst improving the living standard of the poor requires economic growth and investment in human capital, a social safety net is required for those who has not benefited and to protect those against any contingencies such as unemployment, illness or disability.

7.4.1 Promote economic efficiency

The neoclassical orthodoxy (as with many neoclassical prescripts) assumes that markets are free and perfect and they allow individuals freedom of choice. In choosing for them, people maximise their utility and in doing so optimise society's benefit. Tabor (2002:1) asserts that cash transfers are less likely to distort prices and provide the recipient with much more choice.

Theoretical arguments assert that standard revealed preference choice sets are larger for unconditional transfers than if the same transfer is given in kind. Similarly, a consumer is better off with a cash transfer than when the good is subsidised for the same amount. The neoclassical comparison between an unconditional cash transfer and a conditional transfer can be observed in Figure 4 below.

Figure 4: Illustrative comparison between conditional and unconditional cash transfer



Adapted from Schüring (2010:10)

Figure 4 represents two households, one that receives the UCT (household 1) and one that receives the CCT (household 2). The two households have a choice between education and a bundle of other goods within a budget constraint of AB. An unconditional transfer moves the budget constraint to EC and consequently moves household 1 from indifference curve 1a to 1b, where it consumes more education and more of the other goods. Similarly, an unconditional cash transfer to household 2 would move the household from 2a to 2b. However, the imposition of the conditionality creates a budget constraint ADC which household 2 now confronts. Consequently, the household is on indifference curve 2c; where it consumes more (education and other goods) than before the transfer (2a), but less (other goods) than if the transfer was unconditional (2b). This standard economic demonstration assumes that households behave rationally and that the decision of the household (private) as well as society is the same. Hence, in this instance the UCT will be the optimal policy choice. The presence of market inefficiencies due to information constraints or incomplete altruism (section 7.4.1.5) in the household will result in

sub-optimal decisions, thereby justifying conditionality as the optimal policy preference (Schüring, 2010:10).

There is ample evidence that households will consume less of the conditioned good if the household was given an equivalent amount of cash, that is, they will consume more of other commodities than the condition goods (Das, Do and Ozler, 2005:57). Bourguignon, Francisco, Ferreira and Leite (2002:22) in an ex ante study of Brazil's *Bolsa Escola* programme found that unconditional cash disbursements would have no significant impact on school enrolment. This was further highlighted by Cardoso and Souva (2003:22) who also find that the conditionality was instrumental for successfully increasing school attendance in Brazil.

7.4.1.1 Mitigate inconsistent decision-making

Many social services such as education and health are seen as merit goods. These are goods/services from which society derives a higher utility than the individual consuming the good. Possible reasons for not investing includes conflicts of interest within the household or if they are short-sighted. Households may not fully appreciate the positive externalities when making decisions regarding their investment in human capital. A justification for CCTs relies on imperfections in private decision-making by the poor themselves.

When addressing problems in human capital investment in children, externalities appear to be the norm rather than the exception. Children cannot make decisions on their human capital investment and rely on their parents to do this on their behalf. The parent or the individual may have limited information to make 'rational decisions' - bounded rationality. The parents may be poorly informed and may not make decisions that are in the best interests of their children, justifying the need for the conditionality. And since the benefits of education are long-term, the argument goes that the benefits of child labour may be short-term, which the parents may prefer but which will lead to a lower societal outcome. If individuals (or their parents) are limited in their ability to make an appropriate judgement (such as the positive effects of schooling) due to bounded rationality, conditionality acts as the proxy for the paternalistic government to persuade parents to make decisions that will be favourable for their children. The conditional payment increases efficiency by

internalising the externality to avoid any inconsistency between private and social supply of children's education (De Janvry and Sadoulet, 2006:4).

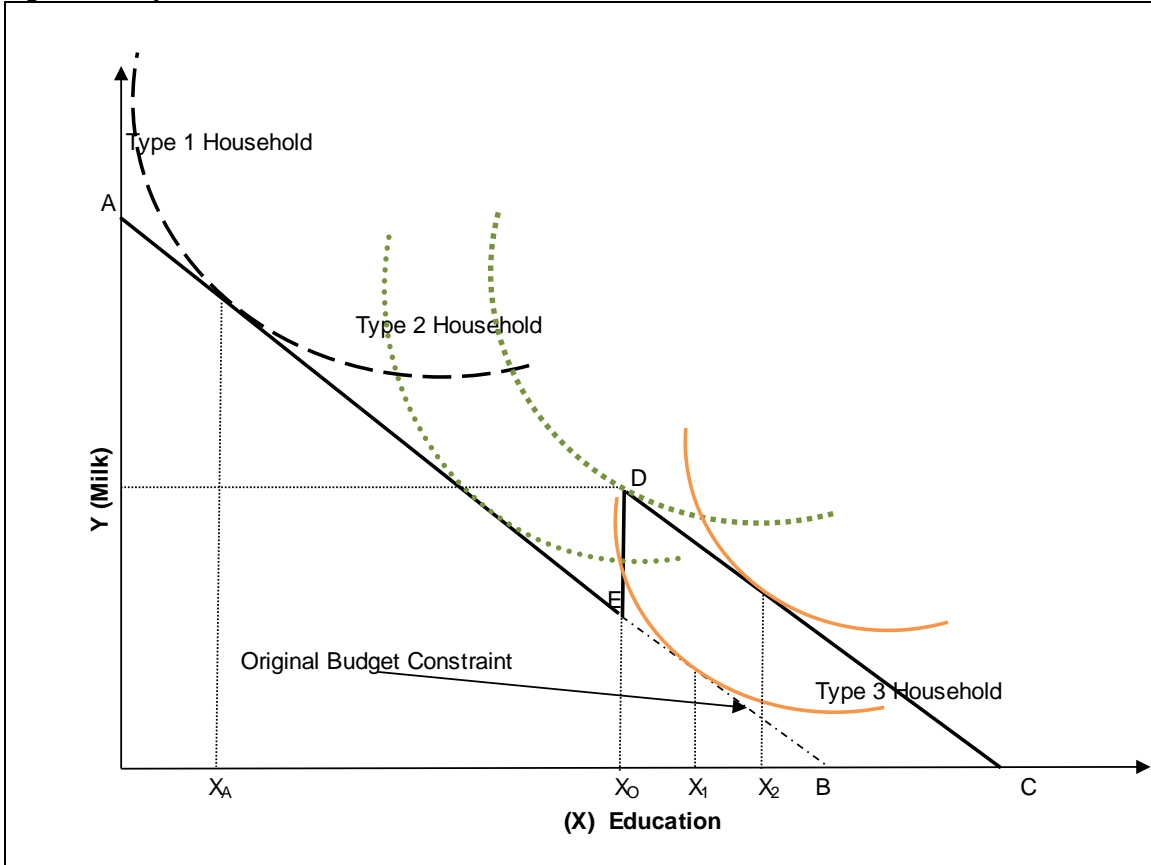
When market failures (such as externalities) exist, the individual's consumption decision is different from the societal optimum. In the presence of externalities, the consumption decision of a single agent will affect the welfare of others and CCTs will serve to reconcile societal preferences with individual choices (Das et al, 2005:72). The adherents of CCTs assert that the existence of market failures leads to a less societal optimal outcome when transfers are not conditional, thereby justifying the implementation of a CCT.

This is then a justification for support of CCTs if society places a higher value on a child receiving health care or education than the child or his/her family. The government may place a larger value on the welfare outcome of the consumption of particular goods than the individual or the family and the CCT will provide the motivation for extra consumption of the merit good. CCTs will provide the incentive for the child's higher level of consumption of the good than would otherwise have occurred. Therefore, in imperfect markets when market failures prevail, due contemplation should be given to CCTs.

7.4.1.1.1 Imperfect education (and health) choices for children

The neoclassical theoretical framework assumes that there are no market failures, and the decisions of the individual are optimal for society. The existence of market failure necessitates the need for CCT to correct market failures so that individual decisions reflect not only individual preference but also society's preferences.

Figure 5: Impact of CCT on household decisions



Source: Das, Do and Ozler (2004:25)

Figure 5 illustrates the economics of cash transfers as demonstrated by Das, Do and Ozler (2005:62). AEDC represents the budget constraint of a CCT programme. There are two commodities from which the household can choose. For a household to receive the cash transfer (ED) it has to consume at least X_0 education. If the household consumes less than X_0 education, it does not receive the CCT and remains on the AB budget constraint.

This figure represents three types of households with different preferences for education. Type 1 does not participate in the CCT programme and consumes the same amount of education and remains on the original budget constraint AB, consuming less than the required amount of X_0 . Type 2 consumes less than the optimal and is originally on the AB budget constraint, but shifts to consuming X_0 once the cash transfer is available. Type 3 consumed more (X_1) before the cash transfer and continues to do so (X_2) after the introduction of the scheme. The CCT benefits

the Type 3 household as it now consumes more of the other good (milk) as well as more education.

The theoretical framework suggests that the utility maximising individual is 'worse off' when it participates in CCT vis-à-vis the UCT. It can be observed in Figure 5, that Type 1 household is not better off with the cash transfer as the household does not elect to participate in the scheme. Type 2 is better off than it was before the transfer as it consumes more of the good; but consumes the same amount of the other good and is therefore 'worse' than Type 3 household. The UCT to Type 3 household enables it to consume more of both goods. The imposition of conditionality restricts Type 2 household from making decisions, rendering them 'worse' off than Type 3 households who can choose for themselves. The individual who does not experience any distortion in their consumption choices will result in the CCT and UCT being equivalent, which is Type 3 who were already consuming more than the minimum education than was necessary.

When the household or individual makes a decision on how much to spend on education it does not take into account the (positive externality) impact of their education on society. If Type 2 household under-invests in education, there will also be an impact on society. The implementation of the CCT leads to a greater investment in education than would an UCT, which is beneficial to society, even if it leads to a reduction in individual welfare. In this case, CCT improves the efficiency when there are market failures.

7.4.1.2 Low participation

CCTs can induce the target populations to participate in chosen programmes whilst the non-poor individuals can opt out. When the benefits exceed the cost induced by the conditionality to access the benefit, then those recipients will participate and where the cost of accessing is greater than the benefit those recipients will opt out of the programme (Das et al, 2004:9). Low participation in the programme will be determined relative to the cost of the conditionality and the size of the transfer. Type 1 households did not participate in the programme. If the size of the transfer was increased or the conditionality was decreased, Type 1 households could be induced to participate, that is, if the programme increased the transfer with a large enough amount, which will make the household/individual satisfy the condition.

In contrast, a decrease in the value transfer or an increase in the burden of the conditionality can result in the Type 2 household withdrawing from the programme. It can therefore be deduced that low participation is due to the mismatch between the transfer and the conditionality. The opportunity cost ('cost' of the conditionality) of a child staying at home may be too high compared to the cash benefits for households to send their children to schools (Das et al, 2004:9).

Targeting (section 8.6.1) the most needy or the poorest is another feature of CCT. In Figure 5, Type 1 opts out of the programme, whilst Type 2 and Type 3 households self-select for the programme. The 2 rationales are different. The first is to increase consumption of the conditional good (due to market failure) causing the household to under-invest from a societal perspective; whilst the second conditioning is used as a tool to identify individuals who self-select [targeting] for the programme. Baland and Robinson (2000:670) find that the inefficiency of child labour and the under-investment in education arises from the mismatch of parent's and child's preferences. As children cannot commit to future repayments, parents may favour the short-term incomes from child labour relative to the long-term return, and the inability of children to commit to reimbursing their parents can lead to an under provision of education.

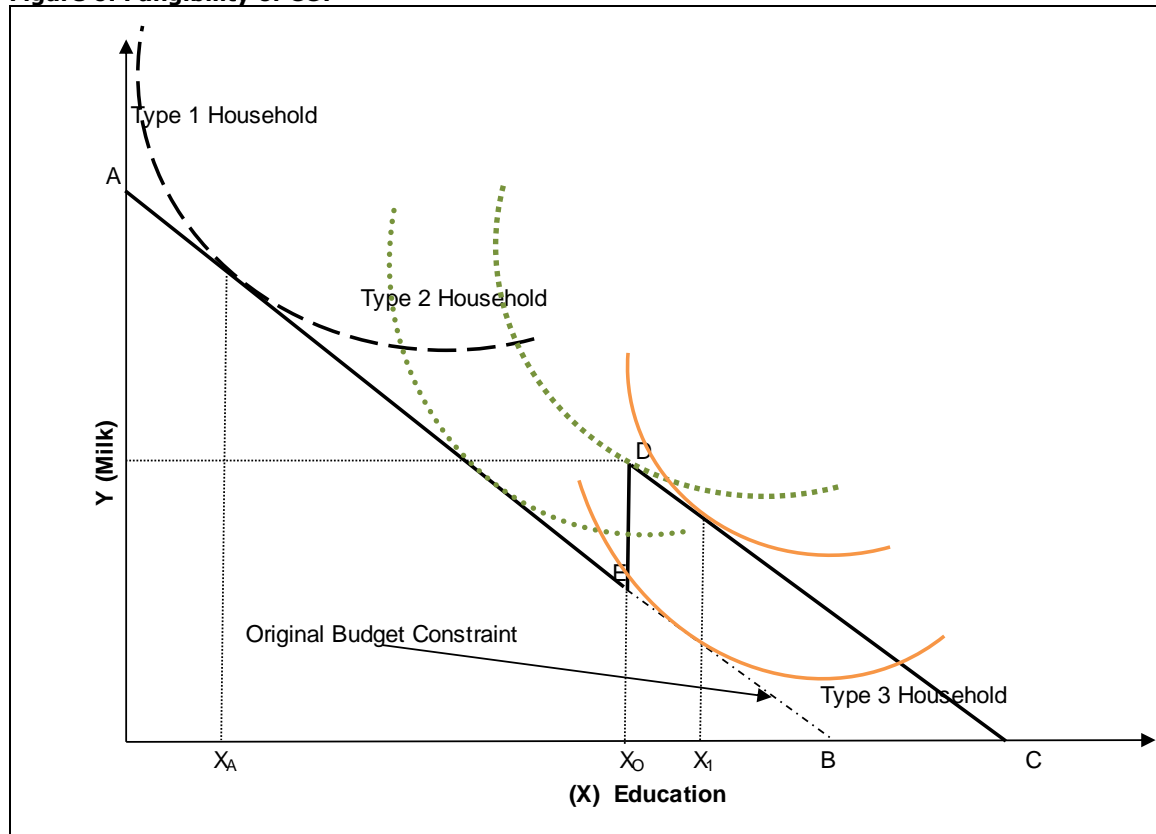
7.4.1.3 Fungibility

This is based on the principle that the condition distorts choices of the individual resulting in a less optimal outcome. The ability to offset any distortion that the condition imposes by the CCT is known as fungibility, which arises when there is a close substitute for the conditioned good. Hence, the beneficiary will mitigate the distortion imposed by the condition if she/he decreases consumption or investment in the substitute, and therefore the net effect is that the overall amounts remain unchanged post the programmes implementation, even though the conditionality has been satisfied.

There is an incentive for the individual or the household to offset the loss of the utility that the condition imposes. Examples include eating less at home when food is provided at school; or decreasing schooling and health care at home now that they are getting the services at school or at the health clinics respectively. Hence, CCT

may increase fungibility although the condition that it aims to address is still being satisfied. This can be demonstrated by using Type 3 household in Figure 6 below.

Figure 6: Fungibility of CCT



Source: Adapted from Das et al (2004:25)

Household 3 was consuming more than the condition good (X_1) prior to the programme and there is no increase in consumption of the good after the implementation of the programme, with the good being perfectly fungible. The grant is in essence an unconditional transfer to the household.

Jacoby (2002:218) finds in the Philippines that there was no substitution by households when a feeding scheme was introduced in schools, with the daily caloric intake rising approximately one-for-one with the feeding programmes calories, that is, the average child's gain was not 'taxed' away at other meals.

But should fungibility be an issue at all or is it only relevant to schemes that have nutritional interventions? If the household ensures that the child attends school (if that is the condition), the decrease in scholarly effort at home should not be

relevant, as the household is satisfying the condition. And even if there was no decrease in scholarly effort at home, there is no guarantee that the attendance of school will improve education outcomes; scholarly effort at home or not. Moreover, fungibility is difficult to demonstrate empirically.

7.4.1.4 Impact of imperfect credit and capital markets

The failure of capital and credit markets to follow the classical paradigm, impacts negatively on the poor of society. The two common market failures that receive much attention in the economic literature are credit markets and capital markets, which are relatively inaccessible to the poorest in society. When market failures are too costly to correct, then the simple redistribution of current resources may be able to reduce efficiency costs (Fiszbein and Schady, 2009:123).

The poorest in society are unable to access credit markets and cannot invest in entrepreneurial activity as well as in the human capital for themselves or for their children. The CCTs to families may provide the opportunity to invest in productive activities in the short-term or in their children (human capital). The transfer is not specific for entrepreneurial activities but is part of the government's poverty strategy. The receipt of the transfer will be conditional on some social service (attend clinic), but the household is not restricted regarding how to disburse the transfer. Consequently, besides using the funds for immediate consumption, the household can save the funds, use the transfer as collateral to attain credit or also invest the transfer in capital assets (section 3.5) [Brooks, 2009:62]. Suffice to mention, CCTs have the ability to increase income by enabling households to invest in productive activities, reduce liquidity constraints, promote micro-enterprise or farm incentives and increase entrepreneurial activities (Gertler et al, 2006:31). The resultant increase in consumption through increased economic activity can lead to a decline in welfare dependence and enable recipient households to achieve a higher standard of living than they would have, had they not received the transfer (Gertler et al, 2007:31).

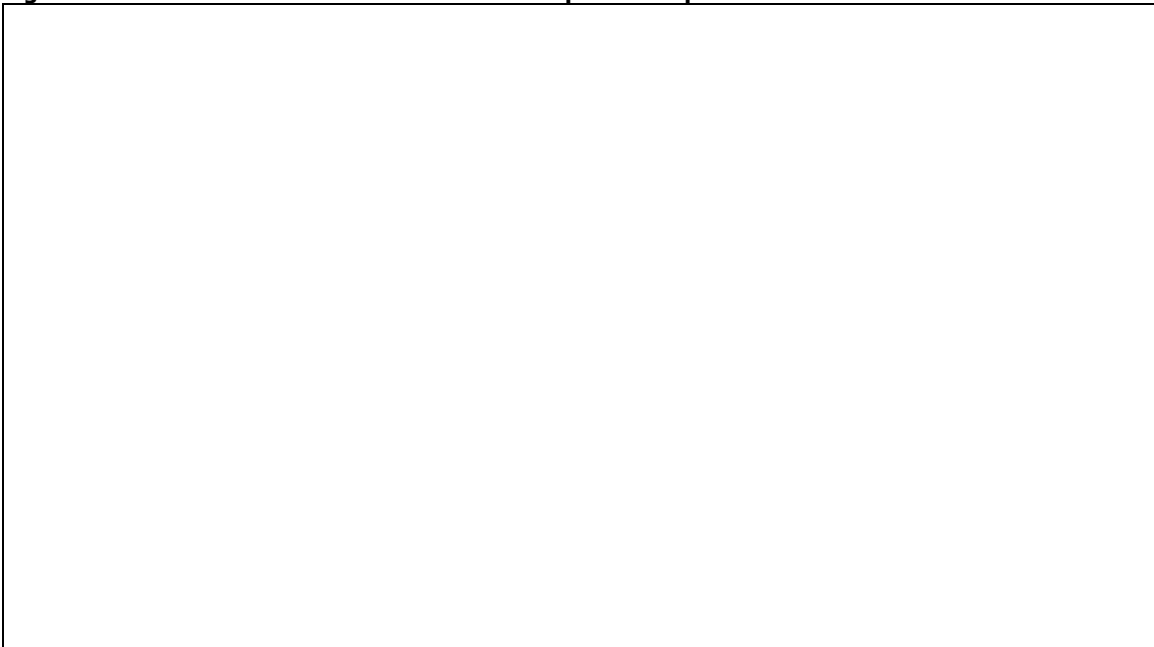
Furthermore, the poor are excluded from insurance markets and cannot insure themselves or their crops as insurance markets are beyond most poor families. When incomes are volatile which translate into unstable economic markets, cash transfers can smooth some of the fluctuations raising household welfare.

Households that face credit restrictions will confront a tighter budget constraint. A CCT provides underlying support when households face credit constraints or credit rationing. Das et al (2005:77) note that credit rationing will best be alleviated with UCTs rather than CCTs as the conditionality creates an unnecessary distortion. In perfect credit markets, a UCT has no impact on investment as credit allows for a separation between investment and consumption.

When credit markets are imperfect or when credit is not accessible to the poor, there will be consumption smoothing by consuming today at the cost of higher remuneration in the future. In this light, conditionality can be the instrument to limit the household's ability to trade off future for present consumption (Schüring, 2010:13).

The economics of this private decision-making that leads to a less than optimal outcome is best illustrated by a dynamic model of educational choices as demonstrated by Ferreira (2008) in Fiszbein and Schady (2009:51).

Figure 7: Investment choices for children in imperfect capital and credit markets



Source: Fiszbein and Schady (2009:52)

Individual welfare consists of two consumption periods - childhood and adulthood, and the link between the two periods is that the children can contribute to household income in the childhood period by working in the first period. But the time spent

working has an opportunity cost as the time spent working comes at the expense of time that could have been spent studying – or investing in the child’s future or human capital or the earnings and consumption during adulthood. There is a trade-off between present and future welfare (Fiszbein and Schady, 2009:51).

The framework illustrates the consequences of educational choices for child welfare. The model demonstrates a choice between UCT versus a CCT when credit markets are absent for the poor. The household’s choice of time that the child spends in school (y-axis) [investment in schooling] is plotted against the market wage rate of the child labour (x-axis) in Figure 7.

Given the existing wage rate and a set of additional conditions (e.g. expected returns to schooling, quality of education from the school and other source of income from the family) the school investment function reveals the household’s demand for education which slopes downward: the higher the opportunity cost of attending school, the lower the investment in education (Fiszbein and Schady, 2009:51). A movement in the investment function can be brought about by various factors, for example, a decrease in the expected return (or quality of education); an increase in the discount rate or a decline in the resources (income) that is available to a household. This is illustrated in Figure 7 above.

When there is persistent misinformation (information asymmetry) about the future returns to education, parents may not appreciate the advantages of sending their children to school. Furthermore, parents may be ill-informed or unable to appreciate the rates of return to education as well as the positive externalities associated with education.

The best policy option will be to educate the parents by empowering them with information (e.g. publicity campaign) to make the acceptable choices. But this may not be possible as the poor may not easily appreciate or see the relevance of the information. This lack of proper information could lead to an under estimation of the returns to education or even health in perfect credit markets. This lower than expected return results in lower demand for education, resulting in a lower investment shifting from A to B. The returns to education are higher than the

household anticipates and therefore B is an inefficient level of investment in education.

The CCT has a substitution effect in comparison to the UCT which has an income effect; and therefore the CCT will have a greater positive impact on investment than a UCT of the same amount. If the household underestimated the expected return of education and shifted to B, then a small UCT would shift the household to C (Investment function with transfer). A CCT of the same amount will move the household to point D which is a higher level of investment in education. By conditioning school attendance the CCT lowers the opportunity cost of education relative to working. It is important to note that if credit constraints were the only obstacle faced by the household with no other imperfection, then a UCT would be preferred, and a CCT of the same amount of the UCT would be inefficient as it will be distorting behaviour via the condition imposed. This model is assuming that the household is operating under incorrect beliefs.

It is also probable that the CCT was set too high thereby encouraging over optimal investment in education. This corresponds to point E and can be interpreted as children who are wasting time in classroom where they learn little instead of helping their parents in the field. Alternatively, the children are taken to unsanitary health facilities where they are more prone to contract diseases and infection, because the parents need the cash. These actions are due to the substitution effects of the CCT.

Therefore, CCTs are more important tools for policymakers to change behaviour than UCTs, especially when policymakers find private behaviour to be sub-optimal.

7.4.1.5 Mitigate principal-agent inefficiencies

Another economic rationale is the principal-agent problems when the parent has to make the decision on behalf of the child. Even when parents have a correct expectation on the future returns of education, they may still discount the future more than is optimal from the perspective of the child and may demand less schooling than is optimal. When the child (principal) is incapable or imperfectly capable of defining or defending his/her interests and imposing them on the agent (parent), then there is a prima facie case for certain types of state intervention in order to protect the child's right and welfare (Munro, 1999:2). The CCTs are

instituted in order to realise the child's right and welfare in this regard. Other examples of dysfunctional principal-agent arrangement between children and parent are the gender differences in health and education which disadvantage girls; as well as parents deliberately deciding against educating their children as that will limit their children's mobility and thereby serve as better security to have them stay and look after them (Schüring, 2010:12).

Something else to take into consideration is incomplete altruism where there is conflict within the household between the parent (who pays for the services such as health and education) and the child (who will benefit tomorrow). De Janvry and Sadoulet (2006:4) argue that this situation prevails if the parents have a higher discount of the future or a lower rate of return than their children. This is all the more acute when the parents are poor and there is more urgency for them to use available resources for survival; and they consequently underinvest in their children's education and keep the children out of school (De Janvry and Sadoulet, 2006:4).

Imperfect information, short-sightedness and incomplete altruism can result in the family's chosen level in human investments to be lower than the 'true' private optimal. This makes the case for the government to behave in a paternalistic manner where the government knows better what is good for the people than they know for themselves as they are not investing at the private optimal. And even when the private investment by citizens is optimal, they may not be socially optimal due to market failure, especially externalities. The incongruity between the social and private optimum could be due to the positive externalities of education and preventative health as well the high future social costs of under-investment in education and health that the household does not take into consideration in their health and education decisions (Schüring, 2010:14).

Besides the conflict between the parent and the child, there could also be conflict between the parents themselves as to what is in the best interest of the child. The solution to this dilemma is to give the transfer to one parent, which is usually the mother, as the mother's objectives may be more affiliated to that of the child. Schüring (2010:12) contends that the mother, whose preferences tend to be aligned with her children's preferences, usually has a lower bargaining position in the household in many developing countries with patriarchal relations. This has been the

rationale for many of the CCTs going directly to mothers. Quisumbing and Maluccio (1999:40) show that when women have power to disburse resources within households more resources are directed to food and children's health and education. Moreover, in situations where a woman's power is limited within a household, the conditional transfer improves her bargaining power within the household and empowers her to make better choices for herself and her children.

In summation, there are numerous reasons for imposing conditionalities on the grants. Firstly, people do not always behave as if they are fully informed rational agents. Secondly, people may not be fully informed to make rational decisions. Thirdly, people's private knowledge of investment or returns may be imperfect. Finally, the short-term decisions may have long-term consequences. Furthermore the short-term actions of the individual may have negative long-term impacts (Fiszbein and Schady, 2009:49).

7.4.1.6 Education and health may already be subsidised

There are also arguments that are against conditioning the transfer, if the same impact can be better attained at a lower cost. It is noteworthy that these externalities must be large in order to institute CCTs to correct them, as the positive externalities are already heavily subsidised. In most countries health and education is already free (heavily subsidised), and therefore a convincing argument has to be made to compensate households for the indirect or opportunity costs of these services. The externalities would have to be substantial to justify conditionality. CCTs will be inefficient if they are paid to households/individuals who already demonstrate the required behaviour (school attendance) [Schüring, 2010:22].

Das et al (2004:3) argues that existence of an externality alone is not adequate reason for the implementation of CCTs without the evidence of additional information. But if the externality was found to be large enough or that the current subsidisation was insufficient, then a CCT (irrespective of other arguments for a CCT) can be justified.

7.4.1.7 In-kind transfers as an alternative to CCT

Some governments (e.g. Americans who disburse food stamps) use in-kind transfers to achieve a societal income instead of giving direct cash transfers. These include food parcels or vouchers which the individual can redeem for a specific good (food) or service (medical check-up). In-kind transfers can be better targeted to provide particular benefits to beneficiary groups, which various types of market failures might not otherwise correct even if they did have the cash (such as post-emergency construction or agricultural materials, foods specific to the needs of children or the sick and so on). In-kind transfers also do not easily permit the recipients to spend inappropriately on gambling and alcohol and tobacco. This is fortified by the large lobby group in countries such as the USA who favour the in-kind transfers or the vouchers. In-kind transfers can stimulate demand for local goods which also has an inflationary impact.

Thurow (1974:190) writing before CCT was on the horizon made a case for in-kind transfer, or more specifically for not giving cash transfers. He argued that cash transfers made economic sense, as they were superior by allowing governments to alter the distribution of purchasing power in the market. This endorses consumers' sovereignty and enables competitive market forces to operate. He lamented that any more intervention would lower consumer's utility from what was optimal.

But Thurow (1974:194) goes on to argue that received wisdom assumes that everyone is the best judge of what is good for himself, but not all actions by the individual result in maximum utility. The explanations cited include incompetence by the individual due to reasons such as mentally retardation, drug addictions and senility, which are problems neither governments nor individuals should ignore.

Governments have numerous policy options which it can use to complement or replace consumer sovereignty, the least coercive of which is the provision of public goods and services. In-kind transfers can coerce individuals to make decisions on which society places a premium, rather than the individual (Thurow, 1974:192).

But this can also be achieved by conditionality which is the main purpose of CCTs as opposed to a UCT. Samson (2009:49) notes that cash disbursements (and also CCTs) are less expensive to transfer than physical commodities; whilst physical

control of food is more expensive and more difficult to audit which makes corruption and leakage potentially greater, relative to cash transfers. The various layers of physical transfers required for food distribution (as with most in-kind transfers) increase the possibility of fraud and corruption (Samson, 2009:49). Furthermore, food and utility subsidies are not easily reversible and have a modest impact on poverty, with huge economic and fiscal costs (Hagemejer and Kim, 2009:27).

7.4.1.8 Labour impact of CCT

The CCT can potentially impact on both the child and adult labour. The rationale for both is in opposition to one another. The aim of CCT is to decrease child labour and not to decrease labour supply for adults.

7.4.1.8.1 Labour supply on children

The reduction in child labour is not only important from a human rights perspective; but also has economic merit. The importance of education for the child has been the impetus for conditionality in most CCT programmes. Suffice to mention that if the child is educated, this will not only have a beneficial impact on the child, but also on society. The reduction of child labour is also beneficial to the child; since the child often works in poor conditions which can impact on their physical and mental health.

However, households may be 'myopic' and find the present income earned from children's activities to be more beneficial than the higher future earning that can be attained from an education (section 4.2.2.2). Hence, CCTs (especially where the condition is educational attendance at a formal school) that require regular attendance allow children little time to participate in employment activities. Studies have shown that whilst CCTs may not have the explicit purpose of the reducing child labour, CCTs have reduced child labour in countries where they are implemented. Rawlings (2004:9) notes that in Mexico, the CCT reduced the probability of children (8-17 years) working by 10-14 per cent after the implementation of the programme.

And although the reduction of child labour is not an explicit purpose of most CCT programmes in Latin America, CCTs do contribute to a reduction in child labour (ILO, 2007b:17).

An important consideration for policymakers is to make the transfer greater than the income that the child would have received from their labour efforts, thereby permitting the child to attend school rather than to work.

7.4.1.8.2 Labour supply on adults

There is a belief that transfers to households will result in a decrease of adults willing to work. It is probable that the cash transfer will result in a decrease in adult labour supply or an increase in unemployment. There may also be a price effect element, as the recipients believe that they have to remain poor in order to qualify for the transfers, and would therefore feel compelled to decrease their labour supply.

Furthermore, parents may decrease labour supply (take time off from work) to fulfil the condition (taking the child to the clinic). However, most studies have focused on the income effect of labour supply due to the CCT. Theoretically, if leisure is a normal good, then the income effect of transfers will result in an increase in leisure and a decrease in work (Fiszbein and Schady, 2009:135).

Many studies of the effects of CCTs on labour supply in Latin America have found no evidence of CCTs impacting of labour market outcomes; in fact some studies have even found a positive effect (income to search for jobs) on adult labour market participation (Amarante and Vigorito, 2010:2). In a study of the *PROGRESSA* programme in Mexico, Skoufias and Di Maro (2006:23), find no significant reduction in labour market participation by adults that receive the transfers. In an ex-ante micro-simulation study of the impact of the *Bolsa Escola* programme on poverty in Brazil, Bourguignon, Francisco Ferreira, and Leite (2003:239) find that the income effect of the transfers on adult labour supply is insignificant. In South Africa, consistent with international evidence, the receipt of social transfers lowers labour supply of the elderly adults and children which is often compensated for by increases in labour supply among adults (Neves et al, 2009:30). Furthermore, workers in households receiving social transfers search for employment more intensively and

extensively and find work more successfully than workers in similar poor households that do not receive the social transfers (Samson, 2009:47).

7.4.2 Promotes equity

Governments do not institute conditionality for altruistic reasons nor as a result of benevolent motivation. The economic rationale is to increase human capital and alleviate household poverty and prevent intergenerational poverty; issues that were discussed in chapters 3 and 4. It may occur that the policymakers are interested in targeting transfers to the poor for redistributive or equity purposes, especially in countries where inequality is high. Van der Berg (2009:1) notes that social spending to the poor has had limited impact on poverty and inequality in South Africa. Inequality (as measured by the Gini-coefficient⁶) in South Africa declined marginally from 0.672 in 1993 to 0.660 in 2007 (Development Indicators, 2010:25).

The motivation for such underlying beliefs could be that social services, though targeted to the poor; may not be adequately reaching the poor; and when they are available to the poor they do not impact on the outcomes that policymakers intend addressing. Van der Berg (2009:16) notes that whilst the poorest 40 per cent of the population in South Africa received more than 50 per cent of the value of social services, they received 24 per cent of the expenditure on housing and only 4 per cent of the expenditure on tertiary education.

Social expenditure on education and health are not impacting on the poor as the social indicators for the poorest are often the worst. Furthermore, infrastructure spending may not reach the poor. Infrastructure expenditure on electricity, water and sanitation is the worst among the poor. In several Latin American countries, the difference in the fraction of households with direct access to water or with electricity in the house is more than 30 percentage points between the top and bottom quintile (De Ferranti, Perry, Ferreira, Walton, Coady, Cunningham, Gasparini, Jacobsen, Matsuda, Robinson, Sokoloff and Wodon, 2004:72). The lack of infrastructure and services among the poor strengthens the case for transfers to the poor; for not only social services, but for other services such as electricity or for utility services.

⁶ The Gini coefficient can range from 0 (no inequality) to 1 (complete inequality).

The implementation of a UCT, CCT or a subsidy cannot easily be delineated on equity arguments as to which is the most feasible; as equity is a value-laden judgement on what the policymaker or the government think is a 'fair' distribution of resources within society. Whilst a fair distribution of resources or wealth may be the objective that the policymaker wants to achieve; the choice of the instrument employed is determined by other factors. For example, if the demand for school services is low a CCT may be a more appropriate policy imperative; if demand is high but the supply (e.g. no school transport), then the subsidy of school transport may be better. And if household poverty is preventing school attendance, then cash transfers may be a better option. Therefore, if the main objective is to transfer cash to targeted categories of the poor (e.g. elderly) cash transfers should be used; but if increased use of school and health services are the objectives, then the CCT would be the better instrument (De Janvry and Sadoulet, 2006:2).

But governments may already be providing these services, and the poor may choose not to access them. Furthermore, should governments be expected to be 'caring' to such an extent, especially if they are already providing the basic services for free? Moreover, the government may be wasting resources (which could be employed elsewhere in the economy) instead of investing in citizens who have little inclination to work or to help themselves.

The funds that are set aside for CCTs, cash transfers or subsidies could be utilised to improve educational supplies (school materials) and health services (medicine) or to invest in teachers and health workers, that will result in better educational and health outcomes. Furthermore (as alluded to earlier) the citizens could already be fully utilising these services (high attendance) which the conditionality aims to address.

7.4.2.1 Paternalism of CCTs

The attachment of conditionality could be indicating to the poor that they do not know what is best for themselves whereas the policymakers do. The implication could also be that the poor are being punished because they are poor or that being poor is their own fault.

Some families may find the opportunity cost of the attached condition too high. The imposition of conditionality could constrain the household even further as the transfers have to be used to satisfy the condition. The cash relative to the condition imposed may not be sufficient to satisfy the condition. If cash benefits are granted for regular attendance of school, but the school is far and transport is necessary for the child to attend; then the household may not participate in the programme, especially if the child engages in productive work in the households.

The rationale for paternalistic actions by government has been that people if were left to choose for themselves will not necessarily choose (or are not capable of choosing) what is best for themselves. This rationale has therefore been used to justify conditional forms of distribution.

The child may be more valuable harvesting or a female child working in the field and fetching water and firewood. CCTs may be imposing a costly burden on families who are attempting to do the best for their families under severe financial constraints. The household may feel that the children could be learning how to weave a basket and tend their fields rather than attending a school or clinic which they may feel offers poor services; and is of no benefit to the household. Hence, the parents may feel that they DO know what is in the best interests of their child rather than the well-intentioned policies of government. Schüring (2010:16) notes that conditionality can be perceived to paternalistic as it is based on the assumption that the authorities care more about the welfare of the next generation than the parents themselves.

Furthermore, the high utilisation of services by the poor may be indicative of their commitment and the importance that they attach to their children's education and health. In a comparison between in-kind transfers and cash in the Mexican government's *Programa de Apoyo Alimentario* programme, Cunha (2010:24) finds that there was no differential impact on total food consumption between households that received the cash with those that received the in-kind food.

Another weakness of the CCTs is that they send a wrong signal and incentive to the poor. The CCTs may discourage people from investing in their own health and education - they will decrease their spending on these social services, that is, it is fungible (section 7.4.1.3).

7.4.2.2 CCTs are politically palatable

Social security financing is an emotive issue among the electorate and the politicians, as social assistance has to be funded from the budget. Voters are assumed to concern themselves about their final welfare level so they care about the net effect of how much they receive in transfers in comparison to what they pay in taxes.

Furthermore, if voters are not recipients of targeted transfers they will be indifferent to the conditions that are attached to the transfers. But they will take a different view when those transfers impact on their tax burden. Subsequently, a narrowly targeted programme that benefits a few, but where the costs are spread across many taxpayers will have limited support and even undermine the programme.

Taxpayers and voters may be more willing to pay for transfers to those who are seen to be helping themselves than to poor people who are perceived to be lazy or who have no inclination to help themselves. Voters who object to unconditional hand-outs to the poor may be more sympathetic to the 'deserving poor' who are investing in their children's future. An increase in the budget (for health and education) for redistribution may be tolerable where such views linger among the electorate. Also concerns of dependence (and corruption) arise from the deeper reluctance and hesitance of government, donors and non-governmental organisation (NGOs) to hand over control and decision-making power to beneficiaries (Farrington and Slater, 2006:507).

The electorate may be more willingly to accept (and even tolerate) CCTs if they know that the poor are endeavouring to help themselves (De la Brière and Rawlings, 2006:6). These arguments find favour with some politicians and certain sectors of the electorate who have a deep-rooted fear that poor people behave irresponsibly and need close supervision (Schubert and Slater, 2006:3).

CCTs will also be more acceptable to the electorate if they are focused on supporting children. They can be seen to be giving opportunities to children who, due to no fault of their own, have limited opportunities. Therefore, using public resources to improve the lives of children may receive more support as a poverty reduction strategy than relief to the parent who can squander the cash on alcohol, cigarettes and gambling.

It is assumed that the transfers are conditional due to the inefficiencies that existed and that the CCT is implemented to correct the inefficiencies. It is worthy to note that attaching conditionality will be sub-optimal if no private inefficiencies exist; and the condition will be burdening the recipient as it adds a constraint. Therefore, when it may not be technically feasible to implement CCTs (as there is no evidence of externalities or imperfect markets), CCTs may be justified as they lead to a 'superior' political equilibrium.

Furthermore, government's policy decision-making process is neither perfect nor ideal and very often, the poor benefit the least from the political discourse. Fiszbein and Schady, (2009:49) note that "governments do not behave like textbook benevolent dictators. Policy decision-making processes involve voting, lobbying, bureaucratic bargaining and a variety of other forms of what is called political economy". And the poor often do not have the political platform to articulate their needs and express their frustration, and may have to passively accept their fate . The CCT is part of a social contract where the state (or society) supports the poor in an attempt to help them to improve their lives – 'deserving poor'. CCTs constitute a form of social contract between the state and the recipients.

7.5 Summary and conclusion

The chapter began by discussing the definition of CCTs. There are different meanings of conditionality which can range from poverty itself being a condition, to regular school attendance as a condition. Different countries have different interpretations of conditionality, although most focus on education (regular school attendance) and health (regular health check-ups).

CCTs share features with other social transfers, but the characteristics that are common to CCTs are their focus on the neediest in society, emphasis on female poverty, their disbursement being conditional, but there being no conditions on how the money is actually spent, as well as supply-side support.

The economic rationale for CCTs was discussed at length in this chapter. Whilst UCTs may be the best option in free and perfect markets as conveyed in neoclassical economic theory, CCTs have a place when markets are not perfect. People may not always make the 'correct' decision for themselves as well as that which is best for

society. Hence, CCTs are instrumental to mitigate inconsistent decision-making. Specifically, parents may make imperfect education and health choices. CCTs compel parents not to underinvest in health and education (positive externalities), for their children. Furthermore, even if poor households wanted to help their children and save or invest for their future, they do not have easy access to capital and credit markets. CCTs exist to help them alleviate the impact of imperfect credit and capital markets that confront the poor, by enabling them to access these markets.

Another justification for a CCT is the principal-agent inconsistency between the parent and the child where the parent does not (both intentionally and unintentionally) make decisions that are in the best interests of the child. CCTs act as a proxy for a paternalistic government to induce the parent to do 'what is best' for the child.

Some countries (e.g. USA) employ in-kind transfers (food vouchers) to mitigate poverty in households, but they are found to be more costly to manage and administratively more challenging relative to cash transfers.

CCTs also impact on the labour supply of both children and adults. Evidence from studies has shown that CCTs do reduce child labour, whilst adult labour supply is not negatively affected by CCT.

An intention of policymakers is often to promote equity, and a CCT is employed to satisfy this objective. That is, for redistributive purposes. But should governments be looking after its citizens, if they are already providing free services (health and education)? Governments may be behaving paternalistically by adding conditionality as they are sending a message to the poor that they know better what is best for them than the poor themselves know. Governments fear that if the poor choose for themselves they may make 'incorrect' decisions. The condition is seen as co-responsibility, where the recipients are seen as individuals capable of resolving their own problems with the state as a partner (not a nanny) in assisting them achieve those outcomes. But the poor may deliberately not access the services (e.g. health) that are conditional to the social transfers.

CCTs are also given for political reasons. Politicians need to appease their taxpaying constituents who may not be happy about giving cash to the poor. However, voters may find conditionality tolerable as it aims to improve the lives of the children who may be poor due to no fault of their own.

CCTs are widely implemented in many countries, the success of which is discussed in the next chapter.

Chapter 8: International experience of conditional cash transfers

8.1 Introduction

Many countries have implemented the CCT, but not all in the same manner or with the same conditions. According to the World Bank database (2010a), there are presently twenty-six active CCTs with conditions, targeted populations, benefits and payments varying between the different countries.

Furthermore, governments are coming under pressure from various quarters to scale back on public expenditure, maintain fiscal discipline, to justify increases in public expenditure; and to make certain that funded expenditure is achieving its objectives. Blomquist (2003:12) notes that the critical question to most policymakers regarding social assistance programmes is whether they are cost effective and truly help those that they are intended to help, and also help those who participate in the programme.

Most countries (not just the developing countries) are looking at evaluating social expenditure to ascertain whether they are getting value for their money. The need for evaluation is important to determine whether the programme delivers what it is intended to and reaches the target population that it is meant to target. Also impact assessments are necessary to determine what the outcomes would have been in the absence of the programme. However, this counterfactual scenario is nearly impossible to examine and methodologies involve constructing a model to determine a plausible counterfactual scenario.

Impact evaluation is important as it demonstrates whether the programme is cost effective, whether participants benefit from the programme and even why the programme is not delivering (Blomquist, 2003:12). But it is important to note that evaluations will not be able to answer all questions that a policymaker has, especially the 'what if' questions. Moreover, there are not many impact evaluation assessments of social security programmes. Blomquist (2003:1) shows that in a sample of projects financed by the World Bank in 1999, slightly more than 20 per cent had evaluation plans and only half had the necessary information to conduct an impact

evaluation, with most programmes having no or incomplete plans to evaluate. The method of evaluation also impacts on the findings, making comparison across programmes difficult.

There is unwillingness among policymakers to even conduct evaluation of the programmes. Firstly, the policymakers may not have the capacity to undertake the evaluation and secondly there may be political resistance. There may be a fear of outcomes of the evaluation and the subsequent political backlash or ramifications, especially if the programmes are seen not to be cost-effective. Blomquist (2003:2) contends that any negative findings could jeopardise social programmes and damage political careers.

However, evaluation of CCT programmes has been undertaken to determine their success and limitations. Consequently, in this chapter the international evidence with regard to CCTs will be studied. The impact of CCTs on school enrolment and school attendance and the subsequent impact of CCTs on actual education outcomes, will be scrutinised. A brief overview of school vouchers will be undertaken as an alternative policy instrument that has been implemented to improve educational outputs.

The international experience of the effect of CCT on health, nutrition and infant and child mortality will be examined. In the last section administrative challenges to CCTs from the perspective of both the government and the household, will be examined. The chapter ends with a summary and conclusion.

8.2 Countries that are implementing CCTs

The World Bank (2010b) refers visitors on its website to the Fiszbein and Schady (2009) 'Conditional Cash Transfers: Reducing Present and Future Poverty, World Bank Policy Research Report' for a full list of the CCTs. The report (Fiszbein and Schady, 2009:216-295) provides a comprehensive list of active CCTs in the various countries as well as those that no longer exist. A summarised list of the countries where CCTs are still implemented is tabulated in Appendix 2. It is worth noting that Fiszbein and Schady (2009) give a comprehensive discussion of the CCTs that are implemented including those that are no longer active (e.g. Nicaragua- *Atención a Crisis* and *Red de Protección Social*) and are subsequently not included in Appendix 2. A detailed enumeration of countries that currently administer CCTs are tabulated in

Appendix 2. The list notes the country, the name of the programme, the date it became active (inception), the conditions (usually health and education) and the education and health outcomes.

In South East Asia the CCT programmes that are active are found in Cambodia: *Cambodia Education Sector Project*; Indonesia: *Program Keluarga Harapan*; Philippines: *Pantawid Pamilyang Pilipino Program (PPPP)*; and Turkey: *Social Risk Mitigation Project*.

In Central and East Asia, the CCTs exist in Yemen: *Basic Education Development Project*; Bangladesh: *Female Secondary School Assistance Program, Primary Education Stipend Program and Reaching Out-of-School Children*; India (Haryana): *Apni Beti Apna Dhan (Our Daughter, Our Wealth)*; Pakistan: *Child Support Program and Punjab Education Sector Reform Program/Punjab Female School Stipend Program*.

The programmes of South America are Argentina: *Programa Familias*; Bolivia: *Juancito Pinto*; Brazil: *Bolsa Familia* which also incorporated earlier programmes (*Programa de Eradicação do Trabalho Infantil, Bolsa Alimentação, and Bolsa Escola*); Chile: *Chile Solidario* and *Subsidio Unitario Familiar*; Colombia: *Familias en Acción*, and *Subsidio Condicionado a la Asistencia Escolar–Bogotá*; Dominican Republic: *Solidaridad*; Ecuador: *Bono de Desarrollo Humano*; El Salvador: *Red Solidaria*; Guatemala: *Mi Familia Progresa*; Honduras: *Programa de Asignación Familiar (PRAF)*; Jamaica: *Program of Advancement through Health and Education*; Mexico: *Oportunidades* (formerly *PROGRESA*); Panama: *Red de Oportunidades*; Paraguay: *Tekoporã/PROPAIS II*; and Peru: *Juntos*.

CCTs also have a footprint in Africa in Burkino Faso: *Orphans and Vulnerable Children*; Kenya: *Cash Transfer for Orphans and Vulnerable Children* and Nigeria: *Care of the Poor*. It is notable that according to the World Bank (2010a) [but not part of the Fiszbein and Schady's (2009) list], South Africa (Child Support Grant [CSG]) is also classified as being a CCT. The World Bank notes the conditionalities of regular health centre visits for children 0-5 years, an 80 per cent school attendance for children 6-14 years and regular participation in development activities for the caregiver.

The health conditionality emanates from the fact that the parent/guardian of the child has to produce a 'Road of Health Card' which denotes the immunisation schedule that the child has undertaken to qualify for the CSG. But this is only when the grant is applied for, and not followed up. Hence, it is a 'soft' condition in that monitoring and evaluation is not conducted on the specific condition. Moreover, regular check-ups are neither definitive nor prescriptive as the parent can choose if they want to vaccinate the child at the public clinic and when to vaccinate them. That is, the parent does not have to have the vaccination done on a specified date.

The education conditionality is also a condition that was part of the grant application, but is not regularly monitored and verified. No record of any CSG being rescinded because of poor school attendance has been recorded. Furthermore, the CSG has been extended to 18 years and the applicability of school attendance for children over 14 and going to school is not valid. The condition of regular participation in development activities is erroneous as that is not mentioned at all in the application for a CSG. It is worthy to note that none of these conditions are listed as criteria for qualification for the grant as specified by South African Social Security Agency (SASSA) [2010]. Hence, this could be the probable reason that South Africa does not feature in the list of countries that have CCTs (Fiszbein and Schady's, 2009).

This study does not look at all the CCT programmes, but reviews the literature on those that are active. Certain programmes focus on other policy imperatives, such as the Bangladesh *Female Secondary School Assistance Program* which has a conditionality of the child (presumably female) remain unmarried until passing the secondary school certificate examination; as well as the Indian *Apni Beti Apna Dhan (Our Daughter, Our Wealth)* which requires that girls not be married until they are 18 years or older.

Some countries implement more than one CCT programme to address health and education outcomes among the poor. For example, Pakistan has the *Child Support Program* which has a condition of 80 per cent school attendance, and passing of final examination; and the *Punjab Education Sector Reform Program/Punjab Female School Stipend Program* which also stresses school attendance and enrolment in grades 6–8 in a government school for girls.

A central principle of the CCT is to improve human capital accumulation. Although not exclusively, most often this is achieved by targeting education and health initiatives. Therefore, most of the CCTs have two components, that is, an education and/or health/nutrition components.

In this study the focus is on those countries that target health and education as part of the CCT programme and not on other conditionalities (as mentioned above) that may be imposed on the recipients. Moreover, most of these programmes have been implemented in Latin America, where most evaluation of the studies has taken place and the literature is therefore rich in studies that evaluate education and health outcomes.

The health and education outcomes that are reflected in Appendix 2 are the health and education outcomes which CCTs inherently aim to correct. But the table is not meant to draw any inference of correlation and causality between the CCT and the health and education outcomes; as there may be other factors that impact on these outcomes. Hence, the impact of CCTs on health and education outcomes (where there is a link) is discussed in specific studies that were undertaken to find the impact of CCTs on health and education.

8.3 Effect of CCTs on education

A transfer is paid to the recipient on condition that the child regularly attends school, usually primary education, although not exclusively. Rawlings and Rubio (2005:4) note that secondary education is a component of programmes in Mexico, Colombia and Jamaica. The grant is often conditional not only on registration but also on regular school attendance (80-85 per cent). The objective of the Brazilian *Programa de Erradicação do Trabalho Infantil* (PETI) [which was incorporated into the *Bolsa Família* in 2006] was to reduce child labour and therefore to encourage participation in after-school programmes.

The size of the education transfer varies from country to country and they all employ different methodologies to ascertain the appropriate grant value. In some countries the transfer covers the direct costs, whilst in others, only the opportunity costs from the income that is forgone as a result of sending the child to school instead of the child working. Mexico and Honduras cover the direct costs of school fees, school

supplies, transportation costs etc., and the indirect costs that the parents would have received had the children been working (Rawlings and Rubio, 2005:4).

In Colombia, the educational grant for secondary education is much higher than for primary school to mitigate the higher opportunity cost of work as children grow older. Grants can also rectify any imbalances that policymakers feel need to be corrected as there may be certain segments of the population that are more disadvantaged than others. Grants for secondary education in Mexico are higher for females. Rawlings and Rubio (2005:4) note that the higher grant for females provides an incentive for correcting the unequal gender participation in secondary education and to internalise the educational externalities when they raise families of their own.

8.3.1 Impact of CCTs on school enrolment and attendance

All evaluations of the impact on education have shown that CCTs do have an impact on enrolment and school attendance. Some programmes are also linked to the performance of the child in school as in Turkey (*Social Risk Mitigation Project*) where the recipient is only allowed to repeat a grade once, whilst a recipient in Nicaragua (*Red de Protección Social*) [RPS] {which has since been stopped} had to pass the grade without repeating. The education criteria can be for either certain age groups (Jamaica) or for certain grades. Most programmes require compulsory school enrolment and a high school attendance.

Fiszbein and Schady (2009:129) evaluating all CCT programmes that aim to improve school attendance conclude that "...all credible evaluation has found a positive effect on school enrolment". The World Bank (2010c) notes that the *Female Secondary School Assistance Program* (FSSAP) of Bangladesh has resulted in an increase in secondary education for girls from 1.1 million in 1991 to 3.9 million in 2005, where it now exceeds enrolment of boys.

Schultz (2004:205) analysed the impact of the *Oportunidades* in Mexico, and found that CCTs have more of an impact on school children who are progressing from primary to secondary school. Fiszbein and Schady (2009:130) note that the *Oportunidades* has also resulted in an increase in the number of children who did not qualify for the CCT; children who were just above the cut-off point to qualify for the

CCT. Bobonis and Finan (2006:23) attribute this to peer influence as these children may want to be schooled with their friends who qualified for the CCT.

Maluccio and Flores (2005:65) find that the *RPS* in Nicaragua produced an average net increase of enrolment of 17.7 percentage points and a 23 percentage point increase on current attendance for the target population. The *Programa de Asignación Familiar* (PRAF) in Honduras had an approximate 1-2 percentage point increase on school enrolment, a reduction of the dropout rate of 2-3 percentage points, increased school attendance by 0.8 days per month and increased annual promotion rates to the next grade by 2-4 percentage points (Glewwe and Olinto, 2004:47).

An evaluation of CCTs on enrolment in the *Bono de Desarrollo Humano* (*BDH*) programme in Ecuador reveals that children from households who participated in the *BDH* were 3.2 to 4.0 percentage points more likely to be enrolled in school than children in households that were not participants in the *BDH* (Schady and Araujo, 2006:24).

Galasso (2006:18) employing regression methodology demonstrates that Chile's *Chile Solidario* programme resulted in a 4-6 percentage point increase on pre-school enrolment. An assessment of the *Familias en Acción* in Colombia was evaluated (using the differences in differences econometric techniques) by comparing the villages in which the programme was implemented with a comparable village in which the programme was not. Attanasio, Fitzsimmons and Gómez (2005:8) found that the *Familias en Acción* led to a 1.3 percentage point increase in school enrolment for children aged 8-13 and 5.5 percentage point increase in school enrolment for children aged 14-17 at the baseline. Levy and Ohls (2007:xvii) in an evaluation of the *Program of Advancement through Health and Education* (PATH) programme in Jamaica found that school attendance increased by 0.5 days per month.

The CCT that was also implemented in Turkey to improve school outcomes had mixed results. Adato (2008:24) notes that CCTs increased secondary enrolment by 10.7 per cent for girls aged 14-17 (starting from a low base of 56 per cent) with little impact at primary level which was already high at 93 per cent.

In Bangladesh the impact of the *FSSAP* program in female school enrolment has been positive. Khandker, Pitt and Fuwa (2003:25) using panel data, estimated that the female enrolment rate increased by 12 percentage points for every year that they are exposed to the programme. Chaudhury and Parajuli (2006) employed a regression discontinuity and triple differencing methodology to investigate the impact of the *Punjab Education Sector Reform Program* in Pakistan. They showed that the programme resulted in an approximate 10-13 percentage point increase in school attendance for 10-14 year old girls (Chaudhury and Parajuli, 2006:23). Filmer and Schady (2006) used the difference in differences technique to investigate the impact of the *Japan Fund for Poverty Reduction Girls Scholarship Program* (JFPR) in Cambodia. This programme was stopped in 2002 and was incorporated within the *Cambodia Education Sector Support Project* (CESSP). Filmer and Schady (2006:18) showed that the programme led to an approximately 30 percentage point increase in school attendance.

Soares, Ribas and Hirata (2008) evaluated the impact of Paraguay's *Tekoporã* programme. They estimated the impact by comparing a treatment group that received the benefit with a control group that did not. The control group consisted of people who should have qualified, but for some reason were excluded. Mostly these people were overlooked by the programmes in its implementation. The authors found that even though there was high enrolment prior to the introduction of the CCT, enrolment rates increased between 5 and 8 percentage points for the treated groups, and grade progression increased between 4 to 7 points (Soares et al, 2008:11). The impact on attendance was larger for boys (between 6 and 11 years) and older students (between 11 and 15). There was limited impact on school attendance among 6-9 year olds which could be attributed to the initial high baseline enrolments (Soares et al, 2008:12).

Son (2008:6) showed that the *PROGRESSA* (precursor to the *Oportunidades*) increased enrolment in secondary school by 6 and 9 percentage points for boys and girls respectively. In Bangladesh, the CCT increased primary school enrolment by 9 per cent and in Nicaragua the CCT programme increased primary school enrolment by 13 percentage points (Son, 2008:6). The enrolment improved significantly in these countries as they had a low base of initial enrolment.

Son (2008:7) also noted that although the CCT had a strong gender focus, the CCT (Mexico and Nicaragua) had been responsible for the improvement in attitudes towards educating girls in general. Moreover, the CCT had increased the women's status within some households as the programmes were usually directed at the female head of the recipient household (Son, 2008:7).

In January 2008 the Philippine government introduced the *Pantawid Pamilyang Pilipino* (PPP) programme, with an estimation of 300 000 households on the programme. The focus on the programme was to provide cash incentives for children younger than 15 years of age to the poorest families to build human capital. The programme requires minimum school attendance of 85 per cent with a monthly benefit of 300 peso. Using a simulation multi-logit model in an impact evaluation of conditional cash transfer programme on school attendance, Son and Florentino (2008:21) found that the cash transfer alone would not improve school attendance, indicating a need for conditionality.

Glewwe and Olinto (2004:48) found in Honduras that there was also greater enrolment of children from households with low per capita expenditures. Fiszbein and Schady (2009:136) contend that the biggest impacts are on the children that have the lowest propensity to register at school at baseline. In a review of a few of the programmes, Skoufias (2009:119) notes that the *Oportunidades* resulted in a decreased drop out between the sixth and seventh grades by 9 percentage points; the *Punjab Program* in Pakistan increased enrolment of 10-14 year old girls by 11 percentage points and in Cambodia the programmes were responsible for a reduction of drop out between the sixth and seventh grades of 20-30 percentage points.

It can be noted from the various evaluation studies that were conducted that although the impact of CCTs on enrolment has been positive, results have varied across countries. Comparison across countries is difficult because of the initial enrolment of children in school. The heterogeneity in results radiates from the original baseline enrolment which impacts on the results. If the initial school enrolment was low, then any change will have a large impact. In contrast, if the initial enrolment was large, then the impact of the CCTs will not be perceived to be very successful. Fiszbein and Schady (2009:130) note this is the reason why the

impact among children in Nicaragua is larger than in Mexico or Colombia for children in primary school.

Similarly, the results could also have an impact within country evaluation. The impact evaluation within Turkey revealed no improvement in the enrolment rates of boys in secondary schools, but a 11 percentage point increase in girl enrolment. This is primarily attributable to the initial low baseline enrolment of girls (Adato, 2008:35).

One would expect the largest transfers to have had the largest impact on school enrolments which indeed does occur. The *RPS* programme in Nicaragua in Latin America that made the largest transfer had the largest impact on school enrolment (Fiszbein and Schady, 2009:132). But *Oportunidades* in Mexico and *Familias en Acción* in Colombia, had a smaller impact relative to their large transfers. In contrast, the *BDH* in Ecuador and Chilean *Chile Solidario* led to larger enrolments relative to their smaller transfers. The biggest impact on school enrolment was found in Bangladesh, Pakistan and Cambodia where transfers were in the region of one and three per cent of the median recipient household income (Fiszbein and Schady, 2009:132). It can therefore be inferred that the outcome on school enrolment is also dependent on other factors besides the transfer.

Fiszbein and Schady (2009:132) infer that factors such as timing of payments could have also affected the different enrolments across the different countries in Latin America. Whilst few studies have been conducted in this area, Barrera-Osorio, Bertrand, Linden and Perez-Calle (2008:36) found that monthly payments, together with a year-end bonus did not reduce school enrolment, whereas lump sum payments at the end of graduation had a positive effect on enrolments, indicating that payment schedules did impact on behavioural change.

The impact of enrolment is greatest in the poorest households. Usually the poorer households have lower educational outcomes at the baseline and there is more room for improvement. Consequently, CCTs will have larger impacts on these households. The opportunity costs for ignoring the transfer may be higher for households that do not fulfil the conditions of the programme. Filmer and Schady (2006:18) found that the *JFPR* in Cambodia had a greater impact on enrolment of girls who came from

poorer households, had parents with less education and lived farther away from secondary schools; as it reduced socioeconomic differences and therefore impacted on enrolment and attendance.

8.3.2 Impact of CCTs on educational outcomes

It is not only important that enrolments increase, but that education outcomes are also improved. And the improvement in enrolment rates does not necessarily attest to better educational outcomes (such as completing school) or even better wage earning potential. The intention of the programme is that the condition will entice parents to send their children to school, that the children will stay in school and hopefully complete schooling, after which they will potentially earn more as adults than they would have had they not received the CCT.

One must then try to appreciate the rationale for the implementation of the CCT. Most often the intention is to increase enrolment in the belief (and hope) that it will improve educational outcomes. As noted from the studies above, the children who are targeted are usually poorer and usually enter school late. Moreover, the children who are in school, even the poorer ones who qualify and receive the benefit will perform better and have a higher return to schooling, than the late arrivals. This type of comparison may often yield a negative impact of CCT, especially if the comparison is limited to poor children, intimating that CCT has no impact on educational outcomes.

Ponce and Bedi (2008:19) employing the regression discontinuity approach, found no significant impact of the *Bono de Desarrollo Humano (BDH)* in Ecuador on test scores. In Mexico, Behrman, Parker and Todd (2005:12) found that exposure to the *Oportunidades* programme resulted in only 0.2 grades in additional schooling, but no statistically significant impact on the reading, mathematics and written language test scores. Furthermore, young adults that received the CCT when they were younger for more than two years did no better than young adults that received the CCT for a shorter period of time (Behrman et al, 2005:13). Therefore, it can be inferred from these results that CCTs had no significant impact on children's learning outcomes in comparison to children who did not have access to the CCTs.

Despite the increase in enrolments and years of completed schooling, many CCT programmes have not been accompanied by increases in learning outcomes; particularly in Cambodia, Ecuador and Mexico where the higher enrolment levels had not translated into better learning outcomes (Skoufias, 2009:120). Paqueo (2009a:19) notes that whilst CCTs have overall had a significantly positive impact on enrolment, CCT children are learning as much as non-CCT students with evidence of CCTs on actual learning outcomes being limited. These arguments are also affirmed by Reimers, Da Silva and Trevino (2006:11) who noted after examining the available evidence, that CCTs did have positive effects on school attendance and educational attainment, but the magnitude of this effect was modest, especially for transfers to pupils in primary schools.

Several reasons have been purported for these outcomes. The education level of the parents could have impacted on the outcomes as more educated parents appreciate the benefits more than non-educated parents. De Carvalho Filho (2008:11) avers that the education of parents positively affects the wage rates of their children by their positive attitude toward education and also as an input to their children's human capital production function. Consequently, in this way, the parent's education increases school enrolment and reduces child labour (De Carvalho Filho, 2008:11).

Furthermore, the quality and experience of teachers have an impact on the child's education outcomes. Rockoff (2004:247) using panel data finds that a one standard deviation increase in teacher quality increases test scores by 0.1 standard deviations in reading and maths. Furthermore, teaching experience between beginner teachers and teachers with ten or more years' experience, manifest in a reading test score of 0.17 standard deviations between beginner teachers and teachers with ten or more years' experience (Rockoff, 2004:247). The effects of teachers are major elements on the impact on scholars' academic gain, with classroom variables of heterogeneity among students and class sizes having minimal impact on academic gain (Wright, Horn and Sanders, 1997:57).

Another possible explanation is that most developing countries (where CCTs are mainly implemented) have a single curriculum that favours the requirements of the elite students leaving many others behind (Glewwe and Kremmer, 2005:10). Schools may inadvertently discriminate against children who are compelled to register for

CCTs as the curricula and educational instruction is more in tune with more advanced students (Fiszbein and Schady, 2009:143).

More plausible, especially in developing countries is that educational outcomes are also dependent on other factors that may be hindering households. Nutrition, poor parenting (alcoholic parents) and the small value placed on education are particularly prevalent among poor households. These cannot be remedied by cash transfers, and limit the impact of a CCT strategy.

In spite of the minimal increase in educational outcomes of the individual, policymakers may still wish to attach an educational condition as there are societal benefits for the child receiving the education. Moreover, there are other positive aspects of education (section 4.2.2.2) such as better health outcomes which are usually related to more years of schooling, reduced fertility, delayed marriage and better childbearing practices.

8.4 Impact of school vouchers

It is instructive to note that policymakers have also used another instrument, namely school vouchers, to improve educational outcomes of the poor in society. When educational choices of the poor are limited to low quality schools, targeted educational voucher scheme (TEVS) can be implemented to mitigate educational inequalities that prevail in society (Shafiq, 2008:1). The TEVS is a voucher which enables the poor household to pay for the school tuition and associated ancillary costs at designated schools, including private schools. The rationale is that if parents could choose and had the resources to make that choice they will choose the better school which is often more expensive and/or private. The school voucher empowers them to make this choice.

Consequently, the supply constraints that poor households confront will be moderated and hopefully improve educational outcomes. Chile has implemented a school voucher scheme in 1981 which entitled any student to attend a private school. Hsieh and Urquiola (2002) evaluated the impact of the vouchers scheme in Chile by comparing the test scores in international tests in science and mathematics in which Chile participated in 1981 as well as 20 years later. The results show that Chile's ranking relative to 12 other countries that also took part in the same surveys, has

worsened in the 20 years (Hsieh and Urquiola, 2002:1). Employing Ordinary Least Squares (OLS) estimates, Contreras (2002:22) find that attendance at a voucher school is associated with higher test scores, although the impact is relatively small. However, the employment of Two Staged Least Squares (TSLS) to control for school choice reveals that attending a school voucher school in comparison to public increase significantly (Contreras, 2002:22). In a review of American school vouchers schemes as well as international ones, Ladd (2002:4) finds that universal voucher programmes do not generate substantial gains in overall student achievement and could also be detrimental to disadvantaged students.

These results contrast with those of other researchers in this domain. In Colombia, the school voucher programme, *Programa de Ampliación de Cobertura de la Educación Secundaria (PACES)*, covered students who were randomly selected (lottery); and were renewable if the student maintained satisfactory academic performance. Angrist, Bettinger, Bloom, King, and Kremer (2002:1535) found that three years after the lotteries, the winners were 10 percentage points more likely to have finished grade 8 and scored 0.2 standard deviations higher on achievement tests. Furthermore, Bettinger, Kremer and Saavedra (2008:26) also found that the voucher recipients had significantly better outcomes than voucher 'losers'. Specifically, the voucher winners were more likely to finish grade eight, less likely to repeat a grade and their test scores were between one third and two-third standard deviations better than the scores of the losers (Bettinger et al, 2008:27).

The utilisation of school vouchers is to address the supply constraints that poor households confront for a quality education in the public arena. CCTs are primarily demand driven, in that the facilities exist, but the poor are not accessing them. Both policy levers are utilised to improve education outcomes for mainly the poor. The literature of both is mixed on the merits of which produces better results, although much more empirical evaluation has been conducted on CCTs. However, only cost effectiveness analysis which compares vouchers with CCTs can determine which will be the 'better' policy instrument. In a hypothetical comparison between a CCT (\$200 per annum) and a TEVS (\$400 for a non-public school), where the goal is to enrol the child for a year, the TEVS is found to be less cost-effective (Shafiq, 2008:13). However, if the objective is the attainment of a better quality education than attending a public school, the analysis gets more complicated (Shafiq, 2008:13).

These empirical comparisons can best be resolved by cost-effectiveness analysis (Shafiq, 2008:13).

Hence, school vouchers must also be a consideration when deciding on strategies to improve education outcomes as well as long-term human capital improvement of children.

8.5 Effect of CCTs on health, nutrition and infant mortality

Many of the CCTs are also linked to the use of health services and/or health preventative measures. Unlike with education where the focus of most CCTs has been on enrolment, the focus on health initiative varies among countries.

Health and nutrition can be targeted to newborn children until they reach school age. The grants are usually linked to a vaccination/immunisation protocol that is necessary for life (and/or is prescribed by the WHO). Health services are usually for children below the age of 5 who must complete the vaccination regimen and are also available to pregnant and lactating mothers to regularly attend clinics. A detailed list of the health conditionalities can be noted in Appendix 2. Some countries have listed in detail the health conditions that the mother and child should fulfil, whilst in some countries (Honduras) they are more loosely defined in that they have to attend a health facility regularly (Fiszbein and Schady, 2009:87).

Brazil requires that the child receives all the vaccinations and follows the schedules of regular health services. Pregnant and lactating mothers receive grants as part of the programme in Jamaica, Honduras, and Mexico. Furthermore, in Jamaica and Mexico, other household members (besides the pregnant and lactating mothers) are also required to have check-ups once or twice a year. Researchers in Honduras determined the value of the nutrition and health voucher to be equivalent to the value of the time it would take the mother to go and wait in the health centre (Rawlings and Rubio, 2003:5). In Colombia, the health and nutrition grant was set at the income that would be necessary for an indigent family to reach the poverty line (Rawlings and Rubio, 2003:5).

The *PATH* in Jamaica requires that children (who are not enrolled in school) between the ages of 0-6 visit a health clinic every two months during the first year and twice

a year thereafter (Levy and Ohls, 2007:6). The *RPS* in Nicaragua is targeted at children between 0 and 3 years and requires a child to visit a health centre to be weighed once every 6 months to qualify for the transfer, as well as full vaccination coverage within 3 years. Maluccio and Flores (2005:49) find that there is a 13 percentage point probability that 0-3 year old child will be taken to a health care facility to be weighed during a six month period in the *RPS* programme.

The *Familias en Acción (FA)* programme in Colombia, requires that a child less than 24 months old complies with the schedule of preventive healthcare visits where the child must be taken for growth and development monitoring (Attanasio, Battistin, Fitzsimons, Mesnard, and Vera-Hernández 2005:7).

The objective of the *Program de Asignacion* in Honduras is to increase the demand for preventive health care in pregnant women (at least five antenatal check-ups), new mothers (check-up within 10 days of delivery), and children (DPT [Diphtheria, Pertussis {whooping cough} and Tetanus] and measles vaccinations) younger than 3 years of age (Morris, Flores, Olinto, and Medina, 2004:2031).

8.5.1 Impact of CCTs on the utilisation of health services

The underlying principle of the CCT is not only that it will improve the uptake of the health services; but that the increase in the uptake of the services will improve health outcomes. In most cases, there is an increase in the uptake of the service. However, in a review of the health outcomes of Chile's *Chile Solidario*, Galasso (2006:17) found that only 2-3 per cent of urban households and 3 per cent of rural households were enrolled in public health systems. Furthermore, health visits by children for preventative care was 4-6 per cent and only in rural areas (Galasso, 2006:17). Moreover, the transfer could result in a 'decrease' in health visits as the CCT has a positive impact on the health of the individual who therefore does not require numerous visits to the health centre. Gertler and Boyce (2001:12) found that the 0-2 year old participants in the *PROGRESA* programmes in Brazil displayed a negative impact on utilisation of public clinics; which the authors believe are consistent with the hypothesis that *PROGRESA* lowered illness and subsequent demand for curative care.

Whilst the impact on utilisation of services, that is, visits to health centres increases, the utilisation of the actual services may not necessarily increase. The results are not only mixed for preventative medicine, but also for immunisation coverage which is also a main focus of the health component of CCT. The CCT in Honduras resulted in an increase in the coverage of the first dosage of DPT/Pentavalent vaccine, but had no effect on the coverage of immunisation against measles (Morris et al, 2004:2036). The *Familias en Acción* in Colombia increased the probability that children younger than 24 months followed the DPT vaccination regimen. (Attanasio, Gómez, Heredia and Vera-Hernández, 2005:10) There was a 5 percentage point increase in tuberculosis (TB) immunisation coverage for the *PROGRESA* for children between 12-23 months, and only a 3 percentage point increase in measles vaccination for children aged between 12 to 23 months after the beginning of the programme (Lagarde, Haines and Palmer, 2009:31).

Fiszbein and Schady (2009:137) found that the *PRAF* had no impact on measles, but resulted in increased coverage of immunisation for DPT diphtheria/pertussis/tetanus. Barham and Maluccio (2008:28) found that the *RPS* resulted in a 14 percentage point (26 per cent) increase in coverage rates for fully vaccinated children. Similarly, the CCTs had increased vaccination coverage in Turkey, where children younger than 6 years old who were immunised as part of the CCT programme were 14 percentage points higher than those who did not participate in the CCT program (Fiszbein and Schady, 2009:137).

Soares et al (2008:13) evaluated the impact of Paraguay's *Tekoporã* Programme on children's vaccination schedules. There was an increase in the proportion of children who possessed a vaccination card from 77.5 per cent to 90 per cent of the population; although only 58 per cent of the cards were actually shown when asked for verification (Soares et al, 2008:13). Similarly, only 56 per cent of non-beneficiaries were able to show their vaccination card whereas 95 per cent of non-beneficiaries said they possessed one (Soares et al, 2008:13). Hence, it was not possible to evaluate the positive impact of the programme on vaccination uptake.

8.5.2 Impact of CCTs on health outcomes

Numerous studies have investigated the impact of CCTs on child health and once again the results are mixed. Studies have attempted to measure the impact of the

CCT on health status by focussing on whether the child's weight for age or height for age improved with the CCT. The logic is that the transfers will provide the means for the family to invest in nutrition for the child, which will be complemented by the health services. This can also be strengthened by the positive externalities of education which result in healthier individuals. Good food combined with adequate health services, will ensure that the child is in good health.

It is also important to take note of the baseline to appreciate the change in the health of the child. If the child is terribly weak, then a small improvement in nutrition will lead to a dramatic improvement in the health status. Conversely, if the child is nutritionally satisfactory when they access the grant, there may be no improvement in the health status. Furthermore, if a child has been nutritionally deficient for a long period, any significant improvement in nutrition will not have the same impact on a child who recently became nutritionally deficient and that receives nutrition support.

Several studies have been done on the impact of health status of children participating in the *PROGRESA/Oportunidades* programme in Mexico. Rivera, Sotres-Alvarez, Habicht, Shamah, and Villalpando, (2004:2563) found that CCTs had significant effects for children younger than 6 months who were living in households with a lower than the median income. The *PROGRESA* resulted in an increase of age-and-length adjusted heights that were greater by 1.1 cm (26.4cm in the intervened groups versus 25.3 cm in the non-intervened group) among infants younger than 6 months who lived in the poorest households (Rivera et al, 2004:2563). Gertler and Boyce (2001:1) found that the *PROGRESA* not only reduced the incidence of illnesses by 23 per cent, but was also responsible for a 1-4 per cent increase in height. Behrman and Hoddinott (2001:49) found that the *PROGRESA* had a significant impact, increasing child growth and reducing stunting. Specifically, the CCT programme resulted in an increase of about a sixth in mean growth for children of this age group, with the impact greater for children from poorer households (Behrman and Hoddinott, 2001:49). Fernald, Gertler and Neufeld (2008:828) noted that the doubling of cash transfers was associated with higher height-for-age z^7 -score, lower prevalence of stunting, lower body-mass index for age percentile and

⁷ The difference between a child's height and the median height of the reference population for the same age and gender, divided by the standard deviation of the reference population for the same age

lower prevalence of being overweight in children participating in the *Oportunidades*, (*PROGRESA*) programme.

An evaluation of the *Familias en Acción* programme in Colombia, found that the z-score had increased by 0.161 (equivalent to 0.43 centimetres) which translated into a 0.069 decrease in the probability of the child being undernourished (Attanasio, Gómez, Heredia and Vera-Hernández 2005:8). Paxson and Schady (2007:24) found that the *BDH* programme in Ecuador did not improve height gain among children for any age group.

Maluccio and Flores (2005:59) found that the *RPS* raised the heights for age z-score by approximately 0.17 points for children younger than 5 years of age. In summary of the programmes in Latin America, Hoddinott and Bassett (2009:16) noted that *PROGRESA* in Mexico, *RPS* in Nicaragua and Colombia's *Familias en Acción (FA)*, were associated with positive and sizeable impacts on child height; and that the *PRAF* in Honduras and *Bolsa Alimentação* in Brazil, had no significant impact on preschool nutritional status.

Another factor that is also commonly used in literature to test for the improvement of nutrition is to test for anaemia, and that is done by examining the blood haemoglobin level. Paxson and Schady (2007:21) found that the *BDH* in Ecuador had a large impact (39 per cent of a standard deviation) on haemoglobin levels among the poorest children. Gertler and Boyce (2001:1) found that the *Oportunidades* resulted in an 18 per cent reduction in anaemia. After one year, the mean haemoglobin level was higher (11.12 g/dl) than in the crossover intervention group (10.75 g/dl) who had not yet received the benefits of the intervention (Rivera et al, 2004:2563). Maluccio and Flores (2005:64) found that although the *RPS* in Nicaragua included the provision of iron supplements, the transfer did not make any significant improvement in the anaemic status of the children. Hoddinott and Bassett (2009:14) also indicate that studies have noted that neither the *RPS* (Nicaragua) nor the *PRAF* (Honduras) had an impact on blood haemoglobin levels or on rates of anaemia.

8.5.3 Impact of CCTs on infant and child mortality

In addition to their impact on improving nutrition, the implicit goal is often to improve the infant and child mortality rates. And this is the yardstick that some would argue that the CCT programmes should be judged against. However, not many studies have focussed exclusively on the impact of CCTs on infant and child mortality, with some focussing on child illnesses (diarrhoea) and childhood development (cognitive and motor development).

Barham (2006:22) found that the *Oportunidades* was responsible for an 11 per cent reduction in infant mortality, but no decline in neo-natal mortality in rural Mexico. Furthermore, Fernald et al (2008:828) found that a doubling of cash transfers in the *Oportunidades* was responsible for children having better motor development, cognitive development, and receptive language. Gertler (2004:340) evaluated the impact of the *Oportunidades* on child illnesses. The children born to families who were participants of the programme, were 25.3 per cent less likely than the control groups to be reported being ill in the previous month. Attanasio, Gómez, Heredia and Vera-Hernández (2005:7) notes that the *Familias en Acción* reduced the incidence of diarrhoea from 32.6 per cent to 22 per cent for children younger than 24 months living in rural areas; as well as from 21.3 per cent to 10.4 per cent for children between 24 and 48 months in rural areas; with no statistically significant impact on older children and children living in urban areas. The *Familias en Acción* had no statistically significant impact on children who suffered from respiratory illnesses (Attanasio, Gómez, Heredia and Vera-Hernández, 2005b:7).

8.6 Administration

A common criticism of CCTs programme is that a significant portion of the budget is taken up by administration costs and fails to reach the intended recipients (Caldés, and Maluccio, 2005:151). De Brauw and Hoddinott (2008:5) argue that compared to UCTs, conditionalities increase administrative costs as well as the complexity of the programme. There is the cost of monitoring to ascertain whether the conditions are being met. The monitoring cost will depend on the number of beneficiaries and also the services that they must utilise to qualify for the grant. The administration costs (those that are incurred by the government) are a summation of costs that could escalate the expenditure of implementing and running the programme. Coady (2000:vii) identifies various types of costs that need to be considered. These include:

- a. Targeting costs – to reach the most needy and deserving
- b. Conditioning costs - to ensure that the recipients fulfil the conditions such as school attendance and/or health facilities attendance
- c. Operation costs - to actually run the programme

Conditions such as school attendance are easy to monitor as well as immunisation, but attendance to a clinic might be more difficult to monitor and document. Firstly, the visit to a clinic can be a condition, but if there is insufficient staff to attend to the person, they may have to return on another day which may not be possible (work, additional transport costs). Secondly, the attendance may be only because they have to satisfy the condition to get the grant and not because they are ill. Thirdly, the person may be genuinely ill, that they are unable to attend the clinic and may have to go to the nearest medical (even private) medical practitioner. The fulfilment of the conditionality in this instance may be arduous.

The administration cost of the CCT varies depending on the conditionality that is imposed. Caldés, Coady, and Maluccio (2006:21) found that monitoring the conditionality of the *PROGRESSA* represented 18 per cent of *PROGRESSA*'s administrative costs and 2 per cent of total programme cost, whilst Gertler (2005:2) found that the monitoring cost of the *PROGRESSA* scheme in Mexico to be one per cent of the total cost of the programme. Son (2008:4) noted that the *Bolsa Familia* in Brazil managed to reach the poorest 20 per cent in Brazil at a cost of 0.4 per cent of GDP in 2007. Son (2008:5) found that nine and two per cent went to monitoring in Honduras and Mexico respectively. Johannsen, Tejerina, and Glassman (2009:147) found that studies in Latin America showed that the administration costs (as a percentage of total programme costs) were on average 8.2 per cent ranging from 4.1 per cent in Ecuador in 2005 to 13 per cent in Jamaica in 2004/05.

The administrative costs of CCTs are burdensome when they are initiated. Son (2008:4) argues that if the administrative cost are spread over the implementation of the programmes; the total ratio of administrative expenses to total transfers will rapidly fall over the years. The share spent on setting up targeting, registration, payment processes, monitoring systems will fluctuate during the course of the programme, with larger processing and investment costs during the first three years (Johannsen et al, 2009:147). During the first year (1997) of implementation the

PROGRESSA targeting costs were 65 per cent of the total programme, with monitoring at 8 per cent and the actual transfer only constituted 8 per cent (Son, 2008:5). By 2000, actual transfers made up 41 per cent of the total expenditure of the programme, monitoring of the condition was 24 per cent and targeting was only 11 per cent (Son, 2008:5).

Hence, to reduce administrative cost, policymakers opt for targeting to reduce costs and improve cost-effectiveness of the programme.

8.6.1 Targeting

Targeting is the essential imperative of CCTs, in that they must reach the poor and the neediest. CCTs must ascertain who (within the fiscal space) are eligible and must be targeted to receive the benefits. Almost all CCTs target the poor and most use geographic and household targeting. Fiszbein and Schady (2009:7) note that most of the countries that implement CCTs use geographic and household targeting via proxy means testing, whilst some use community based targeting. Sometimes targeting is for vulnerable groups in the population such as Pakistan's *Punjab Education Sector Reform Program* which targets female pupils as they are the most marginalised.

However, targeting does have a limitation in that it may exclude people who are genuinely poor and need assistance such as the unemployed poor who may not live in households that receive social transfers. CCTs often do not target all the poor, but only a subset of the poor. Some policymakers have however recognised these limitations and have targeted the vulnerable in some programmes, for example the Old Age Pension in South Africa is specifically targeted at the poor elderly without any conditionality. Although the *PATH* in Jamaica is targeted at the elderly, it is also conditional of visits to health centres.

The primary objective of targeting is to reach people who qualify for the social transfer. Invariably, there will be people who qualify and do not receive the grant (exclusion errors) as well as those who receive the grant and should not (inclusion errors). An effective social transfer programme is one that minimises both these errors, as they undermine the programme. Coady, Grosh, and Hoddinott (2004) reviewed the targeted outcomes of social transfer programmes (both CCT and UCT) in 48 countries. They found that CCT programmes provide approximately 25 per cent

more resources to the poor than random allocations, with the 10 best performers able to deliver to the poor two to four times the share of benefit than they would have got with random allocations (Coady et al, 2004:84). Means testing is often employed in CCT programmes (as well as for other social assistance transfers) as an instrument for optimal targeting.

A verifiable means test is regarded as the gold standard in targeting as it aims to obtain complete information on household's' income/expenditure/wealth and independently verify that information with other sources (Grosh, Del Ninno, Tesliuc and Ouerghi; 2008:100). Proxy means testing using observable characteristics of the household such as quality of the dwelling, the ownership of durable goods, and the education status of the household as a proxy for household income and/or consumption level. This data can be obtained from the census data or household surveys. The specific indicators that are used and their weighting are determined from statistical analysis (regression analysis or principal components) of data from household surveys (World Bank, 2009b).

The households are scored by using the data. And depending on where the cut off is set, applicants who fall below a certain score will be entitled (or eligible) to participate in the programme. The information is verified on application or is confirmed by visiting the applicant's household. Proxy means testing is less costly than true means testing as it requires less information, and is usually available as part of general census and household surveys. More importantly, means proxy test does not measure income of the household which people may want to conceal in surveys.

In fact, some countries first established means proxy tests when they initiated the CCT programmes (Jamaica, Pakistan, Turkey). Other countries (Chile, Colombia) with established means proxy tests strengthened and improved their means proxy systems to the benefit of the CCT programmes (Fiszbein and Schady, 2009:72).

However, it is possible that statistical formulation of the mean proxy test could be incorrect and lead to many deserving individuals being excluded. Fiszbein and Schady (2009:75) found in an ex-ante assessment, the proxy means test of the

Panama programme, the eligibility criteria that was selected resulted in a quarter of the extreme poor being excluded for the programme.

Recipients who would otherwise qualify can also be excluded if they are not informed of the availability and the benefits of the programme. Countries such as Ecuador use information campaigns such as mass media to inform their citizens of the programme. The programme in Cambodia explicitly states that information posters have to be put up in all the relevant schools. These outreach campaigns are initiated to increase participation by the eligible beneficiaries.

Some may choose not to participate, because of the stigma associated or the transactions cost may be too high. Stigma associated with poverty may discourage people from coming forward and registering for the programme. Adato (2004:21) finds that this isn't the case in Mexico and Nicaragua, but that the non-beneficiaries are envious of those that do receive the benefit. In fact, some communities gave non-recipient children school materials to prevent them from feeling stigmatised for NOT getting the transfer. Adato (2004:21) notes that the stigma of social assistance is not as much of an issue in developing countries as it may be in more developed countries as in the Europe.

But has the targeting of the programmes been sufficient to reach the poor? Coverage ranges from approximately 1 per cent of the poorest deciles in Cambodia to more than 60 per cent in Brazil, Mexico and Ecuador (Fiszbein and Schady, 2009:73). In a study that looked at targeting in Latin American social assistance programmes, Lindert, Skoufias and Shapiro (2006:44) find that many scholarships and food-based programmes are regressive and that the governments should consider redesigning them. In contrast, the targeting of CCTs in Latin American are highly progressive as the poor are clearly defined with the explicit use of targeting mechanisms that ascertain eligibility (Lindert et al, 2006:44).

More important are the reasons for the poor coverage. Possible reasons include the actual cash that is offered to the beneficiaries; the budget available for the programme; and also where the CCT fits in the broader poverty alleviation or social policy strategy of the government.

In some countries, CCTs are a relatively small component of the social policy as in the Chilean *Solidario* where the programme is specifically targeted at a small group, with other programmes providing social assistance. In Ecuador, the *BDH* is the main programme to reach the poorest families and children, and the scope of the programme or the coverage is largely determined by the size of the budget (Fiszbein and Schady, 2009:73).

Bolivia has used universal targeting of all grade one learners in its *Juancito Pinto* programme whilst the Colombian CCT programme began by first targeting beneficiaries in municipalities that offered the service.

The other factor is not the poor in general, but which of the poor will qualify for the benefit. Specifically, if education is going to be the determinant to qualify for the CCT, then the age group and the grade, the budget notwithstanding, will determine which of the poor receive the cash.

Another factor is the availability of the services. Even if the people are poor enough to qualify for the services, but none are available, then they cannot make use of these services. Sometimes the services will intentionally not be made available to restrict the number of people who will qualify. Fiszbein and Schady (2009:75) note that the early stage of the *Oportunidades* was set up in areas that intentionally excluded municipalities that had a population of between 50 and 250, as well as primary schools situated within certain municipalities that had access to a paved road and health centre within a 5 kilometre radius. This condition by design excluded some villages that qualified. The conditions were later rescinded as the programme grew.

The benefit is not only dependent to the poverty of the household, but is sometimes dependent on the number of children in the household. Many programmes cap the benefits as a method to discourage parents who think they will get more money if they have more children. Mexico caps the benefit at \$153 which is roughly the amount that corresponds to having one child in primary and one in secondary school. Some programmes (Ecuador) pay a flat rate per household irrespective of the number of children in the programme. Fiszbein and Schady (2009:81) argue that “the logic for flat benefits [is] when there is insufficient budget to cover all the poor,

a disincentive to have more children; and importantly, the household or the family just needs an incentive to learn a new behaviour with and not for every child”.

Very often the benefits are differentiated among the different groups in order to achieve different outcomes that are determined by the policymakers. The *PATH* programme in Jamaica pays a higher amount for secondary education as the policymakers see the opportunity cost for secondary education to be higher than for primary education; and also secondary education is more costly than primary education. The Bangladesh programme was initiated for girls as they had lower enrolments relative to boys. But Jamaica has higher benefits for boys in secondary schools as there is lower enrolment of boys in secondary schools.

The person receiving the actual payment is often the parent or the guardian. Very often the payment is targeted at the mother as research (section 7.3.2) shows that women will spend more on their children relative to men.

8.6.2 Private cost to the recipient or the household

Some programmes pay beneficiaries monthly whilst others pay every second month. Hence, the private costs to obtain the grant may be excessive for some households, which reduces the net value of the social transfer. Grosh et al (2008:96) note that the private costs (transport, verification) are rarely measured and reported in an internationally comparable way. Furthermore, the income foregone from satisfying the condition also denigrates the value of the benefit

Transaction costs can be high relative to the benefit itself, especially in the remote rural areas where the need is greatest. Carrillo and Jarrín (2008) discovered that the isolated communities in Amazon and the Highlands in Ecuador could face higher costs of transportation of \$10-\$50 by motor boat. These costs can be lowered by allowing benefits to accumulate and combining trips to collect transfers with other activities, or by granting rural households an additional to \$0.25 to \$0.50 to compensate for the travel costs (Carrillo and Jarrín, 2008:22). Hence, policymakers must be cognisant of these associated costs when designing the appropriate benefit level.

Although the imposition of conditionality may place a 'burden' on the household, benefits of the transfer most often compensates the household, resulting in relatively high compliance among recipients. Compliance rates are 90 per cent in Brazil and Mexico and about 85 per cent in Nicaragua (Paqueo, 2009a:130). But non-compliance does occur.

8.6.3 Payment or benefit level

The fundamental question confronting any policymaker designing a CCT is what the benefit/payment should be. That will inter alia depend very much on what the objective of the programme is. That is, whether it is to address short-term poverty or consumption; or long-term poverty or development of human capital. There are also other considerations, such as the private costs (e.g. transport costs) which will reduce the net benefit of the value. Furthermore, these decisions are made in a fiscal environment within a political atmosphere which influences the determination of the actual benefit level that is paid to recipients. Finding the optimal benefit level is a balancing act; because if the benefit level is too high it may reduce work incentives or crowd out private transfers, and if it is too low it may not meet its intended objective (Grosh et al, 2008:132).

The benefit received varies from 1 per cent of pre-transfer household expenditure in Bangladesh to 29 per cent in Nicaragua (Fiszbein and Schady, 2009:83). Paqueo (2009a:130) notes that 45 per cent of the *Oportunidades* benefits reach the poorest decile; whilst in Chile and Jamaica, approximately 35-40 per cent of the benefits reach the poorest deciles.

The benefits are targeted to the poorest in society and the impact on their consumption will be higher than it would have been had the transfer gone to a wealthier recipient. Consequently, CCTs accounts for approximately 10 per cent of the recipients' consumption in Brazil, Ecuador and Jamaica, with the consumption effects depending on the benefit level (Paqueo, 2009a:130).

Hence, the benefit levels, due to a myriad of factors will vary among programmes. Generally, benefits that are too low occur more often than programmes which have benefits that are too high (Grosh et al, 2008:132).

8.6.4 Punitive measure for non-compliance

Some countries are not inflexible in the application of the conditions to qualify for the benefit and tolerate exceptions and exemptions. Some countries allow for absenteeism from school for serious illnesses whilst Jamaica exempts disabled children. However, there are usually sanctions for not fulfilling the condition and to act as a deterrent to other potential defaulters. Most common is a temporary repeal or the reduction of the benefits for non-compliance. Fiszbein and Schady (2009:89) note that there is an immediate decrease in benefits in the next disbursement in both Jamaica and Mexico. Paqueo (2009a:130) notes that non-compliance with *Familias en Acción* in Colombia, and *Oportunidades* of Mexico result in full penalties; whilst non-compliance with the *Bolsa Escola* in Brazil and *Chile Solidario* in Chile result in light punitive repercussions.

But some governments are mindful of the fact that the conditions imposed on the poor may at times be difficult to satisfy. Moreover, the poor that are the most vulnerable (and who need the most assistance) may find achieving the conditions most challenging. Non-compliance of the condition may be a symptom of an underlying problem that needs attention. Hence, the design of many programmes involves a social worker to understand the dynamics of specific household to appreciate the circumstances that lead to non-compliance of the specific condition.

8.7 Summary

There is a need for evaluation of CCT programmes as policymakers need to know whether these programmes are reaching the intended targets, as well as to determine whether the programmes are cost effective and fiscally sustainable. Consequently, in this chapter the international evidence regarding CCTs was discussed. There are currently twenty-six countries (World Bank, 2010a) [Appendix 2] that are implementing CCTs.

The evidence presented on the outcomes and outputs (as well as economic principles of CCT) draw heavily from the World Bank study of Fiszbein and Schady (2009). The studies that are quoted were cross-referenced to the actual studies that were mentioned and cited in their study. In the Social Assistance and Conditional Cash Transfers Workshop (2009) that was hosted by the Asian Development Bank, most participants (Bloom, Mahal, Rosenberg and Jaypee, 2009:12; Skoufias, 2009:115;

Paqueo, 2009b:123; Johannsen, Tejerina, and Glassman, 2009:139) in their analysis of country experiences used this study as the foundation for discussion. Shaw (2010:65) in a review of the report notes that the study covers the various aspects of CCTs as well as comprehensively examining the impact of CCTs on health, education, consumption and poverty in many countries. However, the two shortcomings of the report are that it fails to draw on the experience of the International Food Policy Research Institute (IFPRI) with regard to food subsidies in a number of countries; as well as the fact that no reference is made to the work of the United Nations Children Fund (UNICEF) in respect to child health and education, which CCTs alone will not solve (Shaw, 2010:65).

There is evidence that CCTs do lead to an increase in attendance and enrolments, which varies across the different programmes. The impact is greater for the poorest households, female children and when the initial enrolment and attendance baseline is low. Conversely, when enrolment or attendance is already high, the impact of the CCT is marginal. However, the impact of CCT on actual educational learning outcomes is modest. Several reasons have been postulated which include the education level of the parent; the quality and experience of the teachers, curricula that favour non-CCT children and other factors such as nutrition, alcoholic parents and poor parenting.

Some countries have instituted school vouchers to improve educational outcomes of poor children. The vouchers are given to poor households to cover the school fees and associated ancillary costs. Parents can use these vouchers to send their children to schools of their choice including public schools. The impact of these vouchers is mixed and comparisons with CCTs are limited. Only thorough cost-effectiveness studies will make it possible to give some definitive response to this enquiry. Suffice to mention that the CCTs are mostly demand driven, in that the services exist and the poor are not accessing them. The vouchers are supply driven in that there is a great demand but the services offered (usually by the public sector) are weak.

A synopsis of the effect of CCTs on health and nutrition notes that there is an increase in the uptake of health services with CCTs. This is mainly when the initial baseline for the services are low, which mostly occurs in rural households. The impact of CCTs on health outcomes is mixed. Many studies have focussed on the

PROGESA/Oportunidades which revealed that the CCT had led to better health status, but mostly for the children younger than 12 months. Furthermore, the impact of CCT on anaemia was positive for *BDH* and *Oportunidades* but there was no impact in *RPS* and *PRAF*.

There is little literature support for the impact of CCTs on infant and child mortality and morbidity. The *Oportunidades* has resulted in a decrease in infant motility and has resulted in better motor development, cognitive development and language. CCTs are responsible for the decrease in children's (younger than 2 years) illnesses (diarrhoea), especially in rural areas.

Besides the outcomes on health and education, policymakers need to be mindful of the administrative costs and challenges of operating a CCT programme. The administration costs vary across programmes, but on average is 8.2 per cent (as a per cent of total programme costs) ranging from 4.1 per cent in Ecuador to 13 per cent in Jamaica (Johannsen, et al, 2009:147).

Furthermore, the CCT needs to reach intended beneficiaries, and this is achieved by selective targeting. Invariably, there will be people who are missed (exclusion errors) and people who receive the transfer but do not qualify for the transfer (inclusion errors). Policymakers must endeavour to minimise these errors. Means testing is administered to select those who qualify for the CCT and most CCT programmes use some sort of proxy means testing to identify the qualifying recipients.

It is notable that besides the cost to the state, there is a private cost as well as an opportunity cost to accessing the CCT. If the private costs are too high, this may negate the value of the transfer, resulting in the beneficiaries not accessing the grant. The amount of the transfer must be of a value where it will make an impact to the livelihood of the beneficiary or the household. This is usually the case as the CCT is targeted at the poorest households, where income levels are low and the transfer as a portion of household income is acceptable.

Punitive measures and sanctions for non-compliance to the conditionality vary between programmes where some (*Chile Soildaria*) are lenient and do not 'punish'

the households, whilst some programmes (*PATH*) result in an immediate decrease in benefits.

The economics of CCT and the international evidence serve as a backdrop for Section D to determine whether South African authorities should be considering a CCT programme for South Africa.

Section D: Applicability and analysis of conditional cash transfers in South Africa

Chapter 9: Social grants (excluding Child Support Grant) and conditionality

9.1 Introduction

CCTs have the short-term purpose of relieving poverty and increasing consumption among the poor; and a long-term objective of human capital investment and breaking the cycle of intergeneration poverty. Their popularity also stems from the view that the policymaker can employ one policy lever to achieve more than one outcome. But is it the right policy instrument? Is the CCT the best instrument to offer social protection to the poor? Governments also have other priorities and want to get value for their money.

The embracing of CCTs should not be seen in isolation but often as part of a government's strategy to alleviate poverty and increase human capital investment. The poverty alleviation strategy of government informs what transfers should be made, and which lend themselves to conditionality. Furthermore, social security success is dependent not only on the intention of the policymaker to address poverty; but also on the execution and delivery of complementary social services. Besides social transfers, children also qualify for exemption from school fees, whilst children under the age of six are entitled to free health services at public health facilities.

And whilst CCT programmes share common features (section 7.3), most have country specific elements. The consideration of a CCT programme in South Africa will have to consider its uniqueness with regard to its history, previously disenfranchised majority, current political landscape; as well as the present poverty alleviation strategy before embarking on any CCT programme. CCTs may have to be one element of a broader strategy in poverty alleviation.

The current transfers that are disbursed in South Africa were discussed in chapter 6 (section 6.4.2). But not all of them are suitable for conditionality. Before the country embarks on this route, there are two fundamental questions that need to be

addressed. Firstly, if South Africa chooses to look at a CCT, it needs to determine which grant(s) will be most appropriate to implement as a CCT. And secondly, which conditions (health, education) should it choose to attach to the selected grant. Furthermore, the policymakers must determine what the impact of current social transfers is. Rigorous analysis of the appropriate data is necessary to determine whether conditionality should be given consideration.

At the beginning of the chapter the data that was selected for the analysis is discussed. In section 9.2 the National Income Dynamic Study (NIDS) dataset is discussed and why it was chosen as the basis for the analysis for this study. This is followed by a detailed description of the sample (section 9.3.) and its extrapolation to the population. The descriptive statistics (age, gender, race and geography) of the entire population are extrapolated from the sample. This is followed by descriptive statistics of the adult population and descriptive statistics of the children population.

In section 9.4 the focus is on the current social transfers and their suitability for conditionality. The section begins with the premise that all grants are suitable for conditionality, and which social transfers do **not** lend themselves to conditionality is evaluated. The social transfers to adults, that is, War Veterans Grant, Disability Grant and Old Age Pension are firstly evaluated and why these are not suitable for conditionality. This is followed by an evaluation of the social transfers to children, which are, the Care Dependency Grant and Foster Care Grant and their non-suitability for conditionality. The chapter ends with a summary and conclusion. In the next chapter the discussion on the Child Support Grant and its suitability for conditionality is continued.

9.2 Data

There are cross-section studies (General Household Surveys [GHS], Income and Expenditure Surveys [IES]) which are regularly conducted in South Africa to provide valuable information on households/individuals at any given time. However, these surveys do not provide information about the same person or household at different times. This was the impetus for the National Income Dynamic Study (NIDS) that was undertaken by the South African Labour and Development Research Unit (SALDRU) for the Presidency to provide information about people and households over time (SALDRU, 2008:1). Consequently, the NIDS aims to provide panel data for a set of

households and individuals which can be used for policy and social research. The first wave of the research, which is the foundation for analysis, was conducted in 2008. It is envisaged that the survey will be repeated every two to three years with the same individuals, even if they have relocated to another part of the country (Leibbrandt, Woolard and De Villiers, 2009:1).

The survey represents the latest information on individuals and households that is necessary for the analysis and is compared with other sources (e.g. number of grant recipients cross referenced with data from the South African Social Security Agency [SASSA]) during the ensuing analysis. Whilst the NIDS does share common characteristics with GHS on population, gender, and even school attendance which is also relevant to this study; the NIDS does have variables which are necessary for this study, specifically, variables on pass rates and grade repetition. These are necessary elements when comparing grant recipients and non-recipients and are notably absent from other datasets. Furthermore, the GHS survey which has variables such as school attendance which are also found in the NIDS data, lack information on expenditure such as amount spent on food, beverage, transport cost etc., which is found in the Income and Expenditure Survey (IES). The variables such as school attendance are not found in the IES.

More importantly, many of these surveys refer to the households as the recipient of the grants, which the NIDS also does, but the NIDS is unique in that it identifies the individual beneficiaries (especially children) as well. This is an important distinction which allows for comparison between recipients and non-recipients which forms the backbone of much of the analysis of this study. For example, the NIDS data permits the investigation of the transport cost of children who receive a grant versus those children that do not receive a grant.

Hence, for this study, the NIDS data is the most representative information needed to conduct the analysis.

9.2.1 National Income Dynamic Study (NIDS)

The survey covered 7 305 households and 31 170 respondents, with not all respondents answering all questions, with some respondents not even answering any. A delineation of the sample reveals that there is:

- a) One record per household: hhid (n=7 305)
- b) One record per household member: pid (n=31 170),
- c) 16 885 adults
- d) 9 616 children
- e) 1 754 adults who were unavailable or unable to answer the questions
- f) 2 915 non-resident household members without pid numbers

Therefore $16\ 885 + 9\ 616 + 1\ 754 + 2\ 915 = 31\ 170$ is the sum of the total sample (SALDRU, 2008:2). The hhid (household identification) and pid (personal identification) are unique six digit identification numbers of households and individuals respectively. They are employed to identify households and individuals who participated in the NIDS.

The sample is weighted in a two stage process so that it is representative of the South African population. In the first stage, the design weights were calculated as the inverse of the probability of inclusion, whilst the second stage entails adjusting the weights to ensure that the sample is representative of the mid-term 2008 population estimates in terms of the age-gender-race to match totals in the population estimates for 2008 (Wittenberg, 2009:5).

The employment of post-stratification weighting not only ensures that the sample is representative in terms of age-gender-race, but also in terms of distribution across provinces and demography. The detailed assumptions and methodologies used to derive the weights are discussed in 'Weights: Report on NIDS Wave 1 Technical Paper no. 2 (Wittenberg, 2009).

Furthermore, the post-stratification weighting ignores the 2 915 non-resident household members without pid numbers resulting in 28 255 ($31\ 170 - 2\ 915$) members of the sample, that is representative of the population of 48 687 000. Most variables have non-responses such as 'don't know', 'missing', and 'refused to answer'. These are included in the analysis as they frequently constitute a small percentage of the sample and are often discounted and are noted as such. The non-respondents are included in the analysis unless it is stated otherwise. Consequently, analysis is conducted to address specific issues that need answering in the ensuing discussion.

The post-stratification of the sample does materially impact on the extrapolation to the population. This can be observed when the sample of the population is separated by geographical area.

Table 6: Comparison between sample and population

		Percentage-Sample	Cumulative percentage-Sample	Percentage-Population	Cumulative percentage - Population
RURAL FORMAL	Rural	9.8%	9.8%	6.6%	6.6%
TRIBAL		42.9%	52.7%	33.7%	40.3%
URBAN FORMAL	Urban	40.7%	93.4%	48.6%	88.9%
URBAN INFORMAL		6.7%	100%	11.1%	100%
Total		100%	0%	100%	0%

Source: NIDS (2009). Author's own calculation

It can be noticed in Table 6 that 52.7 per cent of the people live in 'rural' (RURAL FORMAL and TRIBAL AUTHORITY) areas according to the sample, but only 40.3 per cent of the population actually live in 'Rural' areas, underlining the importance of the use of the post-stratified weighting. Hence, the post-stratified weighting variable [*w1_wgt*] is applied to extrapolate the population in South Africa to give a more realistic picture as the unweighted result will be erroneous.

The survey analysis calculations were performed using STATA 10 statistical software. When comparisons are conducted between various groups, the F-test is employed to determine whether the difference in the means is statistically significant and robust. The F test tests the null hypothesis (Ho) that the variances are equal.

9.3 Descriptive statistics of population

It must be noted that for the purpose of this study a respondent is defined as an adult if he/she is 15 years or older on the day of the interview.

9.3.1 Overall population

The following descriptive analysis is employed to briefly describe the population of South Africa, after which a description of the adults and children is examined.

9.3.1.1 Population, by age intervals

An overview of the population by age group (*w1_age_intervals*) is shown in Table 7 below.

Table 7: Distribution of population, by age

Age	Percentage	Cumulative Percentage
Don't Know	1.2%	1.2%
Refused to answer	0%	1.2%
Missing	0.1%	1.4%
0-1	2.2%	3.6%
1-4	8.2%	11.8%
5-9	10.7%	22.4%
10-14	10.7%	33.1%
15-19	10.4%	43.6%
20-24	9.7%	53.3%
25-29	8.9%	62.1%
30-34	7.9%	70%
35-39	6.4%	76.4%
40-44	4.8%	81.2%
45-49	4.5%	85.8%
50-54	3.9%	89.7%
55-59	3.2%	92.9%
60-64	2.5%	95.4%
65-69	1.9%	97.3%
70-74	1.3%	98.6%
75-79	0.8%	99.4%
80-84	0.4%	99.8%
85+	0.3%	100%
Total	100%	

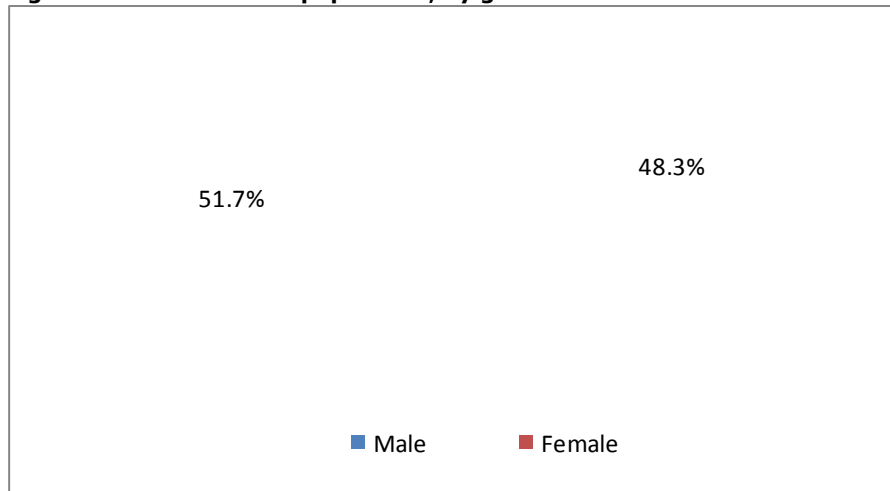
Source: NIDS (2009). Author's own calculation

Using the definition of the adults and children that is employed for this study, it can be noted that once the 'don't know', 'refused to answer' and 'missing' individuals are discounted, 31.8 per cent (33.1 per cent less the 1.4 per cent) of the population are children. This will be analysed further when social assistance to children is deliberated.

9.3.1.2 Population, by gender

The *w1_r_gen* variable is used to derive the proportion of males and females in South Africa as demonstrated below.

Figure 8: Distribution of population, by gender



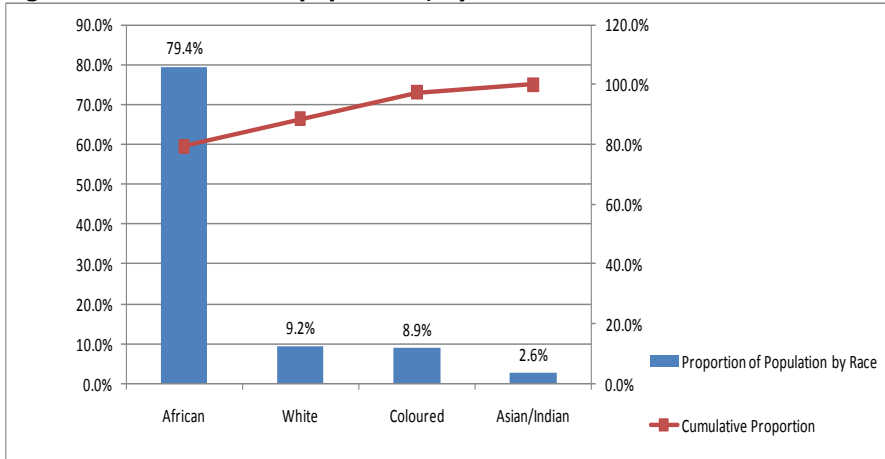
Source: NIDS (2009). Author's own calculation

An extrapolation of the weighted sample (Figure 8) reveals that 48.3 per cent (23 506 084) are males and 51.7 per cent (25 180 916) are females which adds up to the 2008 mid-year population estimate for 2008 of 48 687 000 (Statistics South Africa, 2008:3). Moreover, the mid-term population estimates of Statistics South Africa is 25 242 000 females and 23 444 800 males (Statistics South Africa, 2008:3)

9.3.1.3 Population, by race

The delineation of the population by race (*w1_best_race*) demonstrates that the African population represents 79.4 per cent of the population whilst the Asian/Indians constitute only 2.6 per cent of the population as observed in Figure 9 below.

Figure 9: Distribution of population, by race



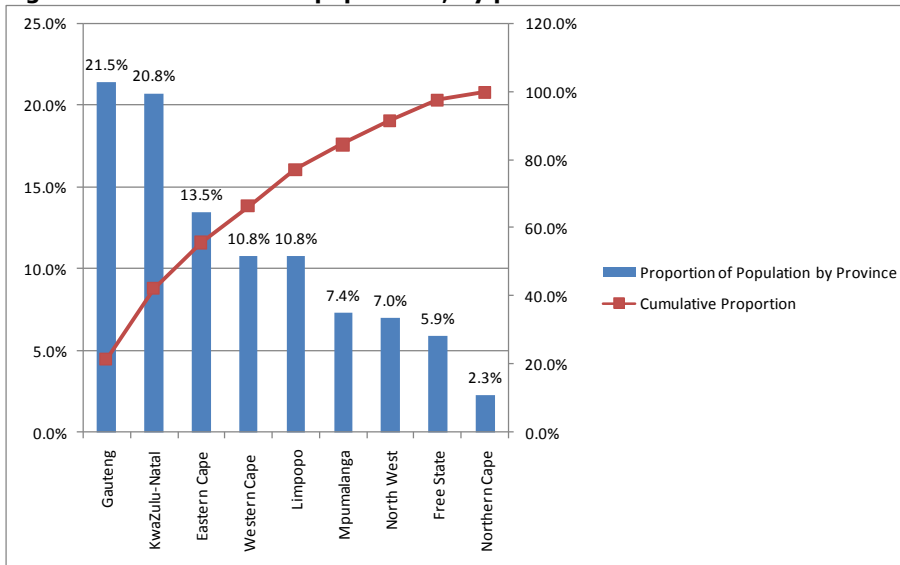
Source: NIDS (2009). Author's own calculation

It can be observed from Table 9 above that the Africans (79.4 per cent) and Whites (9.2 per cent) collectively constitute almost 90 per cent of the population of South Africa.

9.3.1.4 Population, by provinces

A description of individual residency by province is determined by employing the *w1_hhprov* variable.

Figure 10: Distribution of population, by province



Source: NIDS (2009). Author's own calculation

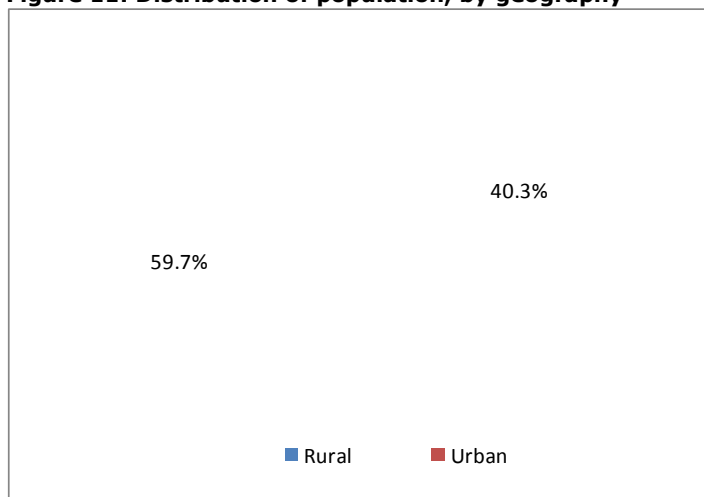
It can be noticed that the majority of the population resides in Gauteng (smallest province geographically) with the fewest residing in the Northern Cape (largest

province geographically). It is worthy to note that both Western Cape and Limpopo have the same number of citizens with the Western Cape being the more urban whilst the Limpopo is the most rural. It can also be observed in Figure 10, that more than 40 per cent of the population in South Africa reside in Gauteng (21.5 per cent) and KwaZulu-Natal (20.8 per cent).

9.3.1.5 Population, by geography

The NIDS data distinguishes geography of residence by using four categories, namely Rural Formal, Tribal Authority, Urban Formal and Urban Informal. For the purpose of this study the Rural Formal and Tribal Authority are combined to form the 'rural' category whilst the Urban Formal and Urban Informal are both classified as 'urban'.

Figure 11: Distribution of population, by geography



Source: NIDS (2009). Author's own calculation

Figure 11 above corroborates the results that were alluded to in Table 6 above. It must be noted that whilst the sample has more (52.7 per cent) rural individuals compared to urban (47.3 per cent) residents; the post-stratified weighting when extrapolated to the population indicates that there are more people living in urban areas than rural areas in South Africa as discussed earlier.

The delineation of the population as adults and children is discussed below in detail when the analysis is done.

9.3.2 Descriptive statistics of adult population

The NIDS survey has 16 885 adult respondents, of which 1 246 observations have no data beyond section A of the questionnaire, as these individuals refused to participate in the survey, leaving 15 639 observations which were used in the analysis.

9.3.2.1 Adult population, by age

The adult population extends from age 15 to 105, which can be observed in Table 8 below. Post-stratified weight [*w1_wgt*] is applied to the sample of 16 885 adults to reveal an adult population of 30 234 306 adults, which is also inclusive of 14 year olds who were misclassified as adults. When these 1 246 adults are discounted from the analysis, the adult population (15 639) is extrapolated to represent 27.5 million adults in South Africa; consisting of 12 019 723 adult males (total male population of 23 506 084 [extrapolated]) and 15 485 364 adult females (total female population of 25 180 916 [extrapolated]) from the total population of 48 687 000.

Table 8: Distribution of adults, by age

Age	Number	Cumulative Population	Percentage	Cumulative Percentage
Don't Know	359 788	359 788	1.2%	1.2%
Refused	6 047	365 835	0%	1.2%
Missing	51 398	417 233	0.2%	1.4%
14	78 609	495 843	0.3%	1.6%
15	810 279	1 306 122	2.7%	4.3%
16	985 638	2 291 760	3.3%	7.6%
17	864 701	3 156 462	2.9%	10.4%
18	1 015 873	4 172 334	3.4%	13.8%
19	976 568	5 148 902	3.2%	17.0%
20	934 240	6 083 142	3.1%	20.1%
21	840 514	6 923 656	2.8%	22.9%
22	816 326	7 739 982	2.7%	25.6%
23	846 561	8 586 543	2.8%	28.4%
24	789 115	9 375 658	2.6%	31.0%
25	764 928	10 140 586	2.5%	33.5%
26	849 584	10 990 170	2.8%	36.4%
27	737 717	11 727 887	2.4%	38.8%
28	767 951	12 495 839	2.5%	41.3%
29	783 069	13 278 907	2.6%	43.9%
30	595 616	13 874 523	2%	45.9%
31	743 764	14 618 287	2.5%	48.4%
32	767 951	15 386 238	2.5%	50.9%
33	740 740	16 126 979	2.5%	53.3%
34	659 108	16 786 087	2.2%	55.5%
35	565 382	17 351 468	1.9%	57.4%
36	628 874	17 980 342	2.1%	59.5%
37	604 686	18 585 028	2%	61.5%
38	562 358	19 147 386	1.9%	63.3%
39	529 100	19 676 486	1.8%	65.1%
40	377 929	20 054 415	1.3%	66.3%
41	450 491	20 504 906	1.5%	67.8%
42	399 093	20 903 999	1.3%	69.1%
43	453 515	21 357 514	1.5%	70.6%
44	501 889	21 859 403	1.7%	72.3%
45	390 023	22 249 426	1.3%	73.6%
46	432 351	22 681 776	1.4%	75.0%
47	438 397	23 120 174	1.5%	76.5%
48	362 812	23 482 985	1.2%	77.7%

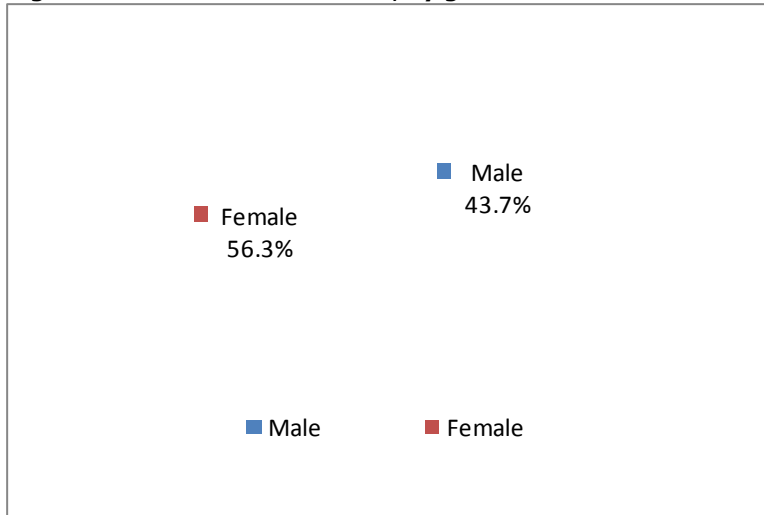
Age	Number	Cumulative Population	Percentage	Cumulative Percentage
49	408 163	23 891 149	1.4%	79.0%
50	380 952	24 272 101	1.3%	80.3%
51	390 023	24 662 123	1.3%	81.6%
52	371 882	25 034 005	1.2%	82.8%
53	281 179	25 315 184	0.9%	83.7%
54	359 788	25 674 973	1.2%	84.9%
55	350 718	26 025 691	1.2%	86.1%
56	308 390	26 334 081	1%	87.1%
57	290 249	26 624 330	1%	88.1%
58	281 179	26 905 509	0.9%	89.0%
59	193 500	27 099 008	0.6%	89.6%
60	275 132	27 374 141	0.9%	90.5%
61	217 687	27 591 828	0.7%	91.3%
62	205 593	27 797 421	0.7%	91.9%
63	253 968	28 051 389	0.8%	92.8%
64	187 453	28 238 842	0.6%	93.4%
65	160 242	28 399 084	0.5%	93.9%
66	163 265	28 562 349	0.5%	94.5%
67	157 218	28 719 567	0.5%	95.0%
68	226 757	28 946 325	0.8%	95.7%
69	133 031	29 079 356	0.4%	96.2%
70	117 914	29 197 269	0.4%	96.6%
71	133 031	29 330 300	0.4%	97.0%
72	93 726	29 424 027	0.3%	97.3%
73	120 937	29 544 964	0.4%	97.7%
74	93 726	29 638 690	0.3%	98.0%
75	57 445	29 696 135	0.2%	98.2%
76	90 703	29 786 838	0.3%	98.5%
77	99 773	29 886 611	0.3%	98.9%
78	48 375	29 934 986	0.2%	99.0%
79	45 351	29 980 338	0.2%	99.2%
80	36 281	30 016 619	0.1%	99.3%
81	39 305	30 055 924	0.1%	99.4%
82	48 375	30 104 298	0.2%	99.6%
83	27 211	30 131 509	0.1%	99.7%
84	12 094	30 143 603	0%	99.7%
85 -105	90 703	30 234 306	0.3%	100.0%
Total	30 234 306		100.0%	

Source: NIDS (2009). Author's own calculation.

9.3.2.2 Adult population, by gender

The distribution of the adult population by gender is illustrated in Figure 12 below.

Figure 12: Distribution of adults, by gender



Source: NIDS (2009). Author's own calculation

The distribution of adults by gender notes that there is 56.3 per cent (12 019 723) females and 43.7 per cent (15 485 364) males of a total population of 27 505 087 adults.

9.3.2.3 Adult population, by race

The distribution of the population of adults among the race groups has to take cognisance of the fact the some respondents refused to answer and there were missing variables. Consequently, the post-stratified weighting of adult population as represented by the NIDS data is observed in Table 9 below.

Table 9: Distribution of adults, by race

	Number	Percentage
Refused	24 755	0.1%
Missing	264 049	1.0%
African	21 456 718	78%
Coloured	2 271 920	8.3%
Asian/Indian	709 631	2.6%
White	2 778 014	10.1%
Total	27 505 087	100%

Source: NIDS (2009). Author's own calculation

Not surprisingly, the African population represents 78 per cent of the adult population with the Asian/Indians being the least represented. A further cross tabulation of adults by race and gender is revealed in Table 10 below.

Table 10: Distribution of adults, by race and gender

	Male	Female	Total	Percentage of males within the race group	Percentage of females within the race group
Refused	11 002	12 377	23 379	47.1%	52.9%
Missing	123 773	141 651	265 424	46.6%	53.4%
African	9 387 486	12 069 232	21 456 718	43.8%	56.2%
Coloured	948 926	1 322 995	2 271 920	41.8%	58.2%
Asian/Indian	313 558	396 073	709 631	44.2%	55.8%
White	1 234 978	1 543 035	2 778 014	44.5%	55.5%
Total	12 019 723	15 485 364	27 505 087	43.7%	56.3%

Source: NIDS (2009). Author's own calculation

It can be observed that the largest group is African females (12 069 232) whilst the smallest group is Asian/Indian males (313 558). It can also be observed that the female population is greater than the male population for all race groups. The ratio between females and males for African, White and Asian/Indian is 56:44 whilst the ratio between Coloured females and males is 58:42.

The sample consists of numerous variables that can be used to describe adults and to differentiate between adults in the sample. The relevant variables are discussed when analysis is conducted about adults in the sample with respect of social transfers for adults being made conditional.

Similarly with children, only the variables pertaining to this study will be discussed in depth, whilst most will not feature in the discussion or in the analysis.

9.3.3 Descriptive statistics of children

The NIDS survey has 9 616 children who are classified as children, however 208 observations have no data beyond section A as these individuals refused to participate in the survey. This leaves the dataset with 9 408 observations which are used for the analysis.

9.3.3.1 Children population, by age and gender

The children sample consisting of the 9 616 observations transposes to a population size of 15 534 999 children; whilst the 9 408 sample transposes to a population of 15 083 925 children. Nevertheless, the distribution of children among the different age groups is observed in Table 11 below.

Table 11: Distribution of children, by age and gender

	Male	Female	Total	Percentage male of total children population	Percentage of female of total children population	Percentage total
Don't Know	48 269	25 643	73 911	0.3%	0.2%	0.5%
0	508 328	529 446	1 039 282	3.4%	3.5%	6.9%
1	509 837	475 144	984 980	3.4%	3.2%	6.5%
2	464 585	543 021	1 007 606	3.1%	3.6%	6.7%
3	524 921	419 333	945 762	3.5%	2.8%	6.3%
4	482 686	426 875	909 561	3.2%	2.8%	6.0%
5	565 647	484 194	1 049 841	3.8%	3.2%	7.0%
6	438 942	457 043	895 985	2.9%	3.0%	5.9%
7	493 244	547 546	1 039 282	3.3%	3.6%	6.9%
8	535 479	515 870	1 052 858	3.6%	3.4%	7.0%
9	541 513	512 853	1 054 366	3.6%	3.4%	7.0%
10	432 909	467 602	899 002	2.9%	3.1%	6.0%
11	529 446	536 988	1 064 925	3.5%	3.6%	7.1%
12	503 803	517 379	1 021 182	3.3%	3.4%	6.8%
13	564 139	466 093	1 030 232	3.7%	3.1%	6.8%
14	491 736	491 736	984 980	3.3%	3.3%	6.5%
15	13 576	18 101	30 168	0.1%	0.1%	0.2%
Total	7 649 058	7 434 867	15 083 925	50.7%	49.3%	100.0%

Source: NIDS (2009). Author's own calculation

It can be observed that the percentage of children is almost evenly distributed among the age groups. It must be noted that the 15 year age group constitutes only 0.1 per cent (30 168) of the children sample. This is primarily due to most 15 years old being classified as adults as per the criteria of the NIDS sample. Moreover, these 15 year olds are misclassified as children. A separation of children by gender reveals a split of almost 51:49 split between male and female children which is 7 649 058 males and 7 434 867 female children.

9.3.3.2 Children population, by race

A detailed breakdown of children by race group shows that that most of the children are African and the fewest are Asian/Indian.

Table 12: Distribution of children, by race

	Percentage	Number
Refused	0%	4 525
Missing	0.3%	37 710
African	84.9%	12 807 761
Coloured	7.9%	1 191 630
Asian/Indian	1.8%	273 019
White	5.1%	761 738
Other	0.1%	7 542
Total	100%	15 083 925

Source: NIDS (2009). Author's own calculation

Whilst Africans are the largest group for both adults and children, there is a larger proportion of children (84.9 per cent) who are African compared to adults (78 per cent) [Table 12, above]. Interestingly, all other race group's adult population is a bigger percentage than that of Africans due to the relatively higher mortality (section 9.4.1.2) amongst the Africans.

The above description gives a broad overview of the population that can be extrapolated from the sample in the following manner.

Table 13: Extrapolation of sample to population estimate

	Sample	Population (estimate)	Population (estimate)
Adults	16 885	30 234 306	
<i>Adults (who responded)</i>	15 639		27 505 087
Children	9 616	15 534 999	
<i>Children (who responded)</i>	9 408		15 083 925
Non-residents	2 915	-	-
Unable or unavailable to answer questions	1 754	2 917 695	
Total Population	31 170	48 687 000	42 589 012

Source: NIDS (2009). Author's own calculation

It can be observed from Table 13 that the sample composes of 16 885 adults which transposes to 30 234 306 in the adult population. However, only 15 639 adults

responded beyond section A of the questionnaire which transposes to a population of 27 505 087 adults. Similarly, with the children sample which has 9 616 children, which is extrapolated into 15 534 999 children. However, only 9 408 responded beyond section A resulting in a population estimate of 15 083 925. Hence, it can therefore be derived that the 1 754 'unable or unavailable to answer questions' will be representative of the balance of the population which is 2 917 695.

This is one of the reasons why the extrapolated grants number from the NIDS data will be lower than the actual numbers for 2008/09 (Table 5). The other explanation for the lower numbers is that the grant numbers for 2008/09 (Table 5) were for the end of that financial year. That is, the figures are representative for 31 March 2009. Whilst the figures for the NIDS study, are representative for 2008/09, is for the period until October 2008, when the study fieldwork was conducted.

The last factor that must not be forgotten is the age limits for the FCG and the CDG. These grants are applicable to children who are under 18 as per requirement stipulated by SASSA (2010), while the sample defines children as individuals under 15. Consequently, the number of FCG and CDG will exclude children between 15 and 18 as they are classified as adults in the NIDS study.

9.4 Suitability of present social assistance for conditionality

Social assistance in South Africa such as Child Support Grant (CSG), Old Age Pension (OAP), and Disability Grant (DG) is widely available, which impacts positively on the fight against poverty (sections 6.4.2.5 [OAP] and 6.4.2.8.1 [CSG]). The current six major non-conditional transfers benefited close to 14 million people in 2009/10 as observed in Table 5. These grants are not universal and targeted to only certain segments of the population. The CSG and the Foster Care Grant (FCG) are targeted to the young, the DG is targeted at disabled adults, the Care Dependency Grant (CDG) is targeted at disabled children, and the Older Age Pension (OAP) as well as the War Veterans Grant (WVG) are targeted at the elderly. There is no grant that is targeted at the unemployed despite the high unemployment rate, which has resulted in many adults being in poverty with no formal social assistance at all. This situation is often exacerbated by the lack of skills that render many of these individuals unemployable, anchoring them in life of poverty.

Whilst all the grants may be making an impact on poverty, the recipients of some of the grants and the criteria for qualification for the grant do not easily lend themselves to conditionality.

The following sections evaluate in an iterative manner which social transfers do **not** lend them to conditionality. Hence, the analysis and ensuing discussions begins with the premise that all of the above grants are eligible for conditionality. It is against this background that the present social assistance grants were evaluated.

9.4.1 Social transfers to adults

The grants pertaining to adults are deliberated followed by the social transfers to children. Furthermore, some of the social transfers depend on the need of the individual to receive the grant.

9.4.1.1 War Veteran Grants (WVG)

The NIDS sample only has two respondents (one African female [who claimed to be receiving R1 600 per month] and one White male [who claimed to be receiving R11 000 per month]) who receive the War Veterans Grant out of a sample 15 628. The NIDS data translates into a population of 1 842 (1 500 according to Table 5) recipients who receive the grant.

The conditionality would be implemented on the belief that it would improve the long-term earning potential of the individual or the household. This is of little value to the recipients of the WVG as they are already too old to fulfil any conditionality. Secondly, what condition does one apply to the WVG? These individuals will not benefit from education or health conditionalities. Thirdly, the number of recipients receiving WVG has been decreasing over the years and the WVG will cease to exist in the future. Therefore, the WVG should not have any other conditions attached.

9.4.1.2 Disability Grant (DG)

The DG is targeted to adults (definition for the grant and not used in the survey) from the age of 18 until they receive their pension after which the DG is converted to OAP as the benefits for the OAP and DG are the same. It is very probable that some respondents, who were receiving an OAP after it was converted from a DG, may

have indicated that they were receiving a DG. Similarly, some recipients who are collecting an OAP, but do not qualify for the OAP, may be real recipients of the DG.

Consequently, adult respondents in the survey who receive OAP, but do not qualify for them have to be reclassified as recipients of DG. Similarly, there could be adults who receive DG, but qualify for the OAP and have to be reclassified as recipients as OAP.

Table 14: Classification of adult recipients of the DG and OAP

	Disability Grant (DG)	Older Age Pension(OAP)	Care Dependency Grant CDG)	Total
NIDS Sample	734	1 845		2 579
Recipients <18 who are receiving DG	9			
Females >= 60 receiving DG	33			
Males>=63 receiving DG	19			
Recipient <60 receiving OAP		178		
Males>=60 but less than 63 receiving OAP		24		
Total	875	1 695	9	2 579

Source: NIDS (2009). Author's own calculation

The reclassification of the adult recipients in the sample into the respective categories can be noted in the Table 14 above.

Firstly individuals below the age of 18 who are receiving the DG have to be removed as they are possibly recipients of the Care Dependency Grant. Since there are adults older than 60 years who receive DG, not all of them remain as DG recipients and should be converted to OAP recipients, once they qualify for pension. Specifically, women older and equal to 60 have to be discounted and 'added' to the OAP sample, even though they may have been indicated as receiving DG. Consequently, 33 women older than 60 have to be removed from the DG sample and added to the OAP sample.

Similarly, men older and equal to 63 of age and receiving DG have to be removed and added to the OAP sample. Hence, 19 men older than 63 have to be removed from the sample and added to the OAP sample.

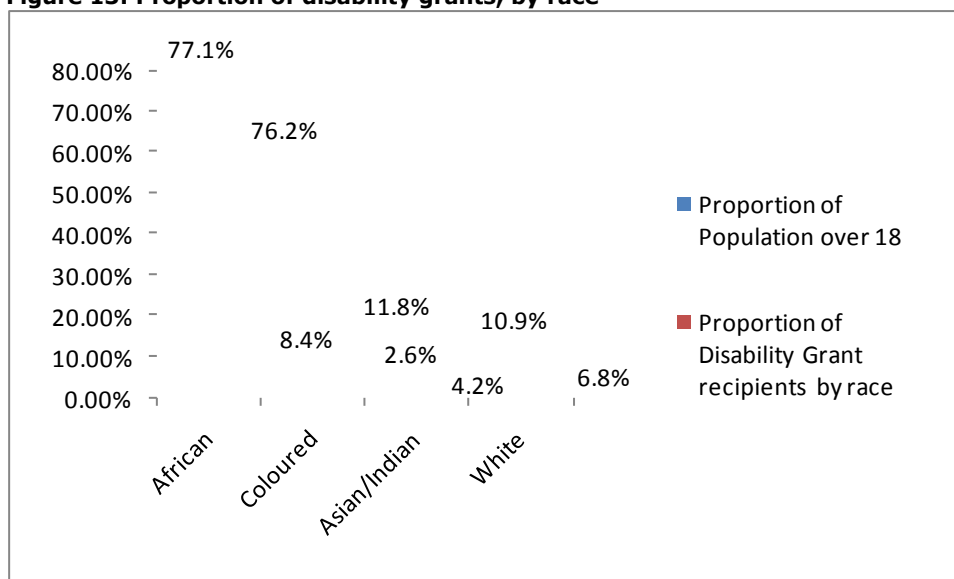
Similarly, recipients of the OAP who are incorrectly receiving the OAP should be classified and added to the DG sample. Hence, 178 people younger than 60 are removed from the OAP sample and added to the DG sample. Similarly, 24 men older

and equal to 60 and younger than 63 years old who are receiving the OAP need to be reclassified as recipients of the DG.

The reclassification of the beneficiaries of the adult sample transposes (with the post-stratified weight [*w1-wgt*]) to 4.6 per cent (1 271 684) of the adult population who are receiving the DG. Before the reclassification, the sample indicated that 4 per cent of adults (1 096 765) were DG beneficiaries. Hence, extrapolation of the reconfigured sample extrapolation is closer to the 2008/09 figures of 1 286 883 (Table 5) that are provided by the SASSA (Annual Report, 2008/09:18).

In this study the proportion of people who are older and equal to 18 who are receiving the grant are compared to those not receiving the grant. Consequently, the race and gender comparison can only be made for persons older than and equal to 18.

Figure 13: Proportion of disability grants, by race

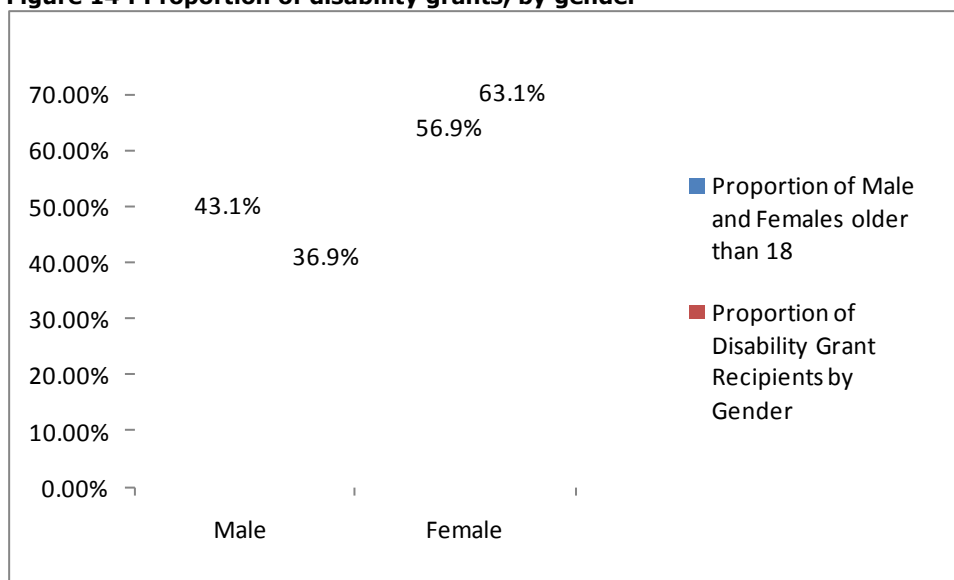


Source: NIDS (2009). Author's own calculation

Whilst Africans constitute the largest population group, it is not surprising that they are the largest beneficiaries of disability grants. However, relative to their numbers in the population, there are fewer Africans receiving the DG. It is noteworthy that the Coloured and Asian/Indian populations receive more disability grants relative to their population sizes. Since the incidence of sicknesses and diseases as well as mortality is higher among the African population (as evidenced by the lower proportion of African adults compared to children) they would be expected to be larger

beneficiaries of DG. Statistics South Africa (2004:10) noted that when looking at poor health, Africans were perceived to have the worst health at 12.7 per cent compared 10.4 per cent to the Coloured population who were the second worst. Furthermore, it has been estimated that whilst on average 38.4 per cent of 15 year old South African men could expect to die before age 60, this estimate was 40 per cent for African men (Bradshaw, Schneider, Norman, and Bourne, 2006:10). Therefore, it can be inferred that access to these grants for Africans is lower than for the other groups. The larger female population relative to males also finds expression in respect to DG beneficiaries by gender as observed in Figure 14 below.

Figure 14 : Proportion of disability grants, by gender



Source: NIDS (2009). Author's own calculation

Interestingly, whilst females make up 56.9 per cent of the adult population, they receive a disproportionate 63.1 per cent of the DG. In addition, the 2001 census noted that disability among males was 5.1 per cent, whilst among female it was 5.0 per cent (Statistics South Africa, 2001:12). There could be several reasons why females are receiving relatively more DGs, although they experience similar disability levels. Firstly, although disability is a qualifying criterion, the DG is means tested. Hence, whilst the prevalence of disability incidence may be similar, more females are accessing the grant as they are judged to be more in need. Furthermore, disabled people are employable in South Africa, but the unemployment rate of females is higher than that of males. The UNDP (2003) found that in 2002, 71.1 per cent of the economically active male population participated in the labour market, compared to

40.4 per cent of females in South Africa (Naidu, Haffejee, Vetten and Hargreaves, 2005:13). Females will have less income and may be unable to meet the criteria of the means test relative to men. Furthermore, the poverty rate of female-headed households is twice that of male-headed households (Fish 2003:405 *in* Naidu et al, 2005:13).

Secondly, people can receive the grant when they are temporarily disabled and lose the DG once they get better. The HIV/AIDS recipients can temporarily qualify for the grants and it could be possible that more females are accessing the grant temporarily or permanently because of HIV/AIDS. The Human Science Research Council (HSRC, 2008:31) study on the South African National HIV Prevalence, find that for all 5 year cohorts between 15 years and 40 years old, female prevalence of HIV is greater than males. Therefore, more females could be accessing the grant relative to males.

Thirdly, the statistics are for disability of the entire population, and not specific for certain age groups. The Department of Health notes that disability is more prevalent (23.1 per cent) among the female population of over 65 compared to their male counterpart (22 per cent) (Department of Health, 1997:2).

The conditionalities (health and education) that are attached to most of the social assistance will not be practical nor feasible to achieve, implement and monitor and evaluate. Firstly, the health conditionality is for the development of the individual rendering the health condition being redundant and burdensome. The Jamaican *Program of Advancement through Health and Education* (PATH) CCT programme requires disabled individuals (as well as elderly) who participate in the programme to visit health centres twice a year at six months intervals. But the most disabled are excused from this conditionality so that their families are not penalised.

Secondly, those individuals with temporary illnesses forfeit the grant once they get better and become employable. Current recipients are randomly reviewed to determine if they are disabled to such an extent that they cannot be employed. There is no need to implement the regular check-up condition as it is already a feature of the DG.

Thirdly, if an education condition is applied to the grant, it must apply to all recipients; and not selected young recipients who are most likely to benefit. The more disabled will not even be able to attend vocational training and will either be discriminated against or will have to be exempted, which could undermine the conditionality.

Fourthly, the CCTs are aimed at addressing long-term poverty, which may not be appropriate for some beneficiaries as the improvement of health (and education) will have minimal impact on their long-term earnings. Moreover, the disability of these individuals is already burdening them and an onerous imposition of health conditionality will require more resources from both the individual and their caregivers.

The age of the disabled individual will preclude them from the conditionality of the education criteria; and the existence of the disability also excludes them from conditionality. Moreover, the criteria of disqualifying those who get better (HIV positive patients) and the disqualification for being taken care of in a state institution need to be reformed.

Similarly, the health and education conditionality will also have little value to the recipients of the Old Age Pension. Therefore these considerations are also instrumental in not making OAP conditional, which is discussed below.

9.4.1.3 Old Age Pension (OAP)

The age criteria for OAP prior to 2008 were 60 for females and 65 for males. The policy was subsequently amended to reach parity of 60 by 2010. That is, the age limit of males has decreased every year until 01 April 2010 when both women and men will be eligible for the OAP on their 60th birthday. The NIDS study was conducted during the change over and therefore women older and equal to 60 and men older and equal to 63 years of age were the eligible recipients.

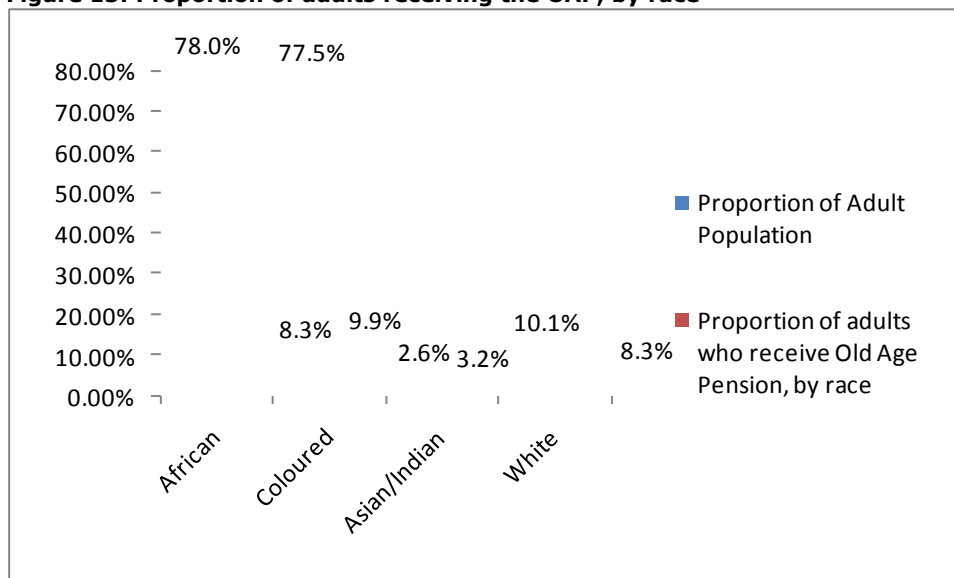
The NIDS original sample of OAP recipients reveals that 1 845 of the NIDS adult population are OAP recipients, which translates (post-stratified weighting [*w1_wgt*]) into an adult population of 2 204 495. However, the recipients of OAP have to be

separated (as in the DG) between those who should be classified as OAP recipients and those who are DG recipients (Table 14).

The reclassification of the grants results in the NIDS sample having a population of 1 990 706 (7.26 per cent) who are receiving the OAP, which is significantly lower when the data which is not 'cleaned'. Consequently, there is a difference of 399 837 individuals who are not accounted for in the NIDS dataset when compared to the SASSA data (Table 5).

It is noteworthy that the employment of the unclean data for OAP, gives a closer approximation of the actual beneficiaries of OAP, with the unclean DG data resulting in an under-counting of the DG beneficiaries. In addition, this must also be seen in the context of people who did not respond which could also account for the difference between the NIDs and the SASSA (Annual Report, 2008/09:18) figures. It can be deduced from Table 13 above, that 2.7 million (30 234 306 - 27 505 087) of the unaccounted population of 2.9 million are adults, which could in part account for the difference between the extrapolated figures and the actual numbers. More importantly, the data of the OAP recipients as well as DG are not for conditionality analysis, but only for descriptive purposes.

Figure 15: Proportion of adults receiving the OAP, by race



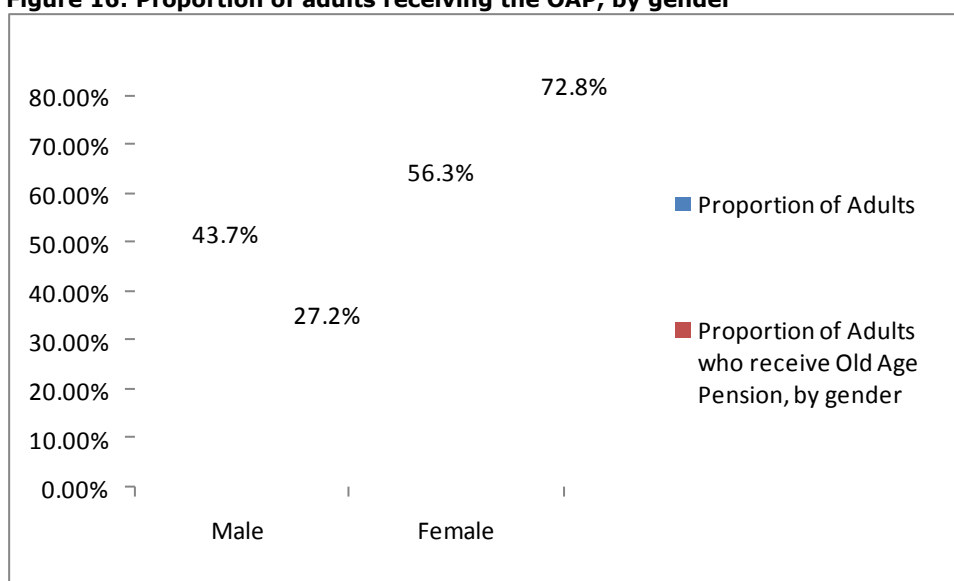
Source: NIDS (2009). Author's own calculation

It can be noted from Figure 15 that most recipients of the OAP are Africans, which is proportionate to their population size. The Asian/Indian and Coloured population are

receiving disproportionately more of the OAP than their population sizes, whilst the White population is receiving less. Given that the income levels of the White population are higher and the OAP is means tested, it can be surmised that many White individuals are excluded from the OAP due to their relatively higher income levels.

One would also expect to find that females who constitute a larger proportion of OAP beneficiaries as there are more females who are economically inactive in their non-pension years and would not have saved for pensions.

Figure 16: Proportion of adults receiving the OAP, by gender



Source: NIDS (2009). Author's own calculation

It is most striking that whilst the female population only makes up 56.3 per cent of the adult population they are receiving 72.8 per cent of the OAP. As was the case with the disability grant, the most probable explanation for the greater proportion of recipients being female, is that the OAP is means tested. Whilst age is a qualifying criterion, women are more likely to be dependent and will not be as well off as men; as well as the poverty levels among women being greater as they may not have saved as much, relative to men.

The OAP is already means tested to target the neediest of the elderly, and the application of educational and health conditionality would not be applicable to them. Moreover, pensions are a significant contributor to poverty alleviation (section 6.4.2.5) in many households. The age of the beneficiaries will preclude them from

fulfilling the education conditions. But the health condition (of regular visits) could be possible as it is in the *PATH* (Jamaican) CCT programme. However, this may not be feasible in the South African context. The OAP (section 6.4.2.5) contributes largely to poverty alleviation for poor households. Resources will have to be diverted to ensure that they meet these conditions. The resources could be better utilised in the household. The supply constraints (health centres) may be limited, further burdening the recipients. Moreover, the sanction for non-compliance may not only punish the elderly, but also those that are most dependent (grandchildren) [sections 6.4.2.5, and Tables 51 and 52] on them. Therefore, OAP as well as the DG and the WVG are not suitable for conditionality.

Therefore it makes sense to make only social transfers meant for children conditional. It is for this reason that most CCT programmes are targeted primarily to children.

It against this backdrop that the social assistance transfers to children are evaluated to ascertain their suitability for conditionality. Moreover, as this policy is crucial to improve the lives of children and to prevent long-term poverty, the grants that go to children would appear to be the most suitable for conditionality.

For that reason, the Care Dependency Grant, the Foster Care Grant and the Child Support Grant are evaluated to determine the feasibility of attaching conditions to them.

9.4.2 Social transfers to children

Since these grants are targeted at children, they may lend themselves particularly for conditionality as a means to improve the health and education outcomes and to address long-term poverty.

According to the NIDS data there are 5 940 children who responded to the question regarding receiving government grants, as observed in Table 15 below.

Table 15: Proportion of children receiving the grants, CSG, FCG and CDG

	Number of recipients	Percentage of sample	Cumulative percentage of sample
Don't Know	1	0%	0%
Missing	126	2.1%	2.1%
Child Support Grant	5 557	93.6%	95.7%
Foster Care Grant	202	3.4%	99.1%
Care Dependency Grant	54	0.9%	100%
Total	5 940	100%	

Source: NIDS (2009). Author's own calculation

It can be observed that 93.6 per cent of grants received (as per the NIDS data) are the CSG, with the lowest percentage being the CDG. The CDG exclude the nine adult disability grant recipients who were below 18. It assumed that these nine disability grant recipients belong within the CDG category as they indicated that they are receiving a disability grant, and as they are not adults and are therefore classified within the CDG category. Once they are included in the sample this increases the number of children receiving a government grants to 5 949 in the sample as observed in Table 16 below.

Table 16: Proportion of children receiving the grants as per the sample (including misclassifications of the DG)

Type of grant	Number of recipients	Percentage of sample	Cumulative percentage of sample
Don't Know	1	0%	0%
Missing	126	2.1%	2.1%
Child Support Grant	5 557	93.4%	95.6%
Foster Care Grant	202	3.4%	98.9%
Care Dependency Grant	63	1.1%	100%
Total	5 949	100%	

Source: NIDS (2009). Author's own calculation

Hence, there are 63 within the sample that are receiving the CDG. The CDG applies to individuals who are below 18, but the NIDS sample only applies to children who are younger than 15 plus the nine individuals. However, for the purpose of this study the children who are receiving any grant are 5 940 recipients from a total of 9 408 children in the sample. This sample translates (post-stratification weight [*w1_wgt*]) into a population of children, of which 93.4 per cent are receiving the CSG; with the CDG making up only 0.7 per cent of the children receiving the CDG as observed in Table 17 below.

Table 17: Proportion of children receiving the grants, extrapolated to the population

	Percentage of children receiving grants
Don't Know	0%
Missing	2.4%
Child Support Grant	93.4%
Foster Care Grant	3.5%
Care Dependency Grant	0.7%
Total	100%

Source: NIDS (2009). Author's own calculation

Moreover, it is instructive to note that the recipients of these grants pertain to children younger than 15. The CDG and the FCG are also received after the age of 15 and are not included in the sample, and would be the probable explanation for these numbers differing from those that actually receive the grant (Table 5).

9.4.2.1 Care Dependency Grant (CDG)

According to the Budget Review (2010:105) there were 107 065 recipients (2008/09) of CDG, which is higher than that which is extrapolated from the NIDS sample. This could be due to the sample pertaining to children (who are older than 15) that are not captured within the NIDS data. Nevertheless, this does not undermine the policy option of whether to render this grant conditional.

The special needs of the disabled child would be more costly and more burdensome on the parents than the needs of a non-disabled child. The criteria of providing care and stimulation does indicate that many of these children will have special vocational/educational needs and that they will not necessarily benefit from the educational conditionalities that will be applicable to children who do not need special care. The educational needs for non-disabled children are different from those of disabled children, and placing a condition (e.g. attending school) that will be achievable may not be possible for a disabled child who is mentally incapacitated or bed-ridden. There will have to be separate conditions which are not only different from those applicable to the able-bodied children, but also different conditions for the different disabilities. This may lead to discrimination against some disabled children relative other disabled children; as well as relative to able-bodied children.

Besides needing more care and subsequent resources, the parent/guardian may not be able to work as he/she has to look after the child. Hence, the opportunity cost of taking care of a disabled child will be higher compared to a normal child. Due to the

above arguments it would not be feasible to implement the CDG with any additional conditions.

9.4.2.2 Foster Care Grant (FCG)

The FCG is intended for children who are placed in the care of a guardian due to their biological parents not being able to take care of them. The FCG is also available to refugees who adopt South African children. Many children are orphaned due to the ravages of HIV/AIDS. The Health Systems Trust (employing the Actuarial Society of South Africa Aids Model) [2010a] reveals that maternal AIDS orphans⁸ less than 18 years old increased from 1 018 548 in 2006 to 1 674 359 in 2010. The FCG is increasingly being accessed to provide support to the guardians of children who have lost their biological parents due to the AIDS epidemic (Pendlebury et al, 2009:80).

The number of FCG recipients has increased from 42 999 in 1996/97 to 474 759 in 2008/09 (SASSA Annual Report, 2008/09:18) representing an average annual growth of the FCG of 22 per cent over the last 14 years (Table 5), emphasising the huge demand for this grant. These figures are higher than the 312 325 that are generated by the NIDS data. It is important to note that the population extrapolation of the FCG excludes recipients between the ages of 15 – 18.

Moreover, a Report on the Incentive Structures of Social Assistance in South Africa, which was commissioned by the Department of Social Development, notes that 52 per cent of foster children were 13 years or older, 10 per cent were younger than 7 years and 8 per cent were older than 17 years. Hence, most foster children (52 per cent) were in the age group that rendered them ineligible for CSG (DOSD, 2006: viii). Consequently, 38 per cent of foster children were between the ages of 7 and 13.

The NIDS study (albeit for children younger than 15) reveal that 48 per cent of foster children live with their grandparents and 11 per cent live with their aunt/uncle, providing some evidence that this phenomenon is indeed occurring. The Report on the Incentive Structures of Social Assistance in South Africa, notes that in 41 per cent of cases, the foster parent was the grandmother, in 30 per cent of the cases the

⁸ Number of children under 18 years who have lost a mother due to HIV/AIDS

foster parent was the aunt and in 12 per cent of cases other relatives were fostering the child (DOSD, 2006:viii).

Another possible reason postulated for the increasing number of people claiming FCG is that it is of greater value (R710) than the CSG (R250), which is deliberated in section 6.4.2.7.

The FCG could lend itself to conditionality to ensure that the foster parent takes proper care of the child and their educational and health requirements are adequately fulfilled. Furthermore, conditionality would also serve as a deterrent for people to adopt children.

While the value of the grant may indeed be the reason many people foster children, the imposition of conditionality could act as a disincentive for people to foster children, which will present the authorities with more challenges. Firstly, the state will have to look after the children which may be more costly than the grant. Many of these children are orphans of parents who have passed away because of HIV/AIDS and will require special care (especially if the children themselves have HIV/AIDS) which the state may not be capable of providing. Hence, this could be the main reason why most foster children are with the extended family as there are blood bonds.

Furthermore, when more than one sibling is fostered, it would be beneficial if they remain together, strengthening the case for fostering by family members. Whilst not empirically demonstrated, the cost of imposing conditionality (which can be empirically estimated) will have to be weighed against the benefits (e.g. care and support of family) which cannot always be calculated.

The conditionality (school attendance) could be imposed on the recipients to ensure that these children receive an education that will ensure that they will not to be trapped in poverty. The imposition of school attendance as a condition is discussed in the next chapter in great detail. But a comparison of the school attendance by recipients of the different grants does provide some insight into whether this conditionality should imposed on the FCG. The variable 'Has the child ever attended school?' [*w1_c_edatt*] which refers to children over the age of seven, is employed to

compare attendance at schools for the three grants. Post-stratification weighting [*w1_wgt*] is applied to attain comparable population estimates as observed in the Table 18 below.

Table 18: Proportion of children attending school versus those not attending school for the CSG, FCG and CDG

	Child Support Grant	Foster Care Grant	Care Dependency Grant
Attending School	96%	98%	69.8%
Not Attending School	4%	2%	30.2%
Total	100%	100%	100%
F-Stat	3.85		
Prob > F	0.0214		

Source: NIDS (2009). Author's own calculation

Once the 'don't know' and the 'missing' variables are excluded it can be observed from Table 18 above that when compared to the other grants, FCG recipients have the highest school attendance. The addition of school attendance as a conditionality is therefore not necessary. Furthermore, conditionality may act as a disincentive or threat leading to relatives not adopting children. The foster parents may be dissuaded from fostering children as satisfying the condition may not be feasible, or burdensome to the guardian. Moreover, the fostering of a child does not always occur when they are young and start schooling (when enrolment or attendance is a criteria); it could happen many years later during their school life when the impact of the conditionality is not as effective. Specifically, the health conditions may not even be necessary if the child is in late primary school as they will be of minimal benefit to the child. If the child has had poor attendance and consequently poor educational outcomes from an early school age, conditionality will not necessarily improve educational outcomes. The conditionality could impose more of a burden on the foster parent to ensure the child fulfils the condition which may not necessarily improve the child's educational outcomes.

9.5 Summary and conclusion

The chapter commenced with an examination of the NIDS study which is the first panel household study to be conducted in South Africa. There are other household surveys (GHS) that are regularly conducted in South Africa, but the NIDS was chosen as it is the latest data available, and more importantly, it supplies the variables that this study requires to conduct the analysis.

The sample consisted of 7 305 households, with 31 170 people who participated in the study. The sample was weighted so that it was representative of the population. The chapter then goes on to depict the descriptive statistics of the population as transposed from the sample. The overall population of South Africa (June 2008) consisted of 51.7 per cent of females and 49.3 per cent males. The largest race group was Africans (79.4 per cent) with the Asians/Indian (2.6 per cent) representative of the smallest race group. Most people lived in Gauteng (21.5 per cent) which is the smallest province geographically, with the lowest percentage of people (2.3 per cent) living in Northern Cape, the largest geographically. Furthermore, more people lived in urban areas (59.7 per cent) compared to rural (40.3 per cent) areas.

A brief description of the adult population revealed that 56.3 per cent of adults were female and 43.7 per cent are males. Furthermore, 78 per cent of adults were African with 2.6 per cent of adults being Asians/ Indians. The descriptive statistics of the children revealed that 51 per cent were males and 49 per cent were females with 84.9 per cent Africans and 1.8 per cent Asian/Indians.

In section 9.4 the suitability of the current social transfers for conditionality was systematically evaluated. The number of grants (with the exception of the WVG) have been increasing in the last 14 years. The grants that are applicable to adults, namely the WVG, DG and OAP are examined and discussed as to why no conditionality should be applied to them. It is not feasible to attach conditionality to the WVG as there are few beneficiaries and they are too old to benefit.

An evaluation of the disability grant revealed that whilst females represented 56.9 per cent of adults over 18, yet 63.1 per cent of DG beneficiaries were female. The probable reasons are that this grant is means tested and males who have incomes may not qualify for the grant. Moreover, disability (stemming from HIV/ AIDs) was more prevalent in females. Nevertheless, the DG was also not feasible for conditionality as the education component which is vital in early development was not applicable to DG recipients. The imposition of health conditionality would be impossible for some disabled people to satisfy, and it would be discriminatory to exempt some disabled and not others. Moreover, the qualification for the grant does

come up for review, where a recipient can forfeit the grant if he/she is found not be disabled.

Similarly, it is not feasible to attach conditionality to the Old Age Pension as the education component is not applicable to the elderly. Whilst the elderly may benefit from regular health visits, the health visits could be burdensome (costly) if they are not ill. Furthermore, the availability of health centres as well as accessibility needs to be improved. In addition, the pensions have been shown (section 6.4.2.5) to alleviate poverty in the poorest households. Conditionality may undermine the current impact the pensions are having on poverty.

This leaves the social transfers to children that should be made conditional. The Care Dependency Grant is meant for disabled children. As with DG for adults, health conditionality may not be practical to implement as it would be burdensome on the caregiver and meeting conditionality could mitigate the value of the transfer. The educational conditionality will have to be specific for the child's disability which may create an array of educational (and health) conditions that have to be met by the different recipients.

The last child grant that was evaluated in the chapter was the Foster Care Grant which had grown from 42 999 recipient in 1996/97 to 569 215 recipients in 2009/10. The rise in FCG is in part due to increases in the number of orphans due to the Aids epidemic. The FCG provides incentives for extended families to adopt children which would otherwise be looked after by the state, which could be more expensive. The imposition of conditionality could deter families from adopting children. Furthermore, school attendance (which conditionality aims to address) is highest among the FCG beneficiaries when compared to recipients of any of the other grants.

All these grants do not easily lend themselves for conditionality; which only leaves the Child Supports Grant (CSG) which has the largest number of beneficiaries. The suitability for CSG for conditionality is discussed in the next chapter. The CSG is discussed in depth as it has also received wide scholastic inspection as well as political cries for conditionality.

Chapter 10: The Child Support Grant and conditionality

10.1 Introduction

The number of Child Support Grant recipients has increased from 7.1 million recipients in 2005/06 to 9.4 million recipients in 2009/10 (Table 5). This is expected to increase further as government extends the qualification age group to 18 years. Consequently, expenditure on CSG is expected to increase from R14.1 billion to R36.5 billion in 2011/12 (Budget Review, 2009:91). Besides the huge cost of the grants to the state, government expenditure on education is also the largest budget item. Government expenditure on education was 19 per cent of total consolidated expenditure in 2008/09 with the second biggest expenditure being social protection of 15.2 per cent (Budget Review, 2010:176). Furthermore, health expenditure has been steadily rising in the past years and represents 11.7 per cent of total consolidated expenditure in 2008/09 (Budget Review, 2010:176). The focus on education and health to improve human capital investment are important concerns of South African policymakers. Samson et al (2004:186) feel that "health and education are better measures of individual welfare (poverty) than income and expenditures, because survey questions in these two categories are usually targeted to individuals rather than household needs".

However, the poor health (low life expectancy and high infant mortality) and education (low literacy and numeracy levels) [section 10.3.2] outcomes that are systemic in South Africa, do make the case, to at least consider linking education and health outcomes to the Child Support Grant. The conditions can be designed to improve the education and health outcomes, as has been done in other countries.

This has been the motivation for conditionality in other countries where social transfers are disbursed to children. There have been calls by the previous Minister of Finance (Trevor Manuel) to make these grants conditional in the past (Budget speech, 2008:09). But no position has been articulated by the present Minister of Finance, Pravin Gordhan.

There have been rebuttals from supporters of the CSG. The Department of Social Development (DOSD) [2008:35/6] affirms that the current Child Support Grant is having a positive impact on children's lives and contributes to the alleviation of household poverty (section 6.4.2.8.1.2). In fact, this has been the impetus for extending the grant to older children. Moreover, it could very well be that the poor health and education outcomes are not due to lack of demand for these services, but because of supply constraints. That is, poor education outcomes (numeracy and literacy) could be due to inefficient and poorly trained teachers, and the lack of books and not because children are not attending school. Similarly, the poor health outcomes in the form of high infant mortality may be due to the lack of doctors and sufficient nurses and the overstretched public health services, and not due to the fact that children are not visiting clinics or hospitals.

Hence, in this study there is an attempt to provide some analytical foundation for policymakers to consider if conditionality for CSG becomes a policy option. This is the principle underlying the analysis of this chapter, which is to compare education and health outcomes of the CSG recipients and non-CSG recipients.

In the previous chapter there was an in-depth deliberation on why the other five social transfers will not be suitable for conditionality. In this chapter there is a thorough investigation on whether it will be suitable and feasible to add conditionality to the Child Support Grant.

At the beginning of section 10.2 the sample is extrapolated to the population to delineate between the recipients and non-recipients of the CSG. A detailed demarcation of the sample into four categories is subsequently undertaken, that is; children that qualify and receive the grant (QR), children that qualify and do not receive the grant (QNR), children that do not qualify and receive the grant (NQR) and children that do not qualify and do not receive the grant (NQNR). This is followed by deliberation on the descriptive statistics (age, gender, and race) of recipients as well as non-recipients of the CSG, as well as the descriptive statistics of the four categories.

This is then followed by section 10.3 in which the education conditionality that can be imposed, that is, school attendance is discussed. A comparison is made between the

CSG recipients and non-recipients that attend school and those that are not attending school. A comparison is also made between the four groups to determine if there is any statistical significant difference in school attendance between these groups. That is, to ascertain whether children receiving the grant have lower attendance in comparison to the other groups. This will provide justification for attaching education (attendance) conditionality to the CSG, if their attendance is lower than that of other groups.

This is followed by an evaluation of the education outcomes (variable 'repeating a grade' [proxy for education outcomes]) between the recipients and non-recipients of the CSG, as well as the education outcomes between the QR, QNR, NQR and NQNR. This investigation is conducted to determine whether all groups are equally affected by the supply constraints (poor quality teachers, lack of education material, etc.) that affect education.

In section 10.4 the health outcomes of recipients of the CSG versus the non-recipients are discussed. There is no specific variable for health welfare in the NIDS dataset. The variable 'possession of health clinic card' is selected as a proxy variable to evaluate health outcomes. Whilst the 'possession of health clinic card' is indicative of demand for health care, there could be underlying causes (lack of proper sanitation and to access to clean water) that results in poor health outcomes in South Africa.

The determinants of health, specifically, access to these services is made between children that receive the CSG versus those children that do not receive the CSG. A comparison is also made between children in households of the QR, QNR, NQR and NQNR groups. Similarly, the other determinants for poor health outcome, namely, water source in household and electricity are also discussed.

In the last part of the chapter other pertinent factors that must be considered before implementing a CCT are mentioned. Although there are myriads of factors that need to be looked at, this chapter focuses specifically on the political consideration, administration and monitoring capability, as well as possible fraud and corruption, and dependency. These factors are discussed within the context of the current CSG.

10.2 Child Support Grant (CSG)

The CSG is the largest of all the grants by number of beneficiaries. The sample that is derived for examination compares the children who receive the CSG versus those that do not receive the CSG. It is noteworthy that the non-recipients of CSG include children who may be receiving other grants such as CDG and FCG. The sample is separated in this manner, as this part of the study is to decide whether to add conditionality to the CSG. Hence, the CSG recipients are compared to the rest of the children. Moreover, in the previous chapter the reasons why the CDG (section 6.4.2.6) and FCG (section 6.4.2.7) should not be made conditional were given, and these children were subsequently grouped in the non-recipients of any grants category. Hence, children are separated into either CSG recipients or non-recipients, with non-recipients referring to non-recipient of a CSG.

It can be observed from Table 19, that 55.4 per cent (8.3 million receive Child Support Grants). The split between the recipients and non-recipients can be observed in Table 19 below.

Table 19: Proportion of recipients vs non-recipients of CSG

	Number	Percentage
Recipients	8 358 003	55.4%
Non-recipients	6 725 922	44.6%
Total	15 083 925	100%

Source: NIDS (2009). Author's own calculation

The number of beneficiaries has been steadily rising in the last 12 years (Table 5). Moreover, the CSG has also been extended to the age of 18 and therefore the number of recipients will grow even further in the next three years. This could initiate dialogue about whether government should start introducing conditionality as the education and health outcomes (section 10.3 and 10.4) have not really been improving.

In his study there is an attempt to determine the need for conditionality by examining the education and health outcomes of those that receive the grant and those that do not. If there is a statistical significant difference between these groups, a case could be made for conditionality, that is, if the education and health outcomes or uptake are 'better' for non-recipients than for recipients. But the non-recipients of CSG may not necessarily be the counterfactual for the recipients of the CSG. The non-recipients may not only consist of children who do not qualify and do not receive

the grant; but also children that do qualify and do not receive the grant. Similarly, the recipients of the grants will not only consist of children who do qualify and receive the grant, but also children who do not qualify and receive the grant.

Consequently, there may be children who are eligible for the grant and do not receive the grant as well as some children who are not eligible and do receive the grant. This needs to be analysed. Therefore, besides comparing outcomes of CSG recipients and non-recipients, the education and health outcomes of four other categories will also be examined. They are:

- a. Those children that qualify and receive the grant (QR)
- b. Those children that qualify and do not receive the grant (QNR)
- c. Those children that do not qualify and receive the grant (NQR)
- d. Those children that do not qualify and do not receive the grant (NQNR)

Therefore a stronger case for conditionality can be made if there is a statistical significant difference (health and education) between these groups, as these groups will be more representative of children in comparison to the other two groups; namely, recipients of CSG and non-recipients of CSG.

The CSG has both a means test as well as age criterion to determine who qualify for the grant. At the time of this study the age limit for obtaining the grant was children younger than 14 years. The means test for a qualifying household was a monthly household income of R800 per month for urban formal households and a monthly household income of R1 100 for rural and informal urban households.

However, during the fieldwork of the NIDS study (October 2008) the government revised the means test to be 10 times the grant amount. As the CSG value at that time was R230 per month and the means test was therefore set at R2 300 per month for children whose parents were not married and R4 600 per month for children whose parents were married. Income therefore had to fall below these levels for children to qualify.

It may appear appropriate to use the rural and urban limits for categorisation of the children in the sample. However, the income threshold of R800 per month for urban formal households and R1 100 for rural and informal households is not the criterion

that the applicants will confront if they apply for the grant or if they are selected for a review.

The ensuing analysis is not intended primarily to enumerate the people who qualify and not qualify for the grant, but rather as means to demarcate the sample under some criteria. It must be noted that the grant follows the child and the recipient of the grant is not necessarily the parent, but the caregiver who does not have to be the parent. Consequently, the parent/caregiver applies for the grant on behalf of the child. Secondly, the new policy is what now determines qualification for the grant, and it will be the policy that the authorities will be using when randomly reviewing beneficiaries. Hence, it will be erroneous to use the old qualifying criteria.

The following steps indicate how the sample was separated into the four categories.

Step1: The sample has various household income levels variables. Some respondents may not remember or know some of their income items or may choose not to give these answers. The income of these items is imputed to calculate an appropriate household income. Also there could be under-reporting of income.

Consequently, the variable: Household income - full imputation [*w1_hhincome*], is used for the analysis. It is a combination of all income earned by the adults in the households. These include household monthly income from labour market [*hhwage*], household monthly income from government grants [*hhgovt*], household monthly income from other government sources e.g. UIF [*hhother*], household monthly income from investment income [*hhinvest*], household monthly income from remittance [*hhremitt*], household monthly income from rental [*hhimprent*] and household monthly income from subsistence agriculture. The variable excludes items of a capital nature (inheritance, retrenchment payments, retirement gratuities, lobola/bride payments, gift income, loan repayments, sale of household goods income and 'other' income) (SALDRU, 2008:117)

The household income also includes income from government grants and this is subsequently excluded to give the net household income that should be used as the means test for the household.

Step 2: The sample is separated between the recipients and non-recipient's i.e.

- 1 – receiving the CSG
- 2 – not receiving the CSG

Table 20: Recipients of CSG vs non-recipients of CSG, sample

	Number	Percentage
Recipients of CSG	5 557	59.1%
Non-recipients of CSG	3 851	40.9%
Total	9 408	100%

Source: NIDS (2009). Author's own calculation

Step 3: Since the qualifying age criteria is up to the age of 14 years, the sample is separated between those that are younger than 14 as well as those older and equal to 14. And these are further separated into those that are receiving the grant and those that are not receiving the grant

- Those that are older and equal to 14 and receiving and not receiving the grant

Table 21: Recipients of CSG vs non-recipient of CSG, children older than and equal to 14

	Number	Percentage
Recipients of CSG	91	14.2%
Non-recipients of CSG	548	85.8%
Total	639	100 %

Source: NIDS (2009). Author's own calculation

- Those that are younger than 14 and receiving and not receiving the grant

Table 22: Recipients of CSG vs non-recipients of CSG, children younger than 14

	Number	Percentage
Recipients of CSG	5 466	62.3%
Non-recipients of CSG	3 303	37.7%
Total	8 769	100%

Source: NIDS (2009). Author's own calculation

Step 4: The children then are delineated according to the income levels of the household in which they reside. Once again, the children are further

separated into those that are receiving the grant and those that are not receiving the grant within these income levels.

- Children living in households with household income of less than and equal to R2 300 per month

Table 23: Recipients of CSG vs non-recipients of CSG, children living in households where income is less than and equal to R2 300

	Number	Percentage
Recipients of CSG	4 085	77.2%
Non-recipients of CSG	1 208	22.8%
Total	5 293	100%

Source: NIDS (2009). Author's own calculation

- Children living in households with household income of greater than R2 300 but less than and equal to R 4 600 per month

Table 24: Recipients of CSG vs non-recipients of CSG, children living in households where income is greater than R 2 300 but less than and equal to R4 600

	Number	Percentage
Recipients of CSG	673	71.8%
Non-recipients of CSG	265	28.3%
Total	938	100

Source: NIDS (2009). Author's own calculation

- Children living in households with income greater than R4 600 per month

Table 25: Recipients of CSG vs non-recipients of CSG, children living in households where income is greater than R 4 600

	Number	Percentage
Recipients of CSG	708	27.9%
Non-recipients of CSG	1 830	72.1%
Total	2 538	100%

Source: NIDS (2009). Author's own calculation

It can be assumed that all children living in households with monthly income of R2 300 or less, qualify for the grant as long as they meet the age criteria of not being 14 years old or older. Similarly, all children living in households with income levels of greater than R4 600 do not qualify for the CSG, irrespective of the age of the child. The 708 recipients of the CSG do not qualify for the grant but receive it, whilst 1 830 non-recipient do qualify for the CSG and do not receive the CSG.

Step 5: The next step is to determine which children live in households where the parents are married. This is the criterion that is used by SASSA (2010) of whether to apply the means test at 10 times the grant or 20 times the grant. Even, if the parents of the child are not married but are living together, this study assumes that the household will be means tested on a threshold of R2 300.

Consequently, the study uses the variable 'the relationship between parents of the child'

Table 26: Relationship between parents of child

Relationship between parents of child	Number	Percentage	Cumulative Percentage
Don't Know	3	0%	0%
Refused	1	0 %	0%
Missing	59	0.6%	0.7%
Married	2 735	29.1%	29.8%
Divorced	167	1.8%	31.5%
Engaged	54	0.6%	32.1%
Girlfriend/boyfriend living together	1 009	10.7%	42.8%
Girlfriend/boyfriend not living together	1 723	18.3%	61.1%
Ex-boyfriend/girlfriend	1 864	19.8%	81%
Never had a romantic relationship	319	3.4%	84.4%
Not applicable - one or both parents deceased	1 472	15.7%	100%
Total	9 406	100%	

Source: NIDS (2009). Author's own calculation

It can be noted that only 2 735 children have parents who are married. Hence, this is used in the study as a guideline for distinguishing between those children that have parents that are married and those who do not have. It is important to note the criteria for the means test as prescribed by SASSA (2010) do not state explicitly that the parents should be living together. Hence, the sample is separated into two categories, those whose parents are married and those whose parents are not married as observed in Table 27 below.

Table 27: Marriage status of parents of child

	Number	Percentage
Married	2 735	29.1%
Not married	6 671	70.9%
Total	9 406	100 %

Source: NIDS (2009). Author's own calculation

It can also be observed that 9 406 of the children responded to this question, whilst there are 9 408 children in the sample. Reconciliation of the sample reveals that there are indeed 9 408. The marriage criterion is only employed to distinguish between children living in households where income is greater than R 2 300 per month but less than and equal to R4 600 per month and parents are married; and children living in households where income is greater than R 2 300 per month but less than and equal to R4 600 per month and parents are not married. All children living in households with incomes lower than R2 300 per month, irrespective of the marriage status of their parents qualify for the grant. Similarly, all children living in households with incomes greater than R4 600 per month, irrespective of the marriage status of their parents, do not. Consequently, only 243 children (Table 28) are living in households where the income is greater than R 2 300 per month but less than and equal to R4 600 per month and parents are married; and 695 children (Table 29) are living in households where the income is greater than R 2 300 per month but less than and equal to R4 600 per month and parents are not married. The balance of the sample (and the 'missing' two) are part of the 9 408 sample resulting in a complete reconciliation of the sample in Tables 30 and 31

Step 6: Determination of children who live in households with monthly income of greater than R2 300 but less than or equal to R4 600 and whose parents are married. The children are further separated into those that are receiving the grant and those that are not receiving the grant

Table 28: Recipients of CSG vs non-recipients of CSG, children living in households where the income is greater than R 2 300 but less than and equal to R4 600 and parents are married

	Number	Percentage
Recipients of CSG	161	66.3%
Non-recipients of CSG	82	33.7%
Total	243	100%

Source: NIDS (2009). Author's own calculation

Step 7: Determination of children who live in households with monthly income of greater than R2 300 but less than or equal to R4 600 and whose parents are not married.

Table 29: Recipients of CSG vs non-recipient of CSG, children living in households where income is greater than R 2 300 but less than and equal to R4 600 and parents are not married

	Number	Percentage
Recipients of CSG	512	73.7%
Non-recipients of CSG	183	26.3%
Total	695	100%

Source: NIDS (2009). Author's own calculation

Step 8: Consolidation of the sample into those that are receiving the grant and those that are not receiving the grant. In summary, the children in the sample are demarcated along the following criteria:

Table 30: Separation into receiving the CSG and not receiving the CSG, according to selected criteria

	Receiving the CSG	Not receiving the CSG	Total
Children older and equal to 14 years	91	548	639
Children living in households with monthly income less than and equal to R2 300	4 085	1 208	5 293
Children living in households with monthly income greater than R4 600	708	1 830	2 538
Children living in households with monthly income greater than R 2 300 but less than and equal to R4 600 and whose parents are married	161	82	243
Children living in households with monthly income greater than R 2 300 but less than and equal to R4 600 and whose parents are not married	512	183	695
Total	5 557	3 851	9 408

Source: NIDS (2009). Author's own calculation

Step 9: Delineation of the sample according the other four categories

Consequently, the criteria that are used to separate the children are used to place them into four categories as observed in Table 31 below.

Table 31: Separation into QR, QNR, NQR and NQNR according to selected criteria

	QR	QNR	NQR	NQNR	TOTAL
Children older and equal to 14 years	-	-	91	548	639
Children living in households with monthly income less than and equal to R2 300	4 085	1 208	-	-	5 293
Children living in households with monthly income greater than R4 600	-	-	708	1 830	2 538
Children living in households with monthly income greater than R 2 300 but less than and equal to R4 600 and whose parents are married	161	82	-	-	243
Children living in households with monthly income greater than R 2 300 but less than and equal to R4 600 and whose parents are not married	-	-	512	183	695
Total	4 246	1 290	1 311	2 561	9 408

Source: NIDS (2009). Author's own calculation

It must be noted that the criteria in this study refer to whether the child (not the parent/caregiver) qualifies/not qualifies to receive the grant. For example, if the child lives in a household that exceeds the income threshold to receive the grant, then the child does not qualify to receive the grant.

In summary, the children older and equal to 14 who receive the grant should not be receiving the grant, and are consequently separated into the NQR and the NQNR categories. The children living in households with a monthly income of less and equal to R2 300 all qualify for the CSG and are consequently placed into the QR and QNR categories. Similarly, children living in households whose monthly income is greater than R4 600 do not qualify for the grant and are placed into the respective categories.

The post-stratified [*w1_wgt*] extrapolation of the sample is observable in Table 32 below:

Table 32: Distribution of QR, QNR, NQR and NQNR, in the population

	Percentage
Children who qualify and receive the Child Support Grant (QR)	40.8%
Children who qualify and do not receive the Child Support Grant (QNR)	11.7%
Children who do not qualify and receive the Child Support Grant (NQR)	14.6%
Children who do not qualify and do not receive the Child Support Grant (NQNR)	32.9%
Total	100%

Source: NIDS (2009). Author's own calculation

Accordingly, only 40.8 per cent of children who are eligible for the grant receive the grant. There is a disproportionately high (14.6 per cent) number of children who are receiving the grant and do not qualify for the grant. There could be various reasons to explain these results.

Firstly, most of the recipients who obtained the grant, qualified under the older means test and new qualifying criteria place them into the respective categories. Nevertheless, the children are supposed to qualify for the grant in terms of the new means test.

Secondly, it is probable that children are not residing in the household category (parents are married versus not married) that they indicated and were subsequently incorrectly classified.

Thirdly, it could be possible that households do not qualify in terms of the total income that they receive as the applicants do not (intentionally or unintentionally) fully declare their incomes.

Moreover, the methodology to separate the children into the different categories is not to determine the number of eligible and non-eligible recipients; but rather to see if there are significant differences between these groups. This will form the basis for the argument of whether or not to add conditionality.

As mentioned earlier and which has been a common theme among all CCTs, the focus is on education and health outcomes and to determine what these outcomes

are among the various groups, and specifically, to find if there are any statistical significant differences among the various groups.

The Review of the Child Support Grant commissioned by the Department of Social Development (Department of Social Development [DOSD], 2008) also separates children into various categories to compare eligible and non-eligible CSG recipients. The study compares education, health as well as other services (housing, electricity, water and sanitation) of eligible and non-eligible CSG recipients. The methodology differs from the one employed in this study, but necessitates mentioning as it covers various elements which are also addressed in this study.

The Review of the Child Support Grant commissioned by the Department of Social Development (Department of Social Development, 2008) consisted of a national household survey which had 2 675 respondents. The sample focussed only on households that were most likely to be eligible for the CSG. Consequently, the sample was extracted from lower income areas. Data was obtained from the Census 2001 sampling frame which was seven years old at the time of the study.

The areas to be included in the study were determined by calculating the average household income. The definition of low income was set at R1 400 per month. Although the means test was R800 per month and R1 100 per month, the limit was set at R1 400 per month to account for inflation and underreporting of income.

The recipients of the CSG are the primary caregivers of the children who receive grants. It is important to note that only households that have children between 0-13 were included in the survey.

The study's focus was on comparing caregivers of children between the age groups of 0-13 living in low income areas who receive the grant and those that do not. Consequently, the sample is delineated into:

- CSG recipients (both eligible and ineligible recipients of the CSG)
- Non-CSG recipients who are eligible
- Non-CSG recipients who are ineligible

The eligibility criteria were loosely determined by using the following indicators as a proxy for a means test:

- a. reported marital status
- b. observed area type to determine whether respondents live in formal areas or rural/informal areas
- c. total reported monthly personal or individual income of the caregiver, and the total reported monthly income for the spouse if the caregiver reported being married (both including earnings, remittances and other income, but excluding grants)

Consequently, the sample is devolved into three categories with the respective percentage of each group as can be observed in Table 33 below.

Table 33: Distribution of the population, according to DOSD study

	Percentage
CSG recipients	72%
Eligible non-recipients	17%
Non-eligible recipients	11%

Source: Department of Social Development (2008:17)

The formation of the groups of this study differs from the formation in the study of the DOSD. The criteria and conditions for the separation of the different groups were discussed at length in the chapter.

Suffice to mention, this study employs the NIDS data that focuses on all children and not only poor households. The income threshold for the means test is R2 300 per month for children of single caregivers and R4 600 per month for children of married parents. Moreover, in this study the focus is on the children as recipients whilst the DOSD focuses on the caregiver as the recipient.

In the DOSD study (DOSD, 2008) three groups are compared, whilst in this study the focus is on four groups. The DOSD combines the CSG recipients (eligible and non-eligible) whilst in this study the CSG recipients (qualifying and not qualifying) are separated to obtain the four groups.

This could be some of the possible explanations for the difference in the size of the different categories. Nevertheless, in both the studies the endeavour is not to focus on who should get the grant or not, but the characteristics of those who do (or do not) get the CSG.

The results of the DOSD will be cited where there is commonality with this study, but the caveat of the different approaches in the formulation of the samples must not be forgotten.

A brief descriptive overview of the sample by these categories is necessary to place in context those that receive the CSG and those that do not.

10.2.1 CSG, by age

The age of children in the sample was spread approximately evenly between the age groups as can be noted in Table 11 earlier. The distribution of CSG recipients and non-recipients of CSG differ from one another as can be observed in Table 34 below.

Table 34 : Comparison of recipient of CSG vs non-recipients of CSG, by age

Age	Recipients of CSG	Non-recipients of CSG
Missing	0.5%	0.5%
0	3.9%	10.5%
1	6.8%	6.2%
2	7.0%	6.2%
3	6.6%	5.9%
4	7.0%	4.8%
5	8.7%	4.8%
6	6.9%	4.8%
7	8.3%	5.2%
8	7.6%	6.2%
9	8.4%	5.2%
10	6.3%	5.5%
11	7.8%	6.2%
12	6.6%	7.0%
13	6.0%	7.9%
14	1.5%	12.8%
15	0.1%	0.3%
Total	100%	100%

Source: NIDS (2009). Author's own calculation

It can be observed that the largest number of recipients of the CSG are the 5 year olds, whilst the largest number of non-recipients are the 14 year olds, which is expected as they did not qualify for the grant. The second largest groups of non-recipients are the children younger than 1 year old. Interestingly, this could be due to the delays in applying and receiving the CSG for children. This assertion can be confirmed when one observes the age by the four categories as observed in Table 35 below.

Table 35: Comparison of QR, QNR, NQR and NQNR, by age

Age	QR	QNR	NQR	NQNR	Total
Missing	0.4%	1.2%	0.7%	0.2%	0.5%
0	4.0%	15.7%	3.9%	8.7%	6.9%
1	6.7%	6.5%	7.0%	6.1%	6.5%
2	7.0%	6.3%	7.1%	6.2%	6.7%
3	6.6%	7.4%	6.3%	5.4%	6.3%
4	6.9%	3.7%	7.2%	5.2%	6.0%
5	8.8%	4.8%	8.6%	4.7%	7.0%
6	6.7%	4.1%	7.4%	5.1%	5.9%
7	7.9%	4.3%	9.4%	5.5%	6.9%
8	7.9%	5.9%	6.8%	6.2%	7.0%
9	8.7%	5.4%	7.8%	5.1%	7.0%
10	6.7%	5.3%	5.3%	5.6%	6.0%
11	8.6%	7.2%	5.4%	5.9%	7.1%
12	6.8%	9.8%	6.1%	6.0%	6.8%
13	6.4%	12.4%	4.9%	6.3%	6.8%
14	0.0%	0.0%	5.6%	17.3%	6.5%
15	0.0%	0.0%	0.4%	0.4%	0.2%
Total	100%	100%	100%	100%	100%

Source: NIDS (2009). Author's own calculation

The largest QR group are the 5 year olds which is the same as CSG recipients as observed in Table 29 above. But it can be noticed that 15.7 per cent of children in the QNR are less than 1 year old. This highlights a dire need when the grant is most needed to aid in providing nutrition which is essential in the child's early life.

10.2.2 CSG, by gender

The split between male and female children was 51 per cent males and 49 per cent. The delineation is similar for both the recipients and non-recipients of CSG as observed in Table 36 earlier.

Table 36: Comparison between recipients CSG vs non-recipients of CSG, by gender

	Recipients of CSG	Non-recipients of CSG
Male	51%	50.4%
Female	49%	49.6%
Total	100 %	100%

Source: NIDS (2009). Author's own calculation

The separation of gender of children by the four categories can be observed in Table 37 below.

Table 37: Comparison of QR, QNR, NQR and NQNR, by gender

	QR	QNR	NQR	NQNR
Male	51%	49.4%	50.9%	50.7%
Female	49%	50.6%	49.1%	49.3%
Total	100%	100%	100%	100%

Source: NIDS (2009). Author's own calculation

It can be seen that all groups contain more males except the QNR, indicating the relative disadvantage of female children as they constitute a smaller part of the sample but constitute a larger proportion of the QNR group. Hence, it can be inferred that female children are being denied the Child Support Grant more relative to male children.

10.2.3 CSG, by race

It is unsurprising that African children constitute the largest group of children who are receiving the grant as they are the largest population group.

Table 38: Comparison of the recipients of CSG vs non-recipients of CSG, by race

	Recipients of CSG	Non-recipients of CSG
Refused	0%	0.1%
Missing	0.2%	0.3%
African	94.6%	72.9%
Coloured	4.3%	12.3%
Asian/Indian	0.5%	3.4%
White	0.3%	11.0%
Other	0.1%	0%
Total	100%	100%

Source: NIDS (2009). Author's own calculation

However, it is enlightening that the African children receive 94.6 per cent of the CSG, whilst they constitute 84.9 per cent (Table 12) of the children population. This

would imply that the poverty levels (and the need) are disproportionately higher among African children. This is also observed when one compares the race groups among the four categories as shown in the Table 39 below.

Table 39: Comparison of QR, QNR, NQR and NQNR, by race

	QR	QNR	NQR	NQNR
Refused	0%	0%	0%	0.1%
Missing	0.3%	0%	0%	0.4%
African	95.5%	91.7%	92.0%	66.2%
Coloured	3.4%	7.7%	6.8%	14%
Asian/In	0.5%	0%	0.6%	4.6%
White	0.2%	0.6%	0.5%	14.7%
Other	0.1%	0%	0%	0%
Total	100%	100%	100%	100%

Source: NIDS (2009). Author's own calculation

It can be observed that of those that qualify and receive the grant, 95.5 per cent are Africans. In fact, the African children are highest for all the groups as they are the largest group. The higher incidence of poverty among African children can be confirmed by the fact that for the three categories (QR, QNR and NQR) there is greater representation of African children relative to the proportion of other race groups. The NQNR which will be more representative of the wealthier households have a disproportionately lower percentage of African children represented. Subsequently, the other race groups have higher representation within NQNR relative to their proportions within the population. Not only does the poverty have a racial dimension within South Africa, it also has a geographic footprint.

10.2.4 CSG, by geography

Whilst 51 per cent (*own calculation from NIDS*) of children live in urban areas, the numbers of recipients of the CSG are much higher in rural areas, underlining the poverty that pervades rural South Africa, as denoted in Table 40.

Table 40: Comparison of recipients of CSG vs non- recipients of CSG, by geography

	Recipients of CSG	Non-recipients of CSG
Rural	58.9%	36.5%
Urban	41.1%	63.5%
Total	100%	100%

Source: NIDS (2009). Author's own calculation

It can be observed in Table 40 above that although 49 per cent of (*own calculation form NIDS*) children are found in rural areas, 58.9 per cent of CSG recipients live in rural areas. When the geographical comparisons are made by the four categories, it is not surprising to see that the QR and the QNR are residing in rural areas.

Table 41: Comparison of QR, QNR, NQR and NQNR, by geography

	QR	QNR	NQR	NQNR
Rural	63.3%	61.8%	46.6%	27.5%
Urban	36.7%	38.3%	53.4%	72.5%
Total	100%	100%	100%	100%

Source: NIDS (2009). Author's own calculation

It is further noticeable that NQR and the NQNR which represents wealthier households in which children reside are more urban based. It is noteworthy that whilst the QR has marginally more recipients living in rural areas, the QNR group could be more disadvantaged. The QNR groups will have fewer resources vis-à-vis the QR to mitigate the challenges of living in the rural areas. For example, the CSG could provide for transport costs to clinics and schools which the QNR group will be unable to do. Pendlebury et al (2009:91) note that 6.9 million children need to travel more than 30 minutes to reach their nearest clinic. The travelling costs to a clinic could be mitigated by the CSG, which the QNR does not have.

These descriptive statistics provide the context to discuss conditionality for the CSG. In brief, it can be surmised that poverty is experienced mostly by African children, and that poverty is more prevalent in rural areas of South Africa. Hence, the question of whether or not to add conditionality, becomes more acute, and will be deliberated below.

10.3 Education

The educational outcomes for the past ten years have at best been modest, and at worst dismal. Studies (see section 10.3.2 below) have shown that South African students performed poorly when compared to their counterparts in other countries. An amount of R148.9 billion was spent on education for the 2009/10 financial year which is the largest expenditure item in the budget (Budget Review, 2010:118). Clearly, education expenditure has not delivered the expected outcomes envisaged by policymakers. These less than satisfactory outcomes reinforces the call to make the grant conditional on the recipients (usually the parent or guardian) fulfilling

certain conditions (enrolment at schools) to improve the long term prospects of children.

Although children may be enrolled in school, this does not necessarily mean that they regularly attend school. Enrolment only occurs at the beginning of the school year. Moreover, higher school enrolment does not necessarily translate into regular school attendance and subsequent improved education outcomes. Consequently, the poor attendance could be the cause for the poor academic outcomes of students.

Attendance refers to the proportion of children that were reported 'attending school' by one of the adults in the households in the General Household Survey (GHS), which is conducted in July each year; whilst enrolment rates reflect the number of children enrolled in basic or secondary education as reported by the schools to the national government in the school years (De Lannoy and Lake, 2009:82).

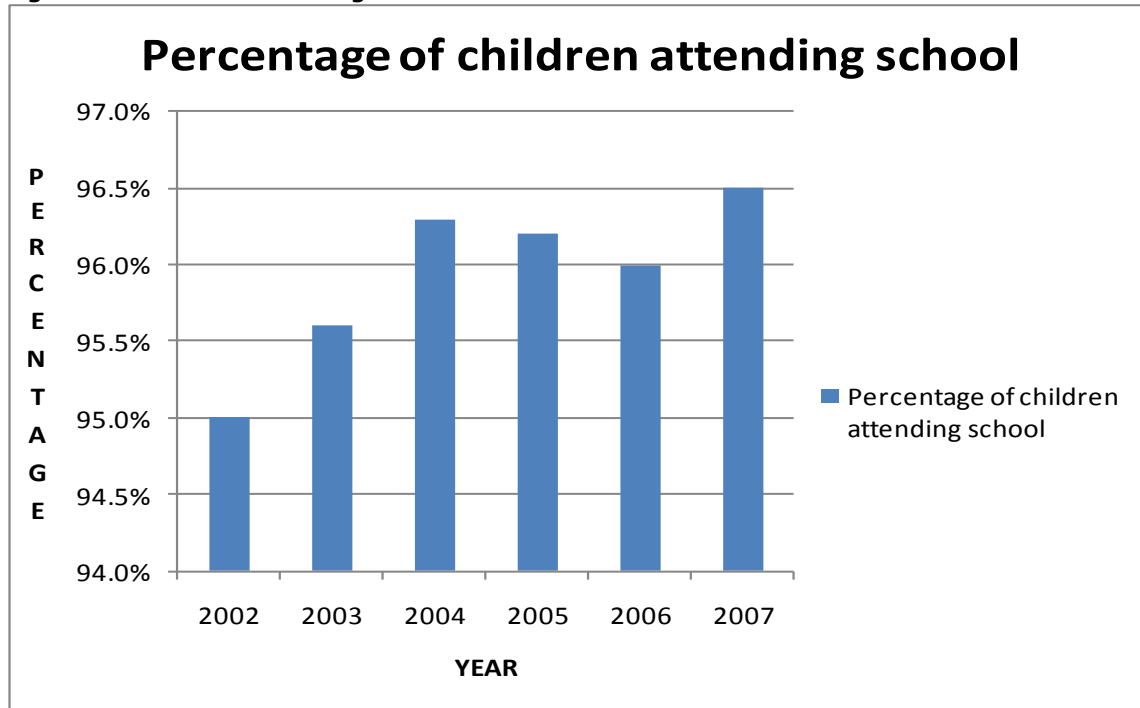
However, there is limited data on school attendance in South Africa. Pauw and Mncube (2007:33) note that the Labour Force Survey (which contains information on school attendance) is limited as it does not take into account punctuality and the regularity of school attendance, nor the quality of the teaching. Also the attendance rate fails to capture a pupil's progress through school. Furthermore, attendance rates in cross sectional surveys hide the problem of drop out among children above the age of 15 (De Lannoy and Lake, 2009:83).

The Systemic Evaluation for Grade 6's was commissioned by the National Department of Education in 2004; in which teachers were asked about the average attendance of learners. At the national level, 51 per cent of teachers reported class attendance was between 90-100 per cent. However, there was poor school attendance in the Eastern Cape and Kwa-Zulu Natal where 43 and 26 per cent of teachers reported that the average learner attendance was below 80 per cent respectively (Pauw and Mncube, 2007:33).

The Children's Institute uses an indicator 'Number of children attending an educational institution' which they obtained from Statistics South Africa (2003-2009) General Household Survey 2002-2008. This indicator measures the proportion of children between 7 and 17 who are reported to be attending any school or

educational facility. Overall, there has been a high attendance rate among children between 7 and 17, as observed in Figure 17 below.

Figure 17 : Children attending an education institution in South Africa between 2002 and 2007



Source: Children's Institute (2010a)

The CI study found that at national level, 95 per cent of children of school going age (7-17) attended some form of school or educational facility (De Lannoy and Lake, 2009:83).

Pendlebury et al (2009:42) compare the attendance rate for 1996, 2001 (census data from Stats SA) and 2007 Community Survey 2007 (revised version). The Community Survey was conducted by Statistic South Africa in 2007 collecting data from 949 105 individuals and 246 618 households. The authors clearly demonstrate that attendance rates for the all age groups between 6 and 14 have increased for the past 11 years (Pendlebury et al, 2009:42).

10.3.1 Attendance rate of the recipients of CSG

In the study there is an attempt to confirm these attendance rates, and subsequently examine the attendance rates for the categories that were created in the sample. It must be noted that the attendance rates refer to children up to the age of 14, whilst

the CI data pertains to the age of 17. Moreover, the NIDS study has data of grade repetition which will be used to analyse the outcomes among the different categories as well.

The NIDS data does not provide information of attendance or regular attendance at school. Only one variable in the NIDS data is relevant to attendance. The variable 'Number of days child was absent from school, month' [w1_c_edmssds] is not an indication of the total number of days that the child was absent from school in the year; rather the number of days that the child was absent in the month before the respondent (parent) was asked the question.

The variable 'Has the child ever attended school' [w1_c_edatt] which refers to children over the age of seven is used to analyse attendance at schools. There were 4 472 respondents in the sample who responded to the question.

Table 42: Proportion of children attending school, sample

	Number	Percentage	Cumulative percentage
Missing	67	1.5%	1.5%
Yes	4 211	94.2%	95.7%
No	194	4.3%	100%
Total	4 472	100%	0%

Source: NIDS (2009). Author's own calculation

Subsequently, the 'missing' variables are eliminated and post-stratification weighting [w1_wgt] is applied.

Table 43: Proportion of children attending school vs not attending school, population

	Percentage
Not attending school	4.8%
Attending school	95.3%
Total	100%

Source: NIDS (2009). Author's own calculation

This translates into 95 per cent of children who were attending school which is similar to the results obtained by Pendlebury et al (2009:83) from the GHS. A deeper analysis of the school attendance by recipients of CSG and non-recipients CSG reveals that more children who receive the CSG attend school than the non-recipients in Table 44 below.

Table 44: Proportion of children attending school vs not attending school, for the recipients of CSG and non-recipients of CSG

	Recipients of CSG	Non-recipients of CSG
Not attending school	4.1%	5.5%
Attending school	96%	94.5%
Total	100%	100%
F-Stat	2.31	
Prob > F	0.129	

Source: NIDS (2009). Author's own calculation

The null hypothesis (Ho) is that there is no difference between the means of the two samples. The output of the F-test reveals that we do not reject the Ho that there is no difference.

Consequently, it can be concluded that there is high school attendance between the CSG and non-recipients of CSG with no significant difference in attendance between the two groups.

Hence, it can be inferred from the results above that not only is school attendance high among children, there is no significant difference in school attendance between those that receive the grant and those that do not the grant. Hence, conditionality of school attendance will not make a contribution as attendance of CSG recipients is high and comparable to that of children who do not receive the CSG. These results confirm children's or rather their caregivers' commitment to education.

The perceived importance of education is not only highlighted by this outcome, but also when the four groups are compared regarding educational attendance. The school attendance rates of the population of the four groups reveals that all but one group has 95 per cent and greater school attendance, as can be observed in Table 45 below.

Table 45: Proportion of children attending school vs not attending school, for the QR, QNR, NQR and NQNR

	QR	QNR	NQR	NQNR
Not attending school	3.8%	8.4%	4.8%	4.7%
Attending School	96.2%	91.6%	95.2%	95.3%
Total	100%	100%	100%	100%
F-Stat	2.18			
Prob > F	0.0877			

Source: NIDS (2009). Author's own calculation

The F-test indicates that there is no significant difference between the four groups in school attendance. That is, we do not reject the H_0 that there is no significant difference between the four groups.

Therefore, it can be inferred that there is no statistically significant difference between all these groups, augmenting the earlier results of not requiring conditionality. . A detailed evaluation of the impact of CCT on school attendance and enrolment is elaborated in section 8.3.1. Suffice to mention that studies have shown that CCTs has had a positive impact on school attendance/enrolment on all CCT programmes (Fiszbein and Schady, 2009:129). But the impact varies between and within programmes and depending very much on initial school attendance. For example if the school attendance is low, the impact is all the much greater. There was an increase in school attendance in secondary education for girls from 1.1 million in 1991 to 3.9 million in 2005, after the implementation of the *Female Secondary School Assistance Program* [FSSAP] in Bangladesh. This underscores the impact of the CCT when the initial base is low.

Schultz (2004:205) found that the *Oportunidades* had an impact on children progressing from primary to secondary school who participated in the CCT programme. However, Fiszbein and Schady (2009:130) find that the *Oportunidades* also resulted in an increase in school attendance of children who did not participate in the programme. The gains in school attendance are modest when the initial attendance rates are high; which is the case in South Africa. Schady and Arujo (2006:24) note that the children who participated in the *Bono de Desarrollo Humano* (BDH) [Ecuador] were only 3.2 to 4.0 percentage points more likely to be enrolled in school than children that were not participants. The *Programa de Asignación Familiar* (PRAF) in Honduras had only a 1-2 percentage point increase in school enrolment

(Glewwe and Olinto, 2004:47). Similarly, Attanasio, Fitzsimmons and Gómez (2005:8) find that the *Familias en Acción* (Colombia) led to a 1.3 percentage point increase in school enrolment. Adato (2008:24) notes that the CCT had little impact on primary school enrolment in Turkey which was already high at 93 per cent.

It can be observed from the analysis above (Tables 42 – 45) that the attendance rates is already high among school aged children, and the highest attendance is among those children that qualify and receive the grant.

The impact on education outcomes by the recipients of CSG in South Africa was also tested by Case, Hosegood and Lund (2004). They use the data from the longitudinal demographic surveillance system of the Africa Centre for Health and Population Studies in KwaZulu-Natal. In 2002, 11 000 African children were receiving the CSG, which represented approximately one third of eligible children who qualified for the grant. The authors were able to evaluate the impact of enrolment of those that received the CSG compared to those that did not, one year later.

The authors compared those children that received the CSG in 2002 and school enrolment in 2003 and 2004 with children who were eligible and did not receive the grant in 2002 and the enrolment in 2003 and 2004. The receipt of the CSG resulted in an 8.1 percentage point increase in school enrolment among 6 year olds and 1.8 percentage point increase among 7 years old when compared to non-recipients of the CSG (Case et al 2004:15). The Economic Policy Research Institute (EPRI) study has shown that there is a 20 to 25 per cent decline in the school non-attendance gap when a household receives a CSG (Hall and Monson, 2006:40). Moreover, the DOSD study found no 'discernable' difference in levels of school attendance between children between the ages of 7 and 13 who were receiving the grant and those that were not receiving the grant (DOSD, 2008:37).

Budlender and Woolard (2006:viii) also find that enrolment of children (who do not receive the CSG) also rises when other beneficiaries receive the CSG within the household. Pendlebury et al (2009:79) note that numerous studies have concluded that social assistance has led to the improvement of the welfare of children, specifically as a result of the availability to food and health and basic services.

The children that receive the CSG, are expected to be exempt from school fees (in terms of the Amended National Norms and Standards for School Funding [2006]) have resources to cover the ancillary costs (school supplies and uniform) and also could be participating in the National School Nutrition Programme (NSNP).

The CSG provides the means for the household to afford school fees and uniforms and other school related material that the child may require. The DOSD study (DOSD, 2008:3) did not find that recipients of CSG are less likely to pay school fees despite qualifying for the exemption as the knowledge of exemption and how to apply for it was low.

Leatt and Budlender (2006:6) note that the receipt of CSG for a child that qualifies for the grant releases resources within the household to spend on other children who may not qualify for the CSG, due to their age.

The children who receive the CSG [QR] will have the means and the resources to pay for educational supplies whilst the QNR will be constrained by the lack of resources. Interesting, the QNR group's school attendance of 92 per cent (although high, but lower than that of the other groups) can be due to the fact that they are too poor to attend school, as they qualify and are not receiving the grant.

Besides their inability to demonstrate their need for the CSG, the QNR may also be unable to demonstrate their need for exemption from school fees. Hence, these households have the twin burden of not receiving the CSG and qualifying for it and also having to pay school fees, although the child qualifies for the exemption. They will not be exempt as they will not have proof of receiving the CSG and will not qualify for exemption.

Table 46: Mean monthly income and mean yearly expenditure of the QR, QNR, NQR and NQNR

	Mean monthly income (including government grants)	Mean expenditure on school fees	Mean expenditure on school uniform	Mean expenditure on books and stationary	Mean amount spent on other school related expenses	Mean expenditure spent on transport to school
QR	1 862	85	170	24	35	41
QNR	1 977	142	160	22	55	82
NQR	4 847	192	195	43	60	160
NQNR	10 429	1 510	340	178	199	432

Source: NIDS (2009). Author's own calculation

It can be observed from Table 46 above that although the QNR has a higher monthly income (although not receiving the CSG) they spend the least amount on school uniforms and books and stationary. This could be attributable to the lack of discretionary income that is available for these households to purchase these items.

Moreover, the QNR income is six per cent greater than the QR groups, but the QNR spend twice as much on school transport. The relatively higher transport costs (which could be indicative of further distance to travel to school) together with the higher school fees could be manifesting in lower school attendance as well as the lower expenditure on school uniforms and books and stationary.

This does not distract from the commitment of these households to their children's education as noted by the attendance (albeit lower than the other groups, but not statistically different), as well as their expenditure on other school related expenses. Fleisch, Shindler and Perry (2009:45) measuring household income found that 60 per cent of children that do attend school in grades 1-9 live in families that are poor.

Not only does the QNR children confront educational challenges (due to lack of resources), they also live in households which lack basic services (water and sanitation). The lack of these services not only impacts on their health, but also on their attendance (miss school when sick) and consequently on the education outcomes. The comparison of basic services among the groups is discussed later (section 10.4.2).

10.3.2 Educational outcomes

An increase in enrolment with a subsequent increase in attendance is no guarantee that educational outcomes will improve. Despite the high enrolment rates and the relatively high attendance rate, educational outputs are still bleak. A study of poor schools in Limpopo revealed that only one in three grade 6 learners could correctly calculate the answer to '53-28' (Van der Berg, Louw and Du Toit, 2007:37). The former Minister of Education Naledi Pandor launched the Foundations for Learning Campaign (FFLC) in 2008 in response, to improve the mathematics and language foundation among school learners.

The 2006 Progress in International Reading Literacy Study (PIRLS) evaluated the performance of grade 4 learners in 40 countries. South Africa's Grade 5 learners were compared with the other learners. Whereas 94 per cent of the other countries' learners achieved the low/basic benchmark, only 22 per cent of South African learners achieved this benchmark (Pendlebury et al, 2009:61).

As part of the Systemic Evaluation for Grade 6's, students were subjected to proficiency tests in a number of significant areas.

Table 47: Learner performance in language, mathematics and natural sciences, 2004

	Mean Scores	Percentage of Learners Achieving 50% or More
Language	38%	28%
Mathematics	27%	12%
Natural Sciences	41%	31%

Source: Pauw and Mncube (2007:34)

Table 47 demonstrates the poor performance of South African Grade 6 learners in these areas. Consequently, a Development Policy Research Unit (DPRU) study [(DPRU, 2006) *in* Pauw and Mncube (2007:35)] on graduate employment found that 82 per cent of first year students at tertiary institutions are 'functionally illiterate' in that their language skills did not meet the requirement to function adequately at an academic tertiary institution.

It cannot be inferred that the poor attendance alone (when it occurs) is responsible for the poor education outcomes. Pauw and Mncube (2007:35) argue that the poor

performance of South African pupils can be attributed to a combination of poor quality teaching, poor facilities, under-funding in schools and low attendance rates. These are responsible for the high failure and repetition rates. Oosthuizen and Naidoo (2005) *in* [Pauw and Mncube (2007:34)] in a study in 2003 of an analysis of school attendance in age appropriate grades, found that less than 50 per cent of Grade 12 pupils were the appropriate age for that grade. Although this could be attributable to the late school enrolment of some pupils, it is also the result of the high repetition rates. Leatt and Budlender (2006:6) find that amongst the children not at school, 16 per cent left school as they felt that "school is useless".

Although the gross enrolment rates are high in South Africa, the numeracy and literacy rates are poor. Whilst the aim of enrolment is for government to improve literacy and numeracy (educational outcomes), the supply-side constraint will not only manifest in poor literacy and numeracy (referred to above) but also in the higher failure rate/grade repetition rate among children.

Presently in South African education, enrolment rates (especially in primary school) are high but the education outcomes have been less than satisfactory. May (1998) finds that South Africa has a relatively high school enrolment rate, but a poor pass rate and a high repetition rate. As mentioned earlier, attendance is not a guarantee that children will pass and even when children do pass, there is no guarantee of the quality of the pass.

Therefore, besides the attendance, it would be instructive to compare the educational outcomes of recipients of CSG and non-recipients of CSG to determine if there is any significant difference between these groups. This is done by comparing the rate of repetition of a grade among the different categories to ascertain if there are any significant differences.

The repetition of a grade can be compared by employing the variable 'Has the child ever repeated a grade' [*w1_c_edrep*] as can be observed in Table 48 below.

Table 48: Proportion of children ever repeating grade vs never repeating a grade, sample

	Number	Percentage	Cumulative percentage
Don't Know	2	0%	0%
Missing	62	1.1%	1.1%
Yes	1 388	23.4%	24.5%
No	4 472	75.5%	100%
Total	5 924	100%	

Source: NIDS (2009). Author's own calculation

The 'don't know' and 'missing' variables are removed and the post-stratified weighting [*w1_wgt*] is imposed on to the sample to give comparative population figures.

Table 49: Proportion of children never repeating a grade vs repeated a grade, for the recipients of CSG and non-recipients of CSG

	Recipients of CSG	Non-recipients of CSG
Never repeated a grade	77.4%	79.5%
Repeated a grade	22.6%	20.5%
Total	100%	100%
F-Stat	1.85	
Prob > F	0.1743	

Source: NIDS (2009). Author's own calculation

Although there is a higher percentage of children who repeated a grade among the CSG, that is not necessarily justification for conditionality. There is only a 2.1 percentage point difference between the recipients of CSG and non-recipients of CSG that have repeated a grade. It can be deduced that both these groups are equally impacted by the poor educational supply-side issues.

As alluded to above, given the higher attendance among CSG recipients, the higher failure is more an indictment of the poor educational quality that these students are being exposed to. Attaching a condition of passing the grade is going to place more burden on the parent/guardian to ensure that the child passes. This condition is further analysed by looking at the four different categories as can be observed in Table 50 below.

Table 50: Proportion of children never repeating a grade vs repeated a grade, for the QR, QNR, NQR and NQNR

	QR	QNR	NQR	NQNR
Never repeated a grade	77.7%	72.7%	76.6%	81.6%
Repeated a grade	22.3%	27.3%	23.4%	18.4%
Total	100%	100%	100%	100%
F-Stat	4.18			
Prob > F	0.0058			

Source: NIDS (2009). Author's own calculation

It can be observed from Table 50 above that there is no statistically significant difference between the four categories. It is unsurprising that the NQNR group has a higher percentage that 'Never repeated a grade' as this group represents children that reside in relatively wealthier households. This group will probably have more resources and not be as constrained by the supply-side factors vis-à-vis the other groups.

The QR group has the third highest percentage of children who have 'repeated a grade' which is not significantly different from the other groups. Interestingly, the QNR groups have the highest percentage of children that 'repeated a grade'. The possible reason is that this group is being constrained by the lack of resources for the child's educational needs. Similarly, the NQR groups could be using the resources that they are not 'entitled' to for educational purposes; as their 'repeated a grade' is only one percentage point higher than that of the QR group of children.

The impact of conditionality on educational outcomes in other countries is deliberated in detail in section 8.2.3. The learning outcomes of non-CCT children are similar to that of the CCT students for most CCT programmes (Paqueo, 2009a:10). Reimers, Da Silva and Trevino (2006:11) find that the impact of CCTs on educational outcomes are at best modest. It is noted that CCTs had not resulted in an increase in learning outcomes in Cambodia, Ecuador and Mexico (Skoufias, 2009:120). Ponce and Bedi (2008:19) also find no significant impact on test scores in participants of the *Bono de Desarrollo Humano* (BDH) in Ecuador. Behrman, Parker and Todd (2005:12) found that the *Oportunidades* in Mexico had no statistically significant impact on reading, mathematics and language test scores.

The impact of other factors (such as education level of parents and quality of teachers) play a significant role in educational outcomes (see section 8.3.2); which should not be discounted in any discussion of education outcomes.

10.3.3 Education as a criterion for conditionality

These results accentuate the children's academic performances are not significantly different from one another, irrespective of whether they receive a social transfer or not. Although the children in some households will have relatively (except the NQNR) fewer resources, the imposition of conditionality may burden these households to fulfil a condition which will not make an impact on educational outcomes. Attaching conditions will increase demand for education only marginally, as there are already high enrolments rates, with little probability of improving educational outcomes. Furthermore, the conditionality of the CSG will not improve educational outcomes if the problem is a supply-side failure.

It is the quality of the schools, the teachers and the support material that has to be strengthened to improve the educational outcomes. Pauw and Mcnube (2007:35) note that the South African education system is plagued with 'severe deficiencies in terms of both quality and distribution' of teachers.

Hence, the binding supply-side constraints that are hindering poor educational outcomes is unlikely to be corrected with the CCT. Moreover, the demand for educational services (especially primary education) is already high, grade repetition notwithstanding, and improving the enrolment further will not necessarily translate to better educational outcomes.

Furthermore, many children do not live with their parents but with other members of the extended family, especially grandparents. The variable 'relationship to resident head' is used to analyse recipients of CSG and non-recipients of CSG.

The sample of 9 408 children can be delineated to reflect the child's relationship to the resident household head. The post-stratification [*w1-wgt*] population can be observed in Table 51 below.

Table 51: Relationship of child to the head of the household, for recipients of CSG and non-recipients of CSG

	Recipients of CSG	Non-recipients of CSG
Missing	1.5%	1.5%
Son/Daughter	45.5%	58.5%
Step child	0.6%	1.7%
Adopted child	0.1%	0.7%
Foster child	0.1%	0.9%
Father or mother	0.2%	0.2%
Step parent	0.1%	0.1%
Adopted parent	0%	0.1%
Foster parent	0%	0%
Brother or sister	0.7%	1.7%
Grandchild	42.6%	27.0%
Father or mother-in-law	0%	0%
Son or daughter-in-law	0.1%	0%
Brother or sister-in-law	0%	0.1%
Uncle or aunt	0.5%	0.7%
Nephew or niece	4.3%	4.1%
Cousin	0.1%	0.2%
Great-grandparent	0.1%	0.1%
Great-grandchild	2.3%	1.3%
Lodger or relative of	0%	0%
Other family	0.7%	0.8%
Other non-family	0.7%	0.4%
Total	100%	100.0%

Source: NIDS (2009). Author's own calculation

Firstly, it is noteworthy that less than 50 per cent (45.5 per cent) of CSG recipients live in households where the parent is the head of the household compared to 58.5 per cent of non-recipients of CSG. Interestingly, 42.6 per cent of CSG recipients live with their grandparents. This strengthens the case of NOT adding any educational conditionalities as the elderly already have the task of looking after these children. Their pensions (private or state) will have to be consumed in order to meet the needs for these children as the CSG may not be sufficient to take care of these children.

The delineation of the children's relationship to household head with regard to the four groups can be observed in the Table 52 below.

Table 52: Relationship of child to the head of the household, for QR, QNR, NQR and NQNR

	QR	QNR	NQR	NQNR
Missing	1.9%	1.7%	0.4%	1.5%
Son/Daughter	50.8%	29.6%	30.7%	67.6%
Step child	0.7%	0.9%	0.1%	2.0%
Adopted child	0%	0.4%	0.4%	0.8%
Foster child	0.1%	2.1%	0.1%	0.5%
Father or mother	0.1%	0%	0.5%	0.2%
Step parent	0.1%	0.0%	0%	0.1%
Adopted parent	0%	0%	0%	0.1%
Foster parent	0%	0%	0%	0%
Brother or sister	0.6%	1.7%	0.8%	1.7%
Grandchild	38.1%	50.9%	55.2%	19.4%
Father or mother-in-law	0%	0%	0%	0%
Son or daughter-in-law	0%	0.1%	0.1%	0%
Brother or sister-in-law	0%	0%	0%	0.1%
Uncle or aunt	0.4%	1.0%	0.6%	0.6%
Nephew or niece	3.6%	5.9%	6.3%	3.6%
Cousin	0.1%	0.2%	0.2%	0.2%
Great-grandparent	0.1%	0.3%	0.2%	0.1%
Great-grandchild	2.0%	3.0%	3.0%	0.8%
Lodger or relative of	0%	0%	0%	0%
Other family	0.8%	1.3%	0.5%	0.6%
Other non-family	0.7%	0.9%	0.6%	0.2%
Total	100%	100%	100%	100%

Source: NIDS (2009). Author's own calculation

It can be observed that 50.8 per cent of children who qualify and receive the grant are living in households where the household head is the parent, which is second only to households where children do not qualify and do not receive the grant (67.6 per cent) [which is the wealthier households]. Interestingly, there are 38.1 per cent of children who qualify and receive the grant who are living with grandparents.

Even more surprising is that close to 51 per cent of QNR and 55.2 per cent of NQR children live with grandparents. The QNR children could well be a strain on the resources of the grandparents. These children's needs would have to be supplemented by the income (grants) of the grandparent. Moreover, the QNR children's parents may be alive but not living with them, hence rendering it difficult for the grandparents to access the grant on their behalf.

Many of the children in the NQR group live with a grandparent. They could be accessing the grant as a coping strategy. That is, their current household resources (grandparent's pension) are insufficient to sustain these households, and they have to obtain the grants as a survival strategy. In poor households, pension income may be the only source of income requiring these households to access the CSG. Burns, Keswell and Leibbrandt (2005:106) find that pension income consists of approximately 90 per cent of income for households in the poorest quintile and approximately three quarters of income for households in the second quintile; thereby concluding that the incidence and severity of household poverty would be significantly worse in the absence of pensions. The pensions for the NQR household may just not be sufficient.

10.4 Health

The South African health status has been declining in recent years. The average life expectancy declined from 54.9 years in 2001 to 50.4 in 2010 (Development Indicators, 2010:36). South Africa's Human Development Index (HDI) has declined from 0.634 in 1995 to 0.597 in 2010 (UNDP, 2010b:150). More worrying, has been the dramatic increase in the Maternal Mortality Ratio (MMR) [number of maternal deaths per 100 000 live births] which has increased from 80.7 in 1997 to 165.5 in 2003 (Development Indicators, 2010:40).

The infant and child mortality rates are used by the World Health Organisation as the main indicator of child health within a country. Mortality is taken as the proxy for development as it best captures more elements of poverty and deprivation than income based measures such as GDP per capita. Ross (2005:7) believes that infant mortality rate and child mortality rate have long been recognised by international agencies as good indicators of the condition of the poor, as they reflect a wide array of factors that characterise extreme poverty: lack of access to clean water and sanitation, indoor air pollution, crowding, low education and literacy rates among mothers, inadequate prenatal and neonatal health services, diets that have insufficient caloric intake and are deficient in essential micronutrients, greater vulnerability to disease and of course low income. Sen (1998:3) argues that "although mortality is not in itself an economic phenomenon, the connection lies in the fact that the factors that increase or decrease mortality have distinct economic

causes and there is thus a prima facie reason for not dismissing mortality as a test of economic performance”.

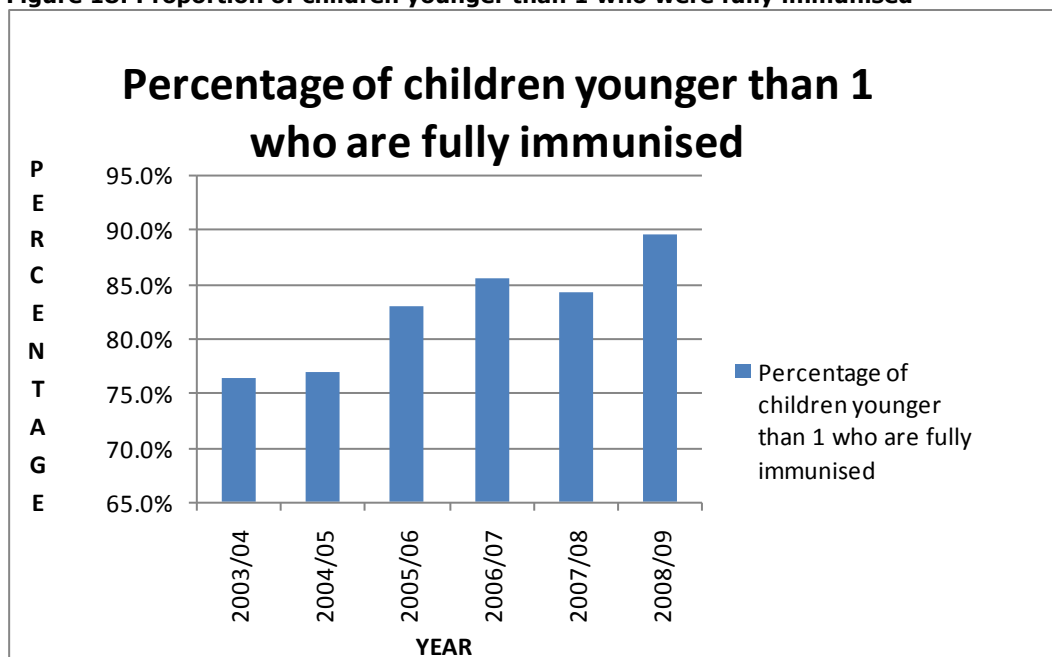
The infant mortality (under one year) rates declined from 55 deaths per 1 000 live births in 2001 to 44.7 per 1 000 live births in 2010 (Development Indicators, 2010:37). It must be stressed that infant and child mortality rates vary depending on the source of the data.

Moreover, these indicators are used as targets of the Millennium Development Goals (Appendix 1) of reducing child mortality and improving child welfare by 2015. There is very little chance of South Africa reaching its Millennium Development Goals of reducing infant and child mortality by 2014. Extrapolation of child mortality trends conducted by Bradshaw (2008:64) from 1980 to 2005, shows that by 2005 South Africa’s under 5 mortality was in the region of 76 against the MDG target of 31.

10.4.1 Immunisation

The immunisation coverage in South Africa has increased from 63 per cent in 1998 to 95.5 per cent in 2007 (Development Indicators, 2010:39). According to the Children’s Institute (2010b) immunisation of children younger than 1 has increased from over 75 per cent in 2003/04 to close to 90 per cent in 2008/09, as observed in Figure 18 below.

Figure 18: Proportion of children younger than 1 who were fully immunised



Source: Children's Institute (2010b)

Yet there are large discrepancies between provinces from 50 per cent coverage in KwaZulu Natal province to 81 per cent coverage in the Northern Cape (Shung-King, McIntyre and Jacobs, 2005:5; Health Systems Trust, 2010b). It does not appear that demand for these services are low, but an indictment of the provincial health department's incapability to deliver these services. Giese and Hussey (2002:30) found that most of the clinics surveyed (which is where immunisation primarily takes place) were ill-equipped to provide basic interventions such as micronutrient supplementation with vitamin A, prevention of tuberculosis etc. And it is the lack of basic interventions that has a negative effect on the quality of health services that are delivered to the public.

It can be deduced that in the case of health (as with education) services there is adequate demand and inadequate supply. It can be inferred from the information above that the demand for health care does exist, but it is the supply constraints which preclude many from accessing health care in South Africa. Pauw and Mncube (2007:39) fittingly note that "before the supply constraints are addressed it will be unwise to stimulate demand for health care further".

The NIDS data is not comprehensive on child health indicators. It does not provide information on child mortality and neither does the survey provide enough data on immunisation levels to conduct any empirical analysis.

However, the NIDS has a variable 'the child has a clinic card' [*w1_c_hlthcrd*]. This variable is employed as a proxy for immunisation as a child must possess an immunisation card once they are born to ensure that they are monitored in order to receive the full regimen of vaccinations.

It can be assumed that the children who have a health card have received vaccinations or are on an immunisation regimen. Accordingly, the NIDS sample reveals that 52.6 per cent of children have a clinic card, whilst only 7.1 per cent do not.

Table 53: Proportion of children that possess a clinic card, sample

	Percentage of children that possess a clinic card	Cumulative percentage
Don't Know	1.3%	1.3%
Missing	2.1%	3.4%
Yes	52.6%	56%
No	7.1%	63.1%
Yes, but not available	36.9%	100%
Total	100%	

Source: NIDS (2009). Author's own calculation

Furthermore, 36.9 per cent of the sample indicate that they do have a clinic card, but it is not available. Consequently, the 'Yes' and the 'Yes, but not available' variables are amalgamated to indicate possession of a card, whilst the 'don't know' and 'missing' variables are discounted.

The post-stratified [*w1_wgt*] extrapolation indicated that most children do possess a clinic card as noted in Table 54 below.

Table 54: Proportion of children that possess a clinic card, population

	Percentage
Yes	92.9%
No	7.2%
Total	100%

Source: NIDS (2009). Author's own calculation

It can be inferred from the Table 54 above, that the caregivers (whether forced to or not) are committed to the child's health (at least the immunisation of the child). A comparison of the 'possession of the clinic card' between the recipients of CSG and non-recipients of CSG, reveals that the possession of a clinic card is higher among the CSG beneficiaries. This is shown in Table 55 below.

Table 55: Proportion of children that possess a clinic card vs. children that do not possess a clinic card, for the recipients of CSG and non-recipients of CSG

	Recipients of CSG	Non-recipients of CSG
Yes	94.4%	90.9%
No	5.6%	9.1%
Total	100%	100%
F-Stat	16.45	
Prob > F	0.0001	

Source: NIDS (2009). Author's own calculation

Moreover, there is no statistically significant difference between those that possess a clinic card vis-à-vis those that do not; between the recipients of the CSG and the non-recipients of CSG, as denoted by the F test.

Hence, we do not reject the Ho that there is no significant difference between those that receive the grant and possess a clinic card and those that do not receive a CSG.

A separation of the 'possession of clinic card' by the four separate categories can be noted in Table 56 below.

Table 56: Proportion of children that possess a clinic card vs. children that do not possess a clinic card, for the QR, QNR, NQR and NQNR

	QR	QNR	NQR	NQNR
Yes	94.4%	89.9%	94.5%	91.3%
No	5.7%	10.1%	5.5%	8.7%
Total	100%	100%	100%	100%
F-Stat	6.23			
Prob > F	0.0003			

Source: NIDS (2009). Author's own calculation

It can be observed that the QR is the highest group that possess a clinic card, even higher than the NQNR. The F test reveals that we do not reject the Ho, that there is no statistical significant difference between these groups. It can be inferred from the

figures above that conditionality on immunisation is not necessary as 'clinic card possession' is already high. In fact, it is lowest among the group that qualifies for the CSG and is not receiving the grant. If anything this group may urgently need the grant to access the immunisation treatment that is available. The QNR children (Table 41) are mostly rural based and may not have the means (relative to QR group) to pay for the travel costs to the clinics for immunisation.

Furthermore, immunisation of children depends not only on the willingness (demand) of the recipients as demonstrated by the high percentage of clinic cards; but also, on the government's ability to effectively deliver (supply) health services to the population. The increasing of immunisation rates (Development Indicators, 2010:39) could be construed as children's (rather their caregiver's) commitment to their health and well-being.

The impact of CCTs on the utilisation of health services in other countries is deliberated in section 8.5.1., where the results are mixed. Morris et al (2004:2036) noted an increase in the coverage of the first dosage of DPT/Pentavalent vaccine, but no effect on the coverage of immunisation against measles in *Programa de Asignación Familiar* (PRAF) in Honduras.

The *Red de Protección Social* (RPS) resulted in a 14 percentage point increase in coverage rates for fully vaccinated children (Barham and Maluccio, 2008:28). In Turkey, immunisation coverage of the recipients of CCTs were 14 percentage points higher than those who did not participate in the programme. However, the *PROGRESSA* programme in Brazil resulted in a decrease in health service utilisation by the recipients. Gertler and Boyce (2001:12) attribute the decline in the utilisation of health services to the decreased illnesses emanating from earlier regular health visits.

It must also be noted that ,the poor health (as well as education) outcomes could be due to the other services which is necessary (although not sufficient) for good health outcomes.

10.4.2 Determinants of health

The direct cause for health problems can be poor nutrition and lack of food as well as inadequate or no health services available. The lack of water and proper sanitation also impacts negatively on health outcomes.

Many of the causes related to poor health are due to the lack or inadequate provision of services such as clean water and proper sanitation, adequate nutrition and safe environments. This can be seen by the fact that the main reasons for under 5 mortality emanate from preventable diseases such as diarrhoea and respiratory infection with malnutrition and HIV being contributory causes (Shung-King et al, 2005:3). Abrahams and Berry (2006:1) argue that the 'diseases of poverty' are the main causes of death among children after HIV/AIDS.

Hall (2007:3) notes that the provision of these basic services will decrease diarrhoeal disease, respiratory infections and other illnesses associated with poor living condition.

Pauw and Mncube (2007:37) find that child mortality rates are double for households without piped water than those with piped water; and households without flush sanitation have a child mortality which is four times greater than houses with flushed toilets.

But access to water and sanitation has improved in South Africa in the last 15 years. The number of households with access to water infrastructure has increased from 6 860 693 (61.9 per cent) of households in 1994/95 to 12 640 515 (91.8 per cent) of households in 2008/09 (Development Indicators, 2010:31). Furthermore, the number of households with access to sanitation has increased from 4 477 400 (50.9 per cent) households in 1994/95 to 9 245 357 (74.5 per cent) households in 2007 (Development Indicators, 2010:31).

These improvements should have had a positive impact on health outcomes, yet there has still been a decrease in the overall health status in South Africa in the last 14 years. The improvements in access to sanitation is broad as there are different types of toilet facilities that are available to households from flush with onsite disposal to bucket toilets. Therefore, it is imperative to investigate if these services

are present in households where poor children reside, that is, in households in the QR and the QNR categories.

The NIDS data has variables of the availability of these services to households and cross tabulation with the different categories provides information on children's access to these services.

Accordingly, the number of households that have access to different types of toilet facilities can be observed in the Table 57 below.

Table 57: Proportion of children living in households with different types of toilet facility

Type of toilet facility available to the household	Percentage	Cumulative percentage without a flush toilet with onsite disposal	Cumulative percentage without any flush toilet
Refused	0%		
Not Applicable	0%		
Missing	0.2%		
Flush toilet with onsite disposal	22.2%		
Flush toilet with offsite disposal	21.7%	21.7%	
Chemical	1.9%	23.6%	1.9%
Pit latrine with ventilation	13%	36.6%	14.9%
Pit latrine without ventilation	28.5%	65.1%	43.5%
Bucket toilet	3.8%	69.0%	47.3%
None	8.5%	77.5%	55.8%
Other	0%	77.5%	55.9%

Source: NIDS (2009). Author's own calculation

It can be noticed from the Table 57 above that 77.5 per cent of children live in households that do not have a 'flush toilet with onsite disposal'. More interesting, is that 55.9 per cent of children live in households without any flush toilets at all. These figures differ significantly from the Development Indicators (2008:33) which claim that 72.6 per cent of households have access to sanitation. The discrepancy stems from the definition that is utilised for the Development Indicators. Specifically, a basic sanitation facility is defined as a ventilated improved pit latrine as specified by the MDG 10 (Development Indicators, 2008:33). Secondly, the definition relates to a household's access to sanitation; a household may share a communal toilet and not have one of their own, but have access to sanitation. The NIDS study refers to the

type of toilet (not access to sanitation) that is available to the household. The type of toilet facility or access to sanitation are not relevant on their own, but are useful when comparing access to these services between the various groups. A comparison of type of toilet facility by households between the recipients of CSG and non-recipients of CSG can be observed in Table 58 below.

Table 58: Proportion of children living in households with different types of toilet facility for the recipients of CSG and non-recipients of CSG

	Recipients of CSG	Non-recipients of CSG	Cumulative Percentage
Refused	0%	0%	
Not Applicable	0.0%	0%	
Missing	0.1%	0.4%	
Flush toilet with onsite disposal	15.1%	31.1%	31.1%
Flush toilet with offsite disposal	15.9%	28.8%	59.9%
Chemical toilet	2.3%	1.5%	
Pit latrine with ventilation pipe	16.5%	8.7%	
Pit latrine without ventilation pipe	34.3%	21.4%	
Bucket toilet	4.8%	2.6%	
None	11%	5.4%	
Other	0.1%	0%	
Total	100%	100%	

Source: NIDS (2009). Author's own calculation

It is unsurprising that the CSG recipients live in households that have less adequate toilet facilities than the non-recipients of CSG. Moreover, most CSG recipients (34.3 per cent) live in households with a 'pit latrine without ventilation' whilst most non-recipients of CSG (59.9 per cent) live in households with a flush toilet. This will be better analysed by comparing the four categories, seen in Table 59 below.

Table 59: Proportion of children living in household with different type of toilet facility, for the QR, QNR, NQR and NQNR

	QR	QNR	NQR	NQNR
Refused	0%	0%	0.1%	0%
Not Applicable	0%	0%	0%	0%
Missing	0.1%	0.7%	0%	0.3%
Flush toilet with onsite disposal	11.9%	13.1%	23.9%	37.5%
Flush toilet with offsite disposal	15.3%	19.2%	17.4%	32.2%
Chemical toilet	2.6%	2.3%	1.3%	1.2%
Pit latrine with ventilation pipe	17.9%	18.1%	12.5%	5.4%
Pit latrine without ventilation pipe	35.8%	34.2%	30.1%	16.9%
Bucket toilet	4.3%	1.9%	6.2%	2.9%
None	12.0%	10.5%	8.4%	3.6%
Other	0.1%	0%	0%	0%
Total	100%	100%	100%	100%

Source: NIDS (2009). Author's own calculation

It can be seen that most children in the QR, QNR and NQR groups live in households that have a 'pit latrine without ventilation pipe'; whilst the children in the NQNR mostly live in households with 'flush toilet with onsite disposal'. Interestingly, the NQR is the group with the highest percentage of bucket toilets underscoring the urban poverty that is experienced by this group relative to the other groups. The NQR (Table 41) has a higher proportion (53.4 per cent) of children living in urban areas relative to the QR and the NQR, inferring that they will experience more urban related problems (bucket toilets) relative to the other groups. The NQNR group will be less likely than the NQR group to experience these problems as they are wealthier than the other groups. Interestingly, the QNR group has the lowest percentage (1.9 per cent) of children living in households with buckets. This could be attributed to the low prevalence of the buckets in rural areas, where there are relatively more pit latrines.

The ancillary challenges to proper health can also be demonstrated by looking at the availability of water in the household; or more specifically, how far a child has to travel to access water. The distance of the water source from the dwelling is evaluated in Table 60 below.

Table 60: Proportion of children living in dwellings that vary in distance from water source

	Percentage	Cumulative percentage	Cumulative percentage of water source greater than 100m
Don't Know	0.8%	0.8%	
Not Applicable	0.8%	1.7%	
Missing	0%	1.7%	
Less than 100m	43%	44.7%	
100m - less than 200m	27.2%	71.9%	27.2%
200m - less than 500m	11.8%	83.8%	39%
500m - less than 1km	9.3%	93%	48.3%
1km or more	7%	100%	55.3%

Source: NIDS (2009). Author's own calculation

It can be observed from the Table 60 above that only 45 per cent of children live in households that have a water source less than 100 meters. Consequently, more than half of all children have a water source which is greater than 100 metres away from their dwelling. Once again, these figures differ from those of the Developments Indicators (2008:32) due to the definition employed. The Development Indicators (2008:32) refer to households with access to potable water, whilst the NIDS data delineate the distances of households from the water source. As in the case with the type of sanitation, this study is more concerned with the difference in access between the different groups, and not with the proportion of households/children that have access to these services. Consequently, the distance of water sources from dwelling for the recipients of CSG and the non-recipients of CSG can be viewed in Table 61 below.

Table 61: Proportion of children living in dwellings that vary in distance from water source, for recipients of CSG and non-recipients of CSG

	Recipients of CSG	Non-recipients of CSG
Don't Know	0.9%	0.7%
Not Applicable	0.9%	0.6%
Missing	0%	0.1%
Less than 100m	42.8%	43.6%
100m - less than 200m	27.6%	26.3%
200m - less than 500m	12.2%	11.2%
500m - less than 1km	9%	9.8%
1km or more	6.6%	7.7%
Total	100%	100%

Source: NIDS (2009). Author's own calculation

From Table 61 above it can be seen that there is very little difference in the distance of water source from dwellings between the recipients of CSG and the non-recipients of CSG. A more instructive comparison is between the four groups as observed in Table 62 below.

Table 62: Proportion of children living in dwellings that vary in distance from water source, for QR, QNR, NQR and NQNR

	QR	QNR	NQR	NQNR
Don't Know	0.9%	1.5%	0.6%	0%
Not Applicable	0.9%	0.1%	1.2%	1.1%
Missing	0%	0.2%	0%	0.1%
Less than 100m	41%	40.4%	50.7%	46.5%
100m - less than 200m	27.5%	30.9%	28.5%	22%
200m - less than 500m	12.9%	11.1%	8.7%	11.3%
500m - less than 1km	9.8%	6.1%	5.6%	13.3%
1km or more	7%	9.9%	4.6%	5.7%
Total	100%	100%	100%	100%

Source: NIDS (2009). Author's own calculation

It can be observed that most children, in all the groups, live in households with a water source less than 100 metres from the dwelling. However, children in the QNR group have the largest percentage (9.9 per cent) of children living more than 1km or more from a water source. The QR group has 7 per cent of its recipients living in households where the water source is more than 1 kilometre away from the dwelling.

Another important service that the government has significantly improved, is the provision of electricity to households. This can be observed in Table 63 below.

Table 63: Proportion of children living in households that have electricity, for recipients of CSG and non-recipients of CSG

	Recipients of CSG	Non-recipients of CSG
Missing	4.2%	4.5%
Yes	69.7%	79.8%
No	26.1%	15.7%
Total	100%	100%

Source: NIDS (2009). Author's own calculation

It can be noticed that the non-recipients of CSG have a larger percentage of children living in households that have electricity.

In Table 64 below the percentages of households in the different categories with access to electricity can be seen.

Table 64: Proportion of children living in households that have electricity, for QR, QNR, NQR and NQNR

	QR	QNR	NQR	NQNR
Missing	4.1%	5.1%	4.3%	4.2%
Yes	65.6%	68.6%	81.3%	83.8%
No	30.3%	26.3%	14.5%	12%
Total	100%	100%	100%	100%

Source: NIDS (2009). Author's own calculation

Whilst most households in all the categories have electricity, it can be noted that the most households without electricity are those within the QR and the QNR categories.

In summary, availability of the services (which not only contribute to health outcomes, but are also a basic necessity) are not sufficiently provided for many poor households; specifically, the children in the QR and the QNR categories. Eligible caregivers tend to have less access to running water or toilets within their dwellings (DOSD, 2008:2). Moreover, these amenities are more readily available to the NQNR and to a lesser extent the NQR group, once more illustrating an urban bias in the provision of these services.

Before the attaching conditionality to the CSG, it would be crucial to improve these services as they are constraining factors to the poor which impacts on their ability to attain optimal education and health outcomes.

The imposition of health conditionality will increase the burden on households to fulfil the health conditionality if it is implemented. Furthermore, children in these households do not have control over these factors. Making the grant conditional on immunisation combined with government's inability to improve these conditions will have minimal impact on health outcomes. In fact, it could lead to the deterioration of health outcomes as the CSG could very well be used to mitigate these risks. For example, the grant will have to be utilised to alleviate the poor health outcomes by providing nutritional supplements and for the treatment of diseases due to poor sanitation.

The South African Constitution guarantees the right to free health care to all children. Although health has a critical role to play in children's welfare, an inter-sectoral approach or comprehensive role is required to sufficiently address the health requirements of children. The new government has initiated many policies to improve the health of the nation as well as access to health. Among the policies that were implemented was the introduction of free primary care for all citizens, free health care for pregnant mothers and for children under the age of six, as well as pensioners who receive a state Old Age Pension qualifies to receive free health care services at public hospitals.

But there are many other indirect costs to medical treatments that could be resulting in many (both poor and non-poor) people not accessing health care in South Africa. Although health care may be free, poor households do not access health facilities such as clinics and hospitals due to the large distances they have to travel to the clinic, the poor quality of the roads to get to the clinic as well as the relatively high transport costs to go to the clinic. Hemson and Owuso-Ampomah (2004:516) estimate that it takes people in the poorest quintile on average of almost two hours to obtain medical attention compared to the richest quintile who take on average 34 minutes to obtain medical attention.

This case is strengthened when one looks at the accessibility of these facilities for children, especially if one observes the distances a child has to travel to obtain access to a health facility. According to the Lake and Marera (2009:91) in their analysis of the GSH of 2007, 40 per cent of children live 'far' from a primary health care facility, which translates into 6.9 million children having to travel more than 30 minutes to reach their nearest clinic. The authors note that the availability and physical accessibility of health care services continue to remain a problem, especially for people living in remote rural areas which are not near health institutions (Lake and Marera, 2009:91).

This is compounded by the poor road infrastructure which makes it difficult for mobile clinics and emergency vehicles to reach these areas. The NIDS data does not provide information on the distances that children (or adults) have to travel to a healthcare facility.

The healthcare service delivery in South Africa is constrained by the limited human capacity or skills to deliver satisfactory healthcare. There are high vacancy rates of medical professionals in South Africa, especially the highly skilled professionals, especially when one looks at the medical personnel to people ratio. In the public sector the number of medical practitioners is 27.3 per 100 000 people compared to 37 medical practitioners per 100 000 population in the private sector in 2010 (Health Systems Trust, 2010c). The medical personnel are already stretched with the current workload. The comparatively lower salaries to developed countries, the long working hours and the poor working conditions has resulted in many health professionals migrating or leaving the public health sector. Ntuli and Day (2004:5) argue that medical personnel cite the low levels of job satisfaction, poor working conditions, and poor salaries as well the HIV epidemic as the main reasons for their dissatisfaction with the health sector.

10.4.3 Health as a criterion for conditionality

While it may appear viable to impose conditionalities to increase health attendance at health facilities, government should be aware of the challenges that the poor face in accessing these facilities; and the challenges the government face in delivering the health services to the poor. Specifically, the government should initiate strategies to retain skilled medical personnel, improving the working conditions by investing more in health facilities and infrastructure. Furthermore, the government should also aim to improve access to the facilities by improving the conditions of the road to get to these facilities.

The institution of conditionalities could lead to an increase in demand for these services as well as place an extra administrative burden on the current personnel. This could lead to a further deterioration in health services delivered to the poor. Woolard, Carter and Agüer (2005:30) find that children who received the CSG for two-thirds of the period prior to turning three gained 40 per cent of a standard deviation in their standardized height-for-age scores.

Hall (2007:7) notes that social grants are associated with improved health and nutrition. This underscores the importance of not adding a condition to the grant, but improving access to the grant as early as possible after birth.

Hall (2007:7) notes that the positive findings of Samson et al (2004) of the Economic Policy Research Institute (EPRI) are to be recognised, as they imply that the CSG is already associated with many of the outcomes (health, education and improved nutrition) that conditionalities intend to satisfy. Social assistance is contributing to 'human capital' effects as these grants are investments in the development of children and future economic growth (Hall, 2007:8)

The Children's Institute (2004:22) argues that the children need nutritional support at the critical stage in their lives which is between birth and two years of age. But presently there is no such programme to link to the CSG, with the NSNP only available once the children begin school, which may be too late.

This strengthens the case for linking cash transfers to nutritional support to babies. But there is already baby milk and formula that are given to mothers of new-borns at health facilities. Secondly, there will have to be an increased roll out of the facilities first before any conditionality can be attached. Thirdly, there is already free access to primary health care to all South Africans.

Moreover, it can be observed in Table 34, that 15.7 per cent of children in the QNR below the age of 1 are not receiving the CSG, when they should in fact be qualifying for the grant. Also (which is more probable in South Africa) the reason people are not accessing the services is that the costs to use the services (or the ancillary costs) as well as distance to travel to the health facilities may be prohibitive. Conditioning the transfer will place an additional burden on the family.

The evidence of CCT on actual outcomes in other countries is mostly positive. The outcomes depends very much on the initial health status of the child. A detailed discussion on the impact of CCTs on actual outcomes can be examined in section 8.5.2. In Latin America, the *PROGRESA* in Mexico; *Red de Protección Social* (RPS) in Nicaragua and Colombia's *Familias en Acción* (FA) are credited with positive impacts on child height, whilst the *Programa de Asignación Familia* (PRAF) in Honduras and *Bolsa Alimentação* in Brazil had no significant impact on preschool nutrition.

The test for anaemia is often used as a criteria to test for health status. Gertler and Boyce find that the *Oportunidades* resulted in an 18 per cent reduction in anaemia,

whilst Paxson and Schady (2007:21) find that the *Bono de Desarrollo Humano* (BDH) in Ecuador had a large impact on haemoglobin levels among the poorest children. However, Maluccio and Flores (2005:64) found that the RPS in Nicaragua did not make any significant difference to the anaemic position of the child.

10.5 Administration and monitoring challenges

The Department of Social Development (DOSD) is responsible for social grants in South Africa under the Social Security Act of 2004 (section 6.4.2.2).

The expenditure for SASSA (2008/09) was R75.4 billion which is inclusive of the social transfers (ENE, 2010:361); but the expenditure for SASSA administration (which is inclusive of administration of all grants) of the organisation is R4.6 billion in 2008/09 and is projected to rise to R6 billion in 2011/12 (Budget Review, 2010:105).

Table 65: Costs of administering current social grants in South Africa

	Past			Current	Projected		
	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12
Average cost of administering social assistance grants (R/beneficiary) each year	25.37	29.16	27.84	29.4	28.37	27.48	26.87
Average cost of manual payment of grants (R/beneficiary) each	16.27	14.01	14.71	21.04	23.08	26.99	31.2
Ratio of administration cost to social assistance disbursements each year	0.066:1	0.067:1	0.073:1	0.063:1	0.062:1	0.060:1	0.060:1
Percentage of beneficiaries receiving payments of grants through the banking system each year	1 158 083 (14.45%)	1 437 433 (16.67%)	1 777 429 (20.02%)	2 101 915 (21.63%)	2 687 260 (22.48%)	3 455 755 (28.9%)	4 418 119 (33.81%)

Source: Estimate of National Expenditure (2009:355) [Note: Font is smaller to accommodate all information]

The average cost of administration per grant in South Africa has increased from R25.37 in 2005/06 (nominal) to R29.40 in 2008/09, whilst the average cost of manual payment rose from R16.27 in 2005/06 to R21.04 in 2008/09. Hence SASSA is encouraging the use of banks. But the uptake is low due to high illiteracy levels and the exorbitant bank charges that the poor perceive they will be paying. The DOSD study found that the reason caregivers did not use the banking facility is that they were concerned that the bank charges would 'eat' into the grant; the lack of banks [especially in rural areas] and the costs of travelling to banks. Therefore, many caregivers preferred collecting the cash rather than using the formal banking system (DOSD, 2006:4).

The payment to the cash payment contractors accounts for approximately 53 per cent of the administration budget, followed by compensation of employees at approximately 29 per cent, and 18 per cent for other operational expenditure (ENE, 2009:355).

The administration cost of implementing the CCT will be much higher than the present grant arrangement as the monitoring of the compliance with conditionality

has to be factored. Son (2008:5) notes that the monitoring of the conditionality was 24 per cent of the total administration cost for the *PROGESSA* in Mexico in 2000, three years after it was established. A crude estimation of the cost of monitoring can be ascertained by using the 24 per cent as a proxy to determine cost of monitoring conditionality, which is denoted in Table 66 below.

Table 66: Additional administration cost for conditionality of CSG

	Total	CSG
SASSA expenditure for 2008/09	R 4 630 000 000	-
Number of beneficiaries	13 026 104	8 765 354
CSG expenditure as a percentage of total grant expenditure		31.6%
CSG beneficiaries as a percentage of total beneficiaries	-	67.3%
Administration cost of CSG as a percentage of total administration cost	R 4 630 000 000	R 3 115 990 000
Average annual administration cost	R 355.44	R 355.49
Average monthly administration cost	R 29.62	R 29.62
Percentage cost of monitoring conditionality	-	24%
Additional administration cost of CSG	-	R 7.11
New average cost of per CSG	-	R 36.73
Additional annual administration cost for CSG	-	R 747 837 600
Increased SASSA expenditure	R 5 377 837 600	-
Percentage increase in SASSA expenditure	16.2%	-

Source: Estimates of National Expenditure (2009:355). Budget Review (2010:106). Authors own calculation

It must be noted that administrative cost of SASSA as well as cost per transfer pertains not only to CSG, but to all grants. Furthermore, the administrative costs of SASSA represents all expenditure (including its operation costs and its own administration) and not just the cost of administering social transfers. SASSA's total expenditure is representative of administrative expenditure of all facets pertaining to grants, that is, payments, means testing, grant review, handling disputes etc. Therefore, the full expenditure of SASSA is employed to ascertain the administrative cost of grants.

The expenditure for 2008/09 for CSG was R22.4 billion of the total transfers of R70.7 billion (Budget Review, 2010:106). SASSA spent R4.6 billion (in 2008/09) [Budget Review, 2010:105] administering grants to 13 026 104 recipients (Table 5). The administrative cost can be duly apportioned to the CSG. Consequently, 31.6 per cent of social transfers expenditure was spent on CSG. It may appear appropriate to apportion 31.6 per cent of SASSA expenditure to CSG, but that would be erroneous. Although, the CSG expenditure is 31.6 per cent, there are more CSG recipients. Consequently, there were 8 765 354 recipients (Table 5) of CSG in 2008/09 which is 67.3 per cent of all social transfers. Hence, 67.3 per cent of administration cost should be apportioned to CSG.

The average administration cost per grant per month is $([R4.6 \text{ billion} \div 13\,026\,104] \div 12)$ R29.62; assuming that each recipient received their grant every month. Similarly, average administration cost per CSG per month $([R3.1 \text{ billion} \div 8\,765\,354] \div 12)$ is R29.62 as can be noted in Table 66 above.

And if one uses the 24 per cent as a proxy for the monitoring of conditionality, then there will be a 24 per cent increase in the administration cost of CSG, which will increase the administration cost per CSG to R36.73. This will translate into a 16.2 per cent (R747.8 million) increase in administration costs due to the monitoring of conditionality.

This expenditure can be mitigated in the future by the implementation of electronic transfers; but there is no guarantee that this will occur. Nevertheless, the increase in administration cost will also affect the benefits that will have to be disbursed to the beneficiary.

Furthermore, there are private costs which policymakers often neglect and which may place an unnecessary burden on caregivers to satisfy the conditions. These primarily relate to time or the opportunity cost as well as the financial cost (such as travelling regularly to the clinic and school). It can be noticed from earlier discussion (section 10.4.2) that the children who are most in need (QR and QNR) already have the least access to municipal services. The imposition of conditionality will increase the private cost incurred by these recipients.

The conditions for education and health are currently under the jurisdiction of the Department of Education and Health respectively. They are concurrent functions where the national departments formulate policy and implementation rests with the provincial departments. This will entail these departments being involved with social security. Present co-ordination between departments (such as in the EPWP) programmes till date has been poor.

Capacity to implement has also been highlighted in a study by Van der Westhuizen and Van Zyl (2002) who investigate the capability of government to expand the social security. The study was conducted with national and provincial departments, at a time when provinces were administering the grants. Interestingly, of the 13 respondents, only three cited budgetary limitations, with most indicating non-budgetary constraints. The main obstacles faced, were the lack of qualified staff, recipients were widespread often in rural areas which were hard to reach, and the people not possessing the correct identification documents. The Disability Grant (DG) was the transfer that was cited as the one that created the most problems, due to the medical examination that the beneficiary had to undergo to access the grant. Specifically, the lack of co-operation and co-ordination with the Department of health was often mentioned (Van der Westhuizen and Van Zyl, 2002:6).

The cost of satisfying the conditions will impose compliance costs on the household and will either decrease the value of the benefit, or totally negate the benefit. Households may not be able to quantify the net benefit of CCTs easily, and could be worse off after satisfying the condition. This will be especially acute for the poorest households in the programme (De Brauw, and Hoddinott, 2008).

Hall and Monson (2006:43) reflect on the many costs and consequences of accessing the grants. These include

- a. The cost and/or time of traveling to the Department of Social Development and Department of Foreign Affairs to obtain proof of documents. Sometimes this entails travelling to other provinces.
- b. Waking up very early and waiting long hours in DOSD offices and other government offices.
- c. The loss of work or time for income-generating activities.

- d. Negotiating leave from employer, making child care arrangements and having to involve others (family members/ friends) in the process.

The institution of conditionalities will require recipients to undertake these activities on a regular basis in order to access the grant, placing an additional burden on already constrained households.

Furthermore, the imposition of the conditionality can lead to intra-household inequality. Molyneux (2007:71) notes that costs are not necessarily shared equally among household members, as mothers often accompany children to health clinics or attend community meetings. The responsibility of making sure that the condition is being satisfied will rest with the mother or the head female in the household. Often this will be the elderly grandmother who is taking care of the orphan child. This will then impact on both the earned and unearned income of the household.

There will be a reduction of total welfare gain among the poor if the imposition of the condition is not aligned with the preferences of the poor who are recipients of the grant. This will result in a decrease in the net benefits of the CCT (De Brauw, and Hoddinott, 2008:5).

10.6 Fraud and corruption

The fraudulent and corruptive practices that plague social transfers result in the inefficient use of resources and less resources for the 'deserving poor', thereby undermining the integrity of the programme.

Fraud pertains to deliberate behaviour on the part of the claimant to defraud the benefit system whilst corruption refers to an intentional attempt by staff to exploit the social protection system for themselves (Van Stolk and Tesliuc, 2010:3).

The main causes of fraud are claimants being deliberately dishonest (undeclared income on benefit forms), claimants purposely exploiting the system by providing a false identity and the complexity of the benefit system, which offers opportunities and incentives for claimants to defraud the system. The main corruptive practices committed by employees of the programme include staff accepting bribes to enrol people in the programme; collusion between administrative staff and claimants; and

collusion between staff who process the claims and those that pay out the benefit claims (Van Stolk and Tesliuc, 2010:7).

Authorities are cognisant that the system can never be faultless and will have to accept that some corruption is occurring. But the system can become threatened and undermined if corruption becomes widespread. The corruption within South African social transfers is endemic to the extent that the previous Minister of Social Development had to institute an investigation. Pauw and Mncube (2007:31) notes that the losses are 'conservatively' estimated at R1.5 billion or 2.6 per cent of the department's budget of R56 billion. In December 2004 the DOSD launched an amnesty drive to grant indemnity to all people who were illegally accessing social grants before March 2005. More than 30 000 people applied for amnesty and had their payments stopped, resulting in a 'saving' of R12 million per month (Mabasa, 2005).

In 2006, the Special Investigating Unit (SIU) and the Department of Social Development conducted an investigation into fraud and irregularities in the social welfare system. During the investigation approximately 12.6 million electronic records were analysed and 333 233 grants (all types of grants) with an annual value of over R1 billion were removed from the system as they were irregular (Skweyiya, 2008). The CSG and the DG were the grants that were the most often fraudulently claimed (Skweyiya, 2008). Piliso (2010) notes the common fraudulent activities for illegally claiming CSG. These include people registering 'phantom' children at Home Affairs and subsequently applying for CSG. There was also a 'rent a child' scam which was uncovered in Mthatha in the Eastern Cape, where people borrow a child - for a fee - from another community member and present that child as their own during the verification process. Also deaths of deceased children are never reported to the Home Affairs and beneficiaries continue to receive Child Support Grants (Piliso, 2010).

The Mail and Guardian (2004) note two cases of corruption where two officials were arrested for their involvement in a R2.3 million social grant scam in which they used fake documents to access Child Support Grants. Another case entailed officials stealing cheques from existing grant beneficiaries and cashing their payment

vouchers, using other people's thumb and even toe-prints (Gedye, James and Lebea, 2004).

From the analysis in this study, it can be inferred that the NQR (children not qualifying and receiving the grant) group are the most likely to commit fraud. The analysis indicated 14.6 per cent of children did not qualify but were receiving the grant. The explanations for the high percentage of the NQR group is substantiated in the discussion after Table 32 where it is noted that fraud is not necessarily the only or the main reason for the high numbers. Nevertheless, this does not distract from the fact that 2.1 million children in 2008 were receiving the grant that they were not eligible for or entitled to.

Hence, although SASSA has been established to effectively administer grants, fraud and corruption is still pervasive within the system; and there is no evidence that the addition of conditionality will stem this tide. The current fraudulent and corruptive practice could be exacerbated by the imposition of conditionality. Conditionality may lead to an increase in corruptive practices where officials can be bribed to certify that recipients satisfy the conditions. Alternatively, officials could seek a bribe to certify even when the recipients genuinely qualify for benefits. Furthermore, more resources will have to be granted to not only increase administration costs for monitoring conditionality, but also to combat corruption.

10.7 Dependency

There is also the argument of grants creating dependency, which can be mitigated by conditionality. The imposition of conditionality would deter women from having children to access the grant. The conditionality will impose costs on fulfilling the conditions that may discourage women having children just for the grant.

However, as mentioned earlier (section 6.6.3; Naidoo [2002:4]) everyone is dependent at some time in his/her life. South African social assistance is targeted to the neediest and people who should not be working, the elderly, the children and the disabled. Hence, very often these segments of the population are dependent. The cash transfers are there to mitigate their dependency on others (Leatt and Budlender, 2006:8).

The cash transfers are explicitly targeted at people who *should not* work: children, the severely disabled, and people in their old age. In other words, they are a response to existing dependency in chronically poor communities, especially where the HIV/AIDS pandemic has increased mortality and morbidity and deepened poverty. Leatt and Budlender (2006:6) add that households use of their own resources to improve their nutrition and their health status, and to seek employment, thereby mitigating dependence on the state.

The receipt of the grant by women can serve as compensation for unremunerated work (caring for the child) instead of being gainfully employed (Leatt and Budlender, 2006:9). Furthermore, if women were able to find work, the grant will allow them to pay other people (especially women) to look after their children.

An argument often cited against the CCT and CSG in general has been that teenagers fall pregnant in order to get the grant. This has to a large extent been refuted by research by Case, Hosegood, and Lund (2004). They find that only 3.7 per cent of children in the Child Support Grant system have teenaged mothers, compared to 8.7 per cent of children not in the system (Case et al, 2004:4). The DOSD (2006) study notes that the proportion of teenagers who claim CSG is much lower (13 per cent) than the proportion of teenage mothers in the South African population (mothers younger than 30). Moreover, comparisons between the number of teenagers who receive the CSG with the incidence of teenage births in the national population indicate that the take-up rate of the CSG by teenage mothers is low. Consequently, teenagers younger than 20 represent only 5 per cent of recipients in October 2005 (DOSD, 2006:47).

10.8 Political considerations

The implementation of conditionality can very often occur for political expediency and populist pacification of the electorate. That is the general argument for all social transfers and not necessarily for conditionality. Conditionality can be instituted to appease the taxpayers that are funding the social transfer. This is discussed in depth in section 7.4.2.2.

Conditional cash transfers are popular among beneficiaries and have been used in many countries to 'buy' votes or obtain political support (Alcázar, 2010:1). Hunter and Power (2007:24) note that in the Brazil election of 2006, the incumbent,

President Luiz Inacio da Silva, was trailing his opponent in the election polls a year before the election. However, he was re-elected with a majority, which they attribute mostly to his government's social policies, especially the *Bolsa Familia*, including raises in public pensions (Hunter and Power, 2007:24).

Nevertheless, in South Africa, social assistance is a constitutional imperative; and the conditionalities may be perceived to be inconsistent with the Constitution and be subject to legal challenges by certain civil societies. More importantly, Chapter 2 of the Constitution sets out a Bill of Rights which lists a set of rights in terms of health, education and housing to which a citizen is entitled. The punitive measures which may be attractive to the political elites, may meet with strong resistance from civil society due to the constitutional imperative that guarantees social assistance to the poor.

And nowhere does it categorically state that these basic services are conditional. Lund et al (2008:18) note that the Constitution indicates that both poverty and unemployment are 'unambiguously stated' as having a structural rather than a personal aetiology and that can be construed to mean that they are due to the apartheid legacy.

Furthermore, conditionality will go against the spirit of the Child Health Service Mandate of the RDP that grants children under the age of six free health care. And what will be the punitive measures that government would implement if one does not meet the criteria?

There are constitutional imperatives that one has to consider before one takes away funding from the poor, as poverty may be the reason that the poor are not accessing the benefits. Conditionality could be perceived as degrading the poor just because they are poor, and implying that they do not know what is good for themselves.

Freeland (2007:77) argues that conditionality is 'morally atrocious' as social protection falls under the Universal Declaration of Human Rights and that it is inexcusable to attach conditions to transfers. It is an argument that active civil society groups in South Africa will latch onto (fortified with the rights to social

protection enshrined in the Constitution), to frustrate endeavours to implement conditionality to social transfers in South Africa.

10.9 Summary and conclusion

The chapter began by extrapolating from the NIDS sample to the population the number of children that are receiving the CSG. It was observed that 55.4 per cent (8.3 million) of children are receiving the CSG in South Africa. This is done to make comparisons between the recipients of CSG and non-recipients of CSG. The sample was also demarcated into four categories which were extrapolated to the population, namely, children that qualify and receive the grant (QR) [40.8 per cent of children], children that qualify and do not receive the grant (QNR) [11.7 per cent of children], children that do not qualify and receive the grant (NQR) [14.6 per cent of children] and children that do not qualify and do not receive the grant (NQNR) [32.9 per cent of children].

In section 10.2 the descriptive statistics of all these groups were evaluated. It was found that of all the age groups receiving the CSG, the largest number of recipients (8.7 per cent) is the 5 year old age group. Similarly, with the four categories it is also the 5 year olds that are receiving the largest share (8.8 per cent) of the CSG. It was noted that within the QNR, 15.7 per cent of recipients are for the 'less than 1 years', accentuating the need for the grant during the critical stage in the child's life.

A reflection of the grants by gender revealed that 51 per cent of the recipients are male children. However, a perusal of the four categories gives similar results with the exception of the QNR, which indicates that more females (50.6 per cent) qualify but do not receive the grant.

A comparison of CSG beneficiaries by race indicated that most recipients (94.6 per cent) are African children. This is higher than the proportion (85 per cent) of African children, which is indicative of the higher poverty levels among African children relative to the other race groups. These results are strengthened when one compares the four categories where it is noted that 95.5 per cent QR beneficiaries are African.

An evaluation of CSG recipients by geography showed that more (58.9 per cent) CSG recipients live in rural areas. A comparison of the four groups showed that more QR

and QNR recipients live in rural areas (63.3 per cent and 61.8 per cent, respectively) whilst the NQR and NQNR categories mostly reside in urban areas (53.4 per cent and 72.5 per cent respectively).

In section 10.3 the addition of education as conditionality on the CSG was discussed. A comparison is made of school attendance between the groups. The underlying precept is that if the attendance is the same among the various groups, then it is not necessary to add conditionality.

The post-weighted extrapolation of the NIDS sample indicated that school attendance is 95.3 per cent among school going children. A comparison of school attendance between the CSG recipients and non-recipients is 96 per cent and 94.5 per cent respectively. Similarly, a comparison of attendance between the QR, QNR, NQR and NQNR are 96.2 per cent, 91.6 per cent, 95.2 per cent and 95.3 per cent respectively. Although there is no statistically significant difference between these groups, the QNR has the lowest school attendance, implying that their inability to access the grant could be constraining these caregivers. In section 10.3.1 it was noted that although the QNR household has higher income relative to QR, they spend less on books and school stationery, indicative of their lower disposal income. All international studies have noted that school attendance and/or enrolment has increased with conditionality. However, the greatest impact (e.g. *Female Secondary School Assistance Program* in Bangladesh) has been in countries where initial enrolment was low. In contrast, in Turkey, the impact of conditionality has been minimal due to the initial high enrolment rates

It is well documented that the educational outcomes (literacy and numeracy) of South African children is comparably lower than in many other developing countries (WEF, 2010:303). In section 10.3.2 the focus is on educational outcomes of the various groups. This is examined by looking if the 'child has ever repeated a grade'. A comparison of the recipients of CSG and non-recipients of CSG showed that 22.6 per cent of CSG recipients repeated a grade compared to 20.5 per cent of non-recipients of CSG who have repeated a grade. A comparison of the QR, QNR, NQR and NQNR groups showed that 22 per cent, 28 per cent, 23 per cent and 18 per cent, repeated a grade respectively; with no statistical difference between the groups.

These results indicate that the academic performance of children does not differ significantly between the groups. These results are consistent with the international literature where it is shown that the impact of CCTs on educational outcomes is modest to minimal.

There is high attendance between the groups underlying the caregivers/parents' commitment to education. The results are more indicative of the supply constraints (lack of books, poor quality teachers) that are manifesting in poor education outcomes. The addition of educational conditionality may improve attendance marginally (as it is already high) and have no significant impact on educational outcomes.

In section 10.4 it was noted that South African life expectancy has been declining in the last eight years. Hence, there may be a rationale for attachment of a health condition to the CSG. A possible conditionality is to ensure that the child comply with the immunisation regimen. The NIDS study does not have a variable on 'child health' per se nor does it have a variable on immunisation. The variable 'does the child possess a clinic card' is formulated as a proxy for immunisation. In the study it was noted that 92.9 per cent of children possess a clinic card. A comparison of the groups showed that 94.4 per cent of CSG and 90.9 per cent of non-recipients of CSG possess a health clinic card with no statistical significant difference between these groups. Similarly, the possession of a clinic card by the four categories, QR, QNR, NQR and NQNR is 94.4 per cent, 89.9 per cent, 94.5 per cent and 91.3 per cent respectively. The international evidence of the impact of CCTs on health utilisation is mixed. In some countries (e.g *Programa de Asignación Familiar [PRAF]* Honduras,) there is an increase in immunisation coverage for some vaccines (DPT) but not others (measles). The *Red de Protección Social* (RPS) in Nicaragua had a 14 percentage increase in immunisation coverage, whilst in Turkey, participants had a 14 percentage point more coverage than those who did not participate in the programme. There was a decrease in the utilisation of health services by participants of the *PROGRESSA* which may be attributed to the improvement of the health of the participants.

In section 10.4.2 the determinants of health were discussed, specifically looking at the availability of services (water and sanitation, electricity) in houses in which both the recipients of CSG and non-recipients of CSG reside. It was observed that 34 per cent of CSG recipients live in households with a 'pit latrine without ventilation', whilst 60 per cent of non-recipients of CSG live in households with a flush toilet. Comparisons of the four categories showed that most children in the QR, QNR and NQR live in households that have a 'pit latrine without ventilation'.

The proportion of children living in dwellings that vary in distance from a water source was also evaluated. It was noted that only 44.7 per cent of children live less than 100 metres from the nearest water source. Furthermore, there is very little difference in the distance of water source from the household between the recipients of CSG and non-recipients of CSG. A comparison between the four categories also showed that most children reside in dwellings with a water source less than 100 metres from the dwelling, with the QNR groups having the most (9.9 per cent) children living more than 1 kilometre or more from a water source.

An evaluation of the proportion of children living in households that have electricity between the recipients of CSG and non-recipients of CSG revealed that 69.7 per cent of CSG recipients and 79.8 per cent of non-recipients resided in households that have electricity. An overview of the four categories to ascertain the household's access to electricity showed that the proportion of children living in households that have electricity, for QR, QNR, NQR and NQNR is 65.6 per cent, 68.6 per cent, 81.3 per cent and 83.8 per cent respectively. It was also observed that the more urban based groups (NQR and NQNR) have greater access to electricity relative to the rural groups (QR and QNR).

It can be inferred that the poor's inaccessibility to these services is a contributing factor to poor health outcomes. Moreover, families' commitment to their children's health is noted by their commitment to the immunisation regimen. The supply-side constraints like too few medical personnel, as well as the lack of accessibility (due to long distances to travel and high transport costs) of health facilities were discussed. This is more acute when it comes to access of these services for children. Moreover, children under the age of six are guaranteed free health care, and the imposition of conditionality may be challenged constitutionally. In section 10.4.3 it was noted that

the CSG is currently having a positive impact on children's health, which could be undermined by conditionality.

The evidence of CCT on actual outcomes in other countries is mainly positive. The outcomes depends on the initial health of the child. In Latin America, the *PROGRESA* in Mexico; *Red de Protección Social* (RPS) in Nicaragua and Colombia's *Familias en Acción* (FA) are credited with positive impacts on child height, whilst the *Programa de Asignación Familiar* (PRAF) in Honduras and *Bolsa Alimentação* in Brazil had no significant impact on preschool nutrition.

The test for anaemia is occasionally employed to ascertain the test for health status of the child. The *Oportunidades* (Mexico) and *Bono de Desarrollo Humano* (BDH) in Ecuador resulted in a reduction in anaemia, but the *Red de Protección Social* (RPS) in Nicaragua did not make any significant difference to the anaemic position of the child.

Hence, conditionality for health service is not feasible, as the poor health outcomes are not due to demand constraints, which conditionality endeavours to rectify.

In the last sections other factors that the government should take note of when considering implementing a CCT, were evaluated. In section 10.5 the current administrative cost and the current administrative challenges that will be heightened by the imposition of conditionality, were discussed. The monitoring of conditionality could increase the total administrative cost by approximately 16.2 per cent (R747.8 million).

Fraud and corruption that is pervasive in the current system, was also examined and it was noted that conditionality will not necessarily ameliorate this, if anything, conditionality will heighten fraud and corruption. In section 10.7 the concept that CSG creates dependency and the grant serves as an incentive for teenage females to have babies was discussed. There is the argument that conditionality should be employed to mitigate dependency, and that teenager mothers deliberately fall pregnant to obtain the grant. This argument is refuted by the evidence from prior studies.

The last factor that was discussed is the political consideration for attaching conditionality. It has been found that the transfers can be used as a political lever to garner support among voters, whilst conditionality can be instituted to appease taxpayers. It was also noted that conditionality may not only be morally wrong, but against the constitutional liberties of the child.

The viewpoint of Schüring (2010:22) pertaining to conditionality is accepted. That is, conditionality will be disadvantageous if the recipients are already demonstrating high school attendance and utilisation of health services, which characterizes the present situation in South Africa. Furthermore, the Child Support Grant is currently having a positive impact on children's health. Therefore, it is doubtful whether adding conditionality to social transfers in South Africa will meaningfully improve outcomes. The implementation of conditionality may even undermine accomplishments already achieved.

Chapter 11: Conclusion and recommendations

11.1 Introduction

The government has implemented several programmes to alleviate the plight of the poor. One of the main strategies to alleviate poverty is social grants which are currently being accessed by close to 14 million recipients (Table 5). In spite of these social transfers, such as Old Age Pensions and the Child Support Grants, many households remain anchored in poverty.

The poor health and education outcomes bring into focus whether South Africa should consider making the grants conditional. The factors that could mitigate against long-term poverty, such as education and health, empower households to lift themselves out of poverty. This has been the motivation for many countries to award cash transfers to recipients on condition that they regularly attend school and/or health centres.

In this study there was an endeavour to determine whether conditional cash transfers (CCTs) will alleviate poverty in South Africa, and more importantly whether it is a policy option that should be considered by the South African government. This is the question that this study aimed to address, that is, **CCTs as a means to address poverty in South Africa.**

After the introduction the study is divided into four sections. In section A the need for social security was examined; in section B social security in South Africa was described; in section C conditional cash transfers were explored and in section D the applicability and analysis of CCT in South Africa was discussed. Each chapter of the study concludes with a summary which highlights the main points of the chapter. Consequently, this chapter will only focus on the major findings and conclusions of the chapters and render recommendations.

11.2 Section A: The need for social security

In section A the focus was on the need for social security as CCTs are one element of social security. Consequently, section A was separated into three chapters.

In chapter 2, *Understanding social security*, the meaning for social security was discussed. There are various interpretations of social security and its meaning is frequently used interchangeably with other terminology such as social protection. For the purpose of this study, social security is composed of two components, namely, social insurance and social assistance. Social insurance refers to programmes that employers and employees are compelled to join to protect against contingencies (e.g. illness, unemployment) that may occur in life. Social assistance are cash or in-kind transfers to the poor in society and are financed from the fiscus with no contribution made by the beneficiaries. Therefore, social insurance and social assistance are the main elements of social security.

In chapter 3, *Social security – A global perspective*, the need for social security from a global perspective, that is, needs for social security that are universal, are evaluated. There are other motives for social security besides poverty alleviation. Social security is first and foremost a human right that entitles people to a decent standard of living because they are human. Furthermore, most countries are legally obliged to provide social security as they have endorsed international agreements (e.g. International Bill of Human Rights) that conferred social security rights on their citizens.

Nevertheless, the primary objective of social security is the prevention of poverty as well as poverty alleviation. Certain segments of the population are more vulnerable and therefore more prone to deprivation than the rest of the population. These include women, minorities, rural citizens, the disabled, children and the youth.

Whilst governments may be impotent to relieve the present levels of poverty, they can attempt to rectify social inequalities in the long-term. The government can use social security to prevent the transmission of poverty from one generation to the next and to create a more egalitarian society.

However, social security is not only dispensed for altruistic reasons or for political patronage, but has economic benefits as well. Social security allows the poor to contribute to the economy by demanding goods and services which is also a stimulus for economic growth. But government must also be mindful of the costs of increased social transfers during an economic downturn.

In chapter 4, Social security in developing countries, the need for social security is explored from the perspective of developing countries. The primary need of social security is to alleviate poverty. The main underlying causes of poverty that were evaluated are:

- lack of income
- education
- health
- the lack of basic services (water and sanitation)

Also globalisation has increased the need for social security for those that are excluded from the benefits that accrue to a selected few. Consequently, social security has the following beneficial outcomes in developing countries:

- enables the poor to live healthy lives
- enables poor households access to clean water and hygienic sanitation
- offers protection when people become unemployed

The need for social security in South Africa is not divergent from that of other developing nations (as well as developed countries). In fact, in some cases (high unemployment) the need is more acute. But South Africa has a relatively well-developed social security system that has evolved over the past century to provide for the poorest in society, which was the focus of section B.

11.3 Section B: Social security in South Africa

The historical course of South Africa is reflected in the social security evolution of the country. Social security was evaluated prior to 1994 as well as in post-apartheid South Africa.

In chapter 5, Social security pre-1994, social security in South Africa prior to 1994 was evaluated. The chapter began by exploring the informal social security framework that was established prior to 1994 and its relevance to poverty alleviation. The early forms of social security had their roots in the colonial period and the opposing influences of the Europeans and the British on social security philosophy were noted. It is noteworthy that informal social security continues to be pertinent as formal social security may not reach everyone who needs it and may be inadequate to many who do receive it. The chronological development of social security was specifically examined during five periods, namely; 1910-1933, 1934-1947, 1948-1970, 1971-1980 and 1981-1993.

In chapter 6, Post-apartheid social security, the focus was on social security in post-apartheid South Africa. The chapter began by scrutinising the Reconstruction and Development Programme (RDP) which was the guiding policy of the African National Congress (ANC) before coming into office, and its effect on social security. The RDP was labour friendly and advocated social security policies which were anticipated to relieve poverty. However, the RDP was too ambitious and most of the targets were not met and were soon abandoned in favour of the Growth, Employment and Redistribution (GEAR) programme. The emphasis of GEAR was to generate economic growth which would create the means to improve the plight of the poor. But there was a real reduction in social expenditure which had a limited impact on poverty alleviation.

The current social security arrangements in South Africa were evaluated. These include:

- Unemployment Insurance Fund (UIF)
- Compensation Fund
- Compensation Commissioner of Occupation Disease
- Rand Mutual Fund
- Federated Employers Mutual Assurance
- Road Accident Fund (RAF)

It is noted in the chapter that the RAF has persistently been in deficit and reforms have been introduced to restore its solvency.

The private sector funds have low coverage with numerous South Africans reaching retirement with no or insufficient pensions. Accordingly, many retirees are dependent on state Old Age Pensions. It is also noted that medical insurance in South Africa covers only approximately 7.9 million of the population of 48 million thereby constraining the public health sector.

The social assistance arrangements were subsequently evaluated. The first grant to be deliberated was the War Veteran's Grant, followed by an appraisal of the Disability Grant where it was noted that the poor (HIV/AIDS) patients are penalised for trying to get better. The next grant that was examined was the Old Age Pension (OAP) and how it contributes to poverty alleviation, especially in three-generation households.

This was then followed by an investigation of the Care Dependency Grant (CDG). The next grant that was assessed was the Foster Care Grant (FCG). It is noted that the value is higher than the CSG, and may create a perverse incentive for extended family members to foster their relative's children. There is also an indication of robust growth of the FCG over the years. But this is attributable to its easier accessibility for those who qualify and also the increasing number of orphans, especially children whose parents have died because of HIV/AIDS.

The State Maintenance Grant (SMG) was the predecessor to the Child Support Grant (CSG). The CSG originally had conditions that were partly responsible for the slow take up, which improved in later years, once these conditions were abolished. However school enrolment and school attendance were attached as a condition (with no punitive measures for non-compliance) in January 2010. The effect of CSG was scrutinised. It was clearly confirmed that CSG has had a positive impact on poverty and the child. However, child poverty still prevails.

In section 6.5 the Expanded Public Works Programme (EPWP) as another strategy to alleviate poverty was appraised, as the present social security setup does not extend to the unemployed poor. Its influence has been inadequate with some experts claiming that the EPWP should be seen as complementary to other poverty alleviation strategies and not the principal policy to improve mass poverty.

In section 6.6 whether the government should be reassessing a Basic Income Grant (BIG) was discussed. The fiscal implication of a BIG varies depending on the methodology of the costing approach employed. Consequently, the spectrum of fiscal cost varies from anywhere between **R23 billion to R60 billion** for a BIG of R100 per month per beneficiary. A cost of R60 billion translates into **2.25 per cent of GDP**. It may be more beneficial for the government to give thought to introducing a conditional cash transfer which was the focus of the next section.

11.4 Section C: Conditional Cash Transfers (CCTs)

In this section CCTs were evaluated from an economic perspective as well as from the perspective of international experience.

In chapter 7, The economics of conditional cash transfers, the economic rationale for instituting a CCT were examined. The chapter commenced by scrutinising the definition of CCTs. Countries have diverse interpretations of conditionality, although most concentrate on education (regular school attendance) and health (immunisations).

Whilst Unconditional Cash Transfers (UCTs) may be the optimal solution in free and perfect markets as conveyed in neoclassical economic theory, CCTs become relevant when markets are imperfect. People may not always make the 'correct' decision for themselves which can also have repercussions on society. CCTs are important to minimise the inconsistent decision-making. Another validation for CCTs is the principal-agent contradiction between the parent (agent) and the child (principal) where the parent does not (both deliberately and inadvertently) make decisions that are not in the best interest of the child. CCTs act as a proxy for a paternalistic government to force the parent to do 'what is best' for the child.

Certain countries (e.g. the USA) utilise in-kind transfers (food vouchers) to alleviate poverty in households. But these in-kind vouchers are found to be more costly to manage and administratively more challenging than cash transfers.

CCTs also influence the labour supply of both children and adults. Evidence (section 7.4.1.8.1) reveals that CCTs decrease child labour, but not adult labour supply. CCTs are also conferred for political reasons. Politicians need to placate their taxpaying

constituents who may be unhappy about disbursing cash to the poor. However, voters may find conditionality palatable as it aims to improve the lives of the children who may be poor due to no fault of their own.

In chapter 8, International experience of CCTs, was reviewed. There are presently twenty-six countries (Word Bank, 2010a) [Appendix 2] that are employing CCT programmes.

The impact of CCTs on education was examined, with specific focus on the impact of CCTs on school attendance and enrolment. CCTs are linked to an increase in attendance and enrolments, which differs across the different programmes. The impact is larger for the poorest households, female children and when the original enrolment and attendance baseline is low. In contrast, when enrolment or attendance was previously high, the effect of the CCT is minimal. However, the effect of the CCT on actual educational learning outcome is marginal.

Certain countries have instituted school vouchers to increase the educational outcomes of poor children. The impact of these vouchers is varied and comparisons with CCTs are limited.

A summation of the effect of CCTs on health and nutrition is also presented in this chapter. Evidence reveals that there is a rise in the uptake of health services. This is mostly when the initial baseline for the services is low, which mainly occurs in rural households. The effect of CCTs on actual health outcomes is varied, with little academic backing for the effect of CCTs on infant and child mortality and morbidity.

Besides the outcomes on health and education, policymakers need to be wary of the administrative costs and challenges of undertaking a CCT programme. The administration costs vary across programmes, but on average is 8.2 per cent (as a per cent of total programme costs) ranging from 4.1 per cent in Ecuador to 13 per cent in Jamaica (Johannsen, et al, 2009:147).

There is also a private cost to access the CCT. If the private costs are too high, this may negate the value of the transfer, causing beneficiaries to not access the grant.

The amount of the transfer must be of a value where it will make an impact to the livelihood of the beneficiary or the household.

Punitive measures and sanctions for non-compliance to the conditionality vary between programmes where some (*Chile Soildaria*) are tolerant and do not 'punish' the households, whilst some programmes such as the *Program of Advancement through Health and Education* (PATH) [Jamaica] result in an immediate cessation of benefits.

The economics of CCT and the international evidence sets the background for the section D to determine whether South African authorities should be considering a CCT programme for South Africa.

11.5 Section D: Applicability and analysis of CCTs

In the study it was assumed that all current transfers in South Africa are suitable for conditionality. This section evaluated in a sequential manner which grants do not lend themselves for conditionality.

Chapter 9, , Social grants (excluding Child Support Grant) and conditionality began by deliberating on the National Income Dynamic Study (NIDS) which is the first panel household study to be undertaken in South Africa.

The sample consisted of 7 305 households, and 31 170 individual who participated in the study. The sample was weighted so that it is representative of the population. A description of the overall population of South Africa (June 2008) in terms of gender, race and geography reveals:

- 51.7 per cent females
- 48.3 per cent males
- 79.4 per cent Africans
- 2.6 per cent Asians/Indian
- 21.5 per cent reside in Gauteng (smallest province geographically)
- 2.3 per cent reside in Northern Cape(largest province geographically)
- 59.7 per cent reside in urban areas
- 40.3 per cent reside in rural areas

A brief description of the adult population reveals:

- 56.3 per cent female
- 43.7 per cent males
- 78 per cent African
- 2.6 per cent Asians/Indians

The descriptive statistics of the children reveal:

- 51 per cent males
- 49 per cent females
- 84.9 per cent Africans
- 1.8 per cent are Asian/Indians

In section 9.4 the suitability of the current social transfers for conditionality was systematically investigated.

An examination of the disability grant (DG) showed that whilst females represented 56.9 per cent of adults over 18, 63.1 per cent of DG beneficiaries were female. The probable reasons are that this grant is means tested and females have lower incomes relative to males and therefore more disabled females qualify for the grant. Moreover, disability (stemming from HIV/AIDs) is more prevalent in females. Nevertheless, the DG is also not feasible for conditionality as the education component which is vital in early development is not applicable to DG recipients, as adults are past the development phase when early education has its most impact. The imposition of health conditionality will be not be feasible if some disabled people are exempt and others are not.

Similarly, conditionality on the Old Age Pension would not be practical as the education component will not be applicable to the elderly. The imposition of compulsory health visits could be arduous (costly) if the elderly are not sick and do not need care. Moreover, the accessibility of health centres as well as their availability needs to be improved before onerous health conditionality can be considered for the elderly. In addition, the pensions have been empirically proven to

contribute to poverty alleviation for the poorest households. Conditionality may consequently undermine the current impact of the pensions on poverty.

This then leaves the social transfers to children as an option for conditionality, for example, the Care Dependency Grant (CDG) which is meant for disabled children. For similar reasons as applicable to DG for adults, health conditionality may be impractical to implement as it would be burdensome on the caregiver; and satisfying conditionality may negate the value of the transfer. The educational conditionality will have to be specific for the child's disability which may create a range of educational (and health) conditions that will vary for different recipients. This may be discriminatory against some recipients.

The last child grant to be examined in chapter 9 is the Foster Care Grant (FCG). The steady uptake in FCG is partly attributable to the increase in the number of Aids orphans. The imposition of conditionality could discourage families from adopting children. Furthermore, school attendance (which conditionality aims to achieve) is highest among the FCG beneficiaries when compared to recipients of any of the other grants.

These five grants are not suitable for conditionality, which leaves the Child Support Grant (CSG) as the only potential grant for conditionality.

In chapter 10, the Child Support Grant and conditionality, the aim was to analytically determine whether it was feasible to attach a condition to the CSG, as well as look at other factors that policymakers should be cognisant of when considering conditionality for the CSG. The chapter commenced by determining the number of children that are receiving the CSG. It was observed that 55.4 per cent (8.3 million) [as extrapolated from the sample] of children were receiving the CSG in South Africa in 2008/09. This was done in order to make comparisons between the recipients of CSG and non-recipients of CSG possible. The sample was also delineated into four categories which are extrapolated to the population, namely;

- children that qualify and receive the grant (QR) [40.8 per cent of children]
- children that qualify and do not receive the grant (QNR) [11.7 per cent of children]

- children that do not qualify and receive the grant (NQR) [14.6 per cent of children]
- and children that do not qualify and do not receive the grant (NQNR) [32.9 per cent of children]

In section 10 the descriptive statistics of all these groups were also explored. A comparison between the recipients of CSG and non-recipients of CSG in terms of age, gender, race and geography reveals that:

- most recipients (8.7 per cent) are in the '5 year old group'
- most non-recipients (10.5 per cent) are in the 'less than 1 year old group'
- 51 per cent of the recipients are male children
- 94.6 per cent of recipients are African children
- 58.9 per cent of recipients lived in rural areas

A comparison among the QR, QNR, NQR and NQNR in terms of age, gender and race and geography reveals that:

- '5 year old' group received the largest share (8.8 per cent) of the CSG for the QR category
- 'less than 1 year old' group received the largest share (15.7 per cent) for the QNR group
- 51 per cent, 50.9 per cent, and 50.7 per cent are males for the QR, NQR and NQNR groups respectively, with the exception of the QNR, where 50.6 per cent are females
- 95.5 per cent, 91.7 per cent, 92 per cent and 66.2 per cent are African for the QR, QNR, NQR and NQNR groups respectively
- QR (63.3 per cent) and QNR (61.8 per cent) recipients mostly lived in rural areas whilst the NQR (53.4 per cent) and NQNR (72.5 per cent) mostly resided in urban areas

In section 10.3 the addition of education as conditionality on the CSG was investigated. A comparison was made of school attendance between the groups. The underlying precept was that if the attendance was the same among the various groups, then it was not necessary to add conditionality. The primary findings were:

- 95.3 per cent school attendance among all school going children
- 96 per cent CSG recipients compared to 94.5 per cent of non-recipients of CSG attended school
- 96.2 per cent, 91.6 per cent, 95.2 per cent and 95.3 per cent school attendance for the QR, QNR, NQR and NQNR respectively; with no statistical significant difference between the groups.

The international literature reveals that the impact of conditionality has been positive for all programmes, that is, conditionality has led to an increase in school attendance/enrolment. However, the magnitude of impact of CCTs is greatest when the initial school attendance is low. In Bangladesh, the *Female Secondary School Assistance Program* (FSSP) resulted in an increase in secondary schooling from 1.1 million in 1991 to 3.9 million in 2005 (World Bank, 2010c). In contrast, CCTs had minimal impact on school enrolment in Turkey where school enrolment was already high (93 per cent) before implementation of the programme (Adato, 2008:24)

An analysis of educational outcomes of the various groups was also done. A comparison of grade repetition was made between the different groups. The main finds were:

- 22.6 per cent of CSG recipients repeated a grade compared to 20.5 per cent of non-recipients of CSG who have repeated a grade
- 22 per cent, 28 per cent, 23 per cent and 18 per cent repeated a grade for the QR, QNR, NQR and NQNR, respectively

These results indicated that the academic performance of children does not differ significantly between the groups. These results are similar to international findings where it is noted that CCTs has not impacted significantly on educational outcomes. The learning outcomes of non-CCT children are similar to that of the CCT students for most CCT programmes (Paqueo, 2009a:10). Ponce and Bedi (2008:19) find no significant impact on test scores in participants of the *Bono de Desarrollo Humano* (BDH) in Ecuador. Skoufias, (2009:120) also finds that CCTs had not resulted in an increase in learning outcomes in Cambodia, Ecuador as well as in Mexico. Behrman,

Parker and Todd (2005:12) found that the *Oportunidades* in Mexico had no statistically significant impact on reading, mathematics and language test scores.

Moreover, there is high attendance between the groups underlining the caregivers/parents' commitment to education. The results are more indicative of the supply constraints (lack of books, poor quality teachers) that are manifesting in poor education outcomes. The addition of educational conditionality may improve attendance marginally (as it is already high) and has no significant impact on educational outcomes. **Therefore, it would not be suitable to attach school attendance (or passing a grade) as a condition as that will not improve educational outcomes. Policy prescriptions should be directed towards improving the education supply constraints which would improve education outcomes of children.**

In section 10.4 the feasibility of attaching a health conditionality (such as immunisation) to improve children's health, was explored. The NIDS study does not have a variable on 'child health' nor does it have a variable on immunisation. The variable 'does the child possess a clinic card?' is used as proxy for immunisation. It was found in the study that:

- 92.9 per cent of children possess a clinic card
- 94.4 per cent of recipients of CSG and 90.9 per cent of non-recipients of CSG possess a health clinic card with no statistical significant difference between these groups
- 94.4 per cent of the QR, 89.9 per cent of the QNR, 94.5 per cent of the QNR and 91.3 per cent of the NQNR possessed a clinic card, with no statistical significant difference between these groups

The international evidence on the impact of CCTs on health utilisation is mixed (see section 8.5.1). But the evidence of CCTs on actual outcomes in other countries is positive (see sections 8.5.2 and 8.5.3)

Consequently, the determinants of health are evaluated, specifically, investigation of the availability of services (water, sanitation and electricity) in households which both recipients of CSG and non-recipients of CSG reside.

In terms of water, sanitation and electricity, the main observations between the recipients and non-recipients of the CSG were:

- 42.8 per cent of recipients of CSG and 43.6 per cent of non-recipients of CSG reside less than '100 metres from a water source'
- 34.3 per cent of recipients of CSG lived in household with a 'pit latrine without ventilation', whilst 60 per cent of non-recipients of CSG lived in households with a flush toilet
- 69.7 per cent of recipients of CSG and 79.8 per cent of non-recipients of CSG reside in households that have electricity

In terms of water, sanitation and electricity, the main observations between the QR, QNR, NQR and NQNR categories were:

- 41 per cent of QR, 40.4 per cent of QNR, 50.7 per cent of NQR and 46.5 per cent of NQNR resided in dwellings with a 'water source less than 100 metres from the dwelling'; with the QNR group having the most (9.9 per cent) children living more than one kilometre or more from a 'water source from their dwelling'
- 35.8 per cent of QR, 34.2 per cent of QNR and 30.1 per cent of NQR lived in households that have a 'pit latrine without ventilation', whilst 37.5 per cent of NQNR lived in households with a 'flush toilet with onsite disposal'
- 65.6 per cent of QR, 68.6 per cent of QNR, 81.3 per cent of NQR and 83.8 per cent of NQNR live in households that have electricity

It can be inferred that the poor access to these services partly contributed to poor health outcomes. Moreover, families' commitment to their children's health was underscored by their commitment to the immunisation regimen. The supply-side constraint of too few medical personnel, as well as unavailability of health facilities hinders accessibility to health services. This is more severe when it comes to access of these services for children.

The international evidence of the impact of CCT on actual outcomes is mainly positive. The outcomes depend on the initial health of the child. In Latin America, the *PROGRESA* in Mexico; *Red de Protección Social* (RPS) in Nicaragua and Colombia's

Familias en Acción (FA) are credited with positive impacts on child height, whilst the *Programa de Asignación Familiar* (PRAF) in Honduras and *Bolsa Alimentação* in Brazil had no significant impact on preschool nutrition

The test for anaemia is sometimes used to determine the test for health status of the child. The *Oportunidades* (Mexico) and *Bono de Desarrollo Humano* (BDH) resulted in a decline in anaemia, whilst *Red de Protección Social* (RPS) did not make any significant difference to the anaemic status of the child.

Presently, the CSG is currently having a positive impact on children's health which could be undermined by conditionality.

Therefore, the institution of health conditionality will not be suitable for the CSG. The demand for health care is high, but there are other factors that are resulting in the poor health outcomes which are responsible for the declining life expectancy of South Africans.

In the last part of chapter 10, other factors that the government must take note of when considering implementing a CCT are evaluated. In section 10.5 it was noted that the present administrative costs and the current administrative challenges will be heightened by the imposition of conditionality. The monitoring of conditionality could increase the total administrative cost by approximately 16.2 per cent (R747 million).

The fraud and corruption that is pervasive in the current system was also examined and it was noted that conditionality will not necessarily rectify this, if anything, conditionality may increase fraud and corruption. In section 10.7 the concept that CSG creates dependency and serves as an incentive for teenagers to have babies was discussed. This argument that cash transfers create dependency was repudiated by the evidence from prior studies.

The last factor that is discussed is the political consideration for attaching conditionality. It was found that the transfers can be used as a political instrument to gather support among voters, whilst conditionality can be instituted to appease

taxpayers. It was also noted that conditionality may not only be morally wrong, but against the constitutional liberties of the child.

11.6 Recommendations

In summation, the recommendations of this study (emanating from the above discussion) are that **it would not be feasible to implement conditionality to any of the present social transfers in South Africa, particularly the CSG.** The objectives which conditionality aims to achieve (health and education outcomes) are mostly demand driven and are already well accessed. The poor outcomes in health and education are supply-side failures which need addressing and which conditionality will not rectify. Moreover, evidence from international studies is that CCTs do increase school attendance and enrolment, but only when there is a low baseline. But the impact on educational outcomes (numeracy and literacy) is mixed. Similarly, with health, the CCT does result in an increase in the uptake of health services, especially when the initial take up rate was low. But the impact on health outcomes is modest. Hence, **CCT as an instrument to increase demand for health and education will be a blunt policy instrument as the impact will only be marginal as the demand for these services is already high.**

The poor outcomes for health and education are primarily supply-side shortcomings (insufficient school books, poorly trained teachers [education], shortage of doctors and nurses [health]) that are manifesting in poor outcomes and the policy priorities should be directed to resolving these. A policy initiative for remedying the poor education opportunities that the poor experience, may be addressed with school vouchers. South Africa has a relatively well developed private school system that can be accessed. Consequently, the feasibility of this option for South Africa should be investigated as international evidence of its success is mixed. Nevertheless, it should not be a policy option that should be summarily dismissed. Moreover, this is more a medium to long-term policy strategy.

It must be noted that the findings of this study is not a validation of the success of the current social security arrangement in South Africa; but rather to demonstrate the non- feasibility of adding conditionality to the current social transfers. Whilst the current social security setup is not perfect, social transfers (especially Child Support Grant and the Old Age Pension) does make a significant contribution to poverty

alleviation in South Africa. Van der Berg, Louw and Du Toit (2007:22) using the All Media Products Survey (AMPS) data between 1993 and 2006, find social grants were responsible for the decline in poverty since 2000.

Several studies, (Duflo, 2000:21; Maitra and Ray, 2003:34, Woolard, 2003; and Woolard et al, 2010) have demonstrated the positive impact of Old Age Pension on poverty to not only the recipients but to other members in the household as well.

Similarly , it is noted in section 6.4.2.8.1.2 that studies (Samson et al, 2004, Leatt and Budlender, 2006; Woolard, 2003 and Woolard, 2009) have clearly demonstrated the positive impact of Child Support Grants. The incidence of poverty among children would have been higher had they not been receiving any social assistance. But this does not mean the current arrangement is perfect.

There are still areas where the government can improve the system to attain efficiency. Whilst the administrative cost will increase if conditionality was attached to the social transfers (section 10.5), there is still scope to decrease current administrative costs. The wider implementation of electronic payments will reduce the average cost per beneficiary and realise savings for the fiscus.

Whilst fraud and corruption cannot be completely eradicated from the system, it has to be reduced before it undermines the entire system. The efficiency social grants system can be enhanced by better targeting so that only legitimate beneficiaries receive the grant. Hence, disbursements to children who qualify and not receive the grant (QNR) should be resolved to alleviate their plight. Similarly, better targeting would allow for the discontinuing of the grants to children who not qualify and receive the grant (NQR). Consequently, savings will be realised which can be channelled to other social priorities. But these are medium to long-term strategies that government should consider to improve the efficiency and effectiveness of the current grant system in South Africa.

In the short-term current programmes by governments can be strengthened and upscaled to alleviate poverty. An example of a short-term initiative to be strengthened should be the careful and considered expansion of the Expanded Public Works Programme (EPWP). The programme does offer some relief for people who

are not covered by any formal social security arrangements. However, the programme does have shortcomings which need to be addressed as government has already committed to phase 2 of the programme.

The BIG has not featured in political discourse in recent years and it appears that government's poverty alleviation strategies do not feature a BIG. Nevertheless, any consideration of BIG must be cognisant of fiscal implications which have led to the BIG being stillborn.

Therefore it would **not be feasible to implement conditional cash transfers as a means to address poverty in South Africa.**

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Appendix 1: Millennium Development Goals (MDGs)

Millennium Development Goals (MDGs)	
Goals and Targets (from the Millennium Declaration)	Indicators for monitoring progress
Goal 1: Eradicate extreme poverty and hunger	
Target 1.A: Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day	1.1 Proportion of population below \$1 (PPP) per day 1.2 Poverty gap ratio 1.3 Share of poorest quintile in national consumption
Target 1.B: Achieve full and productive employment and decent work for all, including women and young people	1.4 Growth rate of GDP per person employed 1.5 Employment-to-population ratio 1.6 Proportion of employed people living below \$1 (PPP) per day 1.7 Proportion of own-account and contributing family workers in total employment
Target 1.C: Halve, between 1990 and 2015, the proportion of people who suffer from hunger	1.8 Prevalence of underweight children under-five years of age 1.9 Proportion of population below minimum level of dietary energy consumption
Goal 2: Achieve universal primary education	
Target 2.A: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling	2.1 Net enrolment ratio in primary education 2.2 Proportion of pupils starting grade 1 who reach last grade of primary 2.3 Literacy rate of 15-24 year-olds, women and men
Goal 3: Promote gender equality and empower women	
Target 3.A: Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015	3.1 Ratios of girls to boys in primary, secondary and tertiary education 3.2 Share of women in wage employment in the non-agricultural sector 3.3 Proportion of seats held by women in national parliament
Goal 4: Reduce child mortality	
Target 4.A: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate	4.1 Under-five mortality rate 4.2 Infant mortality rate 4.3 Proportion of 1 year-old children immunised against measles
Goal 5: Improve maternal health	
Target 5.A: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio	5.1 Maternal mortality ratio 5.2 Proportion of births attended by skilled health personnel
Target 5.B: Achieve, by 2015, universal access to reproductive health	5.3 Contraceptive prevalence rate 5.4 Adolescent birth rate 5.5 Antenatal care coverage (at least one visit and at least four visits) 5.6 Unmet need for family planning

Millennium Development Goals (MDGs)	
Goals and Targets (from the Millennium Declaration)	Indicators for monitoring progress
Goal 6: Combat HIV/AIDS, malaria and other diseases	
Target 6.A: Have halted by 2015 and begun to reverse the spread of HIV/AIDS	6.1 HIV prevalence among population aged 15-24 years 6.2 Condom use at last high-risk sex 6.3 Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS 6.4 Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years
Target 6.B: Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it	6.5 Proportion of population with advanced HIV infection with access to antiretroviral drugs
Target 6.C: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases	6.6 Incidence and death rates associated with malaria 6.7 Proportion of children under 5 sleeping under insecticide-treated bednets 6.8 Proportion of children under 5 with fever who are treated with appropriate anti-malarial drugs 6.9 Incidence, prevalence and death rates associated with tuberculosis 6.10 Proportion of tuberculosis cases detected and cured under directly observed treatment short course
Goal 7: Ensure environmental sustainability	
Target 7.A: Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources	7.1 Proportion of land area covered by forest 7.2 CO2 emissions, total, per capita and per \$1 GDP (PPP) 7.3 Consumption of ozone-depleting substances 7.4 Proportion of fish stocks within safe biological limits 7.5 Proportion of total water resources used
Target 7.B: Reduce biodiversity loss, achieving, by 2010, a significant reduction in the rate of loss	7.6 Proportion of terrestrial and marine areas protected 7.7 Proportion of species threatened with extinction
Target 7.C: Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation	7.8 Proportion of population using an improved drinking water source 7.9 Proportion of population using an improved sanitation facility
Target 7.D: By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers	7.10 Proportion of urban population living in slums
Goal 8: Develop a global partnership for development	

Millennium Development Goals (MDGs)	
Goals and Targets (from the Millennium Declaration)	Indicators for monitoring progress
<p>Target 8.A: Develop further an open, rule-based, predictable, non-discriminatory trading and financial system</p> <p>Includes a commitment to good governance, development and poverty reduction – both nationally and internationally</p> <p>Target 8.B: Address the special needs of the least developed countries</p> <p>Includes: tariff and quota free access for the least developed countries' exports; enhanced programme of debt relief for heavily indebted poor countries (HIPC) and cancellation of official bilateral debt; and more generous ODA for countries committed to poverty reduction</p> <p>Target 8.C: Address the special needs of landlocked developing countries and small island developing States (through the Programme of Action for the Sustainable Development of Small Island Developing States and the outcome of the twenty-second special session of the General Assembly)</p> <p>Target 8.D: Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long-term</p>	<p><i>Some of the indicators listed below are monitored separately for the least developed countries (LDCs), Africa, landlocked developing countries and small island developing States.</i></p> <p><u>Official development assistance (ODA)</u></p> <p>8.1 Net ODA, total and to the least developed countries, as percentage of OECD/DAC donors' gross national income</p> <p>8.2 Proportion of total bilateral, sector-allocable ODA of OECD/DAC donors to basic social services (basic education, primary health care, nutrition, safe water and sanitation)</p> <p>8.3 Proportion of bilateral official development assistance of OECD/DAC donors that is untied</p> <p>8.4 ODA received in landlocked developing countries as a proportion of their gross national incomes</p> <p>8.5 ODA received in small island developing States as a proportion of their gross national incomes</p> <p><u>Market access</u></p> <p>8.6 Proportion of total developed country imports (by value and excluding arms) from developing countries and least developed countries, admitted free of duty</p> <p>8.7 Average tariffs imposed by developed countries on agricultural products and textiles and clothing from developing countries</p> <p>8.8 Agricultural support estimate for OECD countries as a percentage of their gross domestic product</p> <p>8.9 Proportion of ODA provided to help build trade capacity</p> <p><u>Debt sustainability</u></p> <p>8.10 Total number of countries that have reached their HIPC decision points and number that have reached their HIPC completion points (cumulative)</p> <p>8.11 Debt relief committed under HIPC and MDRI Initiatives</p> <p>8.12 Debt service as a percentage of exports of goods and services</p>
<p>Target 8.E: In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries</p>	<p>8.13 Proportion of population with access to affordable essential drugs on a sustainable basis</p>
<p>Target 8.F: In cooperation with the private sector, make available the benefits of new technologies, especially information and communications</p>	<p>8.14 Telephone lines per 100 population</p> <p>8.15 Cellular subscribers per 100 population</p> <p>8.16 Internet users per 100 population</p>

The Millennium Development Goals and targets come from the Millennium Declaration, signed by 189 countries, including 147 heads of State and Government, in September 2000 (<http://www.un.org/millennium/declaration/ares552e.htm>) and from further agreement by member states at the 2005 World Summit (Resolution adopted by the General Assembly - A/RES/60/1, <http://www.un.org/Docs/journal/asp/ws.asp?m=A/RES/60/1>). The goals and targets are interrelated and should be seen as a whole. They represent a partnership between the developed countries and the developing countries "to create an environment – at the national and global levels alike – which is conducive to development and the elimination of poverty".

Appendix 2: Current conditional cash transfer programmes

Country	Name of Programme	Inception	Conditions	Education	Health
				Outcomes	
Burkina Faso	Orphans and Vulnerable Children	October 2008	<p>Health: Children aged 0–6 regularly attend a health centre; this is confirmed by a health care provider.</p> <p>Education: At least 90 % school attendance in a 3-month cycle.</p>	<p>Net enrolment in primary level: 47.8% total (2006): 2.9% for girls 52.5% for boys</p> <p>Net enrolment in secondary level 12% total (2006): 10% for girls, 14% for boys</p>	<p>Prevalence of child malnutrition (stunting): 35% (2006)</p> <p>Births attended by skilled health staff : 53.5% (2006)</p>
Kenya	Cash Transfer for Orphans and Vulnerable Children	2004	<p>Health: Health facility visits for immunisations for children aged 0–1 six times per year Health facility visits for growth monitoring and vitamin A supplement for children aged 1–5 twice a year.</p> <p>Education: School attendance of at least 80% at basic school institutions for children aged 6–17 Attendance at awareness sessions for adult members once a year</p>	<p>Net enrolment in primary level: 75.8% total (2005): 76.1% for girls 75.5% for boys</p> <p>Net enrolment in secondary level 41.5% total (2005): 41.8% for girls 41.3% for boys</p>	<p>Prevalence of child malnutrition (stunting): 35.8% (2003)</p> <p>Births attended by skilled health staff: 41.6% (2003)</p>

Country	Name of Programme	Inception	Conditions	Education	Health
				Outcomes	
Nigeria	Care of the Poor	2008	<p>Health: Pregnant women within benefiting households must attend and show evidence of antenatal care.</p> <p>Education: Beneficiaries must ensure school enrolment of school-age children up to basic education level (that is, primary to junior secondary education). At least 80% monthly school attendance is necessary to access transfer.</p> <p>Other: Trainable member of the benefiting household must attend training in life and vocational skills, basic health, and sanitation as available to the community.</p>	<p>Net enrolment in primary level 63% total (2006):</p> <p>58% for girls, 68% for boys</p> <p>Net enrolment in secondary level: Not available</p>	<p>Prevalence of child malnutrition (stunting): 27% (2003)</p> <p>Births attended by skilled health staff : 36% (2003)</p>
Cambodia	Cambodia Education Sector Support Project	2005	<p>Health: None</p> <p>Education: Enrolment in school Regular school attendance (no more than 10 days of absence in a year without "good reason") Maintaining a passing grade.</p> <p>Other: Agreement to use scholarship funds toward education (not verified).</p>	<p>Net enrolment in primary level 89.9% total (2006):</p> <p>89.0% for girls, 90.9% for boys</p> <p>Net enrolment in secondary level 23.9% total (2005):</p> <p>21.9% for girls, 26.0% for boys</p>	<p>Prevalence of child malnutrition (stunting): 43.7% (2006)</p> <p>Births attended by skilled health staff : 43.8% (2005)</p>

Country	Name of Programme	Inception	Conditions	Education	Health
				Outcomes	
Indonesia	Program Keluarga Harapan	2007	<p>Health: Children aged 0–6 visit health clinics to use health services as outlined in the Department of Health protocols. Pregnant (and lactating) women attend health clinics to receive antenatal (and postnatal) examinations, according to the Department of Health protocols</p> <p>Education: Children aged 7–15 enrol and attend a minimum of 85% of school days. Children aged 15–18 who have not completed 9 years of basic education enrol in an education program to complete the equivalent of 9 years of basic education</p>	<p>Net enrolment in primary level 94.5% total (2005):</p> <p>92.8% for girls 96.2% for boys</p> <p>Net enrolment in secondary level 57.4% total (2005):</p> <p>57.1% for girls 57.7% for boys</p>	<p>Prevalence of child malnutrition (stunting): 28.6% (2004)</p> <p>Births attended by skilled health staff : 71.5% (2004)</p>
Philippines	Pantawid Pamilyang Pilipino Program	2008	<p>Health: Children and pregnant women attend health centres and posts to get regular preventive health check-ups and immunisations, according to the Department of Health's protocol</p> <p>Education : Children enrol in schools and attend more than 85% of school classes</p>	<p>Net enrolment in primary level 83.2% (2007)</p> <p>Net enrolment in secondary level 58.6% (2007)</p>	<p>Prevalence of child malnutrition (stunting): 34% (2003)</p> <p>Births attended by skilled health staff 70.4% (2006)</p>

Country	Name of Programme	Inception	Conditions	Education	Health
				Outcomes	
Turkey	Social Risk Mitigation Project	2001	<p>Health: Health grant and pregnancy grant: visit the clinic regularly, according to the table given by the Ministry of Health</p> <p>Education: School attendance of at least 80% of the total education days each month Not to repeat the same grade more than once</p>	<p>Net enrolment in primary level 97.4% total (2005): 96.1% for girls 98.5% for boys</p> <p>Net enrolment in secondary level 58.6% total (2005): 58.8% for girls 61.2% for boys</p>	Prevalence of child malnutrition (stunting): 16% (2004) Births attended by skilled health staff 83% (2003)
Argentina	Programa Familias	2002	<p>Health: Compliance with the National Immunisation Plan for children under 19 years. Bimonthly check-ups for pregnant women</p> <p>Education: School enrolment Regular school attendance by each child aged 5–19, or completion of the secondary level or "polimodal"</p>	<p>Net enrolment in primary level 98.8% total (2003): 98.4% for girls 99.2% for boys</p> <p>Net enrolment in secondary level 78.9% total (2004): 82.5% for girls 75.5% for boys</p>	Prevalence of child malnutrition (stunting): 8.2% (2005) Births attended by skilled health staff: 99.1% (2005)

Country	Name of Programme	Inception	Conditions	Education	Health
				Outcomes	
Bolivia	Juancito Pinto	2006	Health: Not available Education: Attend class at least 75% of the school year	Net enrolment in primary level 94.9% total (2006): 95.3% for girls 94.5% for boys Net enrolment in secondary level 70.9% total (2004): 70.0% for girls 71.7% for boys	Prevalence of child malnutrition (stunting): 32.5% (2004) Births attended by skilled health staff: 66.8% (2003)

Country	Name of Programme	Inception	Conditions	Education	Health
				Outcomes	
Brazil	Bolsa Família Programa de Eradicação do Trabalho Infantil Bolsa Alimentação Bolsa Escola	2003 1996 (stopped and integrated into the Bolsa Família in 2006) 2001 (stopped and integrated into the Bolsa Família at the end of 2003) 2001 (stopped and integrated into the Bolsa Família at the end of 2003)	Health: Children aged 0–6: vaccine schedules, regular health check-ups, and growth monitoring Pregnant and lactating women: prenatal and postnatal check-ups, and participation in educational health and nutrition seminars offered by local health teams Education: School enrolment of all children aged 6–15 and youth aged 15–17 Daily school attendance of at least 85% each month for all school-age children Participation in parent-teacher meetings	Net enrolment in primary level 94.7% total (2004): 95.2% for girls 94.2% for boys Net enrolment in secondary level 77.7% total (2004): 81.3% for girls, 74.2% for boys	Prevalence of child malnutrition (stunting): 10.5% (1996) Births attended by skilled health staff 96.6% (2003)
Chile	Chile Solidario	2002	Health and education: Signature and compliance with a contract committing to participate in the activities identified, together with personalized assistance in 7 areas (health, education, employment, housing, income, family life, and legal documentation) Education	Net enrolment in primary level: Not available Net enrolment in secondary level: Not available	Prevalence of child malnutrition (stunting): 1.4% (2004) Births attended by skilled health staff : 99.8% (2003)

Country	Name of Programme	Inception	Conditions	Education	Health
				Outcomes	
	Subsidio Unitario Familiar	1981	<p>Health: Regular medical controls for children less than 6 years</p> <p>Education: Regular school attendance for children aged 6–18</p>	<p>Net enrolment in primary level: Not available</p> <p>Net enrolment in secondary level: Not available</p>	<p>Prevalence of child malnutrition (stunting): 1.4% (2004)</p> <p>Births attended by skilled health staff : 99.8% (2003)</p>
Colombia	Familias en Acción	2001	<p>Health: Meet the growth control and development check-ups scheduled every 2 months for children aged 0–1, 3 times a year for children up to 2 years, and 2 times a year thereafter up to 7 years</p> <p>Education: At least 80% school attendance in a 2-month cycle (maximum of 8 unjustified absences in a 2-month period)</p>	<p>Net enrolment in primary level 88.5% total (2006):</p> <p>88.4% for girls 88.6% for boys</p> <p>Net enrolment in secondary level 64.9% total (2006):</p> <p>68.5% for girls 61.5% for boys</p>	<p>Prevalence of child malnutrition (stunting): 12% (2005)</p> <p>Births attended by skilled health staff 86.4% (2000)</p>

Country	Name of Programme	Inception	Conditions	Education	Health
				Outcomes	
	Subsidio Condicionado a la Asistencia Escolar-Bogotá	2005 (pilot program)	Health: None Education: School attendance and/or completion, depending on the type of transfer tested (see benefit structure)	Net enrolment in primary level 88.5% total (2006): 88.4% for girls 88.6% for boys Net enrolment in secondary level 64.9% total (2006): 68.5% for girls 61.5% for boys	Prevalence of child malnutrition (stunting): 12% (2005) Births attended by skilled health staff 86.4% (2000)

Country	Name of Programme	Inception	Conditions	Education	Health
				Outcomes	
Dominican Republic	Solidaridad	2005	<p>Health: Regular visits to health centre for examinations, growth and development monitoring, and immunisations, for children aged 0–12 months (every 2 months) and children aged 1–5 years (every 4 months)</p> <p>Education: School enrolment School attendance on at least 85% of actual school days for children aged 6–16</p> <p>Other: Attendance at capacity-building sessions for household head and spouse (every 4 months) Obtaining identity documents (birth certificate, identification card) for family members who lack them</p>	<p>Net enrolment in primary level 77.5% total (2006):</p> <p>78.5% for girls 76.5% for boys</p> <p>Net enrolment in secondary level 52.1% total (2006):</p> <p>57.4% for girls 46.9% for boys</p>	<p>Prevalence of child malnutrition (stunting): 9.8% (2007)</p> <p>Births attended by skilled health staff : 97.8% (2008)</p>

Country	Name of Programme	Inception	Conditions	Education	Health
				Outcomes	
Ecuador	Bono de Desarrollo Humano	2003	<p>Health: Children aged 0–5: bimonthly visits to health posts for growth and development check-ups and immunisations</p> <p>Education: School enrolment for children aged 6–15 School attendance at least 90% of school days Must be enrolled in school and have attendance at basic education classes of at least 80% (including both justified and unjustified absences)</p>	<p>Net enrolment in primary level 97.3% total (2005):</p> <p>97.8% for girls 96.8% for boys</p> <p>Net enrolment in secondary level 55.4% total (2005):</p> <p>56.0% for girls 54.7% for boys</p>	<p>Prevalence of child malnutrition (stunting): 29% (2004)</p> <p>Births attended by skilled health staff : 74.7% (2004)</p>
El Salvador	Red Solidaria	2005	<p>Health: Compliance with immunisation and regular health and nutrition</p> <p>Education: School enrolment in primary school School attendance rate of at least 80% for children aged 5–15</p>	<p>Net enrolment in primary level 94% total (2006):</p> <p>94.1% for girls 93.9% for boys</p> <p>Net enrolment in secondary level 54.2% total (2006):</p> <p>55.5% for girls 52.9% for boys</p>	<p>Prevalence of child malnutrition (stunting): 24.6% (2003)</p> <p>Births attended by skilled health staff : 92.4% (2003)</p>

Country	Name of Programme	Inception	Conditions	Education	Health
				Outcomes	
Guatemala	Mi Familia Progresa	2008	<p>Health: Meet the growth control and regular check-ups scheduled for pregnant women and children aged 0–16</p> <p>Education : At least 90% school attendance</p>	<p>Net enrolment in primary level: 86.4%</p> <p>Net enrolment in secondary level: 37.5%</p>	<p>Prevalence of child malnutrition (stunting): 54.3%</p> <p>Births attended by skilled health staff: 41% (2002)</p>
Honduras	Programa de Asignación Familiar (PRAF)	1998	<p>Health: Compliance with required frequency of health centre visits; a compliance enforced only in the 4 departments where PRAF is supported by the Inter-American Development Bank (IDB); in the remaining 13 departments, households are encouraged only to send children to school/take them for health visit</p> <p>Education: School enrolment Regular school attendance of at least 85%</p>	<p>Net enrolment in primary level 96.4% total (2006):</p> <p>97.2% for girls 95.7% for boys</p> <p>Net enrolment in secondary level :Not available</p>	<p>Prevalence of child malnutrition (stunting): 29.9% (2006)</p> <p>Births attended by skilled health staff: 66.9% (2006)</p>

Country	Name of Programme	Inception	Conditions	Education	Health
				Outcomes	
Jamaica	Program of Advancement through Health and Education	2001	<p>Health: 4 health centre visits per year for children aged 0–11 months (in keeping with the immunisation schedule stipulated by the Ministry of Health). 2 health centre visits per year, at 6-month intervals, for children aged 12–59 Months. Health centre visits every 2 months for pregnant women, and at 6 weeks and 2 months postpartum for lactating women 2 health centre visits per year, at 6-month intervals, for people with disabilities, elderly people, and other adult beneficiaries</p> <p>Education: Regular school attendance of at least 85% for children aged 6–19</p>	<p>Net enrolment in primary level 90.3% total (2005):</p> <p>90.4% for girls 90.1% for boys</p> <p>Net enrolment in secondary level 78.3% total (2005):</p> <p>80.1% for girls 76.5% for boys</p>	<p>Prevalence of child malnutrition (stunting): 4.5% (2004)</p> <p>Births attended by skilled health staff : 96.7% (2005)</p>
Mexico	Oportunidades (formerly PROGRESA)	1997	<p>Health: Compliance by all household members with the required number of preventive medical check-ups. Attendance of family member older than 15 years at health and nutrition lectures.</p> <p>Education: School enrolment and minimum attendance rate of 80% monthly and 93% annually Completion of middle school Completion of grade 12 before age 22</p>	<p>Net enrolment in primary level 97.7% total (2005):</p> <p>97.3% for girls, 98.1% for boys</p> <p>Net enrolment in secondary level 68.6% total (2005):</p> <p>68.4% for girls 68.8% for boys</p>	<p>Prevalence of child malnutrition (stunting): 15.5% (2006)</p> <p>Births attended by skilled health staff: 83.3% (2004)</p>

Country	Name of Programme	Inception	Conditions	Education	Health
				Outcomes	
Panama	Red de Oportunidades	2006	<p>Health: Immunisations for children aged 0–5 Visits to basic health services providers.</p> <p>Education: Regular school attendance of children. Participation in parent-teacher conferences in school.</p>	<p>Net enrolment in primary level 98.5% total (2006):</p> <p>98.2% for girls 98.8% for boys</p> <p>Net enrolment in secondary level 64.2% total (2006):</p> <p>67.5% for girls 61.0% for boys</p>	<p>Prevalence of child malnutrition (stunting): 18.2% (1997)</p> <p>Births attended by skilled health staff : 91.3% (2004)</p>
Paraguay	Tekoporã/PROPAIS II	Tekoporã: 2005, PROPAIS II: 2006	<p>Health: Follow the vaccination calendar; child health checks, age groups 0–5 and 6–14</p> <p>Education: School matriculation and attendance</p>	<p>Net enrolment in primary level 94% total (2004):</p> <p>95% for girls 95% for boys</p> <p>Net enrolment in secondary level 57% total (2004):</p> <p>59% for girls 57% for boys</p>	<p>Prevalence of child malnutrition (stunting): Not available</p> <p>Births attended by skilled health staff : 77% (2004)</p>

Country	Name of Programme	Inception	Conditions	Education	Health
				Outcomes	
Peru	Juntos	2005	<p>Health: Regular health visits for pregnant women and for children less than 5 years old</p> <p>Education: School attendance of at least 85% for children aged 6–14 who have not completed elementary education</p> <p>Other Participation in the Mi Nombre (My Name) program by all families with children who lack birth certificates and/or are older than 18 years and have no identification card</p>	<p>Net enrolment in primary level 96.4% total (2005):</p> <p>97.1% for girls 95.7% for boys</p> <p>Net enrolment in secondary level 70.2% total (2005): 69.9% for girls 70.5% for boys</p>	<p>Prevalence of child malnutrition (stunting): 31.3% (2000)</p> <p>Births attended by skilled health staff : 86.9% (2006)</p>
Yemen, Republic of	Basic Education Development Project	2007 (Ongoing pilot)	<p>Health: None</p> <p>Education: Child attends 80% of all classes in a 2-month period</p> <p>Other: Additional payment upon successful completion of a grade level; passing score on achievement test</p>	<p>Net enrolment in primary level 75.2% total (2005):</p> <p>64.9% for girls 85.1% for boys</p> <p>Net enrolment in secondary level 37.4% total (2005):</p> <p>25.8% for girls, 48.5% for boys</p>	<p>Prevalence of child malnutrition (stunting): Not available</p> <p>Births attended by skilled health staff: 26.8% (2003)</p>

Country	Name of Programme	Inception	Conditions	Education	Health
				Outcomes	
Bangladesh	Female Secondary School Assistance Program	1994 - Active (as FSSAP II)	<p>Health: None</p> <p>Education: Attends 75% of school days Attains 45% of class-level test score</p> <p>Other: Remain unmarried until passing the secondary school certificate examination</p>	<p>Net enrolment in primary level 88.8% total (2004): 90.5% for girls 87.4% for boys</p> <p>Net enrolment in secondary level 40.1% total (2004): 40.2% for girls 41.8% for boys</p>	<p>Prevalence of child malnutrition (stunting): 47.8% (2005)</p> <p>Births attended by skilled health staff: 20.1% (2006)</p>
	Primary Education Stipend Program	2002	<p>Health: None</p> <p>Education: Attends 85% of school days Obtains at least 40% marks in the annual examinations</p>	<p>Net enrolment in primary level 88.8% total (2004): 90.5% for girls 87.4% for boys</p> <p>Net enrolment in secondary level 40.1% total (2004): 40.2% for girls 41.8% for boys</p>	<p>Prevalence of child malnutrition (stunting): 47.8% (2005)</p> <p>Births attended by skilled health staff: 20.1% (2006)</p>

Country	Name of Programme	Inception	Conditions	Education	Health
				Outcomes	
	Reaching Out-of-School Children	2004	<p>Health: None</p> <p>Education: 75% attendance and 75% performance in examinations, as judged by school teacher</p>	<p>Net enrolment in primary level 88.8% total (2004): 90.5% for girls 87.4% for boys</p> <p>Net enrolment in secondary level 40.1% total (2004): 40.2% for girls 41.8% for boys</p>	<p>Prevalence of child malnutrition (stunting): 47.8% (2005)</p> <p>Births attended by skilled health staff: 20.1% (2006)</p>
India (Haryana)	Apni Beti Apna Dhan (Our Daughter, Our Wealth)	1994	<p>Health: The program implicitly aims to reduce child mortality among girls and the abortion of female foetus</p> <p>Education: Girls receive bonus for completing grade 5 and grade 8</p> <p>Other: Marriage delay: girl must be unmarried at age 18</p>	<p>Net enrolment in primary level 89% total (2005): 87% for girl 90% for boys</p> <p>Net enrolment in secondary level: Not available</p>	<p>Prevalence of child malnutrition (stunting): 48%</p> <p>Births attended by skilled health staff : 46%</p>

Country	Name of Programme	Inception	Conditions	Education	Health
				Outcomes	
Pakistan	Child Support Program	2006 (pilot)	Health: None Education: Admission of children, 80% attendance, and passing of final examination	Net enrolment in primary level 65.6% total (2006): 57.3% for girls 73.5% for boys Net enrolment in secondary level 29.7% total (2006): 25.8% for girls 33.3% for boys	Prevalence of child malnutrition (stunting): 41.5% (2001) Births attended by skilled health staff : 31% (2005)
	Punjab Education Sector Reform Program/Punjab Female School Stipend Program		Health: None Education: Enrolment in grades 6–8 in a government girl’s school in a target district School attendance of at least 80%	primary level 65.6% total (2006): 57.3% for girls 73.5% for boys Net enrolment in secondary level 29.7% total (2006): 25.8% for girls 33.3% for boys	Prevalence of child malnutrition (stunting): 41.5% (2001) Births attended by skilled health staff : 31% (2005)

Source: Fiszbien and Schady (2009:216-295)