Hard cash boosts child health in South Africa

By Jon Cohen

Money may not buy love or happiness, but if you give a poor family a small sum each month for each of their children, it leads to measurable improvements in their health, education, and well-being. That’s the lesson from an ambitious program in South Africa, the Child Support Grant (CSG), which directly reduces poverty with cash transfers.

In South Africa, any family that can demonstrate financial need is entitled to a monthly stipend of about $30 per child, no strings attached. In 1998, when the CSG started, the cutoff was 6 years old; today it is 17, and the program reaches 11 million children. Families can apply to receive monthly payouts for each child, which costs the government more than $3 billion each year.

In 2008, the Cape Town–based Economic Policy Research Institute (EPRI) set out to see how well the program worked, surveying 2500 people in five provinces. Rather than simply comparing families that received help with those that did not, the study took advantage of CSG’s rocky start. At first, many eligible families did not receive the CSG, as a documentary aired on South African TV in 2001 revealed. The exposé spotlighted widespread serious illness in poor, rural children whose caregivers, mainly grandmothers, had not registered for the CSG, often because registration sites were far from their homes or they found the required paperwork overwhelming. In response to the public outcry, the government dispatched vans to the area to sign up eligible families en masse. “That almost created a natural experiment so years later, we could compare the youth in towns where the mobile registration had stopped and signed up people to other youth who were passed over and weren’t getting the grant,” says economist Michael Samson, EPRI’s director of research.

He and his colleagues considered the cash per child the “unit dose” and asked how children fared in households that had received different doses. In May 2012, the South African government and the United Nations Children’s Fund, which funded the EPRI study, published a report detailing the results. Children in families that received higher doses had improved growth, decreases in illness, better grades and attendance at school, and were less likely to take risks with sex, drugs, and alcohol when they reached adolescence. The report asserts that the program is “one of the most comprehensive social protection systems in the developing world.”

Samson says there are “massive scarcities of opportunities” for South Africa’s poor. “A cash transfer effectively allows the household to invest in breaking intergenerational poverty,” he says, noting that unconditional cash transfers have become popular throughout Africa. And in South Africa, he says, the CSG is the main source of income for more than 20% of households.

Samson says many families that are eligible for CSGs still are not receiving them, leading some to urge the government to drop the means test and provide cash transfers to every household with children. “It’s the best way to eliminate the exclusion of the most marginalized,” he says. He points out that two-thirds of South African families are eligible, and says for wealthier families this would be a welcome tax rebate. “Either way, you win.”

The drive to use “easily measured indicators” to claim success and impress donors also worries Michel Kazatchkine, Dybul’s predecessor at the Global Fund’s helm. Kazatchkine would like to move beyond quantitative indicators to more qualitative ones, like changes in laws or social policies. “Numbers of lives saved is a very American concept,” he says. “The European audience would wish to know about something a little more conceptual than just a number. Have we changed the system and addressed the roots and the causal determinants and insured that the people, in addition to having their lives saved, live a proper life?”

CGD’S EFFORT to weigh malaria interventions stirred new controversy. Malaria control didn’t make it into the first two editions of Millions Saved, in 2004 and 2007, which documented triumphs from global ones like smallpox eradication to little-known efforts to combat diarrheal disease in Egypt or trachoma in Morocco. Although malaria has plummeted in many countries, the CGD researchers said none of the existing evaluations met their criteria: a study of a large-scale intervention of at least 2 years duration that demonstrated a clear, causal link to a drop in disease or death. They also wanted to see evidence that the intervention had an acceptable cost based on the number of cases averted or lives saved.

“We know from a bunch of small-scale studies that bed nets can protect you from mosquitoes biting you,” says Amanda Glassman, who heads global health policy at CGD. “That’s not what we’re interested in evaluating.” In the real world, nets aren’t always used, for instance because they’re uncomfortable on hot nights or people think there are few mosquitoes around.

The blog posting led to fierce rebuttals from both the U.S. President’s Malaria Initiative (PMI) and the Roll Back Malaria Partnership. Erin Eckert, an epidemiologist at PMI, says impact evaluations are critical. But when it comes to the type of national level programs that CGD is evaluating, she says a “rigorous academic definition of impact evaluation is not always necessary or appropriate.” As Eckert and a colleague wrote in a riposte to CGD’s blog, “The malaria field is full of examples of solid evaluations of interventions and the impact of scaling up those interventions on malaria burden.”

Monthly child support grants, now issued as debit cards, improve the health and education of South African children.
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