Risk and Vulnerability: Case Studies of Practical Country-Level Instruments and Approaches used by Various Agencies

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INTRODUCTION

In this paper we review a selection of different instruments that address various aspects of risk and vulnerability. Specifically we look at: social pension insurance; social health insurance; microfinance/insurance; public works programmes; conditional cash transfers; cash transfers and school feeding. For each instrument we describe the instrument, locate it within the risk and vulnerability (R&V) and social protection agendas, and provide one or two case studies. These instruments and cases were chosen to reflect the diversity of risk and vulnerability-reducing interventions in terms of the dimensions illustrated in Table 1 in the Annex. Specifically, we aim to highlight how each instrument addresses different types of poverty (active versus chronic poor); different types of risk (subsistence versus production); and different elements of social protection (protection, prevention, promotion and transformation). This paper should be considered a complement to a previous paper (Sabates-Wheeler and Haddad 2005) that mapped out and linked different risk and vulnerability concepts.

SOCIAL PENSION INSURANCE

Social Pension Insurance can be understood as non-contributory cash transfers from the State to elderly people, in which entitlements are not based on a lengthy record of contributions to a pension plan. These include cash transfers for poor old people, pensions and old age grants. However, disability and survivor pensions are excluded (Barrientos, 2004).

Social Pension Insurance differs in its nature from general programs of old-age assistance in two important respects: firstly, that they are unrelated to labour markets, with contributions not being a function of labour income and benefits being independent of labour income and labour force status. This is crucial, as it implies that social pension programs do not explicitly require withdrawal from the labour force, which can restrict large numbers of the poor old age population to access other social protection programs. Secondly, they have a strong anti-poverty focus, based on age. According to Case and Deaton 1998 (quoted in Barrientos, 2004), it would thus be 'more appropriate to consider non-contributory pension programs not as pensions, but as cash transfers tagged on the old'. By definition, social pensions are targeted programs, with targeting directed towards identifying the beneficiaries of the pension as based on their age and poverty status. The methods followed include amongst others: means testing to identify old people with low incomes, workers outside other social insurance plans, people involved in specific sectors such as subsistence agriculture or informal economy, and community selection.

The rationale behind adoption of social pension insurance as an instrument for social protection can be explained in terms of its direct and indirect impacts on the welfare of vulnerable groups.

Rationale for adoption of Social Pension programs: According to a study by Barrientos (2004) of three countries, viz. Brazil, South Africa and Brazil, social pension programs were adopted following the failure of social insurance or occupational pensions to extend beyond workers in formal and especially public employment. This left a vast majority of vulnerable groups without the required safety nets to be able to counter the downward spiral of poverty, and more vulnerable to risks and shocks. Social Pension insurance was brought in to tackle explicitly the vulnerabilities of poor old age people, and thus shares a common mandate with the overall ambit of Social Protection programs.

The focus on older people is justified by a direct link between old age and poverty, arising from the multi-dimensional, persistent nature of old age, and its intergenerational impact (Help age, 2000). Older people in developing countries who live and work outside the formal sector and lack the capacity to save, are often excluded by contributory pension schemes, thus necessitating social pension programs focussing on their specific needs and vulnerabilities.

Indirect welfare impacts: The impact of social pension insurance in preventing, or reducing rural to urban migration, via the redistribution and injection of purchasing power into the rural areas, has been documented by Barrientos (2004). Despite there being other means of encouraging rural development, this was effective because pensions are seen as less likely to create work disincentives. Barrientos (2004) also documents social pensions as instrumental in reducing social unrest, especially in unpopular regimes. This point gains further credence from the work of Devereux (2001), who shows social pensions in South Africa to be initially motivated by 'winning hearts and minds' during the apartheid era.

Further, 'non-contributory pensions are especially effective in addressing old age poverty amongst women, and therefore can play a role in reducing discrimination and exclusion' (Barrientos, 2004). Pensions can also act to ameliorate intra-household inequalities, and empower vulnerable household members (Barrientos and DeJong 2004, quoted in Barrientos, 2004). The regular monthly income transforms elderly relatives from being economic burdens in their old age into net contributors to household income (Devereux, 2001). To this extent, social pensions can be seen as transformative social protection measures.

Social Pensions can also be seen as a flexible instrument of social protection for catering to needs arising from social and economic change such as HIV/ AIDS, Labour migration etc. They thus have the capacity to combine redistribution to the poor with life-course redistribution and targeting of groups made more vulnerable by the changing socio-economic situation (Barrientos, 2004). In addition, formal cash transfers are often converted into informal transfers through redistribution within households, for instance, grandparents in Namibia spending their pension on school fees for grandchildren (Subbarao, 1996).

Direct Welfare impacts: The direct welfare impacts of social pensions lay within the ambit of preventative as well as promotive Social Protection measures. Available evidence from a large number of studies suggests that social pension reduces poverty amongst older people and their households, mainly through increasing incomes and encouraging household economic activity by strengthening the contributions of older people (Help age, 2000). Its effectiveness is further increased by smaller leakages to the non-poor, pointing to a well targeted program. Another strong effect of pensions is on reducing aggregate income inequalities, in so far as that pension benefits go to poor households. This also implies stronger effects for reaching the poorest rather than those living just below the poverty line, thereby promoting equity.

The regularity and reliability of pension insurance enables households to plan for the future, thus facilitating investment in human and physical capital, increasing health and education levels of the beneficiaries and their families, and reducing vulnerability and poverty in the long term. Social pensions thus reduce both the depth and incidence of poverty, and smoothens consumption through difficult times (Devereux, 2001). Though targeted on an economically inactive or less active group, the pension achieves productive impacts indirectly, through informal redistribution to secondary beneficiaries (Ibid). Barrientos (2004) found that pensions had a positive impact on well being defined by a wider range of indicators, reflecting lower incidence of deprivation and improved functionings and capabilities.

Other positive effects of social pensions include stimulation of trade and marketing infrastructure and stabilisation of rural food supplies. Devereux (2001) makes the link between social pensions and social protection explicit in the effect of social pensions in reducing vulnerability by providing a safety net against livelihood shocks such as drought, and through lifting poor households out of poverty. Help Age (2000) see social pensions as a vital measure for extending the 'right to development' to older people.

The above analysis suggests that social pensions relate inherently to the promotive, preventative, and at times, transformative effects of social protection measures, by having important anti-poverty and

intergenerational effects. The following two case studies throw more light on the principles, modalities and impacts of social pension insurance as an instrument for social protection.

Social Pensions in Namibia:

Social pensions in Namibia were initiated in 1965, and have followed a trajectory moving from a narrow and unequal coverage base, to universal broad-based coverage to all its citizens, at an equalised rate implemented from 1994 onwards (Devereux, 2001). Its introduction was based on a wide range of factors, including bolstering the 'apartheid' policies of influx control and separate development, restricting political activism in urban areas through restricting migration, providing a basic minimum means of survival to the large majority of poor people, and winning the hearts and minds of the population.

Presently, the benefits of the pension scheme extend to all men over 65 and all women over 60. It is a publicly funded safety net, administered by the Department of Social Welfare as a cash transfer, and set at a level of N$160 per month (Subbarao, 1996). While there were moves to make the social pension a 'grant' from the state, made only to citizens who are in need of assistance, disagreements on the modality of means testing led to shelving of the subjective discretionary criteria. The social pension continues to exist in Namibia as per the universal age criterion.

The social pension in Namibia provides vital support to the large majority of poor families in the country, especially in the context of a highly unequal (bi-modal income distribution) society characterised by mass poverty. Devereux (2001) considers social pension as the most important formal safety net program in the country, accounting for 83% of the government's spending on social welfare.

In this light, Devereux (2001) categorises this social pension as social assistance rather than a safety net. Namibia's social pension differs from a conventional pension scheme in that it is activated only by an age milestone, not be a change in occupational status. Further, it is a flat-rate defined benefit and non-contributory. It is financed through tax revenues and other sources of government revenue. Thus, 'the social pension is more related to other indicator-based transfers where the indicator proxies individual or household vulnerability, such as cash transfers to' specific groups (Devereux, 2001).

The rationale for targeting social pension on an age criteria in Namibia arises from a dualism of old people being unable to provide for themselves, and high levels of unemployment and very low incomes limiting the ability of the poor to care for their elderly. Seen in this light, the social pension is seen as constituting an additional stream of income. It is often redistributed to the recipient's extended family, and thus used in wider contexts.

The problems with this program include dangers of cost inefficiencies (arising from inclusion errors), wherein non-poor elderly people also benefit from the social pension. 'Perverse redistribution of income' is another possibility, with rich people outliving the poor people (Beattie and McGillivray 1995, quoted in Devereux, 2001). These then need other criterion such as additional eligibility criteria or self-targeting, which are simple yet inexpensive, rather than an expensive means testing method. But all of these have political implications, which need to be considered before any changes are made. Coverage of the program is 88%, however, there are significant regional variations showing exclusion errors (Subbarao, 1996).

The impacts of the social pension are widely perceived as being welfarist in nature. According to Devereux (2001), pension is the third most important source of livelihood for Namibians, in terms of the number of households that depend on it. There is also evidence to show that subsistence farmers show an improvement in their standard of living on reaching retirement age, and the pension might uplift certain categories of households, even lifting some out of poverty altogether. In addition, Namibia's social pension does not come in the category of employment related social insurance

system, as it is a cash transfer targeted only by age. According to Subbarao (1996), social pension constitutes an indispensable source of household income for many poor rural households.

Devereux (2001) also presents evidence on how the social pension has contributed to development of trade and marketing infrastructure, been used in productive purposes such as education, business and agricultural assets, and been a vital source of household food security by stabilising income and consumption in the face of shocks – in this way, it provides non-covariate buffers against livelihood shocks. It thus provided support to a number of people other than the pensioners themselves, and was used in a variety of ways including purchases of basic necessities, payment of household bills, buying personal consumer goods and assets, livestock and transport costs, and supporting contingencies such as health crises. Other important effects of the pension have been an increase in the credit-worthiness of the pensioners, as well as making elderly relatives economically valuable members of the household. According to Narera et al (1993, 15, quoted in Devereux 2001), social pensions provide 'a degree of autonomy to older members of the community which results n pensioners either being an asset to the household or retaining their economic independence and electing to remain a separate household'.

Criticisms towards the social pension insurance have come in terms of it being poorly targeted and fiscally unsustainable. According to Subbarao (1996), it has high transaction costs to recipients, as well as high administration costs. Further, targeting by age is a poor indicator of poverty, especially in a highly unequal society like Namibia. There is also evidence to show that demographic strategies such as missing middle generation households are reinforced by the social pension. Devereux (2001) claims that 'the future of the social pension in Namibia depends as much on its political support base as on its fiscal costs'. Also, Subbarao et al. (1996) explains that the current operation of the program suffers from under-coverage in the heavily populated and poorer North.

Overall, the social pension in Namibia was found to have significant positive effects in welfare and living standards of the rural communities of Namibia, thus providing evidence to its role as an important social protection and poverty reduction strategy.

Social Pensions in Nepal

The program of Social Pension insurance in Nepal is known as the 'Oldage Allowance Program (OAP). It was initiated in 1994 with a universal flat rate pension of Rs. 100 to all elderly above 75 years, which now stands at Rs 150. From an initial pilot phase covering 5 districts for 6 months in 1995, the OAP was extended to the entire country. The program is implemented by Ministry of local development (Rajan, 2003).

Unlike the Namibian Social pension scheme whose implementation has been subcontracted out to a private agency, the scheme in Nepal is administered directly by the government, through municipalities in urban areas, and Village development committees in rural areas.

Apart from the OAP, Nepal also has a program of social pensions to widows above 60 years of age, and to disabled. While the OAP is a universal program, both the Widow Allowance and the disability allowance is provided to beneficiaries with a mean tested criteria[1] (Rajan, 2003). The Nepalese citizenship certificate is required to claim any of these social pensions, but the government has taken innovative steps to overcome administrative hassles, such as allowing horoscopes to be used as proof of age while applying for the OAP.

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[1] The widows allowance is available to all widows who have crossed the age of
60 and do not have any economic sources, those who do not get any care from family members and those who don't get pension of their late husbands. Disabled Nepali citizens are means tested according to the following: completed 16 years of age, blind, do not have both hands or have hands that do not work, who do not have both legs or have legs but don't work.

The ratio of expenditure on the OAP to total expenditure of the government has been decreasing: it went down from 0.6% in 1995-96 to 0.4% in 2001-02. Rajan (2003) has estimated the coverage of OAP to be ranging from 83 to 86%. This was complemented by low costs of accessing the pension by the beneficiaries.

Findings of the survey conducted by Rajan (2003) showed that family continued to be the predominant social institution taking care of the elderly. There is no mention of the kind of autonomy or increase in standing of the elderly as reported in Namibia, yet some children helped the elderly with the process of obtaining the benefits of the pension. Also, the same kind of positive effects, including better health and improved housing facilities were reported, thus showing that the social pension is an important means of reducing vulnerability of the poor beneficiaries. 1 of every 7 person reported to be working even after getting the pension, which again illustrates that the social pension is independent of the labour market and employment conditions of the beneficiary.

SOCIAL HEALTH INSURANCE

The concept of Social Security and its compulsory universal coverage can be traced back to Lord William Beveridge. According to Dror (2002), the Beveridge model of comprehensive social insurance was based on 'flat rate contributions and flat rate cash benefits: the same amount of contributions paid by everybody regardless of earnings or income, or the same amount of benefit for all entitled persons. Beveridge's concept for health insurance was that services 'will be provided where needed without contribution conditions in any individual case.''

Health insurance can be provided through private sources, community based sources, voluntary agencies/ NGOs or a mix of these. While there is no common understanding of 'Social health insurance' (for example, GTZ's program on social health insurance includes public/ government as well as community based schemes and private initiatives), here, we take this term to refer to the public provision of health insurance, so that beneficiaries are able to reduce their costs in accessing health services.

Ahuja and Jütting (2004) see health insurance as schemes that have the potential to improve the risk management capacity of the poor, thereby having a direct impact on poverty alleviation. These schemes meet the health challenges that the poor face, by 'reducing out-of-pocket health expenses of poor households and improving their access to health care services'. They further argue that households without insurance become vulnerable, 'forcing them into the poverty trap.' However, insurance is regarded more as a complement to, rather than a substitute for, other health interventions, as it essentially protects households against the financial consequences of illness, but does not seek to improve the health status of the poor directly.

For Ahuja and Jütting (2004), both social health insurance and community based insurance schemes fall into the ambit of micro-insurance. On the other hand, according to Dror and Jacquier (1999), the term 'micro-insurance' refers to the coverage of communities who have been excluded from both private and social insurance because of demand (people forgoing access because of their disempowerment) and supply (insurers have left out these population groups). It is primarily provided at a small scale through voluntary efforts, links up with multiple small units into larger structures that enhance the insurance function (through pooling of risk) and the governance function, and is different from community based insurance in that it is 'conceived as an autonomous enterprise, independent of external operators or of permanent financial lifelines' (ibid). Micro-insurance is thus a mechanism to pool both risks and resources of whole groups, to provide protection to all members against the financial consequences of mutually determined health risks (Dror and Jacquier, 1999). In its recognition of the complementary roles of community and individual responsibility, it is different from 'savings', which puts the responsibility of the health risk exclusively on the beneficiary (ibid).

While 'insurance is not the only way to deal with risks, and not all risks are insurable' (Ahuja and Jütting, 2004), health insurance is an important way to handle risks related to illness, injury, disability and other such health related issues. This is because these risks are mostly independent or idiosyncratic. Health risks are crucial as they have destabilizing effects on household finances, and hence insurance, which is aimed at reducing these risks, affects household finances positively. In this way, health insurance extends social protection to disadvantaged sections of the population, and can be termed as preventative and promotive social protection.

There is adequate evidence to show that health insurance plays a positive role in reducing the problem of access to health care, especially for poor communities and households. For example, in rural Senegal, community schemes called the 'mutuelles' reach otherwise excluded populations, members have a higher probability of using hospitalization services compared to non-members, and members pay substantially less when they need care (Jütting, 2001, quoted in Dror, 2002). Similarly, the Medical Insurance Fund run by SEWA in India reduces both the risk of high medical expenses and their uncertainty (Ranson, 2002, quoted in Dror, 2002).

The case for social provision of health insurance comes from a number of viewpoints. For one, community health care financing has crucial weaknesses such as low capital base, small size of risk pool and limited capacity to deliver more comprehensive benefits. These can be overcome through social provision of health insurance. The rationale for micro-insurance arises in turn, from the failure of public provision of health services. Coverage is an important issue in the effectiveness of social health insurance. Most developing countries do not have a national social health insurance program. An exception is Kenya, where draft legislation to introduce a National Social Health insurance fund (NSHIF) by the government was brought in 2002. The NSHIF aims to roll out health insurance protection to the country's entire population, increasing its share of bearing health care costs from the current 4% to over 70%. However, the legislation still needs to be enacted, after which implementation can begin (Ministry of Health, 2003).

In the absence of both government–managed risk pooling and a subsidy for the needy, most people seek alternative mechanisms to reduce their exposure to the financial risks of ill health, and hence 'excluded populations' can enhance access to care if they can access health insurance (Dror and Jacquier, 1999). Since the market functioning of health care systems do not result in socially optimal quantity, quality or distribution of health care, as also may restrict demand and hence supply of such services, micro-interventions in providing health insurance can ensure access to health care by the poorest.

Ahuja and Jütting (2004) extend the concept of insurance to the poor by challenging the misconception that the poor are too poor to either buy or save insurance. They view institutional rigidities rather than affordability as constraining demand for health insurance, especially for the poor who are just below the poverty line. Easing the credit constraints that these individuals face, according to them, is better than subsidizing premium in order to improve the reach of insurance schemes. Through this, they conclude that savings and credit functions need to 'at least be taken concurrently with insurance, if not before insurance', and one way to do this would be to embed micro-insurance functions in already existing micro-credit schemes. Institutional rigidities can also be removed through public interventions.

However, removing the credit constraints does not work for the poorest of the poor, who might need direct public support to meet their health care needs. However, subsidising the premium would be essential for the poorest to participate in the existing health insurance schemes, which then comes under the ambit of social health insurance. In addition, 'public intervention can contribute to the success of micro-insurance schemes by insuring against the covariate risks that undermine micro-insurance arrangements against uncorrelated shocks' (Ahuja and Jütting, 2004).

According to Dror (2002), micro- insurance units in low-income countries run the risk of insolvency due to small group size, high cost variance, low claim load and unstable income and expenditures. Pooling and adjusting the risks of these units can be achieved through what is termed as 'social reinsurance'. Social reinsurance provides both risk management and strengthening of the technical capacity of micro-insurance units to act as first-line insurers. In this way, both social health insurance and micro-insurance can mutually reinforce each other in extending the coverage of health insurance available to differentiated categories of the poor.

Furthering the argument for these to go hand in hand, ILO recognizes both community and social provision of health care. According to them, 'the state has a priority role in the facilitation, promotion and extension of coverage of social security…when coverage cannot be immediately provided to these groups (those not covered by existing systems…certain groups have different needs…the successful extension of social security requires that these differences be taken into account. the potential of micro-insurance should also be rigorously explored' (quoted in Dror, 2002).

The key element of social health insurance systems, according to ILO, WHO and GTZ, is the principle of mutual solidarity, on which the insurance scheme is financed. Solidarity based on consensus allows information sharing and promotes mutual understanding, thereby leading to sustainable decision-making (ILO, 2002). This guarantees access to social health care for the poorest of the poor, especially extending its coverage to the informal sector. People in the informal sector are more vulnerable to ill health and have limited capacity to absorb risks and shocks. Thus, by extending coverage to the informal sector, social health insurance can play the role of preventative social protection. GTZ also conceptualizes social health insurance as reducing poverty, thus viewing the provision of social services as instrumental to poverty reduction.

Socially balanced health insurance systems based on solidarity not only protect families living in poverty or at risk of poverty, but can also have wider spin-offs by promoting social justice and stability within a society. In this way, social health insurance takes on a more transformative form of social protection.

Below we look at Senegal's social health insurance system, in order to trace the modalities of social health insurance as an instrument of social protection.

Health insurance and health status in Senegal

Senegal is classified as a low-income, moderately indebted country, which suffers from high levels of poverty, very high rural-urban migration, unemployment, illiteracy and poor access to primary health care services. Income and geographical inequalities in access to heath care, small tax base of the government and failure of the market in the health insurance sector aggravate the health risks that the poor have to bear.

Senegal drafted a National Health Development Plan (PNDS) for the period 1998 – 2007, but the total expenditure on health as a percentage of GDP has been declining (from 5.1% in 1997 t0 4.8% in 2001. About 21% of the health expenditure is financed by the private sector. However, the share of insurance in all of this is very low, and hence the population has to bear most of the health expenditure from out-of-pocket expenses. These trends combine to expose people to 'catastrophic health expenditure', which is defined as 'a situation where a household's out-of-pocket expenditure consumes more than 40% of its non-subsistence expenditure or 20% of its total expenditure' (Xu et al., 2003 quoted in Asfaw, 2004). Community health insurance schemes emerged as a response to the market and government failure, in Senegal known as the 'les mutuelles de santes' (Mutual health organizations).

A survey was conducted by Asfaw (2004) in order to analyze the impact of health insurance (both mandatory and social) on health status and health care seeking behavior. In this, it was found that

insured people were less likely to not get health care given need, compared to non-insured respondents. Insured members also faced lesser waiting times and more hospital or outpatient care as compared to non-respondents. Also, insured members were found to be less likely to raise the affordability issue as a reason for not seeking health care and not getting the medicines prescribed to them. These results imply that the health care system in Senegal was responsive to the demands of the insured individuals.

Another interesting finding was that though the average health expenditure of insured households was higher than their non-insured counterparts, the shares of out-of-pocket expenditure from their total expenditure was very low for insured households. The proportion of non-insured households who faced catastrophic health expenditure was more than double of insured households. Thus, insured households were found to be better off, while poor and non-insured households faced a double vulnerability with high incidence of catastrophic health expenditure.

This could be aggravated by the regressive mechanisms for financing out-of-pocket expenditures that were most likely to be followed by the poor. These included borrowing from outside, as well as unplanned sale of assets, especially productive assets, which decreased the productive ability of the household and their future income generating capacity, thereby magnifying their vulnerability. It was found that health insurance helped in preventing these kinds of distress sales, and thus played a major role in protecting households from welfare threatening health care financing mechanisms.

Health insurance was thus found to have a direct impact on poverty, by protecting households from unforeseen out-of-pocket expenses, reducing the chances of impoverishment (defined as the state of being reduced to poverty because of health payments) and preventing deepening of poverty (a situation where health payments intensify the problem of poverty within poor households). Going by these definitions, it was found that more than 5% of non-insured households were impoverished as compared to 2.91% of insured households.

An additional positive effect of health insurance was to improve the health status of individuals and consequently to reduce the problem of unemployment associated with ill health. While more than 4.7% of non-insured households were found to be unable to work due to illness, none of the insured households were unemployed due to ill health.

These results show that health insurance plays a significant role in enhancing health care utilization, protecting households from catastrophic out-of-pocket health payments in Senegal and helping to reduce illness-inflicted unemployment. Thus it can be concluded that health insurance is an important instrument of preventative as well as promotive social protection. However, some of the challenges that Senegal faces for making health insurance an effective mechanism of social protection include an extremely low coverage of health insurance and distributional inequalities in coverage, with a bias towards educated and urban households. With an increased coverage of health insurance, both impoverishment and deepening of poverty resulting from catastrophic health expenditures can be considerably reduced.

Is large-scale replication of micro health insurance a realistic way forward for Uganda?[2]

An alternative private insurance mechanism is small scale micro-health insurance. These can function on the principles of savings groups such that risk-pooling enables health risk management. Micro health insurance in West and Central African countries has been shown to positively impact informal

[2] This case study and discussion is taken from Devereux, S. and Sabates-Wheeler, R., October 2003, *Phase II Report: A Vulnerability Issues Paper,* Social Protection in Uganda: Facilitating the Process of Mainstreaming Social Protection into the PEAP Revision. Kampala: Ministry of Gender, Labour and Social Development

and rural sectors.[3] An example of a Ugandan NGO that provides health insurance is FASERT (Foundation for the Advancement of Small Enterprises and Rural Technology), which facilitates micro-health insurance to informal sector workers to cover periods of illness when their inability to work leaves them with no income. The ILO-supported project functions similarly to a rotating group savings scheme; members (minimum 30, all with the same occupation) pool contributions that individuals can draw on when needed. The groups are based on mutuality and peer pressure. The funds cannot cover major diseases that are very expensive – e.g. AIDS, or cancer. It deals better with opportunistic illnesses – fever, flu, malaria. Members get a 'swipe card' with their photograph as an ID, and use this to claim benefits at participating hospitals and health clinics. By late 2002 there were 17 groups on the scheme. This represents a very limited outreach, mainly because FASERT faces resource constraints. But it is voluntary – being funded by members' contributions.

Evaluations of community health insurance schemes in Uganda have been mixed. Initial evaluations conducted in 2001 suggested that the schemes were financially unsustainable, that membership was unstable and that the schemes were not pro-poor. However, a recent evaluation presents evidence that since 2001 membership has been increasing, evidencing a revealed demand for such initiatives. This evaluation claims that these schemes need long-term support, their success being fundamentally linked to information, mobilisation campaigns and positive demonstration effects. It is further argued that private micro-health insurance schemes can not limit themselves to targeting the poor, as there would not be enough savings to cover claims, thus a need to target middle classes also. However, data from the same report also show that membership over the same period has been very unstable. Before discounting such initiatives an effort should be made to evaluate the extent and nature of the revealed demand for such schemes and to expend more effort on awareness raising concerning such schemes. In the short-run this may require continued subsidy, however these are long-run projects by nature and so they need time before solid conclusions can be drawn. If subsidies are required these could be provided by NGOs or/and donors but not the Government. Any additional government monies should be used for improving the quality of the publicly-provided health care system. The Government of Uganda should focus on increasing the budget and upgrading the quality of health service delivery so that the poor have access to adequate publicly funded health care and no longer need to seek out expensive private or NGO alternatives. The clear demand for micro-health insurance is evidence of the fact that improved access to government health services following the abolition of cost sharing has not yet been matched by improvements in quality.

Clearly, widespread take-up of private health insurance in Uganda is not a short or even medium term solution. However the argument for completely disregarding this as an option is not clear. For the very poor and marginalised social health insurance may be an option. This would clearly entail a social assistance element from the Government and unfortunately this will have to remain a long-term agenda due to budgetary constraints.

MICROFINANCE/ MICRO-INSURANCE PROGRAMMES

Micro-finance institutions have emerged as important mechanisms for helping manage vulnerability in many parts of the world. The Grameen Bank is perhaps the most well-known example of a successful micro-finance scheme that has subsequently evolved into micro-saving and micro-insurance. Other examples include BancoSol of Bolivia, Bank Rakyat Indonesia and SEWA. The purpose of micro-finance programs is to provide small loans to households lacking access to the formal banking sector. The loans are typically earmarked for small-scale business development.

How do micro-finance programmes address issues of vulnerability? Where do they sit within a social protection agenda? Do they function primarily as safety nets or 'springboards'? Dercon (2004)

[3] Atim, Chris Bukari Technical Report No. 19, 'The Contribution of Mutual Health Organizations to Financing, Delivery, and Access in Health Care in West and Central Africa: Summaries of Synthesis and Case Studies in Six Countries' Partnerships for Health Reform *May 1998* http://www.phrplus.org/Pubs/te19fin.pdf

argues that risk is a cause of poverty traps, of untapped profitable opportunities and of lower growth. Therefore, the return to 'social protection' is substantial, and public action to reduce vulnerability is good for equity and efficiency/growth. Microfinance programmes contribute to pro-poor growth by helping households increase their incomes and thereby increase savings, which in turn will relieve investment constraints facing poorer households. This clearly has an effect of reducing vulnerability overtime. Microfinance can also be used for diversifying activities/ business and thus has a mitigating effect on vulnerability. A further way that micro-finance can reduce vulnerability has to do with the (typically) fungible nature of the loans. As long as funds are not strictly tied to investments they can be diverted in the event of a consumption shock, which may provide households with the security that enables them to take productive risks that they would have not taken in the absence of the loan.

However, as pointed out by Morduch and Sharma (2001), tying households to rigid repayments schedules can in fact increase their vulnerability. In the face of a crisis, debt repayments are much more difficult and may put stresses on the individual or household that lead to asset depletion, reduction in consumption and coping strategies that undermine long term productive investments. Of course, many micro-finance programmes have evolved micro-insurance functions in response to this problem and the problem of debt default. Well known examples are the Self-Employed Women's Association (SEWA) and Grameen Kalyan (an off-shoot of the Grameen Bank). Micro-insurance within micro-finance schemes typically takes the form of life insurance or health insurance. These types of insurance address idiosyncratic shocks head-on.

Credit-life insurance is an example of micro-insurance that has been very successful. "For a small fee the insurance pays off the client's debt should the client die with an outstanding balance, sparing neighbours and relatives to assume the burden. This is clearly a benefit for the lender as well as the borrower (e.g: FINCA in Uganda). Typically to deal with adverse selection problems the lender will limit or eliminate coverage for older members. (this may keep costs down but does not provide a safety net to possibly the most vulnerable groups).

Micro-health insurance is a facility that is increasingly being built into micro-finance programmes. One reason for providing health rather than life insurance is the assumption that poor people prioritise health status over the impacts of death on friends and family. Evidence indicates that micro-health insurance programmes face high costs, due in large part to moral hazard and adverse selection problems associated in particular with poor people.

Micro-finance schemes various enormously in their aims. Some aim to provide simple service delivery –health, employment insurance, maternity and sickness benefits – while others are motivated by general development principles that over the longer term focus on larger issues such as, the equitable distribution of resources, better lifestyles for the poor, broad-based pro-poor development strategies and an improvement in the wellbeing of the poor. In this way micro-finance/insurance schemes can address a range of vulnerabilities of poor people by addressing the whole range of social protection mechanisms – safety nets, insurance, transformation and springboards. An important part of some micro-finance/insurance programs, particularly those that work with women, is the 'transformative' agenda that aims to empower certain groups. For instance, programs variously aim to strengthen women's position in the family, raise consciousness about the advantages of group solidarity, and raise agricultural wages by strengthening their bargaining power *vis-à-vis* the employers. Many microfinance programmes combine services for risk reduction, mitigation and coping. Risk management can be approached through multiple social protection products within one programme (for instance in SEWA and the Grameen bank) or by just one (in the case of SHINE – micro health insurance in the Philippines).

While most micro-finance programmes report extremely high rates of repayment and have benefited large numbers of households below the poverty line, there is growing recognition that they are failing to reach the extreme poor (Hulme and Mosley, 1996). These are households whose per capita income is less than three-fifths that of the poverty line, who tend to have less than 6 decimals of land, as compared to the maximum of 50 decimals that constitutes eligibility for lending under poverty-

oriented schemes, and who generally earn their living as agricultural day labourers. They operate in the 'mini-economy' in which production, consumption, exchange, trade, savings, borrowings and income earning occurs in very small amounts (Matin et al., 1999). Consequently, the 'unit' of transaction is small, making it difficult for financial institutions attempting to deal with them to charge standardised administrative costs.

The constraints posed by the high transaction costs of dealing with the extreme poor have been exacerbated by the increasing emphasis within the donor community on the 'sustainable', as opposed to the 'subsidised', transfer of resources to the poor. This has led to an increasing stress on loan repayment by various micro-finance organisations affecting their ability to be responsive to the fluctuating income flows of the very poor. The stress on weekly repayments generates additional pressures at the level of groups to exclude the very poor who are likely to have difficulties in meeting their repayment obligations and could hence jeopardise the group's future access to loans.

From the perspective of the extreme poor themselves, the knowledge that they do not have guaranteed income flows to provide the weekly repayments or is likely to lead to considerable risk aversion on their part and self-exclusion from credit programmes. In addition, other practices of microfinance organisations also militated against their appeal to this group. Grameen, BRAC and ASA in Bangladesh all required compulsory regular savings from their members as contributions to de facto 'lump-sum' pension which members could only claim when they left the organisation. This limited a potentially important source of consumption-smoothing, an important aspect of the demand by the poor for financial services.

Kabeer (2001) reports that a recognition of the failure of micro-credit programmes to reach the extreme poor has elicited a number of different responses. On the one hand, there are those who argue that 'microcredit is not relevant for the poorest of the poor and the most illiterate of the illiterate. For them wage employment is necessary for poverty reduction' (1998, p. 17). This position echoes that taken in earlier debates in India in relation to the IRDP where, among others, Dreze (1990) argued that the very poor would be more likely to benefit from the expansion of wage employment through public works programmes than from the provision of subsidised credit. Others have opposed microcredit for the poor on ideological as well as economic grounds. Nijera Kori in Bangladesh, for instance, argues that it has merely replaced older dependency relationships between poor people and moneylenders with new forms of dependency between poor people and purportedly pro-poor non-governmental organisations (Kabeer, 2001).

Trying to reach the extreme poor: BRAC and Grameen

A number of NGOs in Bangladesh have sought to redesign their interventions to account of their failure to reach the extreme poor. BRAC's Income Generation for Vulnerable Group Development programme (IGVGD) seeks to combine some assurance of household food security with assistance in enterprise development over a longer-than-usual time frame. It targets the poorest among poor women: members of assetless households, women with irregular or no household income, women who work as casual wage labour and female household heads. They are provided with monthly wheat rations for two years during which time they are expected to form savings groups and to participate in training in income generating activities (poultry, livestock and sericulture). Credit is provided to help them set up these activities. Relief, credit and training are thus combined in this attempt to address the exclusion of the very poor. Surveys of the IGVGD have found it to be successful in targeting destitute women who are either excluded, or self-exclude themselves, from NGO activities and in enabling them to reach a stage where they can become members of the NGO's microfinance activities.

BRAC now proposes to extend this programme to other sections of the excluded poor over the next five years. In addition to asset grants and credit, BRAC will also supply inputs and provide necessary technical services and supervision. BRAC, government and private sources will all be used to procure

inputs. Necessary marketing services will also be provided. BRAC is also proposing to extend its Employment and Enterprise Development Training Programme to the poorest sections. This will aim to provide skills development and confidence building and prepare participants to initiate an enterprise of their choice (BRAC, 2000).

Grameen Bank also changed its lending approach when it found that its loanees in the Rangpur area were falling behind on their repayments. Rangpur is one of the economically most depressed areas in Bangladesh. There is little economic activity, and during the lean season, food scarcity was so great that declining body weights were recorded in the period between mid-September and mid-November. Offering loans in this context was likely to exacerbate the situation, as poor loanees would use the loans either for consumption or to pay off other loans. Instead Grameen embarked on a goat-leasing programme, providing defaulting loanees with a goat which they could raise and then pay back in the form of a kid from the first litter and another from the second litter. No cash repayments were required. Since goats were hardy animals, women had repaid their loans by the end of the first year. The programme has proved successful and brought many of the poorest sections back into its micro-credit programme.

EMPLOYMENT SUPPORT AND PUBLIC WORKS PROGRAMMES

Many poor people depend to a large extent on meeting consumption needs through wage employment, thus, one way of protecting their livelihoods is through targeted employment on state projects. Implementing public works programmes in poor areas with high unemployment has the advantage of smoothing incomes in the short-run and creating livelihood-promoting capital in the longer run, such as roads, wells, bridges, etc. Investment in infrastructure such as roads will have multiplier effects on incomes locally and nationally by linking local producers to potential markets.

Public works programmes can contribute to poverty alleviation in several ways, the most direct routes being through transferring income (in cash or in kind), and by creating useful economic infrastructure. Indirect or 'second round' effects include income multipliers generated by spending of public works wages, impacts on labour markets, and enhanced employability of workers after the programme finishes.

A distinction can be made between labour-intensive employment programmes, that maximise short-term employment creation as a response to a crisis, and labour-based employment programmes that focus attention on asset creation as well as employment (Devereux 2002, v.). The former represents a safety-net social protection measure, with the primary concern being poverty alleviation. Whereas the latter is concerned with promotive or springboard aspects of social protection, where poverty reduction is the focus. An example of an employment-based safety net would be the Maharastra Employment Guarantee Scheme (MEGS). Examples of a labour-based infrastructure programme would be Food and Assets for Sustainable Development.

India is one country that has used public works as a tool for social protection for centuries. PWPs appear to more effective than other forms of prevention and protection in reaching the poorest. Evidence from India shows that they have been more effective than either the public distribution system or the subsidised provision of credit. In Bangladesh, an evaluation of the three main food-based safety net programmes found that Food for Work and Vulnerable Group Development programs appeared to be most successful at targeting the poor who made up 74% and 93% of their beneficiaries respectively. Food for Education had the highest leakage costs. At least a third of its households came from above the poverty line.

Public works programmes are considered to be effective in reaching the poor because they are self-targeting: no attempt is made to define who is eligible but the programme is designed in such a way as to ensure it is mainly the poor and vulnerable who come forward. However, the programmes do raise questions about the *terms* on which public assistance is provided to the poor. What makes self-targeting effective is the social stigma attached to participation, a stigma that is largely borne by those

who are the most vulnerable and excluded in society. To that extent, it could be argued that while such programmes may have lower administration costs than other targeted programmes from the point of view of providers, they have higher social costs from the point of view of intended beneficiaries. However, debates on this issue suggest that stigma can be reduced, though not completely eliminated, through some degree of sensitivity in the design of public works.

Targeting on traditional public works programmes has well documented differential gendered impacts. Programmes that include a heavy manual labour requirement may be a disadvantage for women. Jackson and Palmer-Jones (1998) report that long working days and excessive effort requirements are likely to exacerbate women's 'time-famine' and have negative effects on their health and wellbeing. Jackson and Palmer-Jones point out that when thinking about women, poverty and employment, it is crucial to analyses the specific content and character of work that different policies of programmatic interventions may entail –especially in terms of the physical arduousness of the work. SP schemes that focus on employment, should not see labour as an abstract category, but, rather as a physical experience. This is because evidence shows that women and men have different capacities for physical effort at different stages in their lifecycles. Furthermore, the arduousness of labour relates not only to physical input but also psycho-social characteristics of work. An understanding of these characteristics of work is essential for designing successful social protection schemes.

Social stigma has often been used as a devise for targeting. For instance, it could be argued that the social stigma around the 'untouchables' caste in India facilitates group-targeting. Devereux (2001) reports that during the 1983/4 African drought, food aid was provided in Kenya in the form of subsidised yellow maize – a less preferred staple grain that is often used as animal feed – in order to discourage the non-poor from accessing this resource transfer. Devereux points out that while food-for-work is universally stigmatised as "poor person's work", these programmes have been used explicitly as a means of reaching poor women. Evidence that food-for work is more stigmatising than cash-for-work comes from Malawi's Social Action Fund (MASAF) public works Programme (Devereux, 1999). In this programme men tend to dominate waged employment whereas, women dominate on the food-for-work projects.

Cash-for-work, rather than food-for-work, is likely to encourage a shift towards market oriented production, as it supports both producers and traders, who are often undermined by food-for-work programmes.

Feeder Roads in Mozambique

ILO technical cooperation on public works programmes is provided under the heading of "Employment-Intensive Programmes" and it provides support in long-term development and in after-crisis situations. One example of the latter is the support given to the Mozambique Feeder Road Programme. The National Roads Administration of Mozambique (ANE) formerly (DNEP) has been running a labour-based feeder roads programme since 1982. From small beginnings the programme has grown to one of the largest labour-based programmes in Africa. The FRP uses labour-based methods for rehabilitation and maintenance of roads across the country.

As well as wide-ranging economic benefits, the programme has had positive social impacts. The most significant are to do with a reduction in vulnerability, improved access to social services, increased food production, increased availability and use of transport and small increases in employment opportunities. All these factors were enhanced and expedited when the original roadwork initiative and subsequent maintenance is carried out by cash paid labour-based methods.

An evaluation conducted in 2003 indicated that the expected marketing improvements for the rural farmers had not been observed since market forces and outsider traders and middlemen have taken quicker advantage of the improved road access to enter the area to purchase agricultural produce at

lower farm prices. Other observed negative influences of improved access to isolated communities were increased illegal logging, charcoal burning, and higher incidence of HIV/AIDS.

However, the same report also concluded that the biggest single positive effect of road rehabilitation is the slow and increasing realisation on the part of the members of the community that opportunities exist and a consequent willingness to invest the time and effort required to change, having seen that the effort can now bring reward. Utilising labour-based methods can increase the stimulus to development by injecting initial amounts of cash into the local system. The reopening of roads has enabled the government to re-establish social services in remote areas; has enabled rural farmers to access markets to sell their surplus agricultural produce; has promoted skill transferral; and most importantly has injected cash in needy households struggling to recover from the effects of civil war.

Cash-for-work in Western Zambia[4]

Like many public works projects, cash-for-work in western Zambia had both livelihood protecting and livelihood promoting objectives. Apart from providing immediate consumption support to drought affected farmers in the form of wages to purchase food, the project aimed to stimulate local trade and to enhance market integration by building feeder roads, thereby reducing food prices and improving food security at household, district and provincial levels. Evaluation s concluded that the impact on current poverty was significant, especially in district where workers were employed for lengthy periods. However, most of this income enhancement was a temporary effect; when the project ended few workers found employment elsewhere and the only lasting impact was in terms of assets acquired with cash-for-work incomes.

TRANSFER PROGRAMMES[5]

Unconditional Cash Transfers

Every economics graduate knows that compared to all other transfers, cash transfers are, in theory, utility maximising for the recipient. If so, why don't we see more of them? There are a number of reasons: (a) other resources, such as food, are more readily available to donors in the sense that they have a lower opportunity cost (and in many cases support powerful domestic lobbies), (b) the distribution of cash has been thought to be difficult for security reasons, (c) the preferences of donors and recipients often did not match closely. However, as we move to a world where support to domestic producers in donor countries is under pressure, where the technology to deliver cash safely via pay points, and where donor preferences are moving towards those of recipients as witnessed by direct budget support and PRSPs, it is more difficult to object to unconditional cash transfers to households.

Unconditional cash transfers are claimed to be less likely to damage self-esteem of recipients, more likely to stimulate the local economy, entail fewer transactions costs, and more likely to be spent on things to improve the welfare of the household members. The key issue is: what is the benchmark? If it is no transfer, then of course we would expect to see positive effects. If it is versus a non-cash transfer, in most dimensions we would expect to see superior impacts on well being. Compared to conditional cash transfers, the answers are less clear. Conditional cash transfers (see next section) stipulate conditionality on the receipt of the cash, not on its expenditure. The programmes try to alter

[4] Case study taken from Devereux 2002, page 20
[5] For a comprehensive review and analytical analysis of the range of transfer programmes see the hot topic paper prepared for the DACPOVnet R & V team: Cash *transfers in the context of pro-poor growth,* John Farrington, Paul Harvey and Rachel Slater, 2005.

time expenditures, not cash expenditures, by linking receipt to child health clinic visits and school attendance. The rationales relate to classic arguments for public goods investment (a) equality concerns—children have no voice in the spending of the cash, (b) information asymmetry—parents may not know the severe consequences of poor health and education (mortality, morbidity, low productivity, low birth weight of their children's children, greater likelihood of chronic disease in middle life), and (c) market failure—the inability to borrow against future income flows from healthier grown up children.

Pilot Social Cash Transfer Scheme--Zambia, Kalomo District

This is a programme aimed at households that are below a critical poverty line of 1400 kcal/day/person AND have few or no able-bodied household members--estimated to be about 200,000 households in Zambia (Schubert 2004). Scoping research by Schubert indicated that few development programmes were targeted to thee households. The Pilot, supported by GTZ, now reaches 143 villages in Kamolo and Kanchele Districts, but the study of the Pilot is confined to Kamolo and to the first 6 villages and 1000 households that were reached. The size of the transfer is $6 a month, equivalent to the cost of a 50kg sack of maize and sufficient for a household of average size to add an extra meal per day per person to the number of meals currently consumed (believed to be only one).

As of December 2004 there were no quantitative data on the impact of the scheme with regard to changes in the number of meals consumed, the nutritional status of children, school attendance and the health, the self-esteem, and the social position of different categories of household members—these are being collected by the monitoring and evaluation system, but are not yet available. The methods used to generate the following conclusions are not outlined in the report—we have written to Dr. Schubert to request them.

Findings from the evaluation of the experience of the 6 villages:

- Few inclusion errors—only the very poor and incapacitated were included
- Large exclusion errors—but due to the fact that many more households were eligible than the budget would support
- Distribution is reliable and timely if close to a pay point, but not so if >15km away
- The transfer is used to buy basic necessities (but we do not know if this would be different from the cash they would spend anyway although research on the South African pension scheme (Case and Deaton 1998) concludes "a rand is a rand")
- Schools report improved attendance of children from beneficiary households
- Cash is much more appreciated than in kind transfers
- Some of the cash received is saved for later use

Conditional Cash Transfers

In the last five years such interventions are increasingly found in South and Central America, and to a lesser extent in South Asia. The general idea behind them is to prevent shocks from disrupting household asset accumulation (as happens when a child is pulled out of school or not taken to a health clinic, or when the quality and quantity of the household diet is reduced). They transfer cash (PROGRESA in Mexico and Red de Proteccion in Nicaragua) or food (Food for Education in Bangladesh) in return for school attendance and the attendance of preschoolers at health clinics with a focus on growth-promoting activities. The programmes can be targeted to poorest households (PROGRESA) or to all households in the poorest communities (RED). PROGRESA also targets transfers to women to maximise the health and education effects of the cash transfers (Coady and Morley 2003).

The programs are generally classified as development interventions but are motivated by a desire to keep chronic poverty and shocks from undermining the long-term accumulation of human capital, hence supporting long-term development processes. They have been evaluated extensively by IFPRI. The credible evaluations (Mexcio, Nicaragua, Brazil) demonstrate that the conditional cash transfers are effective: they have had medium to large effects on child development, child schooling rates and household consumption. The one case in which they were not effective at improving child nutrition status (PRAF in Honduras) was due to the small size of the transfer

PROGRESA, Mexico

Progresa is a large-scale anti-poverty programme ($800 million in 1998) that aims to transfer cash to women in households that aims to transfer cash to women in households that fall below a "marginalisation index" cutoff. The programme was born in the wake of the Peso crisis of 1997 and was designed to prevent shocks disrupting the long-term accumulation of human capital. It was the first of the new generation of conditional cash transfers. It was not premised on the idea that parents do not know what is best for their families, but rather on the basis that the combination of health information asymmetries facing parents (not realising the consequences of infant undernutrition, or indeed even if their children were undernourished) and credit constraints (impossible to borrow for current investment in children against the expected returns from enhanced labour force productivity). It was also seen as a way of empowering women by linking the cash transfer to what are traditionally considered female responsibilities, even though the cash transfers themselves are entirely fungible (Skoufias and McClafferty 2001).

Table 2: Impacts of Progresa, Rural Mexico

Dimension of Programme Impact	Impacts of Progresa (based on randomised intervention at community level with baseline and follow-up surveys
Severity of poverty (poverty gap squared)	Decreased by 46% (compared to 36% with untargeted transfer)
Number of visits to health clinics	Increase of 8% for first pre-natal visit in first trimester of pregnancy
Secondary school enrolment	Increased by 10%
Nutrition status (weight for age)	Increase of 16% per year for children under 3

Source: Skoufias and McClafferty 2001

The *Red de Protección Social* (RPS) or "Social Safety Net" -- Nicaragua

Modeled largely after PROGRESA, RPS is designed to address both current and future poverty via cash transfers targeted to households living in extreme poverty in rural Nicaragua. The transfers are conditional, and households are monitored to ensure that they undertake prescribed actions intended to improve their children's human capital development; when they fail to fulfill those obligations, they lose their eligibility for the program.

The RPS's objectives include:

- Supplementing household income for up to three years to increase expenditures on food
- Reducing school dropout during the first four years of primary school, and
- Increasing the healthcare and nutritional status of children under age five.

The findings from the 2 year pilot phase of the RPS are summarized below. Effects are large and statistically significant.

Table 3: Impacts of RPS, Nicaragua

Indicator	Statistically significant change in Indicator between Treatment and Control groups over 2002-2000 period, expressed as % of baseline value for treatment group
per capita household expenditure (Cordobas)	12.4
per capita food household food expenditure (Cordobas)	20
percentage of household expenditures spent on food	6
enrollment of children 7-13 in 1st-4th grades	26
percent of children age 0–3 taken to health control in past six months	no statistically significant difference
percent of children age 0–3 taken to health control and weighed in past six months	32
percentage of children under 5 who are stunted (HAZ < -2.00)	no statistically significant difference
height for age z-score for children under 5	9.5
percentage of children under 5 who are underweight (WAZ < - 2.00)	39.2
percentage of children under 5 who are wasted (WHZ < -2.00)	no statistically significant difference
percent of children age 0–3 given iron supplement (ferrous sulfate) in past 12 months	80

Source: Maluccio and Flores 2003.

Food for Education (FFE)Pprograms

There are two types of food for education programmes: food for schooling as in the Bangladesh government-run programme and food in school programmes, many of which are resourced by WFP.

Table 4 outlines the two different types.

Table 4: Food for Schooling and School Feeding programs

	Take-home food for Schooling	**School Feeding**
Pros	-Focus: Reduces long-term hunger and educates children. -Gives food to needy families -Transfers income to poor families: food can be sold to purchase other critical needs or family budget can be reduced. -Provides strong incentives to send children to school -Encourages children to stay in school.	-Focus: Reduces short-term hunger and educates children -Increases child's learning capability in the classroom -Provides incentive to send children to school -Encourages children to stay in school
Cons	-May not alleviate short-term hunger so that the child can learn in class.	-Does not benefit preschoolers or adults in the family -Difficult to target neediest students

Source: Caldes and Ahmed 2004

Like all of the social protection programmes listed in this paper, there are many different modalities (see Table 5) of FFE programme, all of which will be factors in determining effectiveness.

Table 5: Food For Education modalities

Factors and criteria:	Different modalities of FFE:		
Where is the food being distributed	At schools (SFP)		
	Take home rations (FFE)		
	Both (at schools and take home rations)		
Type of food that is being delivered:	Food grain (for FFE)	Regular	
		Fortified	
	Prepared	At school	Regular
			Fortified
		Pre-prepared	Regular
			Fortified
Where is it the food being produced/procured/prepared	Locally produced/procured/prepared		
	Not locally produced/procured/prepared	Nationally or Regionally	
		Internationally outside Region	
Who is running the program	National Government		
	NGOs (local or international)		
	International Organizations / food aid donors		
	All/some of them as a joint effort		
Targeting criteria	Geographic targeting	Communities	
		Regions	
		Municipalities	
		Rural / Urban	
	Categorical targeting (Who is intended to benefit?)	Children (both girls and boys)	
		Girls	
		Families	
		Aids orphans	
		Displaced children	
		War affected children	
How sustainable is the project	National government commitment exists to run the program	Food supplies exist	
		Institutional capacity	
		Community involvement	
	International community is involved	Phase-out plan is clearly planned	
		International resources and commitment are unlimited.	
Complementary activities in place (jointly with FFE); Examples:	De-worming treatment		
	Latrine installation		
	Micronutrient supplementation		
	Teacher training in health education		
	Provision of clean water		
	HIV/AIDS prevention education		
	Construction of school gardens		
	Malaria prevention measures		

Source: Caldes and Ahmed 2004

In their review of FFE programs, Caldes and Ahmed (2004) present the social protection roles played by food for education (FFE) programs by evaluating them on their educational and nutritional impacts, and impact on local agricultural production. As they state

"In terms of education outcomes, to date, most of the evidence has shown that FFE programs –if well targeted to poor regions-, can greatly improve both enrolment and attendance. While there is substantial evidence that FFE programs have a positive effect on cognitive functions and educational

attainment (especially for previously malnourished children), the evidence is not as strong as it is for enrolment and attendance. This is probably so due to the complexity involved in the evaluations and the multiple factors influencing the learning process.

Regarding nutrition outcomes, the food rations or snacks provided by FFE programs have been shown to reduce short-term hunger particularly among chronically undernourished children. Nevertheless, while there is evidence that FFE participation increases the dietary intake of macro and micronutrients (especially when rations are fortified), its impact on nutrition outcomes has not been definitively demonstrated.

Finally, we found no research that has explicitly explored the link between FFE programs and local agriculture stimulation. However, in this paper we have made a step forward in reducing this research gap by discussing and presenting the conditions under which FFE could affect -both negatively and positively- local agriculture production. By outlining number and complexity of possible pathways through which FFE programs affect local agriculture, we hope to open new lines of research that help increase the existing body of knowledge of FFE programs and improve their effectiveness in contributing to the development process."

The Bangladesh FFE Programme

The Food for Education (a food for schooling programme) program in Bangladesh started in 1993. By 2000 it covered 17,811 public and private primary schools, accounting for about 27 percent of all primary schools. Under the FFE program, a free monthly ration of food grains is delivered to the beneficiary children's families.

Impact on enrolment and attendance: A recent evaluation of the program found that the program has been successful in increasing primary school enrolment, promoting school attendance, and reducing dropout rates. The enrolment increase was greater for girls (44%) than for boys (28%). On the contrary non FFE schools experienced an enrolment increase of only 2.5% over the same period, providing strong evidence that the ration was a huge incentive for enrolment. The program also was found effective in reducing drop out rates and promoting children to stay at school. From 1999 to 2000, only 6% of the FFE beneficiaries dropped out while 15% did in the non FFE schools. (Ahmed and Del Nino 2002).

Impact on educational attainment (test scores): the Bangladesh programme is successful in increasing enrolment and attendance, but do the new children actually learn anything in school and do they reduce the learning of current students via larger school sizes? Work by Ahmed and Arends-Kuening (2003) shows that test scores were constant or improved with the new entrants, but only until class sizes expanded to numbers consistent with an average of 44% of FFE-receiving students in the classroom. After this point, the test scores began to decline as class sizes increased and as the percent of new FFE students increased.

Impact on Nutrition: ***t***here is evidence that the Bangladesh FFE increases the dietary intake of macro and micronutrients, but its impact on nutrition outcomes is not clear. For example, in the context of the 1998 floods, Ahmed and del Ninno (2002, quoted in Caldes and Ahmed, 2004) find that increased access to food provided to households is necessary though not sufficient to eradicate malnutrition in the most vulnerable households. Again, this points to the complexities involved in nutritional patterns and weaknesses in program design, implementation or evaluation.

Comparing Transfer Programmes

Table 6 below compares unconditional cash transfers, conditional cash transfers and food transfers. Many of the conclusions are tentative, because even the best evaluations (such as the Conditional Cash Transfer ones with randomized treatment and control and baseline and follow up surveys) do not compare their designs to other designs (e.g. unconditional versus conditional).

Table 6: Attributes of Stylised Transfer Programmes

Attribute	Unconditional Cash Transfer (e.g. Zambia Pilot Social Cash Transfer Scheme Kalomo District)	Cash Transfer-Conditional on children in school or health clinic visits (e.g. Progresa in Mexico)	Food transfer (typically food aid)
Fungibility of transfer	Complete	Complete if child goes to school or health clinic	Partial as some cash may be freed up
Potential effectiveness for households without children	Yes	In theory, yes, but not yet tested	Yes
Ability to target	Depends on location of paypoints in remoter areas	Depends on location of paypoints in remoter areas	May be more easily hijacked due to bulkiness
Ease of delivery	Depends on investment in pay system	Depends on investment in pay system	Expensive in terms of fuel
Predictability of delivery	In theory, more predictable	In theory, more predictable	Can be unpredictable due to logistical and donor issues
Stimulus to local economy	Likely to be positive *Very positive in South African Pensions, but due to large size.	Likely to be positive	Could be positive if local foods are sourced, but this is very transactions cost intensive
Stimulus to local services	Unknown	Likely to be stimulus to local schools and health clinics	Unknown
Impact on self-esteem	Likely positive	Likely positive, but conditionality may be resented	Likely to be less positive, esp if food culturally inappropriate or deemed inferior
Impact on health and nutrition status	Likely to be positive, but need M&E to know for sure, also distribution of benefits within hh unknown	Evidence from Progresa, Red de Proteccion show positive results, esp for target group (children)	Likely to be positive, but need M&E to know for sure, also distribution of benefits within hh unknown
Impact on educational enrolment	Likely to be positive, but need M&E to know for sure, also distribution of benefits within hh unknown	Evidence from Progresa, Red de Proteccion show positive results, esp for target group (children)	Likely to be positive, but need M&E to know for sure, also distribution of benefits within hh unknown Can be enhanced if food distribution if done via school meals (FFE)
Impact on food security	Likely to be positive, but need M&E to know for sure, also distribution of benefits within hh unknown	*Likely to be positive, but need M&E to know for sure, also distribution of benefits within hh unknown *May be stronger benefits as tend to be targeted to women	Likely to be positive, but need M&E to know for sure, also distribution of benefits within hh unknown Some evidence to show food transfers have greater impact on food security than cash transfers
Financial sustainability	Unknown	Unknown	Unknown
Political sustainability	Unknown	Seen more as a transfer to women and therefore less able to be captured	May be politically more acceptable to elites
Administrative sustainability	Yes	Only if investments made in supply side (schools and clinics)	Depends on external food aid agencies
Cost effectiveness	Need credible studies to compare (baseline and follow up; with and without transfer)		

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Annex: Table 1: Proposed Criteria to be Used in Selecting the Case Studies to be Included in a Report on Practical Country-Level Instruments and Approaches to Reduce Risk and Vulnerability (case-studies in this paper are highlighted)

Target group	Objective: Risk	Design Feature							
		Demand-side enhancement						Supply-side enhancement	
		Unconditional			Conditional/Smart			Universal	Targeted
		Cash		Food/other	Cash		Food/other		
engaged in productive economy	Reduction (ex-ante)		South African pensions	AIDS prevention efforts	**Cash for education, Cash for health care** **Progresa (Mexico)** PRAF (Honduras) **RED (Nicaragua)** Bolsa Alimentacao (Brazil)	**Cash for work programmes** **Employment guarantee schemes** Targeted input packages/ Subsidies	Food for work programmes **WFP School Feeding Programmes;** **Food for education programmes** Early childhood interventions in nutrition Food stamps/vouchers Food subsidies on inferior foods (e.g. North Africa)	**Social Health insurance** **Microfinance & Microinsurance (with some targeting)** Commodity price insurance Climate insurance Trade insurance	PRAF/Honduras strengthening of schools and health clinics
	Mitigation (ex-ante)								
	Coping (ex-post)	Cash to AIDS sufferers Child benefit schemes (UK)		Emergency relief food aid				Improve accessibility of transfers Improve access, quality of schools, health services	
Unable to engage in productive economy	Reduction (ex-ante)		**Zambia cash transfer to bottom 10%** South African pensions Indian pensions	AIDS prevention efforts				Social Health insurance	
	Mitigation (ex-ante)								
	Coping (ex-post)	Cash to AIDS sufferers		Emergency relief food aid				Improve accessibility of transfers Improve access, quality of schools, health services	