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A Rapid Assessment of the Lesotho Child Grants Programme

Report prepared for the Government of Lesotho
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Preface / Acknowledgements

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Executive summary

This report presents a rapid assessment of the Lesotho Child Grants Programme (CGP) pilot Phase I, round 1A. The CGP Phase 1, round 1A transferred M360 per household each quarter for around 18 months. In addition, UNICEF signed a memorandum of understanding with the World Food Programme to provide a three-quarters ($\frac{3}{4}$) food aid ration per child for each CGP household. In total (cash and food), the value of this transfer represents around 35% of rural household expenditure, with cash comprising 14% of expenditure on average for a family of five. This Rapid Assessment Report (RAR) presents findings from quantitative and qualitative fieldwork conducted at the end of this pilot phase in three community councils (Thaba Khubelu, Mathula and Semonkong). This assessment is not designed to provide robust scientific results or to focus on operational issues, but to give an indication of the likely impact of the programme.

Overall, given the limitations of this rapid exercise and other changes in the context of rural Lesotho, we have found that the CGP cash and WFP food have significant positive impacts on recipients' well-being. Little more than 50% of households find easy to purchase maize meal or hygiene products after receiving the CGP, while they experienced problems before. And about 25% can purchase over the counter medicine that they could not previously afford.

Recipients typically used the food for consumption, and this tended to increase portion quantities, particularly in the period after the transfer was received. Recipients preferred the cash to food, because it allowed them to meet their prioritised needs – whether these were food, other basic needs such as toiletries, educational needs or others, such as health.

The overwhelming majority of households spent the cash on the prioritised needs of the household, paying particular attention to the requirements of children. Although of course these needs differ slightly in each household case, they usually included food, basic household goods (such as Vaseline and toiletries), educational needs (such as uniforms and shoes), and other clothes. There was very little evidence of significant spending on 'non-essential' items, but also little evidence of productive investment.

A very large proportion (80.7%) of households reported spending their first CGP transfer on educational needs of the children including school uniforms, shoes and other supplies. Around 80% of households report buying clothes and shoes for children (not for school) in the three months prior to the survey.

The vast majority (87.5%) of households reported expenditure of the subsequent transfer on basic food items as one of their three main uses of the cash grant payment. Expenditure on education, personal care products, clothing and special food items (meat, eggs, milk, beans etc.) was also reported amongst the main three expenditure items by 60.6%, 45.2%, 34% and 17.1% of CGP households respectively.

Since households spent the transfers quite differently according to their situations, we would not expect to find significant impacts in the aggregate on any single dimension of well-being. Nevertheless, there are examples of how the CGP made specific improvements to different dimensions of well-being:

- Principally the WFP food, but also the cash grant increased the portion quantity for most households, and many households consumed more protein (from the beans) than they had been able to previously. Many households were also able to afford occasional purchases of rarer but preferred foods, such as meat or bread.

- The grant was rarely used to pay for formal healthcare, since public primary healthcare is free and illnesses need not coincide with grant payments. However, recipients felt better able to purchase over-the-counter medicines (such as those available from small shops without prescription).
- Cash was very often used to buy uniforms and toiletries for children, and together with the greater food portions this led to children feeling more confident at, and enthusiastic about, school (mainly primary school). Although attendance and enrolment are most likely not directly affected by the GCP, improving attitudes towards school is in the long-run likely to have an impact on these indicators.
- The additional resources provided to families enabled some children to work less for money. It also let some adults reduce the number of hours worked, and this sometimes freed up time for children who would otherwise have spent their leisure time caring for relatives.
- Recipients of the CGP had better access to credit. In a context where saving is almost non-existent, this is an important way of smoothing consumption.

We would therefore recommend that the CGP expansion be continued, and we present some specific recommendations on this expansion.

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Abbreviations

ARV	Anti Retro Viral
CGP	The Lesotho Child Grants Programme
CHAL	Christian Health Alliance of Lesotho
CMS	Continuous Monitoring Survey
ED	Electoral Division
FAO	Food and Agriculture Organisation
FGD	Focus Group Discussion
HIV/AIDS	Human Immunodeficiency Virus/Auto Immune Deficiency Syndrome
IDI	In Depth Interview
M	Maloti
MHSW	Ministry of Health and Social Welfare
MIS	Management Information System
NUL	National University of Lesotho
OAP	Old Age Pension
OPM	Oxford Policy Management
OVC	Orphans and Vulnerable Children
RAR	Rapid Assessment Report
UNICEF	United Nations Children's Fund
VHW	Village Health Workers
VSG	Village Support Group
WFP	World Food Programme

1 Assessment context and methodology

1.1 Purpose

The main purpose for undertaking the Rapid Assessment Report (RAR) is to provide evidence on the role of the current ('pilot') phase of the Child Grants Programme (CGP) in improving the various dimensions of children's wellbeing, including nutrition, education, health and poverty as well as any possible negative impacts. The CGP transfers cash to poor households looking after/ caring for Orphans and Vulnerable Children (OVC). For the pilot (phase I – round 1A) assessed here¹, UNICEF signed a memorandum of understanding (MOU) with the World Food Programme (WFP) to transfer a three quarter ($\frac{3}{4}$) food aid ration to every child in every household receiving CGP cash. CGP cash and WFP food were transferred every quarter to 1,250 households between April 2009 and December 2010.

The reason for conducting this assessment is to provide initial and independent information to assist the Government of Lesotho (GoL) and UNICEF in deciding whether and how to scale up the programme in phase II, as well as to provide a wider range of donors and stakeholders a snapshot of the results achieved to date. The key outcomes of interest are those both that the programme hopes to influence and that are of key importance in children's well-being in Lesotho.

Three restrictions on the findings should be noted at the outset.² First, the set of hypotheses around the programme were exploratory and straightforward. The report simply asks:

What were the impacts of the CGP on the well-being of children, particularly their:

- Food consumption and nutrition,
- Health,
- Education, and
- Time spent working?

Other impacts (including negative impacts) would also be noted as found during fieldwork. The RAR was also intended to explore whether communities preferred receiving cash or food.

Second, the RAR does not constitute a full impact evaluation of the CGP. The fieldwork was conducted over a very short period, and was not underpinned by a rigorous impact evaluation methodology. While conducted as rigorously as possible, it was not designed to produce statistically representative results, but an indicative impression of the impact that CGP is having on those households and children which it covers. A long-term rigorous impact evaluation of the subsequent round 2 of the CGP pilot (under Phase I) is currently underway, and entails full baseline data collection in 2011 and a follow up with final results in 2013.³ This Rapid Assessment

¹ There are two CGP phases. The CGP phase I has three rounds. Phase I round 1A (April 2009 to December 2010) ran in six community councils and is assessed here with fieldwork in three community councils. Phase I round 1B added five community councils and ran from July 2009 to December 2010. Phase I round 2 is rolled out from January to December 2011 and will be assessed in the full impact evaluation. Phase II is expected to start in January 2012. The memorandum of understanding with WFP applies only to Phase I round 1A.

² See 'Limitations' below.

³ The instruments used for and the initial findings from the RAR were used to inform the design and implementation of the quantitative baseline survey, which will provide a full long term rigorous impact evaluation.

is conceived to provide early evidence on the effectiveness of the CGP, while the results of the rigorous impact evaluation unfold.

Third, the RAR refers to the first round 1A of CGP implementation. The subsequent rounds of Phase I (round 1B and round 2) and Phase II will be different in two key ways. First, during round 1A most of the implementation processes were tested for the first time. Since then, several modifications have been made to the operational dimensions of the programme, with the aim at improving targeting, registration, information, payment and case management systems. There is a general acceptance that implementation systems were relatively weak in the early piloting round 1A, and this underlies the decision to focus the RAR on the impact of the CGP. However, these early implementation challenges are relevant for the RAR insofar as they may have hindered the overall programme effectiveness and therefore impact. Second, during round 1A of the pilot CGP cash recipients were also provided with food, whereas the subsequent pilot phases, and possibly scaled up programme, will provide cash only as the MOU with WFP will no longer apply. This imposes significant restrictions on the inferences that can be drawn from the pilot round 1A findings in terms of the likely impact of cash alone. Taken together these two elements make using the impact results of round 1A of the pilot to estimate the impact of a scaled up programme very difficult.

1.2 Context

This section provides a brief summary of the CGP pilot round 1A, together with key social protection mechanisms currently implemented in Lesotho.

1.2.1 The Lesotho Child Grants Programme Pilot – Phase - I

The primary objective of the CGP according to the child grant operational manual “is to improve the living standards of Orphans and Vulnerable Children (OVC) so as to reduce malnutrition, improve health status, and increase school enrolment among OVCs”.⁴ Round 1A of the CGP pilot aimed at reaching about 1,250 households with OVC and began during 2009 in three Community Councils within three Districts:

- Thaba-Khubelu Council (Qachas Nek). First payment in October 2009
- Mathula Council (Mafeteng). First payment in April 2009
- Semonkong Council (Maseru). First payment in October 2009

The pilot was expanded in early 2010 under round 1A to include three additional councils: Mzenod (Maseru), Qibing (Mafeteng) and Ramatseliso (Qacha’s Nek). In subsequent phases of the CGP pilot (Round 1B, and round 2) the programme has further expanded to a larger number of Community Councils, but these are not covered by this assessment.

The CGP is targeted at poor households with children and includes poor households caring for orphans (either single or double), child headed households and poor households caring for children who are deemed vulnerable. During round 1A beneficiaries were identified via a community targeting process. According to the operations manual (November 2008), income poverty estimates from the census were used to estimate the number of poor households in each community and to set a ceiling on the number of households that could be selected in each

⁴ Manual of operation in use for round 1A of the CGP pilot. November 2008.

village.⁵ In each village, a community targeting system would identify household up to that ceiling guided by poverty indicators developed from Bureau of Statistics data. This process was to be led community representatives (in most cases village traditional leaders, health workers and the village assistance committee).

The village-level process was to take place as follows. Following a public information campaign publicising the CGP and targeting criteria, households who considered themselves eligible would apply to the programme. A Village Verification Committee (composed of the Chief, Councillor, two members of the Village Caregiver Group who are not potential beneficiaries, and the Auxiliary Social Welfare Office) would then produce a ranking of applicant households based on vulnerability (according to verifiable criteria). Households would have two weeks to appeal through an Appeals and Complaints Committee (composed of district and council officials and teachers and health workers), and then the final list would be entered to the programme Management Information System (MIS).

Each targeted household is given M360 every quarter. However, as payments started later than expected, several payments were accumulated as part of the first transfer in April or September 2009, when households received up to M1080.

During the implementation of the Pilot round 1A, the same households also received a three quarter food aid ration per child (except in the final quarter). The food ration given was equal to 200g maize meal, 60g oil and 20g pulses. This is approximately equivalent to M180 per quarter in monetary terms. The distribution of food rations was organised by the World Food Programme (WFP).

1.3 Methodology and Approach

The RAR draws on both quantitative and qualitative information. This section provides a description of work undertaken under each method.

1.3.1 Quantitative approach

The source of quantitative information for the Rapid Assessment is a representative survey of beneficiary households. Data was collected in March 2011 but unfortunately no baseline was available that would provide a sense of households' conditions prior to the introduction of the CGP.

The scope and size of the quantitative survey were limited by time and budget restrictions. A quick questionnaire covering key indicators was administered to 300 households in the three Community Councils covered in Round 1A. The scope of the 'mini-survey' questionnaire form is not intended to be very comprehensive; rather it focuses on priority areas of concern to the programme. These include (the full questionnaire is available in Annex A):

- Household structure and socio-demographic characteristics (all members)
- Health status (all members): permanent disability, chronic illness
- Education (members 6-17): current attendance, reasons for non-attendance
- Child labour (members 6-17): household chores, paid and unpaid work, type of work activity
- Health (household level): availability of medicines, access to health facilities, access to specialist HIV/AIDS health facilities, perceived health status

⁵ Manual of operation in use for round 1A of the CGP pilot. November 2008.

- Food security (household level): number of meals for children, frequency of protein rich food intake, hunger, food support
- Livelihoods (household level): participation in income generating activity, auto production.
- Investment (household level): home improvement, investment in home equipment, family business, livestock, savings and frequency of savings, levels of debt, access to credit.
- Exposure to the CGP (household level): date of first and last payment, amount of first and last payment, cost of transfer collection.
- Exposure to food aid (household level): number of food aid packages received since receipt of CGP, date of last food aid package received.
- Cash usage (household level): use of transfer, decision making process, frequency of expenditure on selected items, access to markets
- Appropriateness of cash, as opposed to other modalities of support (household level).
- Other social support received: pensions, social assistance

The analysis of the quantitative data component cannot provide a direct causal link between observed trends and impacts and the CGP. Rather the quantitative study presents simple descriptive statistics around key indicators and perceived trends. These findings feed into the analysis led by the qualitative component which attempts to provide a causal interpretation.

1.3.1.1 Sample Design

Households were randomly selected from the CGP payroll for December 2010, which contained 1097 households in total. The sample was drawn in multiple stages. First, villages were clustered according to the Electoral Division (ED) they belong to. There are twenty nine (29) EDs in total across the three Community Councils (Table 1.1). Second, in each of the three Community Councils five (5) EDs were selected with probability proportional to the size of their population of beneficiaries, leading to a total of fifteen (15) selected EDs. Fourth, in each of the selected EDs twenty (20) beneficiary household were selected with equal probability from the December 2010 payroll, which contains 1183 households. The survey design is stratified at the Community Council level, as the same number of observations was expected in each council

As reported in the last column of Table 1.1, 100% of the planned number of interviews have been realised, though slightly over 30% of the initially selected households had to be replaced as they could not be found or were not available for the interview. Overall the sample is well balanced across the three Community Councils

Table 1.1 Sample design and survey report

Community Council	Total Number of Electoral Divisions	Selected Electoral Divisions	Total Number of beneficiary households	Selected beneficiary households	Replacements	Actual interviews
Mathula	11	5	497	100	33	97
Thaba Khubelu	9	5	249	100	16	103
Semonkong	9	5	437	100	45	100
TOTAL	29	15	1183	300	94	300

Source: OPM.

1.3.1.2 From Attribution to Contribution Analysis

The possibility to use the quantitative information collected for the Rapid Assessment in a traditional rigorous impact evaluation fashion - by trying to estimate quantitatively the change in a set of outcomes of interest that can be attributable to the CGP - is hindered by at least three elements: (i) the absence of a baseline; (ii) the limited sample size imposed by time and budget restrictions; and (iii) the absence of a suitable control group that can serve as a counter-factual for beneficiary household.

Due to the combination of these limiting factors that are the direct consequences of time and budget pressure, the purpose of the quantitative rapid assessment is different for that of a traditional rigorous impact evaluation. Its purpose is twofold: a) to provide statistically representative evidence on the use of the transfer as reported by beneficiaries, and their perceived contribution of the CGP on household and children well being; and, b) to provide statistically representative evidence of the trends of indicators of interest and the change over time subjectively perceived by beneficiaries.

To respond to the first objective, direct questions on the use of the transfer were included in the questionnaire. They distinguish use of the first (cumulated) transfer from the use of subsequent quarterly transfers. They distinguish use of the first (cumulated) transfer from the use of subsequent quarterly transfers. The second objective is pursued by introducing in the questionnaire a set of retrospective questions where respondents are asked to remember the state of a series of outcome in a situation precedent to when they started receiving the CGP. While retrospective questions are surely affected by serious recall bias, it is generally accepted in the literature that the quality of the data increases when they focus on discrete recordable events. By comparing the current situation of beneficiaries (e.g. "does NAME go to school now") to the situation prior to receiving the transfer (e.g. "did NAME go to school then") it is possible to infer about the perceived trends for a series of outcomes of interest since the programme started. It is important to stress that, because the recall process is based on respondents' memory, it necessarily provide evidence on individual and subjective perceptions of changes, rather than real objective changes.

The wording of recall questions is important as it may heavily affect the quality of the data. It was considered preferable that recall questions did not explicitly refer to the CGP (e.g. "did NAME go to school before you started receiving the CGP"). This in fact may have worsened the recall bias, by coupling memory errors with errors associated to the subjective perception of the effect of the CGP. Instead, the purpose of retrospective questions is to measure subjective perceptions of the changes of outcomes over time. For this reasons all recall questions were anchored to a specific and neutral point in time (April or September 2009) that corresponded to when the CGP was first introduced in the Community Council of residence of respondents. Table 1.2 provides examples of the wording of alternative types of recall questions used for the Rapid Assessment.

Table 1.2 Examples of quantitative retrospective questions

	Current	Retrospective
Type A	Has this child been attending school in the last 12 months?	Was this child attending school in the 12 months before September/April 2009?
Type A	In the last 12 months, how many meals did children (under 18) in this household normally eat in a day (not including meals eaten outside the house at school etc.)?	In the 12 months before September/April 2009, how many meals did children (under 18) in this household normally eat in a day (not including meals eaten outside the house at school etc.)?
Type B	How would you describe the health situation of this household over the last 12 months?	In comparison to the 12 months before September/April 2009, how would you describe the capacity of the household to afford to deal with health issues in the last 12 months?
Type B	When someone in this household gets sick do you usually experience any difficulties in taking them to a normal health facility (not a specialist HIV/AIDS facility)?	In comparison to the last 12 months, in the 12 months before September/April 2009 how easy was it to take someone to a normal health facility when you needed to?

Source: OPM, Rapid Assessment Questionnaire.

The comparison of answers provided in current and retrospective questions permits eliciting perceived trends over time, by differentiating the perceived well being of the household “before the CGP” and “after the CGP”. While this provides useful contextual information, the causal attribution of trends observed to the CGP cannot be undertaken on a quantitative basis. In fact there is a plethora of other potential actors and factors that may be responsible for the changes (positive or negative) perceived by beneficiaries, and it is not possible statistically to determine what proportion of the changes is due to the CGP. These potential confounders may refer to the general social and economic context (i.e. policy changes, labour market conditions, whether patterns, quality of the supply of social services) or to idiosyncratic shocks (i.e. family circumstances, illness, theft of livestock) that affect individually a specific household. In an attempt to capture some descriptive evidence of the distribution of shocks a specific module was included in the Rapid Assessment questionnaire where respondents reported negative events that substantially reduced household’s income and assets since when they started receiving the CGP. While it is not possible to control statistically for such confounders⁶, when appropriate we present separately the perceived changes in outcomes over time for households who report having and not having been exposed to shocks.

More interestingly, it is also possible to take a mixed method approach and triangulate qualitative and quantitative information to reconcile perceived quantitative trends and in depth qualitative understanding of how changes accrued as a result of the CGP. The question of contribution (rather than attribution) is hence mainly addressed by the qualitative component of the rapid assessment, which reveals beneficiaries’ and communities’ experience of the CGP and the link, if any, between the CGP payments and observed trends in impact indicators.

1.3.2 Qualitative approach

Qualitative field work was conducted in three community councils of Mathula, Semonkong, and Thaba-Khubelu. In each community councils two villages were selected. In each village two focus groups were conducted with recipients of CGP; one with household representatives and another

⁶ As the sample size is small, we only elicit the main negative shocks, some confounders may not be observable, and some may be correlated with the CGP.

with the children. In addition in each village semi-structured interviews were conducted with Chiefs, Village Health Workers (VHW), teachers, traders, nurses, Village Support Groups (VSG) recipients and non-recipients. A full list of groups and interviews conducted is in Table B.1 in the annex. The selection of research areas and respondents was as scientific as possible. However, the data generated from this qualitative fieldwork should not be interpreted as representative of the CGP areas.

Within each community council, villages were selected randomly from the initial piloted communities that began the CGP in 2009, subject to them a) having sufficient recipients to conduct focus groups and interviews, and b) (in Thaba Khubelu) being accessible in the fieldwork timeframe given the heavy rainfall that preceded fieldwork and blocked river crossings.

For focus groups and interviews, CGP recipients were randomly selected from payroll data. Non-recipients were selected through a snowballing method where recipients, village authorities and key informants were asked to identify non-recipients who were nearly selected.

The FGD guides were developed based on the objectives of the study and following meetings with key stakeholders in the Ministry of Health and Social Welfare (MHSW), Ministry of Finance and Development Planning, UNICEF and the World Food Programme (WFP). The guides were piloted in Mathula and subsequently refined.

FGDs consisted of between 5-8 recipients and were undertaken by a facilitator and note taker in Sesotho. The FGDs were undertaken in a neutral environment and in private. The FGDs for children were mostly conducted in the school premises, after the end of the school day.

The FGDs explored issues surrounding the following areas:

- Impact of the CGP on livelihoods and incomes
- Use of cash and food transfer
- Impact of the CGP on food security and diet
- Impact of the CGP on school attendance and drop outs
- Impact of the CGP on child health (treatment and impact)
- Impact of the CGP on child Tasks
- Impact of the CGP on community relations

Semi-structured interviews focused on specific topics. The teachers were primarily asked about schooling and education, the VHW and VSG were asked about health situation of the community and changes in the health outcomes of children. The chiefs were asked about the overall livelihoods mechanisms and community relations. Traders were asked questions on the effect of CGP on their business and whether they had been able to supply and sell more goods, or change the prices of their goods as a result of the transfers.

1.4 Limitations

The RAR should not be taken for a full rigorous evaluation of the CGP. The RAR is merely intended to provide indications of the initial impact of the programme, but the limitations around the fieldwork and study design mean that findings presented here should be used with caution. These have been mentioned above but we summarise them here.

- **Qualitative findings not statistically representative.** The findings of this study are not statistically representative of the CGP and no inference can be drawn on the performance of

the CGP pilot programme as a whole. The qualitative work draws on subjective views and perceptions of community members. While these views are highly informative in understanding their experiences of the programme and what impact the CGP has had on their lives, it cannot be aggregated into one single narrative representing all CGP household beneficiaries. While the quantitative sample is representative of the pilot 1A recipients, it is not representative beyond this.

- **Not an experimental or quasi-experimental design.** This assessment is based on one-off qualitative and quantitative fieldwork, not a before and after or treatment and control methodology. This means that we cannot establish a counter-factual – i.e. what would have happened in the absence of the CGP – and this therefore significantly complicates identifying the specific impact of the CGP. Therefore causal attribution is attempted through qualitative fieldwork – asking respondents to discuss how they feel the CGP affected them and by developing a theory of change for the CGP and testing this. However, this remains subjective. Quantitative results identify differences before and after the CGP (through recall – see below) but do not themselves imply that differences are caused by the CGP; because there may be confounding factors (see below).
- **Based on recall.** The impact assessment is largely based on asking respondents to recall changes in their lives and make comparisons between their lives now and before the CGP. Any methodology based on recall is fraught with problems of nostalgia and inaccuracy. These can to some extent be offset by careful wording of the questions (see above), triangulation of independent sources and careful testing of links of the causal chain, but they cannot entirely be eliminated.
- **No attention given to programme operations.** The RAR does not look at operational side of the programme. However, the way in which the programme has been designed, how beneficiaries are targeted and selected, and the payment mechanism all have major implications on the potential impact of a programme such as the CGP.
- **Both cash and food provided.** During the implementation of the CGP, most of the households also received food rations. Therefore this impact assessment is, to a large extent, looking at the impact of a cash-plus-food programme of support. Although the analysis attempts to separate the effects of the CGP, we expect the use and effect of the CGP in a non-food aid environment to be different. This is firstly because in the presence of food aid household can direct their expenditures to non-food needs and therefore result in different potential impacts (i.e. expenditure on education or health, etc.), and secondly because the food aid is providing an additional resource that depending on household size can be larger than the CGP cash. For example, for a household with two children, the food aid is equivalent to an additional payment of M360 to the households, in effect doubling their available resources.
- **Important potential confounders.**⁷ It is also important to note that some major policies have been introduced just before or during the implementation of the CGP that are likely to overshadow any potential impact of the CGP. In particular, this includes the abolition of consultation fees in public health care facilities that has resulted in higher uptake and access to health facilities. In addition in 2010, the government made primary school attendance compulsory, with the (theoretical) penalty for non-compliance being imprisonment. This change alone, if enforced, has the potential to dramatically increase enrolment and attendance independent of the CGP. However, it is not clear whether, how or by whom this change was communicated. Moreover we expect free primary education, provision of free anti retro-virals (ARVs) and free schooling feeding programmes to have more visible impact on educational and health outcomes than the provision of the CGP grant.

Other important confounders include climatic and economic changes that have significant influences on people's lives. For example, the ongoing retrenchment of mine workers and the

⁷ See also the section on 'Changing Context of the Pilot CGP'.

tightening of border restrictions by South Africa have had significant negative impacts on many households' incomes, which may potentially have offset any positive impact of the CGP. Alternatively, recent floods and droughts have restricted food production, also offsetting the CGP positive impact. For a final example, global and local food price increases mean that household purchasing power may have declined in the absence of the CGP. Households in Lesotho are also very likely to suffer from shocks (over 50% of our quantitative sample had suffered a shock in the last 12 months). Together, these mean that finding no change in households' well-being during the CGP period may indicate the success of the CGP, rather than no impact. This issue could only be explored with more technical rigour in an evaluation that incorporated a treatment/control methodology.

1.5 Structure of report

The next section sets out a theory of change for the CGP by describing the CGP and the households receiving it. Section 3 then describes findings on transfer use, food security, health, education, child tasks, livelihoods and community relations. Section 4 provides brief conclusions and recommendations for programme scale-up.

2 A theory of change for the CGP

This section sketches a theory of change for the CGP. It sets out what the CGP could realistically be hoped to accomplish. Subsequent sections then test this notion. We describe CGP recipient households, based on fieldwork conducted for the RAR and on data from other sources. We describe the value of the CGP food and cash (around 35% of average rural household expenditure). We note several economic and policy changes that affect households and therefore mediate the impact of the CGP. We finally suggest a theoretical model for how the CGP might affect recipients' lives.

2.1 Characteristics of households receiving the CGP

This section draws on data from surveys and the RAR fieldwork to present basic data of households who receive the CGP. The RAR fieldwork sample collected for the quantitative rapid appraisal is representative of 1097 households that were receiving the CGP in December 2010.

2.1.1 Demographics

The average household size is generally very high (5.1 people) and we estimate that around 5,500 people live in beneficiary households across the three Community Councils of round 1A. While this is an indication that the targeting may have been generally pro-poor (as poverty is correlated with household size, at least in per capita terms) it also indicates that the amount of the transfer is shared amongst a large number of household members, and particularly of children (2.78 on average between 0 and 17). 55.9% of members of beneficiary households are women (Table 2.1).

Table 2.1 Gender composition in CGP households

Gender	Percentage	Number of people (weighted)
Male	44.1	2,442
Female	55.9	3,096
Total	100	5,538
n = 1530		

Source: OPM, Rapid Assessment Survey.

The breakdown and projection of distribution by age (Table 2.2) provides an estimate of the total number of children covered by round 1A of the CGP: slightly over 3000 in total.

Table 2.2 Age composition in CGP households

Age	Percentage	Number of people (weighted)
0-5	14	764
6-13	29.3	1,598
14-17	12.6	688
18-59	35.5	1,936
60+	8.6	467
Total	100	5,453

n = 1530

Source: OPM, Rapid Assessment Survey.

2.1.2 Disability and illness

The distribution of beneficiary household by the number of able bodied members (Table 2.3) is a means to ascertain the type of targeting operated by the community. While only 1.3% of beneficiary households are child headed, 11% are elderly headed households (with no adult members), with a predominance of elderly female headed households. In a similar sized group of households (9%) the only potential bread winners (18-59) are chronically ill or disabled.

Still the vast majority of households (76.3%) contain at least an adult able bodied member between 18 and 59, with 29.7% only containing at least one female able body, but no male able body.

Table 2.3 Able bodied members in CGP households

Household types	Percentage	Household size	Avg. Number of children
At least one male able body (18-59)	46.7	5.8	2.8
At least one female able body (18-59), no male adult able body	29.7	4.6	2.9
Chronic ill or disabled adult (18-59), no adult able body	9.0	4.6	3.0
Elderly male (60+), no adults	3.7	4.6	2.2
Elderly female (60+), no adults	9.7	3.6	2.5
Only children (0-17)	1.3	1.8	1.8
Total	100.0	5.1	2.8

n = 300

Source: OPM, Rapid Assessment Survey.

Results from our quantitative survey also show that, regardless of household composition, in around 31% of beneficiary households live a chronically ill member (including member with HIV/AIDS) and in around 5% a disabled member (Table 2.4). HIV/AIDS is a very significant problem in recipient households, as we explore in more detail in the health section.

Table 2.4 Disability and illness in CGP households

	Percentage
HHs with any chronically ill member (incl. HIV/AIDS) (%)	30.7
HHs with any disabled member (%)	8.1

n = 300

Source: OPM, Rapid Assessment Survey.

2.1.3 Education

The levels of education of adult members (18+) in beneficiary households are rather limited (Table 2.5), as only 17.8% have completed secondary education or have achieved any tertiary education.

Table 2.5 Education levels of adults in CGP households

Highest level of education achieved by any adult 18+ in the household	All households
No adult 18+ in household	1.4
No formal education	5
Primary incomplete	35.3
Primary complete	25.7
Secondary incomplete	12.1
Secondary complete or Higher	17.8
Don't know	2.6
Total	100

n = 300

Source: OPM, Rapid Assessment Survey.

Amongst children, education levels are better, particularly after the introduction of Free Primary Education which theoretically eliminates school fees. Enrolment rates for primary school aged children are around 95%, according to the quantitative survey. In practice, children still face barriers to attending primary school of distance, transport, need to do other jobs (particularly in labour constrained households), and a lack of interest (either because the quality is poor or the perceived benefits are low). There are still financial costs of attending primary school, such as fees for maintenance and trips, and uniforms are not cost free. A third of the 18 primary school age children were not enrolled due to costs (but this sample is too small to draw clear conclusions). However, typically children can attend most schools without uniforms. The high cost of secondary school (M600 per quarter) prevents many households from sending their children to secondary school unless they have a bursary (see below).

2.1.4 Livelihoods

The main source of livelihood of the CGP households in the villages visited was own production. According to the quantitative survey, around 70% of households grew vegetables or crops, and around 5% had no land. Own production consists mostly of maize or sorghum, supplemented with small vegetable gardens and fruit trees. Any surplus from own production is sold or bartered to attain other households needs and necessities. In the mountains (such as in Thaba Khubelu), agricultural production was constrained because people lacked livestock to plough their fields. Livestock are routinely stolen, and once stolen very difficult to recover. This means that few

households now invest in livestock, and hence agricultural production is low. However, most households also had their own smaller livestock and poultry – typically goats and chickens – that are less susceptible to theft and also provide an income and a form of saving.

In addition, most households (over 50%) contained individuals working for other sources of income, including casual work, trading, and livestock rearing (looking after their own or others' livestock). Around a third of households had at least one adult aged 18-50 engaged in casual labour in the last 12 months, and just under a third had an adult over 50 engaged in casual labour. Individuals in these households undertake other menial jobs such as collection of wood, working on other people's fields and cleaning and washing of clothing for other households to supplement their incomes and meet their basic needs. Typically, these piece jobs are undertaken as and when the need for cash arises – such as during a food shortage or health problem. According to the quantitative survey, just over 10% of households contained an 18-50 year old and 10% a 50+ adult engaged in petty trading. Trading ranged from brewing and selling beer (common in both lowland and the mountains), but also selling produce and making small items for sale.

Around 7% of households contained adults engaged in livestock rearing, and 7% in self-employment. Only 3% of CGP households had members employed – usually in Maseru, Mafeteng or South Africa. These individuals usually remitted some money back. Such households are usually part of the more well to do segments of the villages.

The overall pattern of livelihoods is not typically one of accumulation. The wider business environment is not typically very conducive to investment, since returns are uncertain and capital can be stolen (particularly livestock). Moreover, the assets need to invest in new enterprises are typically costly – far more, for instance, than the amount provided by the CGP.

2.1.5 Expenditure

Data from the Bureau of Statistics' Continuous Monitoring Survey gives the most up to date figures on rural household consumption expenditure. These figures remain draft and are not based on a full year of data collection so are prone to outliers, but are nonetheless useful. The CMS⁸ provides details on consumption expenditure in 2009-10. As shown in Table 2.6, across the CMS rural sample, the mean monthly expenditure is M857, meaning that the CGP gives nearly 15% of rural households' total monthly expenditure.

The striking feature of rural expenditure is that it is overwhelmingly on consumables (i.e. food). Rural households spend 60% of their monthly expenditure on consumables, but the next largest category is 8% on housing, 7% on transport and 5% on education and 4% on clothing. Health accounts for only 1% of average monthly spending.

⁸ Continuous Multipurpose Survey (CMS) launched in May 2009 is a monthly survey run by the Bureau of Statistics. Data come from May 2009 – July 2010, with a national sample of 4,628.

Table 2.6 Mean monthly rural household expenditure

Commodity	Monthly expenditure (Maloti)	% of total
Consumables	512	60%
Housing	67	8%
Transport	63	7%
Misc	44	5%
Education	42	5%
Clothing	38	4%
Furnishing	23	3%
Communication	17	2%
Recreation	16	2%
Hotel and rest	15	2%
Alcohol & tobacco	11	1%
Health	9	1%
Abroad	2	0%
Total expenditure	M 857	100%

Source: BoS, Continuous Multipurpose Survey (CMS), 2009. Based on rural sample only. The average rural household size in the sample is 5.0

The CMS findings are not likely to be exactly representative of the CGP recipients, since the CMS is not targeted at vulnerable or poor households. However, the findings on the primacy of expenditure on consumables are to some extent reflected in expenditure questions from the RAR. The quantitative data indicate that even after the CGP, only 7% of CGP recipients made improvements to their house, 5% bought furniture items, less than 5% bought poultry, less than 2% bought livestock, and less than 1% bought productive equipment.

The other point of importance here is that most rural households, including those receiving the CGP, hardly save. Data from the quantitative survey for the RAR indicates that 3.2% saved in the 12 months prior to the survey. This means that they tend to spend cash when they have it – i.e. after being paid for work or receiving assistance. If they need to spend cash at other times – such as in a health emergency – they must either do piece work or borrow. This absence of accumulation is important for understanding how households are likely to use the CGP.

2.2 How much is the pilot CGP providing?

Every three months, the pilot CGP provided selected households containing children with M360 in cash for the entire household. As part of the MOU with UNICEF, the WFP provided each CGP household with a three quarter food ration (maize, pulses and oil) per child.⁹ The cash value of the food ration is approximately M180. Selected households have around three children on average¹⁰, so that the value of the food provided per household is approximately M540. Different households receive different total values, as Table 2.7 shows.

⁹ The subsequent rounds of CGP Phase I and CGP Phase II do not provide any food. This naturally means that a scaled up programme will have different impacts to the pilot. See Limitations.

¹⁰ According to RAR quantitative survey data.

Table 2.7 CGP cash and WFP food value

Number of children	Cash (M/quarter)	Food value (M/quarter)	Total value (M/quarter)
1	360	180	540
2	360	360	720
3	360	540	900
4	360	720	1,080
5	360	900	1,260

Source: OPM. Notes: (1) Values are approximate estimations only and will vary with market prices.

The quantitative data provided a check on this. Most of the beneficiaries have been participating in the CGP for a significant time (between 5 and 6 quarters on average) and since the beginning of operations in their respective community councils.

Table 2.8 CGP payments and WFP food grants received

	Number of CGP payments received (%)	Number of packages of food aid received (%)
0	0.0	0.8
1	0.8	0.6
2	2.4	17.2
3	3.9	16.1
4	16.4	19.3
5	23.2	29
6	30.4	11
7	13.8	5.6
8	9.1	0.5

n = 300

Source: OPM, Rapid Assessment Survey.

Only a negligible fraction of all households covered by round 1A of the CGP pilot (estimated around 10 of a total of 1097 households) did not receive the food package provided by WFP at least once. There is a close correlation between the number of CGP payments and WFP food packages received, though in general beneficiaries have received the food parcel one quarter less. This reflects the CGP programme design and the MOU with WFP.

2.2.2 How do pilot CGP values compare with consumption expenditure?

Initial analysis of the CGP suggested that the cash value was around 25% of the national extreme poverty line, calculated using data from the 2002/03 Household Budget Survey.¹¹ However, this

¹¹ Ayala Consulting, (2009), 'Child Grants Programme and Social Assistance Assessment Report', prepared for UNICEF. Government of Lesotho. Page 19.

figure is misleading for two reasons. First, prices have increased rapidly since 2002/03.¹² Second, this ignores the value of the food provided by WFP to CGP cash recipients in round 1A.

How then does the value of the CGP round 1A transfers compare with household expenditures?

The CMS data set out above indicate that an average rural household contains 5 people and has a consumption expenditure of M857 per month, or M2,571 per quarter.

The CGP cash and WFP food bundle is therefore approximately 35% of an average household's total expenditure. The proportion of expenditure covered by the CGP cash varies by household size, since the CGP cash component is invariant to household size. This proportion varies between 23% (a family of 3) and 10% (a family of 5), as Table 2.9 shows.

In some areas, the first transfer contained two quarters worth of cash, meaning that this transfer provided twice as much as others.

Table 2.9 CGP cash and food value as proportion of expenditure

Number of children	CGP total value (M/quarter)	Average expenditure (M/quarter)	% expenditure covered by CGP + WFP food	% expenditure covered by CGP cash
1	540	1,543	35%	23%
2	720	2,057	35%	18%
3	900	2,571	35%	14%
4	1,080	3,085	35%	12%
5	1,260	3,599	35%	10%

Source: OPM. Notes: (1) Assumes 2 adults in the family. (2) Consumption expenditure data extrapolated from figures for family of 5 in BoS (2009) and should be taken as indicative only.

2.2.3 How do pilot CGP values compare with other social protection programmes?

This value can be compared with the value provided by other social protection programmes in Lesotho. As presented in Table 2.10, 19% of CGP households were receiving state pensions at the time of interview and 6% received other government social assistance in the previous year.

Table 2.10 CGP households receiving Old Age Pension and Social Assistance

	All households
HHS where any member currently receiving a state pension (%)	19.3
HHS that received government social assistance in the previous year	5.3
n = 300	

Source: OPM, Rapid Assessment Survey.

- The **Old Age Pension**, given to everyone above the age of 70, provides M900 cash per pensioner per quarter (M300 per month). This is the same as the total CGP value for a household with three children including the contribution made by WFP ration. The coverage of

¹² Ibid.

the pension for the 2009/10 fiscal year was estimated at 80,000 people, this is 4.3% of total population, implying full coverage of elderly above the age of 70 which according to the 2006 Population and Housing Census stands at 4% of total population. Coverage amongst CGP recipients appears to be much higher (19%).

- The **Public Assistance Package** is comprised of monthly allowances, food packages, medical exemptions and coffins. It is a means tested grant designed to cater for basic needs of the destitute, people with disability, chronically ill persons and orphans who cannot engage in economically productive activities and is accessed by request. It provides M300 per household per quarter.¹³ This is similar to the CGP cash value but represents one third of the total CGP value. In 2008/09 there were a total of 6,090 beneficiaries of the programme, which again suggest a surprisingly high coverage amongst CGP recipients.

There are two other social protection programmes that are relevant to many households receiving the CGP, and although these were not asked about specifically in the quantitative fieldwork, they are worth noting here.

- **School Feeding Programme:** Currently, the Government of Lesotho, with the assistance of the World Food Programme (WFP), provides free school meals to all of Lesotho's enrolled 390,000 primary school children. The Government of Lesotho provided for 325,000 children in 951 primary schools, at a cost of M202.6 million according to the 2009/10 Annual Budget. WFP provided for 65,000 children in 476 schools, predominantly in remote areas at an approximate cost of M16 million in 2009/10.

In 2009/10 the Government took over the feeding of additional schools which were previously served by WFP, who are phasing out their support to primary school feeding and instead concentrating on methods of support that build livelihoods.

- **Secondary School Bursaries:** In 2008/09, some 22,735 bursaries to secondary schools were provided to orphaned and vulnerable children, using the currently accepted definition of being below 18 and without one or both parents. Some bursaries were also given to pre-school children for Early Childhood Care and Development Centres. Selection of recipients is performed by the Ministry of Education and Training. The Global Fund provides additional bursaries for around 7,000 children. These interventions differ from the CGP selection process in both its target group (on children rather than households) and targeting method.

Secondary school bursaries are hugely important in promoting the access of OVC to secondary education as school fees are around M600 per quarter usually beyond the means of many poor households.

2.3 Changing context of the pilot CGP

The evaluation of the pilot CGP through testing these hypotheses is complicated because several other policy and economic changes took place simultaneously with the pilot CGP. These changes had significant impacts on recipient households, making the identification of CGP impact challenging (see Limitations). For instance, negative economic changes such as employment cuts may have reduced households' food consumption or caused them to employ their children more, but the CGP cash and WFP food may have increased consumption or reduced child work, leaving a net effect of zero.

¹³ A new formula to calculate the value of Public Assistance has recently been introduced (M100 for the first household member + (Total additional members in the household/ 2) * M100), but it is not clear whether this is already implemented.

While we certainly do not attempt to produce a comprehensive list, key trends and changes include:

- The ongoing introduction of Free Primary Education (FPE). Primary education in Lesotho has been free since 2000, but in practice this is being rolled out on an ongoing basis. The impact of FPE on education is not always straightforward. Some schools continue to charge informal fees, and in any case costs remain for uniforms, trips, stationery and maintenance (NUL 2008). The removal of fees has also led to a more variable quality of schooling and an increased tendency for parents to shop around (as inter-school transfers are now easier to make), which makes tracking enrolment and attendance difficult (NUL 2008). Moreover, in 2010, the government made primary school attendance compulsory, with the penalty for non-compliance being imprisonment. This could have a significant impact on attendance if enforced, but the enforcement appears mixed at best.
- The ongoing introduction of Free Primary Healthcare since 2008. This policy change has removed user fees at primary health centres operated by the government and by the Christian Health Alliance of Lesotho (CHAL). This elimination of user fees has removed a key barrier to access to health centres but has contributed to a shortage of essential drugs at these centres, particularly for pneumonia, hypertension, diabetes, and pregnancy. This policy change is likely to have altered patterns of health access at the same time as the CGP was operating.
- Continued inflation, which has driven up food prices. This has been exacerbated in many places by poorly timed rains in early 2011, and by continuing livestock theft.
- Retrenchment of mine workers and the tightening of borders with South Africa have had significant negative effects on formal employment. This affects not only the households with an employee, but many other households in their communities who depend on these households for casual employment and loans.
- HIV/AIDS continues to exert heavy pressure on most households in Lesotho, with nearly a quarter of adults infected and nearly 100,000 children having lost one or both parents due to HIV related causes.¹⁴ This very much underlies the rationale for the CGP. HIV/AIDS creates hugely significant problems for livelihoods (as adults are unable to work), social relations (as some stigma persists), and psychological well-being. In each household and village, the epidemic continues to unfold, with very large consequences for those it afflicts.

It is difficult to estimate how much households are affected by these evolving processes. However, the quantitative survey captured information on the shocks that CGP recipient households underwent since they started receiving the CGP. Slightly more than half (48.1%) of beneficiary households report that their source of income and assets have decreased sharply as a consequence of an unexpected event since in the recent past. As Figure 2.1 shows, illness and death of family members are the most prominent shocks (with economic effects), affecting respectively 20.2 and 18.9% of the households. This is a clear reflection of the high incidence of the HIV/AIDS epidemic in the population benefitted by the grant.

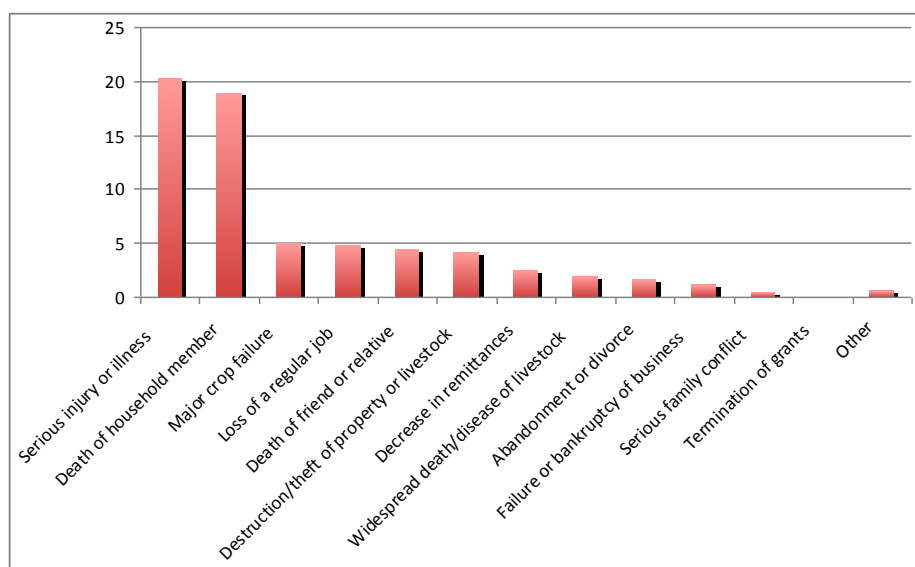
Crop failure is the second main source of shocks reported by beneficiary households (4.9%). Unexpected recent climate events (particularly recent floods) and whether changes have severely affected households' agricultural productivity, with major consequences on food security for many of them.

The last potentially confounding trend is related to the loss of regular jobs (most probably in South African) due to a combination of a fall of demand for workers in mines and the recent restrictions to

¹⁴ Government of Lesotho (no date), Child Grants Programme Pilot Phase.

trans-border mobility. This affected around 4.7% of interviewed beneficiaries, which is in line with the proportion of households who had these jobs in the first place.

Figure 2.1 Shocks suffered by beneficiary households since they started receiving the CGP



Source: OPM, Rapid Assessment Survey.

2.4 A brief theory of CGP impact

This section draws on the findings and analysis above, as well as the theory of change set out in the inception report for the CGP evaluation (OPM 2011), to set out a brief set of hypotheses on the potential impact of the CGP.

OPM (2011) presents a series of direct and indirect impacts of providing cash to poor households that fall within two broad arguments of first reducing poverty and inequality and second leading to longer term positive dynamics through risk mitigation and productive investment. In the case of the round 1A, the CGP provides direct transfers of cash and food that represent around 35% of households' expenditure, as we have seen. This section presents some very brief ideas on what the impacts of this may be.

First, these transfers will have first order impacts on expenditure patterns, and this is well documented in the transfers' literature. Household resources are fungible and this additional 35% can be spent on any type of expenditure, assumed to be households' most pressing need, in the view of the decision-maker. There are three points to note here:

- Households' expenditure would increase across a range of expenditure types. "The impact on expenditure is heterogeneous, as prioritised needs may differ across households."¹⁵ At the aggregate, therefore, we may not find a significant impact on the quantity of any single expenditure type, but a small impact on each expenditure type. Findings from other transfer studies indicate that transfers in food, and cash transfers given to female decision-makers, will tend to increase food consumption (particularly by children), and so we would expect to find

¹⁵ OPM 2011: 4.

evidence of this. This suggestion is bolstered because 60% of rural household spending is on consumables (CMS 2009).

- Additional income may also cause households to change not only the amount of expenditure, but its type, shifting from low to high quality items, or opening a new expenditure stream (such as paying for healthcare or secondary school).
- Given the very low savings rates, households are likely to spend their money instantly on whatever is the pressing need at the moment they receive the transfer.

Second, it is also possible, in theory, that households reduce their earnings from other sources in response to getting this transfer, so the net impact of the transfer on food consumption may be less than 35%. This is less commonly found in the literature but remains a possibility, particularly where cash is usually obtained from casual work in response to specific and immediate needs.

Third, there is a range of less direct impacts that derive from receipt of regular transfers. These include being able to obtain credit (since creditors know that recipients will be able to pay), being able to give or obtain loans and thereby strengthening social networks and safety nets.

Fourth, there is a range of outcomes affected by these three processes. Those that could be assessed in this rapid assessment include:

- An improvement in recipients' psychological well-being resulting from being better able to address their families' needs, from improved social status associated with greater wealth, from reduced stress, and from feeling connected to the government. This is a very important indicator of positive impact, particularly in the context of the trauma of HIV/AIDS and negative economic changes described above.
- An improvement in the quantity of food eaten in recipient households and in the diversity of their diets, as a result of the food transfers and spending the cash on food.
- Access to education may not change significantly, because primary education is free and secondary education too expensive to be covered by the grant without a school bursary. As noted above, almost all primary aged children are enrolled in school, and only a very small number of children are not enrolled in school because of cost (other from school fees in secondary). Transport costs make a high barrier to access in several sub-Saharan countries, but public transport infrastructure seems to be generally very poor in Lesotho and children generally walk to school. However, what may change are other expenditures on primary education, such as uniform and smaller fees, and this may have a positive impact on children's attitudes to education, and eventually performance.
- Child work patterns may alter in the households where children were working in order to earn money to cover basic household needs (e.g. because there are no able-bodied adults in the household, which is the case in 15% of households in the sample). Cultural practices of children assisting around the house on fields or with livestock (before or after school) are unlikely to change, while the value of the transfer seem to be too small to reduce the number of "full time" herd boys.
- Access to public healthcare may not change significantly, because since 2008 primary healthcare has been free and the main barriers are distance and unavailability of medicines. Moreover, given the low savings rates this impact would be indirect only (i.e. through easier borrowing) unless people happen to be ill when they receive the transfer. However, what may change is the choice of public or private provider (as private providers are costly but are considered to have better supplies), and this may have a slightly positive impact on access to treatment overall, as well as the possibility to purchase medicines on the counter.
- In households where the cash component of the grant is not spent on other items, it is possible that households may save the grant to invest in productive assets. However, this seems

unlikely for two reasons. First, the value of the grant is small compared to the value of most useful productive assets. Second, spending on productive assets is typically low anyway, since the broader livelihood environment does not seem to support much investment.

3 Finding of Assessment

3.1 Overview of findings

The section describes the overall impact of the CGP cash and WFP food, both in general and on various components of child wellbeing such as food security, education, health and labour.

Households are very glad to receive the transfer and felt that it increases their well-being. Most households spent the cash transfer on consumption needs, particularly for their children. Many quotes illustrate the positive view of recipients on the impact of the CGP on their well-being:

“We are happy and satisfied. Children eat many times a day.”¹⁶

“Since I started receiving it there have been changes. I have been able to buy my child clothes, and sometimes food. There is a change for the children as they had no clothes before, but now they are able to eat.”¹⁷

“The grant has jacked us so much because we now can give food to children.”¹⁸

Children in recipient also had largely positive views on the transfer:

“We now look like other children whose parents have money. We can now enjoy living more like other children.”¹⁹

“Since we got food and money – our lives have changed for better. There is more food.”²⁰

The CGP cash therefore resulted in recipient households being better able to meet their food and non-food needs. This is shown in Table 3.1 where more households reported it much less difficult to obtain hygiene products, over the counter medicine or maize meal since receiving the CGP.

Table 3.1 Difficulty in meeting certain needs, trends over time

Grade of difficulty in meeting needs during the previous year	Hygiene Products		Over the counter medicines		Maize Meal	
	Before CGP	After CGP	Before CGP	After CGP	Before CGP	After CGP
Not difficult (%)	4.2	57.2	19.4	55.3	3.1	57.2
Quite difficult (%)	31	34.4	20.9	32.9	22.1	31
Very difficult (%)	64.8	8.4	59.7	11.8	74.9	11.4
Total (%)	100	100	100	100	100	100

n = 300

Source: OPM, Rapid Assessment Survey.

¹⁶ Adult focus group, Semonkong.

¹⁷ Adult focus group, Mathula.

¹⁸ Adult focus group, Thaba-Khubelu.

¹⁹ Child focus group, Semonkong.

²⁰ Child focus group, Thaba-Khubelu.

It is clear from these findings that the CGP had a positive impact on the well-being of recipients, and of their children, by allowing them to purchase more of a range of items and to have greater certainty of obtaining enough food. While the food grant covered substantial proportions of their food needs, due to multiple needs and problems with the food delivery, households would prefer to receive cash rather than food, which bodes well for subsequent rounds and phases of the programme where the MOU with the WFP will not be continued.

However, significant impacts on single dimensions of well-being are hard to discern, and some respondents reported that overall impacts were limited in some dimensions.

This is for two reasons. First, as noted above, the heterogeneity of the family structures and the multiplicity of needs, and the very limited savings of most households, mean that different households used the cash transfer for meeting different needs as and when they arose. Second, the size of the cash transfer implies that at any given time households can only meet part of their households' needs and poor households are still likely to be struggling, even if they are better off than previously.

Nevertheless, we can present findings by specific outcome:

- Qualitative interviews showed increases in the quantity of portions of food for between one to two months, driven largely by the food transfers. Unsurprisingly, the number of meals is not increased by the grant (and is usually around three per day).
- Many households reported spending the CGP on educational needs of the children, including shoes and school uniforms. This has resulted in improvements in the psychosocial well being of the children who feel less stigmatised and more confident. This is widely reported in interviews as a very significant impact of the CGP. While there are some positive perceived changes in school enrolment and attendance, it is not possible to say that this is a consequence of the CGP. This is because primary enrolment is already very high, and attendance is mostly not driven by cash (as hypothesised above). The CGP transfer is too small to cover secondary school costs.
- There was a slight reduction in the amount of paid work undertaken by children (according to the qualitative interviews), but (unsurprisingly) no change in the number of children undertaking household tasks or paid work.
- While the CGP has improved households' perceptions of their ability to buy medicines, it has not significantly changed households' access to health care services. This is because the major barrier to health access is distance to the health facility. The CGP may however affect the choice of health care facilities and allow them to spend at private clinics where medicines are more reliably available.
- The CGP has resulted in improved access to credit and borrowing for CGP households from economic actors (such as shops), but led a to slight reduction in informal lending as some non-recipients feel no need to support households now receiving the grant.
- The CGP has not led to substantial productive investment by recipients, as saving is limited and cash is used elsewhere. In some cases, recipients have reduced the amount of casual piece work they do (usually compensating with additional time caring for children or sick relatives), but there is no reduction in the number of people working. Overall, the impact on the local economy is usually negligible except in remote areas where local shops have benefitted substantially from additional sales.

3.2 Cash versus Food – Community stated preference

In general almost all households (98%) stated a preference for cash over food. This was reflected in an overwhelming preference for cash expressed in the focus groups and interviews. The main reason for this preference was the multiplicity of needs and the flexibility of cash in meeting those needs. For example:

“We would prefer to get the money on a monthly basis and not to get the food, then we would afford to buy food with the cash we receive.”²¹

“The reasons will differ since our needs differ.”²²

This very positive assessment of the importance of cash was often paired with strong criticism of the delivery of the food. Households in each district complained that the food ration was not always in full amount and that some of the food was at times rotten and not fit for consumption. For example: “Food is kept for a long time in the store room and sometimes gets rotten, so it is better to be given more money instead of the food.”²³ Others felt that the food came too infrequently to store: “the food comes after a long time; we even end up using the money to buy some food so as to ensure that the children do not go to school hungry.”²⁴ In contrast, all households reported receiving the cash in full and on time.

Most households argued that the cash amount was very small and complained that this was not sufficient in enabling them to meet all their basic needs. Many of the household representatives stated that the grant money should be increased to between M500-M600. They also preferred that the cash should come on a monthly basis so that they are able to cover more of their ongoing consumption needs. For example:

“The cash is not sufficient for the needs of the children but if the money could be increased we would be able to send our children to secondary schools. We would prefer to get the money on a monthly basis and not to get the food, then we would afford to buy food with the cash we receive.”²⁵

The desire for more money more frequently is a familiar refrain of cash transfer recipients around the world. In this case, however, the complaint is given validity for two reasons:

- The transfer is not indexed to inflation or family size, and there was significant inflation during the CGP implementation period.
- Households do not save money (partly because they lack access to financial services) so a more frequent transfer would help them smooth consumption better.

²¹ Adult focus group, Mathula.

²² Adult focus group, ThabaKhubelu.

²³ Adult focus group, Semonkong.

²⁴ Adult focus group, Mathula.

²⁵ Adult focus group, Mathula

3.3 Use of Transfer

The food transfer is typically mostly consumed, rather than sold or bartered. This has a positive impact on the quantity of food that household members eat, particularly children. This is explored more below in section 3.4. This section focuses on the use of the cash transfer.

Qualitative and quantitative research indicated that the cash transfer is generally spent on the immediate consumption needs of households. Recipients are aware that they should prioritise the educational needs of children, and most often do this in the absence of other pressing priorities.

We analyse separately the use of the transfer between the first (cumulated) payment and the subsequent ones. The first payment was substantially greater than the others in many cases, where two or three quarters were aggregated. The broad pattern is that the first transfer is spent primarily on educational needs (such as uniforms) and then basic needs, and subsequent transfers spent primarily on basic needs, then education and hygiene, with lump sum education expenses already met. The latter pattern – of spending on basic needs, education and personal hygiene – is reflected in focus groups and interviews.

3.3.1 First transfer

Table 3.2 shows what households reportedly spent their first cash transfer on as their first, second or third main use of the cash grant payment. A very large proportion (80.7%) of households reported expenditure on educational needs of the children including school uniforms, shoes and other supplies. This reflects the size of the first transfer, but more importantly the messaging around educational spending and also the fact that many children lacked uniforms and other educational items that were not necessarily keeping them out of school but may have been inhibiting their performance (see section 3.6 on education).

In addition to the food provided, 78.6% of households reported expenditure of the first transfer on basic food items and other basic needs (such as washing powder, Vaseline, and so on) as one of their three main uses of the cash grant payment.

Expenditure on clothing, special food items (meat, eggs, milk, beans etc.) and health expenditure was also reported amongst the main three expenditure items by 37%, 17.1% and 16.1% of CGP households respectively.

Table 3.2 Percentage of CGP households that spent their first transfer on ... (either first, second or third expenditure)

HHs that spent the first transfer on... (either first, second or third expenditure)	All households
Education (school uniforms, shoes, supplies) (%)	80.7
Basic food items and other basic needs (%)	78.6
Clothes (%)	37
Special food items (meat, eggs, milk, beans etc.) (%)	17.1
Health expenditure (%)	16.1
Small household items (crochery, linen etc) (%)	3.6
Savings (%)	0.4
Multiple items/cannot say (%)	1.4
Other (%)	2.2
Don't know (%)	0.6

n = 300

Source: OPM, Rapid Assessment Survey.

Expenditure on educational needs is often a lump sum expenditure made at the beginning of the school term. Therefore one expects less expenditure on education from subsequent CGP cash payments, after this initial need is met.

3.3.2 Subsequent transfers

In response to what households *usually* spend the cash transfer on, 87.5% of households reported basic food items and other basic needs as one of their main three expenditure items. In this instance, educational needs and hygiene and personal care products were reported by 60.6% and 45.2% of households respectively as one of their main three expenditure items (Table 3.3).

Table 3.3 Percentage of CGP households that usually spent their transfer on ... (either first, second or third expenditure)

HH that usually spend the transfer on... (either first, second or third expenditure)	All households
Basic food items and other basic needs (%)	87.5
Education (school uniforms, shoes, supplies) (%)	60.6
Hygiene and personal care products (%)	45.2
Clothes (excluding shoes and school uniforms) (%)	34
Special food items (meat, eggs, milk, beans etc.) (%)	17.1
Shoes (excl. School shoes) (%)	9.1
Health (%)	4.9
Burial societies (%)	0.5
Transport (%)	0.4
Other (%)	0.5

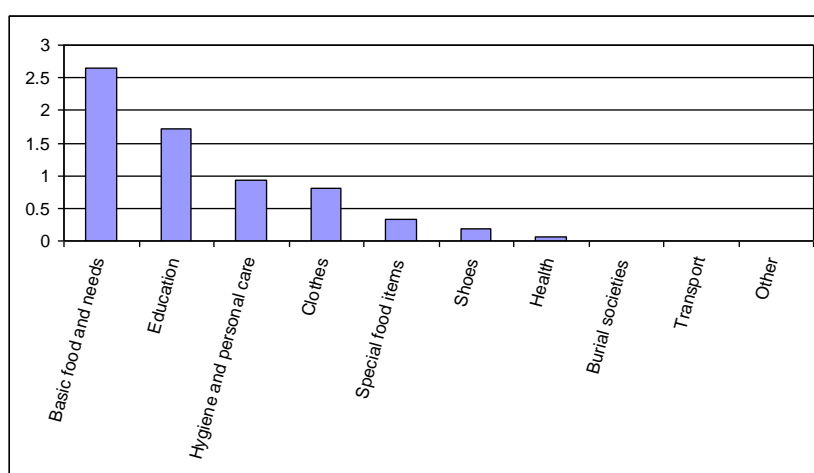
n = 300

Source: OPM, Rapid Assessment Survey.

As respondents provided a measure of the importance of the expenditure on different items, by ranking them according to whether they represented the first, second or third use of the CGP, it is possible to construct an index of the transfer use that provides a higher weight to higher ranked expenditure items. The index indicates the relative importance of different items in the overall CGP expenditure.²⁶

The results reported in Figure 3.1 confirm the general pattern discussed above. In normal payments (excluding the first) the expenditure on basic food items and other basic needs is the item of expenditure with highest importance (index of 2.6), indicating that it is the first item of expenditure in the vast majority of cases.

Figure 3.1 Use of transfer by household priority, after first transfer



Source: OPM, Rapid Assessment Survey.

This prioritisation of food, basic needs, education, hygiene and clothes is confirmed in qualitative fieldwork from both adults and children. For example, adults report that:

“I buy soap, Vaseline and a packet of maize meal.”²⁷

“We buy school uniforms and cosmetics.”²⁸

“They buy food and they also spend money for educational needs. They buy cheap shoes for children and after a short period the shoes are torn again and replaced and they also buy stuff for their personal needs, washing soap and bathing soap.”²⁹

²⁶ This index provides a weight of “0” if cash transfer was not spent on a particular item, “1” if spent as third expenditure item, “2” if spent as second expenditure item, “3” if spent as the first expenditure item, “4” is first and second expenditure but no reported third expenditure, and “5” if first expenditure and no second and third.

²⁷ Adult focus group, Mathula.

²⁸ Adult focus group, Mathula.

Several respondents mentioned this aspect of the poverty trap – of being forced to buy low quality items that will have to be replaced – and it raises the question, apparent throughout this report, of the value of savings.

Children confirm this basic pattern of spending in each district, but are slightly more forthright than their parents about spending on ‘non-essential’ items such as snuff and alcohol (see below).

3.3.3 Who benefitted from the transfer?

Qualitative and quantitative fieldwork indicated that while the grant was to be used for the needs of children where possible, as was emphasised by the programme during distribution, the grant was also used for household spending where necessary. In some focus groups, adults made it clear that they believed the grant should be used for children. For example:

“I do not spend the money at all. I bring all of it home and I show it to the children and ask them what they want their needs are. We discuss and then I buy the things e.g. buying shoes and other clothes.”³⁰

However, it was also clear from discussions with adults that sometimes, other household spending had to take priority. For example:

“Cash is mostly used for household needs and not just the children as we all live in one household. When I buy maize meal it is meant for the entire family to eat.”³¹

This wider household spending is convincingly corroborated by children, who tended to argue that the transfer was used for household needs and sometimes adults’ personal needs in addition to spending on children themselves. For example:

“Our parents buy school clothes for us, and other casual clothes, shoes and food (rice, samp, Russians, tomato sauce, mayonnaise, simba chips, bread flour, maize meal when the grant one is finished, fish, soup pack, chicken). They also buy things for themselves – shoes, clothes, snuff, beer.”³²

“The money is spent on school clothes and shoes. It is also used to purchase paraffin, meat, cabbage, beans, bread flour, mealie-meal, soap, Vaseline and other small basic necessities. The money is sometimes spent on cigarettes, snuff and shoes for adults.”³³

It is likely that the extent this ‘non-essential’ spending depends on the structure of the household and the level of additional disposable income provided by the transfer. This could be explored in more detail in the full evaluation.

As shown in Table 3.4, CGP households have generally devoted sufficient resources to cover specific needs of children (though this may not be specifically CGP money). Around 80% of households report buying clothes and shoes for children (not for school) in the three months prior to the survey. Slightly less than 70% have bought school uniforms and school shoes during the last

²⁹ Adult focus group, Semonkong.

³⁰ Adult focus group, Mathula.

³¹ Adult focus group, ThabaKhubelu.

³² Children focus group, Semonkong.

³³ Children focus group, Mathula.

year, and a smaller proportion (40.8%) have devoted some resources to school equipment. Only few households (7.4%) have spent money on toys for children during the last year.

Although the pattern observed is that the CGP is generally only sufficient to buy uniform, shoes and clothes for one child at the time, particularly when the resources are also used to face basic households needs, the implicit message that at least part of the resources should be targeted to improving the well being of children has been absorbed by beneficiary households.

Table 3.4 Spending on children's items, CGP households

Proportion of households who bought	Within the last 3 months	Within the last year	Longer ago	Never purchased	Total
Children's clothes (not including shoes or school uniform)	80.5	10.8	8.2	0.5	100.0
Children's shoes (not including school shoes)	79.2	11.3	9.1	0.5	100.0
School uniform (not including school shoes)	40.3	26.5	28.6	4.6	100.0
School shoes	39.9	30.8	24.4	5	100.0
School equipment (e.g. school bag)	19.5	23.7	30.2	26.7	100.0
Sweets and/or soft drinks for children under 15	30.6	10.2	27.5	31.4	100.0
Toys for children under 15	1.8	5.6	10.8	81.6	100.0

n = 300

Source: OPM, Rapid Assessment Survey.

As is evident from the above tables and the qualitative fieldwork, most households are using the CGP cash sensibly, usually for immediate consumption needs in large part the needs of children. The key expenditure items for which the CGP was used for includes the educational needs of children (school uniforms, shoes, books, etc.), basic foods and necessities, clothing and special food items.

While there are isolated reports from qualitative data of households using the transfer on alcohol or snuff or other items that do not contribute to children's well-being, there is no evidence from this review to suggest that this is significant in terms of value or frequency. This reflects findings from other cash transfer evaluations and is a positive finding.

3.3.4 CGP transfer decision-makers

The literature on cash transfers suggests that women are likely to make decisions on cash that prioritise their children's needs, and as such many cash transfers are targeted towards women. While this was not the case in this transfer, adult women were typically the main decision-makers over CGP cash, as shown in Table 3.5. This may partly explain the positive findings on use. Children make the decisions on the use of the transfer in only 2.3% of households.

Table 3.5 Age and gender of main decision-maker over the transfer

Main decision maker over transfer is	All households
Male	24
Female	76
Total	100

n = 300

Source: OPM, Rapid Assessment Survey.

Main decision maker over transfer is aged	All households
0-5	0
6-13	0
14-17	2.3
18-59	65
60+	32.7
Total	100

n = 300

Source: OPM, Rapid Assessment Survey.

Qualitative findings reflect this broad pattern, with women being the main decision-makers. In some cases, they consult their children, but this is not the norm. The following attitude from a female adult recipient is typical:

*"I make the decision on how the money is to be spent. The food is used by the whole family. The money is spent on the children; this is because the money is theirs."*³⁴

3.4 Impact on Food Security

3.4.1 Food security situation

The basic staple food of most people interviewed consisted of maize (papa, mealie-meal, etc.), and moroho (green vegetables). This was occasionally supplemented with beans, eggs and meat when resources allowed. Some households also consumed seasonal fruits and vegetables such as peach, apricot and apples. The qualitative and quantitative fieldwork indicated little variety in diets, particularly before the transfer.

As shown in Table 3.6 in the majority of cases children are provided with regular meals, with 72% of households reporting children to have 3 meals a day on average during the previous year (excluding school feeding).

³⁴ Adult focus group, Mathula.

Table 3.6 Number of meals consumed by children

In the last year how many meals did children (under 18) in this household normally eat (excluding school feeding)	All households
2	21.6
3	71.6
4	5.7
5	1
Total	100
n = 300	

Source: OPM, Rapid Assessment Survey.

Primary school children, attending school also received free meals in the school. These meals provided more protein for the children in the form of eggs and milk.

Table 3.7 shows that an important fraction of households (43%) have experienced serious food insecurity occurrences in the previous 12 months, as household members had to go to bed hungry as a consequence of the lack of food. Households report that food security has improved since they started receiving the CGP + WFP food parcels, as about 10% more were suffering for lack of food before. On the contrary, the trend in overall food security has generally been relatively stable in terms of the number of meals per day per child.

Table 3.7 Trends in food security

	All households		No shocks since CGP		Shocks since CGP	
	Before CGP	After CGP	Before CGP	After CGP	Before CGP	After CGP
Average number of meals consumed by children in HH (excluding school feeding)	2.841	2.862	2.868	2.877	2.812	2.845
Household has not had enough food to feed all its members (i.e. people have gone to bed hungry) at least once during the year (%)	53.4	42.9	51	42.4	55.9	43.5
	n= 300		n= 160		n= 140	

Source: OPM, Rapid Assessment Survey.

A closer look at the periodicity of food insecurity episodes shows (Table 3.8) that the context of food availability may have even deteriorated over time, as an increasing proportion of households report suffering hunger more frequently after the CGP than before.

Table 3.8 Frequency of going to bed hungry

If not enough food, how often went to bed hungry	All households	
	Before CGP	After CGP
At least once a week (%)	12.2	16.4
At least once a month (%)	30.5	40.2
A few times throughout the year (%)	50.5	40.4
Less frequently (%)	6.7	3
Total (%)	100	100
Index mean	1.5	1.7
	n= 155	n=135

Source: OPM, Rapid Assessment Survey.

Given the fact that most of the CGP expenditure is reportedly related to basic food items, and that the CGP was coupled with food aid, this negative trend is clearly not attributable to a perverse effect of the transfer. On the contrary, it suggests that food security conditions have generally worsened significantly during the time of operation of the programme, possibly due to unexpected shocks in agriculture productivity (change in whether conditions) and other idiosyncratic shocks. As previously mentioned, a significant proportion of household mentioned crop failure as a cause of drop in cash and crop income in the recent past.

In such a context the CGP+WFP food parcels may have instead contributed to mitigating the negative general conditions, by providing households alternative means to provide food in the context of decreasing self production.

3.4.2 Impact of CGP and Food Aid on food intake and nutrition

Within the generally worsening context described above, qualitative evidence is reasonably clear that the cash and particularly food grant had a positive impact on households' food consumption. This did not necessarily imply a positive overall change in food consumption, but the CGP certainly cushioned the negative consequences.

Almost all respondents in qualitative focus groups and interviews described increases in the size of portions (but not the number of meals), and additions of oil and beans improving the quality of diets. The oil and beans are principally from the food grant, but the cash also contributed to increased amounts of food:

*"The quantity of food on the plate has now increased and now they eat oiled moroho."*³⁵

*"The number of times is the same; but the quantity of food is a bit more than before, as we know there is still some food in the house."*³⁶

"Sometimes we feel that this food and grants have changed our lives. At the time we receive the food and grant we are able to make better meals. There is change because we can eat better. We are able to use the grant money to make better food for children. With money I buy bread flour which I don't always have. We buy some soups as well. We buy more items; like fish at least 5

³⁵ Adult focus group, Semon-kong.

³⁶ Adult focus group, Mathula.

tins. We buy based on the number of household members....I buy sugar and peanut butter to make my children happy."³⁷

Qualitative evidence suggests the food grant given to these households resulted in increased consumption of protein (beans), often from very small amounts (especially in mountain areas) to about 1-2 month's worth of consumption. The food grant also resulted in slight increases in the portion quantity of maize and oil for about one to two months per quarter.

Children within the focus groups indicated that there was now more food available within their household. For example, children in Thaba Khubelu claimed that "hunger is no longer that much of a problem."³⁸ While it appears that some children still are hungry, the CGP has clearly had a positive impact on this.

The CGP cash has increased the diversity of food consumption, but not substantially. Some households reported buying some meat or eggs when receiving the cash but this is not widespread and households do not spend significant quantities on these items. The impact on dietary diversity is shown in Table 3.9 where the perceived trend of intake of protein rich food (meat, milk, eggs or beans) by children does not regard the daily or weekly consumption of protein but indicates an increase in frequency of protein rich food from every few months/a couple of times a year or less to a couple of times a month.

Table 3.9 Consumption frequency of protein rich food by children, trends over time

How often did the children in this household eat protein rich food (meat, milk, eggs, beans)?	All households		No shocks since CGP		Shocks since CGP	
	Before CGP	After CGP	Before CGP	After CGP	Before CGP	After CGP
Everyday (%)	0.2	0.2	0.4	0.4	0	0
Couple of times a week (%)	7.7	8.3	5.7	7.1	9.8	9.7
Couple of times a month (%)	16.2	26.4	15.9	24.3	16.5	28.7
Every few months (%)	39.6	33.6	45.4	34.8	33.5	32.4
Couple of times a year or less (%)	36.2	31.3	32.6	33.3	40.1	29.2
Total (%)	100	100.0	100	100	100	100
Index mean	1.0	1.1	1	1.2	1	1.1
	n= 300		n= 160		n= 140	

Source: OPM, Rapid Assessment Survey.

Where cash was given in the absence of food, the consumption pattern of households differed and more of the money was spent on the consumption of food, especially for the purchase of maize but this very much depends on the agriculture season. Food needs are at their highest just before the harvesting season during November-December. For example in Thaba-Khubelu and Mathula no food was given during December and in villages in these community councils it was evident that more of the cash during December was spent on food.

³⁷ Adult focus group, Thaba-Khubelu.

³⁸ Children focus group, Thaba-Khubelu.

Although there was evidence of improvements in the amount consumed, it is more difficult to measure the effect of the CGP cash and WFP food on nutritional outcomes. Outcome results will come from the full evaluation.

Qualitative respondents made the point that the transfer cannot address food and other needs simultaneously, particularly where there were problems with the food grant provided. Though by no means typical, the following quote is useful to illustrate the point that the grant may improve schooling or food but not necessarily both:

“In terms of food the grant has not made any changes to our lives. In fact the food is a problem as it is rotten and it makes our children suffer from diarrhoea; especially the peas. Also, the food comes after a long time; we even end up using the money to buy some food so as to ensure that the children do not go to school hungry. The change is for children mainly with their schooling as they now have uniform. There is a change for the children at school.”³⁹

In summary, increases in food security have been mostly driven by the food aid packages given by WFP, but where there were problems with the food or it was not provided the cash was also used for food spending. In a context of worsening food insecurity, there may not be significant improvements in nutritional outcomes, but it is likely that the situation would have been very much worse for recipients in the absence of the CGP. When cash only is provided in further piloting phases and the scaled up programme, the impact on food security of cash specifically (and not food) is likely to be much bigger than in round 1A. The long term impact evaluation will be able to explore this.

3.5 Impact on Health

3.5.1 Health situation

In most of the communities visited HIV/AIDS was the main illness affecting children and other community members. The village health workers and clinic nurses also reported diarrhoea to be common in children and although this may primarily be driven by water-borne diseases and lack of hygiene, it is also a symptom of HIV/AIDS. Other illnesses reported such as TB, common cold, influenza and skin rashes also represent some of the visible symptoms of HIV, although they do not necessarily mean a person has HIV/AIDS. Moreover, village health workers and nurses also report malnutrition to be prevalent amongst young children.

The village health workers reported some improvements in the health status of the village which they attributed to availability of Anti Retro Viral (ARV) drugs. Access to health care has also reportedly improved due to the introduction of free health care in public primary health centres in 2009.

Of the 300 households interviewed as part of the Rapid Assessment almost 31% reported some or all members to be in generally poor health and not to be able to cope with the health challenges (Table 3.10). As expected, there is a positive correlation between facing health challenges and having been affected by any recent shock, as most of the reported shocks are related to chronic illness and notably HIV/AIDS.

³⁹ Adult focus group, Mathula.

Table 3.10 Health Situation of Household

How would you describe the health situation of this household over the last year?	All households	No shocks since CGP	Shocks since CGP
Generally healthy / could afford to deal with minor health issues (%)	16.6	18.6	14.4
Generally healthy but could not afford to deal with minor health issues (%)	35.9	35.6	36.2
Some members in generally poor health, but could afford to cope with health challenges (%)	16.8	16.6	17
Some members in generally poor health, and could not afford to cope with health challenges (%)	20.6	16.9	24.6
Whole family in generally poor health, could not afford to cope with health challenges (%)	10.1	12.4	7.7
Total (%)	100	100	100
	n = 300	n= 160	n= 140

Source: OPM, Rapid Assessment Survey.

In the event of illness household's first point of action is to treat it themselves, often with the use of traditional herbs or home made medicines. Households also seek help and support from the VHW for instances of minor illness (for example in cases of diarrhoea). In the event that the illness is prolonged and the barriers to access are surmounted (i.e. transportation costs), households then access basic allopathic health care facilities (public or private) or traditional healers (*sangomas*).

The choice of healthcare is dependent on many factors including distance of health care facilities, transportation costs, the state and functioning of the facilities, availability of alternatives, income status of households and traditional and personal beliefs of health seekers.

The public health clinics are free of charge. However, one of the main shortcomings of the public health facilities is that many facilities lack certain types of medicine. ARVs and tuberculosis treatments were typically available but other medicines less so. Public clinics operated by non governmental organisations tend to have more medicine of all types available. This was the case in the surveyed area in Thaba-Khubelu where there were Partners in Health clinic in Lebakeng; treatment was free and medicines usually available.

Where households know the availability of medicine to be a problem in public clinics, many prefer to go straight to private clinics (if they had cash to pay for consultations and medicines). This is because public and private clinics are not always in the same place, so households risk paying for transport to a public clinic where medicine was not available, and then having to pay again for transport to a private clinic. As some participants in focus groups explained, "In most cases there are not enough drugs in public clinic, but in private clinics the drugs are always available."⁴⁰

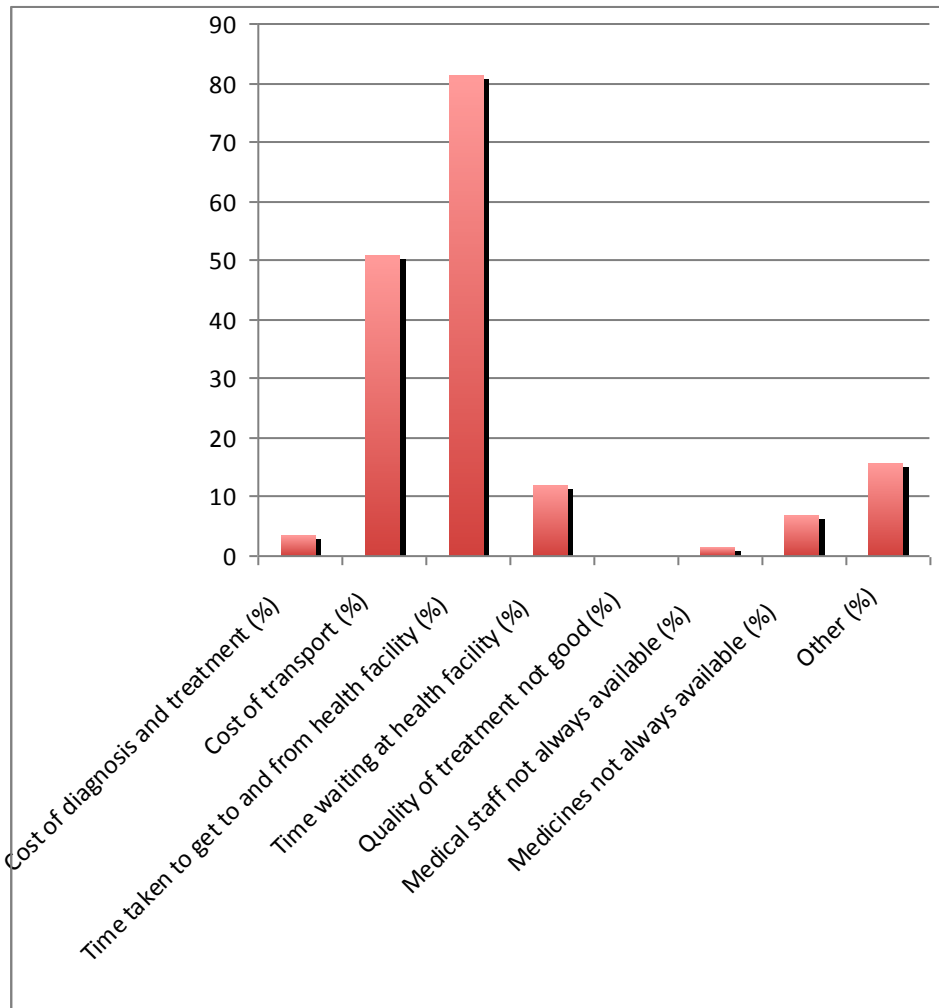
Traditionally held beliefs and personal preferences also play an important role on the decision of where to seek healthcare. Traditional healers are used first by many households in certain types of illness (such as where a vein is observed to pulse on a child's head), irrespective of the cost of alternatives. In some cases, households will use both allopathic and traditional sources of care. This appeared to be particularly strong in the mountain areas. For instance, in Thaba-Khubelu

⁴⁰ Adult focus group, Mathula.

many focus group participants noted that, for example: “You find the child has evil spirits “thokolosi” and cannot be treated elsewhere other than traditional healer.”⁴¹ In another group, they noted that “We take them to clinic where we don’t pay. But we are Basotho so we still take them to traditional healers.”⁴²

The average consultation fee for private clinics is between M50-M60. This fee includes the provision of medicine. The fees paid to traditional healers varies more widely ranging anything from M10 to M100 or more, depending on the type of treatment. However, questions on barriers to access make clear that this consultation fee is not the principal barrier to health access. When asked about the barriers to access 81% reported the time it takes to get to and from the health facility as one of the reasons for finding it difficult to access an allopathic health facility and 51% cited transportation costs as an impediment to access (Figure 3.2). The cost of diagnosis and treatment was very rarely an issue – possibly because many went only to public clinics.

Figure 3.2 Barriers to accessing an allopathic health care facility



Source: OPM, Rapid Assessment Survey.

⁴¹ Adult focus group, Thaba-Khubelu.

⁴² Adult focus group, Thaba-Khubelu.

It should be clear from this review that at least in cases where distance or availability of medicines are the major barriers, additional cash will probably make little difference to health-seeking unless people go more to private clinics. Cash availability probably plays a role in health-seeking, but perhaps principally around transport costs and where medical treatment is sought. If households lack cash and transport costs are low, or if they live near a well-stocked public clinic, most individuals will seek treatment from public health clinics. Where households have cash and public facilities lack medicine or are inaccessible, they may prefer to go straight to private clinics. If households have cash and public clinics are available and reliable, they will probably go to public clinics.

3.5.2 Impact of the CGP on health

While for most households (50.7%) the capacity to cope with health shocks seems to be stable over time, a significant proportion of respondents (25.3%) indicate that their ability to deal with health issues has increased over time, even if they have suffered shocks. For a similar fraction of interviewed households the perceived ability to cover cope with health shocks has instead decreased since they started receiving the CGP (Table 3.11).

Table 3.11 Perceived capacity to deal with health issues

Perception of the capacity to deal with health issues	All households	No shocks since CGP	Shocks since CGP
Better after GCP (%)	24	24.7	23.1
About the same (%)	50.7	48.3	53.4
Better before CGP (%)	25.3	27	23.5
Total (%)	100	100	100
	n = 300	n= 160	n= 140

Source: OPM, Rapid Assessment Survey.

Still, 55.6% of households report facing difficulties in taking members to normal (allopathic) health facilities when needed, even long after receiving the CGP, and on the particular issue of accessing formal health facilities the vast majority (89.2%) of beneficiaries does not recall a improvement over time since they started receiving the CGP (Table 3.12).

Table 3.12 Perceived changes in access to health

	All households
Households experiencing any difficulties in taking members to a normal health facility when needed (%)	55.6
Perception of change in the capacity to take household members to a normal health facility when needed	
Easier after the CGP (%)	8.5
The same (%)	89.2
Easier before the CGP (%)	1.8
Total (%)	100
n = 300	

Source: OPM, Rapid Assessment Survey.

The qualitative findings indicate that most households continue to obtain healthcare from public facilities. For example:

“We take them to the clinic when they are sick. We do not pay for the services at the clinic. We also get medication for free. Sometimes we do not get the medication; we are told there is no medicine. To get to the clinic we use buses, sometimes we walk.”⁴³

However, a few respondents use private facilities for recurring problems, such as allergies, where they know they need healthcare. Alternatively, they may visit hospitals for major problems, where they need to pay. There are examples of the CGP being used for this. For example:

“The cash grant is very important; I was able to take my grandson to Queen II in Maseru to get medication. I took him to Maseru when he had a tooth-ache.”⁴⁴

Several respondents also report buying non-prescription medicines from local shops, and the CGP undoubtedly has a positive impact on their ability to do this. Most people also purchase healthcare from traditional healers, and some respondents reported spending CGP money on this.

The impact on actual health purchases may be more limited than people’s confidence in being able to purchase because people are not ill when the grant comes, and savings are limited. For example:

“It has never happened that when we have the grant money children are sick...If the money from the grant is there I take my child to the traditional healer.”⁴⁵

The evidence on CGP impact on accessing health facility and the quality of health facility accessed is therefore mixed. On the one hand, recipients report being in better position to deal with health issues now than in the past. On the other hand, while the CGP could potentially enable households to afford some of the transport costs that prevent access to formal health facilities, this does not seem to be generally the case. There are several possible interpretations of these results.

a) Most of the perceived positive change in the ability to face health challenges has to do with additional purchasing power to buy on the counter medicine (as documented in Table 3.1) or accessing informal health care (traditional healers), rather than formal care. This increased purchasing power could be from greater direct availability of cash or from easier access to credit (see below).

b) The CGP may influence the choice of the health facility, rather than the decision to seek treatment or not. As a consequence of receiving the transfer some recipients (possibly few) household may have switched to private treatment. While this implies a maximisation of the quality of health treatment sought, it does not affect the proportion of households accessing treatment overall.

c) Households keep perceiving that the main barrier to access is physical distance and the non-availability of health facilities in the area. Additional resources to be spent on the demand side are likely to have a little effect on access if (where) the main bottlenecks are on the supply side. Households that were able to access clinics cheaply (e.g. because they lived next to a well stocked

⁴³ Adult focus group, Mathula

⁴⁴ Adult focus group, Semonkong.

⁴⁵ Adult focus group, Semonkong.

public clinic, such as that in Lebakeng in Thaba Khubelu) continued to be able to do so, since money was no barrier.

d) In general, interviewed households reported small amounts of expenditure on health care (see also Table 2.6), and this was to a large extent validated in our qualitative field work where we did not find many instances where individuals had used the CGP grant money for health care expenditures. This is partly because the CGP cash is usually spent immediately after it is received on a quarterly basis whereas occurrence of illness is more unpredictable and could happen at any given moment. In this respect it is relevant to note that a bigger proportion of the grant was spent on health in consequence of the first (cumulated) payment, which suggests that the value may be too small to produce a significant change in health seeking behaviour, when there are competing needs from the household.

Overall therefore the CGP has mixed impact on health. The perception of people's ability to cope with health shocks has improved over time, but due to supply side constraints and competing needs, the programme had little or no impact on whether individuals seek health care treatment or not. In some instances it has impacted on the choice of facilities health seekers make. In most cases it has increased households ability to buy on the counter medicines.

3.6 Impact on Education

3.6.1 Education situation

Lesotho has impressive educational indicators compared to similar countries. Enrolment rates are typically fairly high – around 95% of primary aged children are enrolled in school according to our quantitative survey. Although not captured in our quantitative survey, attendance is generally considered to be less impressive, and many children drop out and repeat years of school.

There are many factors determining whether children are enrolled or attend school. These include whether education is valued by the households, whether schools are available, how far they are, the costs of school, the availability of teachers and quality of education, the economic situation of the household, legal obligations and the views and perceptions of the guardians and children themselves. Some of these are likely to be affected by providing cash, and others are not.

Qualitative research was in keeping with other evidence in indicating that most children attend primary school up to Standard 7. Some also send their children to pre-school. However, far fewer children attend secondary school. Typically parents sent their children to primary school because they valued it, either so that “he can have a better future” or so that “they can care for us.”⁴⁶ Some parents were aware of the law: “There is a law that if children don't go to school parents will be locked up in jail.”⁴⁷ Free primary education was mentioned by many respondents as having a significant impact on school attendance. For instance, “Free education has influenced a lot on attendance of children, as parents can no longer complain of lack of school fees.”⁴⁸

Against this positive scenario, educational problems can be broken down into three types. First, there are some children who do not attend primary school regularly. In some cases, this is due to an inability to meet other costs of school attendance. For instance: “Other children are not attending school because they have been abandoned by their parents or guardians. Sometimes the children cannot afford to buy educational needs e.g. shoes. There are such cases but not that

⁴⁶ Adult focus group, Thaba-Khubelu.

⁴⁷ Adult focus group, Semonkong.

⁴⁸ Adult focus group, Mathula.

much.”⁴⁹ This was most common among the small number of non-enrolled children in the quantitative baseline. In other cases, however, distance and terrain to the schools represent major barriers according to the CMS and other reports (NUL 2008). In other cases, children or parents lack interest in schools. Sometimes, boys become herdboys and drop out of school. Finally, illness is a major barrier to regular attendance, but this is not likely to have very long-term consequences unless serious and is in any case not substantially affected by the CGP.

Second, children who attend primary school do not learn very much or enjoy school, and this can contribute to their eventual drop out. This poor performance was due, in the view of children, principally to hunger, having a lot of work or worry at home, and not feeling comfortable without uniform. For instance: “You are unable to perform well because in class you see that others wearing uniform and you are the only one who is not wearing it.”⁵⁰

Third, children drop out of school, mainly at secondary school when school costs go up substantially (as fees are no longer waived) and a break in the school process means that less interested students can more easily drop out, work, or go to initiation school. According to the quantitative survey, only around 20% of 13-15 year old children are enrolled in secondary school (with 10% not enrolled and 70% enrolled in primary school). This is partly related to costs (of around M600 per quarter, depending on the school), but partly also for reasons for work and interest.

In drop out, the influence of peer pressure and initiation schools appear important (and are unlikely to be influenced by the grant). Peer pressure is referred to by many parents: “Boys are always influenced by peers and feel they are men.”⁵¹ In some cases, this is more explicitly linked to alcohol and drug abuse and spiralling lack of interest: “Some drop out from school due to drug abuse; as many drink beer at an early age. The children fail at school because they are very close to town and it is easy for them to get drugs. This children leave us in the houses and go and drink.”⁵² Children, for their part, note the role of early marriage in leaving school.

Initiation schools are embedded in the Basotho culture and the decision for attendance is primarily in the hands of the children with little control or influence from the parents and as one of the interviewees put it “if my son wants to go he will go whether I allow it or not and I have pay for it”. Going to initiation schools is a very costly endeavour with reported expenditures of between M200-M300, together with one sheep and blanket commonly reported. When the children were asked whether they would like to attend initiation schools more than half the boys said they would attend but many would do so during school holiday and return after. Most of the girls were not planning to go to initiation schools. However, parents felt that children would sometimes not return to formal school after initiation school: “initiation school also makes children refuse to go back to school afterwards.”⁵³

3.6.2 Impact of the CGP on education

Which of these problems does the CGP deal with? Most recipients reported using the CGP to purchase uniforms and shoes for children, principally of primary age. This was corroborated to some extent by their children. Recipients of the CGP also improved their food consumption.

⁴⁹ Adult focus group, Semonkong.

⁵⁰ Children focus group, Mathula

⁵¹ Adult focus group, Thaba Khubelu.

⁵² Adult focus group, Semonkong.

⁵³ Adult focus group, Thaba Khubelu.

Parents were also able to buy more toiletries (such as Vaseline) and soaps. All of these impacts improved children's feeling at primary school and their enthusiasm for education. Although this did not substantially impact their attendance at primary or enrolment in secondary school, this was felt to have a very important impact on children's schooling overall.⁵⁴ These quotes are illustrative:

*"Yes it happens that although we receive grants sometimes our children do go without eating. But generally, things have changed because I have been able to buy them school needs, uniform and food containers."*⁵⁵

*"There is change because my child has uniform like other children."*⁵⁶

*"CGP has made a huge impact as parents/guardians can now pay exam fees (M10) for standard 7 children and for school trips especially for the children in primary school. The problem is still there for children who are in secondary school."*⁵⁷

*"The grant has made changes to school attendance – children are highly motivated. It is usually boys who do not go to school even under free education. Some don't go because of lack of uniform and school shoes or lack of food or even lack of soap and Vaseline. Children have all their needs met now. Children can now go on school trips as we are able to pay for the trips."*⁵⁸

We can investigate these improvements in more detail, identifying two principal avenues. First, children eat larger portions and slightly more diverse food than they would otherwise (as set out in section 3.4 above) and they therefore perform better at school. This connection between hunger and educational performance is widely acknowledged in research on education. It was also noted by the parents, children and teachers. For example, children argued that for good performance "children must leave home to school having eaten,"⁵⁹ and that "if there is no food to eat then a child does not perform well."⁶⁰ Performance is usually linked to attendance and drop out, and over the long term it is likely that these indicators may improve as well.

Second, many children are better dressed and presented and this makes them feel more comfortable at school, and therefore perform better and probably attend marginally more. Parents are able to spend the grant (particularly the first grant) on uniforms and shoes, and are able to spend ongoing grants on smaller items and toiletries, such as Vaseline, that contribute to children's cleanliness and comfort. The connection between having a clean uniform and good performance is less intuitive than food but is widely recognised in Lesotho, and was very evident from the qualitative fieldwork. For instance, some parents felt that "in the past the children were embarrassed to go to school without uniforms, and they ended up refusing to school."⁶¹ Children themselves feel that "if a child is poor and has no uniform and shoes, they get disturbed in class and end up not performing well."⁶² Teachers observed some changes in some of the CGP children

⁵⁴ The impact on children's work is explored in the next section.

⁵⁵ Adult focus group, Thaba Khubelu.

⁵⁶ Adult focus group, Thaba Khubelu.

⁵⁷ Adult focus group, Mathula.

⁵⁸ Adult focus group, Mathula.

⁵⁹ Children focus group, Mathula.

⁶⁰ Children focus group, Thaba-Khubelu.

⁶¹ Adult focus group, Mathula.

⁶² Children focus group, Semonkong.

in terms of clothing, appearance and state of well being (but not for all children). Observations within the FGDs with children conducted in the school premises also confirmed this, as many but not all CGP recipient children were wearing uniforms. This emphasis on appearance not only included clean uniforms but also have enough Vaseline to put on, and being washed and appearing clean.

This is an important barrier to educational 'comfort' and achievement. It is rare that teachers will prevent children from attending school without uniform. However, although not immediately related to enrolment or attendance, it is very clear that educational comfort and achievement have important effects on subsequent attendance and enrolment in secondary school. Children are far more likely to drop out of school or not enrol in higher education if they or their parents think they have no aptitude for formal school (for instance if they have to repeat years) or if they do not enjoy it. This is emphasised by many parents: for example, some children are "embarrassed of being in school with children younger than them."⁶³ Spending on these items is therefore very important, in the context of rural Lesotho, to improving educational outcomes.

Covering these needs is costly, and difficult for many families without the CGP. The cost of uniform is between M120-140 and a pair of shoes costs around M100-M150. Therefore 60-80% of one quarterly grant payment is consumed for one child alone, leaving little resources for other expenditures. In families with multiple children this will consume further resources of subsequent grant money.

From a quantitative stand point the perceived change in school enrolment seem to have been significant over time (Table 3.13). Enrolment rates are reported as being around 7 percentage points higher after receiving the CGP for children 6 to 12, and around 4.5 percentage points for children 13 to 15. Based on the discussion above, it is plausible that only a portion of this change can be attributed to the CGP itself, as the improvement in enrolment in primary may also be a reflection of long lasting effect of the free-education policy. The perceived change over time may also be affected by telescoping effects associated with the recall methodology. The real effect on school enrolment must be confirmed by the full evaluation.

Table 3.13 Trend in school enrolment

Enrolled in school?	6 to 12		13 to 15		Total: 6 to 15	
	Before CGP	After CGP	Before CGP	After CGP	Before CGP	After CGP
Yes	89.5	96.3	83.8	88.4	88	94
No	10.5	3.7	16.2	11.6	12	6
Total	100	100	100	100	100	100
	n=365	n=377	n=134	n=151	n=499	n=528

Source: OPM, Rapid Assessment Survey.

For their part, most teachers stated that overall enrolment has been relatively constant during the past 3-5 years⁶⁴ and in some cases enrolment has declined due to opening of more schools and further competition. Teachers noted no clear pattern of CGP impact on attendance, amongst the

⁶³ Adult focus group, Mathula.

⁶⁴ Most of the impact of free primary education was between 2001 and 2005. In one of the schools visited for example enrolment increased from 130 pupils in 2001 to 412 pupils in 2005.

children that they knew. A review of available attendance sheets and CGP recipient lists by the researchers corroborated this absence of a pattern.

One of the reasons why observations at the aggregate school level show less visible change in attendance and well being of children is that there are many more orphans in most schools than those receiving the CGP and as a result and, as teachers and school principals are not aware of who all the CGP children are, any change in the well being of the CGP receiving children becomes diluted with the overall status and well being of orphans and other pupils as a whole. As shown in Table 3.14, for example, 34% of all school children in one primary school in Semonkong are orphans.

Table 3.14 Number of Orphans in a Primary School in Semonkong

Grade	Number of orphans	Total number of students	Number of orphans as % of total students
1	14	86	16%
2	18	61	30%
3	23	62	37%
4	20	50	40%
5	17	48	35%
7	42	86	49%
Total	134	393	34%

Source: OPM, Qualitative

In addition, some teachers highlighted some cases where parents are “careless” and do not expend this money for the benefit of the children. They further suggested that one way of enforcing or ensuring that expenditures are made for children is by including teachers in the process and informing recipient parents that the teachers are also aware of who the recipients are. This seems a sensible suggestion for reducing the small proportion of inevitable non-prioritised spending.

The story of the effect of the CGP on schooling is different between primary and secondary. While free primary education and the provision of free school meals in primary mean attendance is in any case reasonably high, secondary school attendance and enrolment is rather more difficult to attain without a school bursary. The CGP has had a fairly limited impact on secondary school, mainly because the costs (around M600) are too high to be covered by the grant without further support. While there are a few examples of the CGP assisting households with secondary costs, this is not widespread and difficult to estimate given the small sample in this exercise. The other barriers (interest, other work), are not directly addressed by the CGP, although a change of the communication strategy might improve this. However, this should certainly not be interpreted as a failure of the CGP: it was never designed to address this.

In sum, the effect on primary education is channelled through increased expenditure on school uniforms, schools and personal care items for children. Enrolment is not an area of major concern at primary; only in some marginal households children don't attend primary school, and a more holistic case management approach may be required to solve these particular situations. While attendance can only be marginally affected by the CGP, it is the improved sense of self-esteem and general well being that may produce the most positive results. This is however very difficult to test in the current study

3.7 Child Tasks and Work

3.7.1 Definition and context

In Lesotho as elsewhere, many children undertake tasks within and outside the household. Although economic circumstances are often the primary driver of children having to work or take on large responsibilities within their households, child work is also expected by the social and cultural norms embedded in the Basotho culture. Children's work is seen as a necessary process in the development of the child and preparation for adulthood.

This section briefly sets out some of these norms. It does not discuss specifically whether these tasks amount to child labour as internationally defined (see Box 3.1), since the instruments used in the RAR were not designed to capture this. However, it will be evident that much of the work described interferes with children's development and schooling.

Box 3.1 Definition of Child Labour

According to UNICEF, "child labour" is work that exceeds a minimum number of hours, depending on the age of the child and the type of work. Such work is considered harmful to the child and should therefore be eliminated.

- Ages 5-11: At least one hour of economic work or 28 hours of domestic work per week.
- Ages 12-14: At least 14 hours of economic work or 28 hours of domestic work per week.
- Ages 15-17: At least 43 hours of economic or domestic work per week.

Source: http://www.unicef.org/protection/index_childlabour.html

In the study areas, children usually help their households with tasks such as cleaning, cooking, rearing of animals, and work in the field. The burden of work is usually more in households where there are fewer able bodied adults.

Moreover, some children undertake paid work to supplement or provide livelihoods for their family members and households. This work may be undertaken within the household or for the extended family or undertaken outside the households. It is particularly common to find primary school age boys in Lesotho working as herd boys. Boys start herding from an early age sometimes as young as 4. There is large difference between a child herding for the family and one herding for other families. In the first instance the work is often undertaken before or after school or over weekends and is less likely to interfere with schooling and can be referred to as "herding as cultural practice". The later however is driven more by economic necessities "herding as economic practice". In these instance children often work longer hours and the work is more likely to affect children's schooling.⁶⁵ It is the latter two cases of overburdened domestic work and/or long spells of paid work outside the households that may result in limited or lack of education for children.

According to the quantitative survey, over 90% of CGP children provided support in and around the household (Table 3.15). The children helped with cooking, fetching of water and wood, and herding of animals. These activities are often undertaken before or after school. The table shows an apparently reduction over time in the involvement in household chores for young children (though

⁶⁵ Kimane et al, "Rapidly Assessing Children at Work in Lesotho", 2000.

this result may be affected by telescoping effects), and in businesses operated by the household as well as paid work for older children. We explore potential CGP mechanisms of impact below. However, based on the methodology employed for this rapid assessment it is not possible to ascertain whether this change can be fully attributed to the CGP, as other factors may explain the perceived trend (e.g. adult labourers returning from mines, or an increase in the number of children overall).

Table 3.15 Tasks undertaken by children, trends over time

	6 to 13		14 to 15		Total: 6 to 15	
	Before CGP	After CGP	Before CGP	After CGP	Before CGP	After CGP
% Children performing tasks around the home	84.1	77.9	97	98.6	86.4	81.8
% Children assisting in business operated by the hh	8.1	6.7	18.1	10.8	9.9	7.5
% Children performing activities for someone outside the hh	0.6	0.3	6.7	2.2	1.7	0.7
	n=410	n=438	n=96	N=95	n=506	n=533

Source: OPM, Rapid Assessment Survey.

Qualitative interviews confirmed that children are much more likely to perform tasks for the household than to work for money, except in dire circumstances. Most children reported combining work with school. Usually, they did not work to the extent that this causes problems for school, but in some cases children felt that work restricted schooling and play, as the following discussion from a focus group shows:

Respondent (R) 1: *“Yes it hinders me from school work. It hinders me because I come back late from herding animal.”* R 2: *“No we can still play.”* R3: *“This work hinders me. After school I cook and cannot play.”* R4: *“No for me when herding animals I can still play.”* R5: *“Parents should not give much work because we need to do school work. This man hits me when we are herding with him because he wants me to care for the animals.”⁶⁶*

Respondents in the focus groups were clear that children work more when there are fewer able bodied members in their households or when someone falls ill. When asked about hypothetical scenarios, children’s opinions were divided as to whether children would miss school if family members fell ill. Some argued that they would have additional duties but would combine this with school; others that they would have to stop going to school to care for their ill relatives. Typically, girls would have primary duties to care for members of the household, while boys are more likely to take over herding and agricultural duties. In some instances, village health workers and the village support group members provide support to these families and ensure that the children attend school.

From this brief review, we can identify four types of work undertaken by children:

1. Tasks around the home/businesses operated by the household
2. Full time employment such as herding
3. Paid work (such as piece work) to meet household needs

⁶⁶ Children focus group, Thaba-Khubelu.

4. Additional time caring for sick relatives

Overall, therefore, the situation of children working in the study areas appears heterogeneous, with the extent and nature of tasks dependent on the household structure and assets. This is in keeping with studies elsewhere.

3.7.2 Impact of CGP on child tasks

The impact of the CGP on child tasks is similarly heterogeneous, depending on household structure and circumstance. Table 3.16 summarises the likely impact across the four work types.

Table 3.16 Child Tasks and Work and Impact of CGP

Task	Possible drivers	Impact of CGP
Support with household tasks	Cultural norm	No impact
Fulltime work (e.g. herding)	Economic, cultural expectation, perception on usefulness and necessity of education	No impact – insufficient amount
Paid piece work	Economic/driven by basic needs	Some impact by alleviating burden on children
Caring for sick relatives	Household shock, lack of external care support	Small impact – probably insufficient amount to hiring of external care support

Source: OPM.

The fieldwork conducted (corroborated by the quantitative evidence) suggests that the principal impact of the CGP on child work is through reducing the need for children to undertake piece work outside the household. This is because recipient households now have more resources available. This is an important positive impact, because it allows children to spend more time on school work and at play, key parts of their development. There may also be some additional effects on children having to spend less time caring for sick relatives, since the work burden on other adults may be reduced (see section 3.7.3 below) so they can undertake some caring tasks previously undertaken by children. Some quotes provide examples of this:

“Yes [the grant will have an impact on children working], because they will get money and the tasks will get reduced. They will no longer have to work hard to get money from elsewhere.”⁶⁷

“The grant would help as the children would not have to go and work.”⁶⁸

There was some disagreement in the focus groups as to whether the CGP money would be enough to hire in a carer or someone to work on the fields. Some respondents thought it was, and that for instance “the child will end up employing someone to work in the field after getting the grant.”⁶⁹ Others, however, were clear that “The grant money would not help solve the problem as the money is too little. It would not be sufficient to pay for the employee and cater for the needs of the children.”⁷⁰

⁶⁷ Children focus group, Mathula.

⁶⁸ Adult focus group, Mathula

⁶⁹ Adult focus group, Semonkong.

⁷⁰ Adult focus group, Semonkong.

It is probably the case that if all the money was spent on hiring in a carer, the CGP grant could cover this. However, it is much more likely to be the case that households spend the money on their prioritised needs, such that not enough would be left to employ anyone.

The downward trend shown in Table 3.15, of a fall of young children's involvement in household tasks seems unlikely to be entirely an effect of the CGP. It is not clear along which transmission mechanism this change may accrue, and this would be interesting to explore in the full evaluation.

3.7.3 Economic Changes and Labour Market

3.7.3.1 Economic Impact

The likely impact of the CGP on the wider economy is dependent on the size of the CGP transfer, the number of recipients receiving the transfer, the total size of the community, their livelihoods strategy and the proximity of the villages to nearby market centres.

The CGP money is a quarterly payment of M360 per household, or M120 per month. This represents 14% of mean rural household monthly expenditure⁷¹. In addition to representing a small fraction of monthly rural expenditure, this amount is only given to a small number of people in each community (approximately 20% based on qualitative research).

Given this the impact of the grant on the wider economy of the communities is expected to be small.

In the Lowlands or communities close to market centre the CGP money represents a very small fraction of currency in circulation and therefore has little or no recognisable impact on the sales.

A number of shop owners were interviewed in or near the villages visited. In Semonkong town, the main trading centre for the areas visited, interviews with shop owners did not indicate to increases in sales due to the CGP. Many reported the sales to be driven by the wage and salaries of workers in general and to some extent by the pension payments.

This was also the case in Mafeteng where although the sales had marginally increased (shop assistance could not provide any figures) during pay day the overall sales of the shops had not witnessed sharp increases due to the CGP.

In Thaba Khubelu, however, given its remoteness and difficulty in reaching larger market centres the CGP had substantial impact on the sales of shops with additional revenue of between M100 to M2000 on pay days. Many also reported increase in informal sales in and around the payment points.

3.7.3.2 Labour Market

Job opportunities in the areas visited are often very limited. Most people work on their own lands or are engaged in some sort of domestic activity such as cultivation of vegetable, production of eggs and home made beer.

Remittance from migrant workers in the factories in Maseru and mines South Africa used to provide an important source of livelihoods in many households in the rural settings, however this has severely diminished in the recent past through large retrenchment of mine workers in South Africa.

⁷¹ Continuous Multipurpose Survey (CMS), May 2009-July 2010.

Some households are able to engage in public works programmes when they are available and for a limited time period but otherwise when in need of certain food items or commodities, households often revert to undertaking of casual labour and piecemeal jobs to meet those needs, these include washing of clothes, working on other people's fields.

Table 3.17 indicates that more households reported having household members who were engaged in work of all types after receiving the CGP. This is probably a reflection of underlying changes on in the labour market rather than the transfer itself. In qualitative fieldwork, however, this trend was nuanced in that some individuals reported working fewer hours as a result of the CGP. This was because the CGP had covered some immediate consumption needs for which they would ordinarily do piece work. Note that this does not mean that people stopped working altogether; just that they worked less. As these focus group participants pointed out, "we are still working, but not as hard as before."⁷² Moreover, in the time that they were not working, they usually reported spending more time at home with their children, sick relatives, or household tasks. This should certainly not, especially in the context of HIV/AIDS, be interpreted as an indication of dependency or apathy.

Table 3.17 Perceived trends in labour supply

If HH has member in this age group, HHs where any member of an age group was engaged in livelihood activities during the previous 12 months	18-50 years*		50+ years*	
	Before CGP	After CGP	Before CGP	After CGP
Casual labour (including agricultural and non-agricultural work, washing clothes, etc.) (%)	35.6	43.9	22.3	34.5
Self-employment (%)	6	9.8	6	7.6
Paid regular employment (e.g. in factory or mine) (%)	1.9	3.7	3.1	1.9
Work in family business or farm (%)	2	2	0.4	1.2
Petty trading (selling vegetables, clothes, bottles, etc.) (%)	11.5	14.3	10.5	9.3
Rearing livestock (herding etc.) (%)	5	7.8	1.8	2.6
HH (if has member in this age group) where no member of the respective age group was engaged in any of the aforementioned livelihood activities (%)	49.1	36.5	65.2	53.1

n=300

Source: OPM, Rapid Assessment Survey. Notes: (*) Unlike in all other tables in the document, age ranges (before and after the CGP) refer to the age at the time of the survey (after the CGP).

Overall, given the current constrained labour market environment and high unemployment the CGP pilot is unlikely to have had strong effects on the labour market, although this may need to be more carefully thought out in the expansion phase.

3.7.3.3 Money management

The receipt of CGP money has increased the ability of recipients to borrow or get credit – although not to save. Borrowing and credit-taking are extremely important consumption smoothing mechanisms, particularly in a context where saving is rare and quite small, so this should be considered a positive impact. The CGP cash recipients did not lend the money they received to

⁷² Adult focus group, Mathula.

other community members but some did report lending food stuffs to non-recipients. Table 3.18 makes very clear that saving is very rare and that most recipients would typically spend all of the money immediately. On the contrary, access to credit seem to have increased substantially since the introduction of the CGP, as about one third of beneficiaries report owing money to someone different from a shock. This is probably a reflection of the indirect function of the CGP as collateral.

Table 3.18 Household debt and borrowing ability

	All households		No shocks since CGP		Shocks since CGP	
	Before CGP	After CGP	Before CGP	After CGP	Before CGP	After CGP
HHs able to save money during the previous year (%)	0.9	3.2	0.8	2.9	0.9	3.5
HHs owing any money (not to a shop) (%)	25	33.9	22.6	33.6	27.6	34.3
HHs who obtained credit from a shop during the previous year (%)	32.7	33.3	31.5	32.1	34	34.6
	n = 300		n= 160		n= 140	

Overall, only a relatively small group of recipient households report undertaking investment in the year previous to the quick survey, with most expenses concentrated in households' improvement (13%) and the purchase of poultry (4.6%). It is not possible to determine whether the CGP has promoted investment in any of these areas, but given the size of the transfer and urgency of competing needs it seems unlikely that the programme has a remarkable effect in this area.

Table 3.19 Investment

HHs that in the previous year:	All households
made any improvements to the house (%)	7.5
bought any items such as furniture (%)	5.5
bought any productive equipment for farm or family (%)	0.9
purchased any livestock (%)	1.7
purchased any poultry (%)	4.6
n = 300	

3.7.4 Community Relations

The impact of cash transfers on relationships is extremely important and needs detailed investigation. In this brief review, both positive and negative impacts appeared.

There are two ways in which the CGP has improved relationships. First, some respondents discussed the easing of the situation within households. For example: "The grant has caused good relations amongst other family members."⁷³ Second, some recipients felt that the grant meant that

⁷³ Adult focus group, Mathula.

they had to borrow less from others, which made relationships more relaxing. For example: “[I] have good relations with other people as [I am] no longer borrowing from them.”⁷⁴

However, more respondents referred to tensions caused by the CGP. These were largely caused by the targeting mechanism and since this has changed in the scaled up programme, this section will be brief. It is nevertheless important to discuss this since it is important to people and should also feed into ongoing programme design.

First, there is jealousy from the non-recipients who also feel that they deserve the CGP. For instance:

“Yes, there are some members who are not happy that they are not receiving the grants. They keep asking why we are the ones who receive the money. It has caused hatred.”⁷⁵

“Some villagers are jealous and some are angry because they do not receive the grant. The relationship is not good, as some are not receiving the grant.”⁷⁶

Second, some (but certainly not all) children reported a negative impact of the CGP on their relationships with other children, as Table 3.20 shows. The negative consequences are clearly important for a programme designed to assist children and should be taken seriously.

Table 3.20 Some Quotes on Impact of CGP on Community Relations

Question: Has your relationship with other children in your school changed since you've received the child cash grant and food? If so how? How about the children in your village?	
Respondent A	“They tease us, and say we do not play with them because we get money.”
Respondent B	“They say we shouldn't be proud because the grant “motente” will come to an end.”
Respondent C	“We still play well together.”
Respondent D	“The parents of some of the children say their children should not play with us.”
Respondent E	“Some people are jealous. Some mock us because they say we get things for free as they are purchased using grant money.”

Source: OPM, Qualitative Fieldwork.

Negative impacts on social relations are clearly concerning in themselves, but it is not clear whether these negative impacts have further material effects on community sharing or lending systems. In general there is little pure giving in the communities visited but most people lend or borrow foodstuffs and other commodities from one another in reciprocal arrangements.

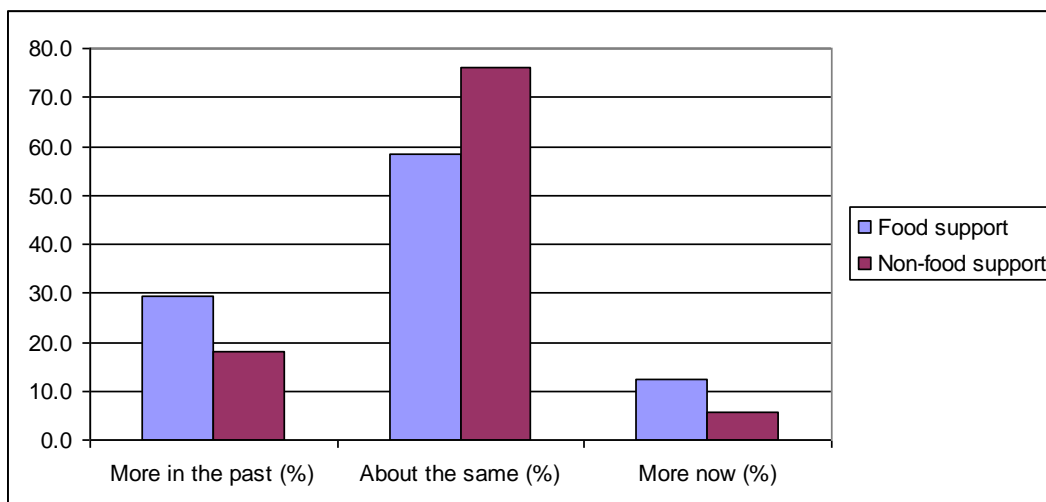
The CGP appears not to have substantially affected the borrowing and lending relations of the community members. Some CGP recipients are lent less in some instances. This is highlighted in Figure 3.3 where CGP recipients receive less support from informal sources after the receipt of CGP grant. This is probably partly caused by jealousy (as some quotes above suggest) but also because CGP recipients now need less support from others.

⁷⁴ Adult focus group, Mathula.

⁷⁵ Adult focus group, Mathula.

⁷⁶ Adult focus group, Semonkong.

Figure 3.3 Perception of change in support received from informal sources



Source: OPM, Rapid Assessment Survey.

4 Conclusions and Recommendations

Overall, given the limitations of this rapid exercise and other changes in the context of rural Lesotho, we have found that the CGP cash and WFP food have significant positive impacts on recipients' well-being. Recipients typically used the food for consumption, and this tended to increase portion quantities, particularly in the period after the transfer was received. Recipients preferred the cash to food, because it allowed them to meet their prioritised needs – whether these were food, other basic needs, educational needs or others.

The overwhelming majority of households spent the cash on the prioritised needs of the household, paying particular attention to the requirements of children. Although of course these needs differ slightly in each household case, they usually included food, basic household goods (such as Vaseline and toiletries), educational needs (such as uniforms and shoes), and other clothes. There was very little evidence of significant spending on 'non-essential' items, but also little evidence of productive investment.

Since households spent the transfers quite differently according to their situations, we would not expect to find significant impacts in the aggregate on any single dimension of well-being. Nevertheless, there are examples of how the CGP made specific improvements to different dimensions of well-being:

- The food and cash grant increased the portion quantity for most households, and many households consumed more protein (from beans) than previously. Many households were also able to afford occasional purchases of rarer but preferred foods, such as meat or bread.
- The grant was rarely used to pay for formal healthcare, since public primary healthcare is free and illnesses need not coincide with grant payments. However, recipients felt better able to purchase over-the-counter medicines (such as those available from small shops without prescription).
- Cash was very often used to buy uniforms and toiletries for children, and together with the greater food portions this led to children feeling more confident at and enthusiastic about school (mainly primary school). Although attendance and enrolment were not directly affected by this, improving attitudes towards school is in the long-run likely to have an impact on these indicators.
- The additional resources provided to families enabled some children to work less for money. It also let some adults reduce the number of hours worked, and this sometimes freed up time for children who would otherwise have spent their leisure time caring for relatives.
- Recipients of the CGP had better access to credit – although they did not save the money. Taking credit and borrowing are important ways of smoothing consumption, especially where saving is limited.

On the basis of this brief review, we would recommend that the CGP programme be expanded.

We now present some tentative reflections and more specific recommendations:

1) In view of a scaled up version of the programme its objectives should be further clarified.

While the focus on redistribution of resources to vulnerable and poor households who can spend them according to their prioritised needs is perfectly legitimate, there is an inherent tension between unconditional social assistance to households who cannot provide their own livelihoods and the provision of a safety net to households with residual productive capacity to boost (human and productive) investment in the long run.

In the first case (household without residual labour capacity) the transfer can be conceived as a last resort measure to provide a minimum living standard to households (elderly or child headed, disabled, chronically ill) who would otherwise only rely on family and community support. This would also serve to ease the burden on informal sharing arrangements that have been put to extreme stress as a consequence of the HIV/AIDS epidemic, at the time of protecting the rights of household members, particularly children. This transfer would ideally need to be calibrated to cover the gap between incomes and expenditure needs, and would therefore be indexed to prices. The value of the transfer needs to be reconsidered at the light of new evidence of consumption expenditure and welfare levels as they become available in the country (from BoS or the full evaluation survey).

In the second case (non labour constrained households), the transfer can be considered as a means to protect and increase physical and human assets, so to stimulate further productive investment in the future, strengthen coping mechanisms and reduce vulnerability to shock. In this case the transfer component could be coupled with specific capacity building dimensions (financial literacy, money management) and coordinated with other interventions, e.g. projects aimed at improving livestock and agriculture productivity. Opportunities for sustainable productive investment seem to be rather limited in the context of rural Lesotho, hence further analysis is required on the viable pathways that can produce significant multiplier effects around the CGP. Schemes of soft conditionality or “incentives” could be developed to strengthen the link between the transfer and productive investment (i.e. with training, education). A stronger inter-institutional coordination will be required to bring the issue of the linkages between social protection and the broader development agenda to the attention of a larger set of stakeholders and sectors (health, education, agriculture).

The role that the CGP is intended to play between these two extremes is not completely obvious, but each of the two options comes possibly with a different set of design and implementation challenges, particularly along three dimensions: targeting, value of the transfer and (soft) conditionality/incentives.

Furthermore, it is important to be realistic about the likely impacts of such a cash transfer. There are many practices and situations in rural Lesotho that may harm children and their families' well-being but which are not likely to be significantly affected by a cash transfer programme unless a stronger social mobilisation component is developed from the early stages of programme implementation. This is because their causes are either rooted in the supply of services (such as the quality of education and healthcare), or in historical social and cultural practice (such as initiation school or traditional healing). It is not the case that these causes are themselves negative (i.e. we are not arguing that initiation school is ‘bad’), but it is the case that many reasons why children do not attend formal school (e.g. because they drop out for initiation school) are not likely to be affected by a cash transfer. Careful analysis of the constraints to improved outcomes will reveal which are likely to be amenable to change by a cash transfer and which require other sorts of intervention (if desirable by the communities concerned). Overcoming these problems would require extensive community mobilisation and social change, rather than the provision of cash.

2) The decision to move away from the categorical definition of OVCs and target on the basis of poverty is extremely positive, as it acknowledges that vulnerability is complex and hits transversally across demographic categories. This at the same time implies that the programme is currently targeting some very heterogeneous groups of households. The most notable difference is that some of them have significant residual productive capacity while others do not.

If the objective of the CGP was more oriented towards social assistance (see above) it would be necessary to narrow down the poverty eligibility criteria, by combining poverty targeting with some

ways to identifying households without able bodies (or at least with a particularly high dependency ratio). As the targeting becomes finer, however, the programme may achieve a smaller critical mass, which may in turn jeopardize the process of scaling up both from an implementation and political economy standpoint (focussing on disability and illness may be a trap that social protection takes a long time to escape, as it has been the case in other sub-Saharan countries).

If the long term objective is to boost/protect productive investment, periodical retargeting becomes an essential feature to design as part of the system.

3) While the communication strategy has generally centred around children's needs, uniforms and school shoes the programme should strengthen its theory of change.

Specifically it should clarify whether: a) some sort of soft conditionality is required to incentivise specific behavioural change; b) which are the areas in which behavioural change is possible with a demand side intervention like the CGP, given the state of the supply of public services (particularly in health and education), as well as the prevailing livelihood strategies and available investment options.

4) Household money management practices are key mechanisms for regulating the impact and use of the cash transferred. One possibility for improving outcomes in the short-term might be to improve financial literacy and services. This might enable households to smooth consumption and plan their budgets more effectively, as well as open the possibility for greater accumulation and investment. This could be carried out by strengthening the local institutions for community mobilisation (training processes).

5) The value of the transfer should be increased to represent a higher fraction of household consumption (particularly when there is no food transfer) and indexed for inflation and household size. As the targeting process currently gives priority to larger households (and households with a larger number of children) this implies that per capita values are in most cases minimal. If the programme has an intention to incentivize particular behavioural changes (e.g. increase secondary school enrolment, mitigate herd boy syndrome, etc) the value should be set on the basis of the consideration of all direct, indirect and opportunity cost involved.

6) The frequency of the transfer could be increased to help recipients to smooth consumption. Given the lack of savings practices and facilities (although see recommendation on financial literacy below), this would increase the likelihood that the transfer could be spent on recurrent expenditure. At the same time, if the amounts were to be reduced as a result of increasingly frequent transfers, this might make it harder to spend on costly items (such as uniform), since transfers are not saved. Increased frequency, therefore, should be carefully considered along with the desired objectives of the programme (spending on recurrent or 'lumpy' items). This distinction could be mitigated with more saving, or with a larger lumpsum in some periods (e.g. at the start of the school year) and smaller more regular payments throughout the rest of the year.

7) It is important that, along with showing early results on the effectiveness of cash transfers, the CGP is conceived as an opportunity to start building a comprehensive social protection system in Lesotho. If the pilot achieves putting in place national and local structures and systems (involving payment mechanisms, case management systems, communication strategy, MIS), that can be further used by the Government of Lesotho to develop social protection systems in the future this main goal will be accomplished. This requires that a significant amount of time and resources are devoted to setting up such a system and implementing them at the local level in the field with extreme care to the details of the process and the institutional setting (more than results themselves). In this respect the involvement of Department of Social Work in the process, particularly at the local level, is a key ingredient to ensure sustainability of the pilot.

Inter-institutional coordination is essential, both at the national and at the local level, as synergies have to be sought to build a unified systems and processes in areas like targeting and beneficiaries' identification, payment, case management and follow up. Rules on the possibility to cumulate different types of transfers (e.g. Pension and CGP) will have to be defined as part of a comprehensive social protection strategy.

8) Social mobilization processes should be streamlined, particularly to strengthen local institutions for case management. The process of community mobilization is essential to ensure that the different elements of the system are adequately implemented in the field. In such a scenario the development, operationalization and strengthening of local management systems are of key importance. Social mobilisation, sensitisation and organisation of local level institutions should play a stronger role in the design, to ensure stronger case-by-case management and strengthen linkages between the cash and social service components of the social protection system. Local social mobilization processes should involve a broad set of stakeholders, i.e. teachers (to monitor and sensitize around school enrolment and attendance) or rural support programmes (to promote saving and investment). Counting with stronger local institutions in place would benefit implementation at several levels of: targeting, payment, monitoring and follow-up, case management system, training, etc. Currently local structures (Village Assistance Committees) are extremely weak and little formally connected with DSW. The risk is that the pilot is identified more with the external donors' involved (EU and UNICEF) or field implementers (World Vision) than as part of a systemic government strategy.

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Annex A Quantitative questionnaire

Child Grants Programme Phase I, Round 1 A Rapid Appraisal – Cover sheet

HOUSEHOLD AND AREA CODES			
District:		District code:	
Community council:		Community council code:	
ED:		ED code:	
Village:		Village code:	
Household ID:			

HOUSEHOLD INFORMATION					
Address:					
Name of household head:					
First name:		Family name:			
Gender:		DOB:	DD	MM	YYYY
1 Male					
2 Female					
Contact tel 1:		Contact tel 2:			
Name of Designate:					
First name:		Family name:			
Gender:		DOB:	DD	MM	YYYY
1 Male					
2 Female					
Contact tel 1:		Contact tel 2:			

POST CHECK			
Respondent name:		Member ID:	

VISIT INFORMATION								
Date of interview				Start time		End time		Interview result
	DD	MM	YYYY	HH	MM	HH	MM	
Visit 1								
Visit 2								
Visit 3								
Interview result codes								
1	Interview completed							
2	Interview partially completed							
3	Household could not be found							
4	Household refused interview							
5	Household away for a short time							
6	Household away for an extended time							
7	Household moved away							
97	Other							

DATA CHECK						
Interviewer Name:				Interviewer ID:		
Interview checked by interviewer, signed and dated						
Signature:				DD	MM	YYYY
Interview checked by supervisor						
Supervisor name:				Supervisor ID:		
Data entry						
Data entry Person:				Data enterer ID:		

Preamble

PREAMBLE

My name is _____ and I work for _____

This is a study for the evaluation of the Lesotho Child Grant Programme. The purpose of this study is to understand the positive and negative effects of the Child Grant Programme on household and children's lives, including health, nutrition, schooling and employment. This project is run by an international team of researchers on behalf of the Department of Social Welfare in the Ministry of Health and Social Welfare of the Lesotho Government and UNICEF. Your household was randomly selected amongst the beneficiaries of the Child Grant. As part of this study we will be asking to provide some information about your household, such as who usually lives here, whether your children are currently attending school, what sort of work the members of your household are involved in, and other such questions.

Before we begin the interview, we want to make sure you understand the following information about the study:

- Your participation is entirely voluntary. You may refuse to take part in the interview, and you may stop at any time if you do not want to continue. You also have the right to skip any particular question or questions if you do not wish to answer them.
- The time it takes to complete the interview will vary depending on how many people live in your household, but it should take no more than around half an hour.
- You have the right to ask questions at any point before the interview, during the interview, or after the interview is completed.
- All information collected for this study will be kept strictly confidential. While the data collected will be used for research purposes, information that could identify you or your household will never be publicly released in any research report or publication and won't be shared with the Department of Social Development or any other government institution.

Section A – Household roster

	QA_01	QA_02	QA_03	QA_04			QA_05	QA_06	QA_07	QA_08	
Member ID	Family name <i>List all household members, starting with the head of the household</i>	First name(s)	Gender 1 Male 2 Female	Date of birth 98 Don't know			Age	Relation to head of household 1 Head of household 2 Husband/wife 3 Son/daughter 4 Father/mother 5 Brother/sister 6 Grand parent 7 Grand child 8 Nephew/niece 9 Son/daughter in-law 10 Father/mother in-law 11 Grandparent in-law 12 Other relation 13 Other no relation	Did any of the household members listed here join the household in the last 12 months? 1 Yes 2 No <i>skip ▶ QA_09</i>	Date joined 98 Don't know	
				D	M	YYY				M	YY
				D	M	Y				M	YY
01											
02											
03											
04											
05											
06											
07											
08											
09											
10											
11											
12											
13											
14											
15											

			QA_09	QA_10	QA_11	QA_16
Member ID	First name <i>Carry over from previous page</i>	Age <i>Carry over from previous page</i>	Does this person suffer from a permanent physical, mental or psychological disability (deaf, blind, crippled etc.)? <i>Code yes if person has sustained any permanent disabling condition from a prior illness or injury (e.g. a limp)</i> 1 Yes 2 No	Does this person suffer from a chronic illness? <i>A chronic illness is an illness or ailment that recurs persistently and/or has lasted for longer than 3 months</i> 1 Yes 2 No	FOR INTERVIEWER ONLY (do not read out): Has the respondent indicated that this person is HIV/AIDs positive? 1 Yes 2 No	FOR OVER 17 YEARS ONLY: What is the highest level of education achieved by this person? 1 None – cannot read or write 2 None – but can read and write 3 Did not finish primary school 4 Completed primary only 5 Did not finish secondary 6 Completed secondary 7 Not finished high school 8 Completed high school 9 Vocational training 10 Teacher/technical college 11 University diploma/degree 12 Post graduate qualification 97 Other
01						
02						
03						
04						
05						
06						
07						
08						
09						
10						
11						
12						
13						
14						
15						

Section B – Education (children aged 6-17)

		ONLY FOR CHILDREN AGED 6-17 YEARS					
Member ID	First name	Age	QB_01	QB_02	QB_03	QB_04	
	<i>Carry over children 6-17 from previous page</i>	<i>Carry over children 6-17 from previous page</i>	Has this child been attending school in the last 12 months? 1 Yes skip ▶ QB_03 2 No	What is the main reason this child has not been attending school? <i>After answering skip ▶ QB_05</i> 1 Costs too high (fees, transport, uniforms etc.) 2 Too young 3 Too old 4 Domestic duties 5 Working in family business or farm 6 Working for others 7 Too far / no school 8 Not necessary / no point 9 Child refused to go to school 97 Other reason	Which class are they currently in? 1 Grade 1-8 skip ▶ QB_05 2 Form A -E	In the last 12 months who paid for the school fees? 1 Household pays 2 Government social welfare funds pay 3 Friends / neighbours / relatives pay 4 NGO pays 97 Other (specify)	
						Answer code	Specify
01							
02							
03							
04							
05							
06							
07							
08							
09							
10							
11							
12							
13							
14							
15							

			ONLY FOR CHILDREN AGED 6-17 YEARS				
			QB_05	QB_06	QB_07	QB_08	
Mem ber ID	First name <i>Carry over children 6- 17 from previous page</i>	Age <i>Carry over children 6-17 from previou s page</i>	Was this child attending school in the 12 months before September /April 2009? 1 Yes <i>skip</i> ▶ QB_07 2 No	What was the main reason this child was not attending school in the 12 months before September/April 2009? <i>After answering skip ▶ QC_01</i> 1 Costs too high (fees, transport, uniforms etc.) 2 Too young 3 Too old 4 Domestic duties 5 Working in family business or farm 6 Working for others 7 Too far / no school 8 Not necessary / no point 97 Other reason	Which class were they in? 1 Grade 1-8 <i>skip</i> ▶ QC_01 2 Form A -E	In the 12 months before September/April 2009 who paid for the school fees? 1 Household pays 2 Government social welfare funds pay 3 Friends / neighbours / relatives pay 4 NGO pays 97 Other (specify)	
						Answer code	Specify
01							
02							
03							
04							
05							
06							
07							
08							
09							
10							
11							
12							
13							
14							
15							

Section C – Child labour (children aged 6-17)

Mem ber ID	First name <i>Carry over children 6- 17 from previous page</i>	Age <i>Carry over childre n 6-17 from previo us page</i>	ONLY FOR CHILDREN AGED 6-17 YEARS				
			QC_01	QC_02	QC_03	QC_04	
			In the last 12 months has this person been performing any tasks around the home to help the household (e.g. cooking, child care, cleaning, fetching water etc.)? 1 Yes 2 No	In the last 12 months has this person been assisting in any business operated by the household (e.g. shop, street vending, farming activities, etc.)? 1 Yes 2 No	In the last 12 months has this person performed any activities for someone outside the household in order to earn money, food or goods (e.g. child care, gardening, cleaning, street selling, etc.)? 1 Yes 2 No <i>skip ►</i> QC_05	What is the main work activity this child has been engaged in? 1 Casual labour 2 Paid regular employment 3 Street trading 4 Rearing livestock (herding) 97 Other (specify below)	
						Answer code	Other specify
01							
02							
03							
04							
05							
06							
07							
08							
09							
10							
11							
12							
13							
14							
15							

Mem ber ID	First name <i>Carry over children 6- 17 from previous page</i>	Age <i>Carry over childre n 6-17 from previo us page</i>	ONLY FOR CHILDREN AGED 6-17 YEARS				
			QC_05	QC_06	QC_07	QC_08	
			In the 12 months before September/April 2009 did this person perform any tasks around the household (e.g. cooking, child care, cleaning, fetching water etc.)? 1 Yes 2 No	In the 12 months before September/April 2009 did this person assist in any business operated by the household (e.g. shop, street vending, farming activities, etc.)? 1 Yes 2 No	In the 12 months before September/April 2009 did this person perform any activities for someone outside the household in order to earn money, food or goods (e.g. child care, gardening, cleaning, street selling, etc.)? 1 Yes 2 No <i>skip ►</i> QD_01	What was the main work activity this child was engaged in? 1 Casual labour 2 Paid regular employment 3 Street trading 4 Rearing livestock (herding) 97 Other (specify below)	
						Answer code	Other specify
01							
02							
03							
04							
05							
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Section D – Shocks

Question number	Question text and instructions	Answer options	Answer	
QD_01	<p>We would like to learn about any economic shocks that this household has suffered since the end of September/April 2009—an economic shock is any event that has led to a serious reduction in your asset holdings, caused your household income to fall substantially, or resulted in a significant reduction in consumption.</p> <p>Has this household been affected by any of the following economic shocks?</p> <p><i>PROMPT</i></p> <p>1 Yes 2 No</p>	A	Death of a household member	
		B	Death of another friend or relative that you depended on for financial or in-kind assistance	
		C	Serious injury or illness keeping any household members from doing normal activities for more than 3 months	
		D	Loss of a regular job of a household member	
		E	Decrease in remittances to household	
		F	Serious family conflict	
		G	Termination of government grants (not due to death)	
		H	Abandonment or divorce	
		I	Theft, fire, or destruction of household property (including livestock, vehicles etc.)	
		J	Failure or bankruptcy of business	
		K	Widespread death/disease of livestock	
		L	Major crop failure due to, e.g., drought, flood, hailstorm, pests	
		M	Other, Specify below	
	Specify			

Section E – Health

Question number	Question text and instructions	Answer options	Answer
QE_01	Are medicines for treating basic illnesses (headaches, coughs, stomach ache etc.) available within an hour's walk of this village (either to buy or for free)?	1 Yes 2 No	
QE_02	Were medicines for treating basic illnesses (headaches, coughs, stomach ache etc.) available within an hour's walk of this village in September/April 2009 (either to buy or for free)?	1 Yes 2 No	
QE_03	When someone in this household gets sick do you usually experience any difficulties in taking them to a normal health facility (not a specialist HIV/AIDS facility)?	1 Yes 2 No <i>skip ► QE_05</i>	
QE_04	Which of the following reasons make it difficult to access a normal health facility? <i>PROMPT</i> 1 Yes 2 No	A Cost of diagnosis and treatment	
		B Cost of transport	
		C Time taken to get to and from health facility	
		D Time waiting at health facility	
		E Quality of treatment not good	
		F Medical staff not always available	
		G Medicines not always available	
		H Other (specify below)	
QE_05	In comparison to the last 12 months, in the 12 months before September/April 2009 how easy was it to take someone to a normal health facility when you needed to?	1 Easier before September/April 2009 <i>skip ► QE_07</i> 2 The same <i>skip ► QE_07</i> 3 More difficult before September/April 2009	
QE_06	Why was it more difficult to access the health facility in the 12 months before September/April 2009? <i>PROMPT</i> 1 Yes 2 No	A Cost of diagnosis and treatment	
		B Cost of transport	
		C Time taken to get to and from health facility	
		D Time waiting at health facility	
		E Quality of treatment not good	
		F Doctor not always available	
		G Medicines not always available	
		H Other (specify below)	
QE_07	<i>FOR INTERVIEWER ONLY (do not read out):</i> Are any members of this household HIV/AIDS positive (refer to QA_14)?	1 Yes 2 No <i>skip ► QE_10</i>	

Question number	Question text and instructions	Answer options	Answer
QE_08	When a household member with HIV/AIDS gets sick do you usually experience any difficulties in taking them to the specialist HIV/AIDS health facility?	1 Easy <i>skip</i> ► QE_10 2 Quite difficult 3 Very difficult	
QE_09	Which of the following reasons make it difficult to access the specialist HIV/AIDS health facility? 1 Yes 2 No	A Cost of diagnosis and treatment B Cost of transport C Time taken to get to and from health facility D Time waiting at health facility E Quality of treatment not good F Doctor not always available G Medicines not always available H Other (specify below)	
QE_10	how would you describe the health situation of this household over the last 12 months? <i>PROMPT the respondent by first reading all the options, then asking them to choose the one that best describes their health situation. Repeat the answer they chose back to them to confirm.</i>	1 Family was generally healthy and could generally afford to deal with minor health issues 2 Family was generally healthy but couldn't afford to deal with even minor health issues 3 Some members were in generally poor health, but the family could afford to cope with these health challenges 4 Some members were in generally poor health and the family could not afford to cope with those health challenges 5 The whole family was in generally poor health and could not afford to cope with those health challenges whether large or small	
QE_11	In comparison to the 12 months before September/April 2009, how would you describe the capacity of the household to afford to deal with health issues in the last 12 months? <i>PROMPT the respondent by first reading all the options, then asking them to choose the one that best describes their health situation.</i>	1 Better able to afford to deal with health issues now 2 About the same 3 Less able to afford to deal with health issues now	

Section F – Food security

Question number	Question text and instructions	Answer options	Answer
QF_01	In the last 12 months, how many meals did children (under 18) in this household normally eat in a day (not including meals eaten outside the house at school etc.)?	Number of meals	
QF_02	In the 12 months before September/April 2009, how many meals did children (under 18) in this household normally eat in a day (not including meals eaten outside the house at school etc.)?	Number of meals	
QF_03	In the last 12 months how often did the children in this household eat protein rich food (meat, milk, eggs, beans)?	1 Everyday 2 Couple of times a week 3 Couple of times a month 4 Every few months 5 Couple of times a year or less	
QF_04	In the 12 months before September/April 2009, how often did the children in this household eat protein rich food (meat, milk, eggs, beans)?	1 Everyday 2 Couple of times a week 3 Couple of times a month 4 Every few months 5 Couple of times a year or less	
QF_05	In the last 12 months have there been any times when the household has not had enough food to feed all its members (i.e. people have gone to bed hungry)?	1 Yes 2 No <i>skip ► QF_07</i>	
QF_06	How often? <i>PROMPT</i>	1 At least once a week 2 At least once a month 3 A few times throughout the year 4 Less frequently	
QF_07	In the 12 months before September/April 2009 were there any times when the household did not have enough food to feed all its members (i.e. people went to bed hungry)?	1 Yes 2 No <i>skip ► QF_09</i>	
QF_08	How often?	1 At least once a week 2 At least once a month 3 A few times throughout the year 4 Less frequently	
QF_09	In the last 12 months how often did this household receive food support from other households (friends, relatives, neighbours etc.)? <i>PROMPT</i>	1 At least a few times every week 2 At least a few times every month 3 At least a few times every year 4 Less frequently / never	
QF_10	Compared to the 12 months before September/April 2009, in the last 12	1 A lot less in the last 12 months 2 A bit less in the last 12 months	

Question number	Question text and instructions	Answer options	Answer
	<p>months how much food support did this household receive from other households (friends, relatives, neighbours etc.)?</p> <p><i>PROMPT</i></p>	<p>3 About the same 4 A bit more in the last 12 months 5 A lot more in the last 12 months</p>	
QF_11	<p>In the last 12 months how often did this household receive non-food support from other households (e.g. help with education expenses etc.)?</p> <p><i>PROMPT</i></p>	<p>1 At least a few times every week 2 At least a few times every month 3 At least a few times every year 4 Less frequently / never</p>	
QF_12	<p>Compared to the 12 months before September/April 2009, in the last 12 months how much non-food support did this household receive from other households (friends, relatives, neighbours etc.)?</p> <p><i>PROMPT</i></p>	<p>1 A lot less in the last 12 months 2 A bit less in the last 12 months 3 About the same 4 A bit more in the last 12 months 5 A lot more in the last 12 months</p>	

Section G – Livelihoods and investment

Question number	Question text and instructions	Answer options	Answer			
QG_01	<p>In the last 12 months have any members of this household been engaged in any of the following livelihood activities?</p> <p><i>List the total number of household members of each age group that have been involved in each livelihood activity. List zero (0) if none</i></p> <p><i>Take time to understand ALL the livelihood activities that are undertaken by any members of the household. Probe to discover where the income that allows the family to live and survive is coming from</i></p>		Total number of people of each age group	Under 18s	18-50 yrs	+50 yrs
		A	Casual labour (including agricultural and non-agricultural work, washing clothes, etc.)			
		B	Self-employment			
		C	Paid regular employment			
		D	Work in family business or farm			
		E	Petty trading (selling vegetables, clothes, bottles, etc.)			
		F	Rearing livestock (herding etc.)			
		G	Other (specify below)			
QG_02	<p>Were any members of this household engaged in any of the following livelihood activities in the year before September/April 2009?</p> <p><i>List the total number of household members of each age group that have been involved in each livelihood activity. List zero (0) if none</i></p> <p><i>Probe to understand any differences between then and now and record livelihood activities undertaken by any members of the household accordingly; you may have to go back and correct QG_01</i></p>		Total number of people of each age group	Under 18s	18-50 yrs	+50 yrs
		A	Casual labour (including agricultural and non-agricultural work, washing clothes, etc.)			
		B	Self-employment			
		C	Paid regular employment			
		D	Work in family business or farm			
		E	Petty trading (selling vegetables, clothes, bottles, etc.)			
		F	Rearing livestock (herding etc.)			
		G	Other (specify below)			
QG_03	In the last 12 months have you made any improvements to your home, such as building work, extending or repairing the property etc.?	1 Yes 2 No				
QG_04	In the last 12 months have you bought any items for your home such as furniture, cutlery and crockery, etc.?	1 Yes 2 No				

Question number	Question text and instructions	Answer options	Answer
QG_05	In the last 12 months have you bought any productive equipment for your farm or family business, such as spades or pick axes, calculator for shop etc.?	1 Yes 2 No	
QG_06	In the last 12 months have you purchased any livestock (cattle, goats/sheep, pigs, horses, donkeys etc.)?	1 Yes 2 No	
QG_07	In the last 12 months have you purchased any poultry?	1 Yes 2 No	
QG_08	In the last 12 months have you grown any vegetables or other crops in your garden or plot of land? <i>Do not include fruit</i>	1 Yes 2 No 3 Have no plot of land	
QG_09	In the 12 months before September/April 2009 did you grow any vegetables or other crops in your garden or plot of land? <i>Do not include fruit</i>	1 Yes 2 No 3 Have no plot of land	
QG_10	In the last 12 months have you been able to save any money?	1 Yes 2 No <i>skip ► QG_12</i>	
QG_11	How regularly were you able to put money into your savings?	1 Every week 2 Every month 3 A few times per year 4 Less frequently	
QG_12	In the 12 months before September/April 2009 did you save money?	1 Yes 2 No <i>skip ► QG_14</i>	
QG_13	In the 12 months before September/April 2009 how regularly did you put money into your savings?	1 Every week 2 Every month 3 A few times per year 4 Less frequently	
QG_14	Do you currently owe any money, not including credit to a shop?	1 Yes 2 No <i>skip ► QG_16</i>	
QG_15	How much do you currently owe (maloti)?	9999 Rather not say	
QG_16	Did you owe any money in September/April 2009, not including credit to a shop?	1 Yes 2 No <i>skip ► QG_18</i>	
QG_17	How much did you owe in September/April 2009 (maloti)?	9999 Rather not say	
QG_18	In the last 12 months have you been able to obtain credit from a shop (directly, i.e. not through a friend or neighbour)?	1 Yes 2 No	

Question number	Question text and instructions	Answer options	Answer
QG_19	In the 12 months before September/April 2009 were you able to obtain credit from a shop (directly, i.e. not through a friend or neighbour)?	1 Yes 2 No	

Section H – The Child Grant, spending patterns and other social transfers

Question number	Question text and instructions	Answer options	Answer									
QH_01	Every 3 months you receive M360 from the Child Grants Programme. Would you prefer to receive this payment in cash or in-kind support?	1 Cash 2 In-kind support										
QH_02	When did you receive your first Child Grant payment? <i>If possible ask to see a receipt to confirm the date</i> <i>If respondent gives an answer that does not correspond to the actual date of first payment in this district and community council (consult the table on the right), gently probe their answer. DO NOT give them the answer in the table, and record their final answer faithfully.</i>	<p><i>FOR INTERVIEWER ONLY:</i> <i>Date of first payment by district:</i></p> <table border="1"> <thead> <tr> <th>District</th> <th>Community council</th> </tr> </thead> <tbody> <tr> <td>Mafeteng</td> <td>Mathula</td> </tr> <tr> <td>Qacha's Nek</td> <td>Thaba Khubelu</td> </tr> <tr> <td>Maseru</td> <td>Semonkong</td> </tr> </tbody> </table>	District	Community council	Mafeteng	Mathula	Qacha's Nek	Thaba Khubelu	Maseru	Semonkong	M M YY YY	
District	Community council											
Mafeteng	Mathula											
Qacha's Nek	Thaba Khubelu											
Maseru	Semonkong											
QH_03	How much was it for (maloti)?	Record the amount of the first payment in maloti										
QH_04	What did you spend the first transfer on? <i>Respondent can list up to three items. List the items in order of most money spent on each</i>	1 Basic food items and other basic needs 2 Special food items (meat, eggs, milk, beans etc.) 3 Health expenditure 4 Education (school uniforms, supplies etc.) 5 Clothes 6 Small household items (crocery, linen, bucket etc.) 7 Large household items (furniture, appliances etc.) 9 Investment in family farm or business (including productive items such as spade or axe etc.) 9 Investment in livestock 10 Saving 11 Multiple items/cannot say 97 Other (specify below) 99 NA Specify:	1 st 2 nd 3 rd									
QH_05	When did you receive the most recent payment? <i>If possible ask to see a receipt to confirm</i>		MM YY YY									

Question number	Question text and instructions	Answer options	Answer
	<i>the date</i>		
QH_06	How many payments have you received to date?	Enter total number of payments received	
QH_07	Have you also received food aid as well as the cash payment?	1 Yes 2 No <i>skip ► QH_09</i>	
QH_08	How many packages of food aid have you received in total since you received your first payment from the Child Grant Programme?	Enter total number of food packages received	
QH_09	How much does it usually cost to collect the child grant (in transport fees etc.)?	Record the amount in maloti; record 0 if it costs nothing	
QH_10	Can you tell us the top three things you usually spend the transfer on? <i>PROMPT the respondent with the line items if they are unable to tell you what they spend the transfer on.</i>	1 Basic food items	1 st
		2 Special food items (meat, eggs, milk, beans etc.)	2 ⁿ _d
		2 Hygiene and personal care products (soap etc.)	3 rd
		3 Clothes (excluding shoes and school clothes)	
		4 Shoes (excluding school shoes)	
		5 Education (school uniform, shoes, supplies...)	
		6 Health	
		7 Transport	
		8 Burial societies	
		99 NA	
QH_11	Who is the main decision-maker over how the Child Grant transfer is spent?	Enter the member ID number from the household roster	
QH_12	In the last 12 months how difficult has it been to meet your needs on the following items? 1 Not difficult 2 Quite difficult 3 Very difficult	A Hygiene products (soap, washing powder, Vaseline etc.)	
		B Over-the-counter Medicines (pain killers, cough syrup etc.)	
		C Maize meal	
QH_13	In the 12 months before September/April 2009 how difficult was it to meet your needs on the following items? 1 Not difficult 2 Quite difficult 3 Very difficult	A Hygiene products (soap, washing powder, Vaseline etc.)	
		B Over-the-counter Medicines (pain killers, cough syrup etc.)	
		E Maize meal	

Question number	Question text and instructions	Answer options	Answer
QH_14	<p>When did you last purchase each of the following items?</p> <p>1 Within the last week 2 Within the last month 3 Within the last 3 months 4 Within the last 6 months 5 Within the last year 6 Longer ago 7 Never purchased</p>	A Children's clothes (not including shoes or school uniform)	
		B Children's shoes (not including school shoes)	
		C School uniform (not including school shoes)	
		D School shoes	
		E School equipment (e.g. school bag)	
		F Sweets and/or soft drinks for children under 15	
		G Toys for children under 15	
QH_15	<p>How far away was the place that you purchased most of your food and other basic needs items in the last 12 months?</p>	Distance to walk one way <i>Do not leave blank; enter 0 as appropriate</i>	Hours
			Minutes
QH_16	<p>In September/April 2009 how far away was the place where you purchased most of your food and other basic needs items?</p>	Distance to walk one way <i>Do not leave blank; enter 0 as appropriate</i>	Hours
			Minutes
QH_17	<p>Have you noticed any tension in your community between recipients of the Child Grant and people who do not receive the transfer?</p>	1 Yes 2 No	
QH_18	<p>Does any member of this household currently receive a state pension?</p>	1 Yes 2 No	
QH_19	<p>Did any member(s) of this household receive a state pension in September/April 2009?</p>	1 Yes 2 No <i>skip ► QH_20</i>	
QH_20	<p>Are they still a member of the household?</p>	1 Yes 2 No	
QH_21	<p>In the last 12 months did this household receive government social assistance?</p>	1 Yes 2 No	
QH_22	<p>Did this household receive government social assistance in the 12 months before September/April 2009?</p>	1 Yes 2 No	

CLOSE OF INTERVIEW

Please thank the respondent for their time and return to the cover sheet to complete the VISIT INFORMATION (end time of interview) and POSTCHECK sections (respondent name and ID code – taken from the Household Roster). Remember to also check through the completed interview thoroughly to ensure there is no missing or wrongly entered data and complete the DATA CHECK section of the cover sheet with your name and interviewer ID code, signature and the date you checked the interview.

Annex B Qualitative interviews

Table B.1 List of key informant interviews

Number	Position	Name/location	Date
1	UNICEF Social Policy Chief	Mohammad Farooq	15/02/2011
2	UNICEF Child protection specialist	Mamakheta	15/02/2011
3	UNICEF Health specialist	Victor Ankrah	17/02/2011
4	UNICEF Education specialist	Nurbek Teleshaliyev	17/02/2011
5	WFP programme manager	Napo Ntlou	17/02/2011
6	Justice and Peace representative	Mosele Masotsa	17/02/2011
7	Chief	Mathula	18/02/2011
8	Village health worker	Mathula	18/02/2011
9	Principal, primary school	Mathula	21/02/2011
10	Teacher, primary school	Mathula	21/02/2011
11	Class 7 boy	Mathula	21/02/2011
12	3 primary school children	Mathula	21/02/2011
13	Shopkeeper	Mathula	21/02/2011
14	Female recipient	Mathula	21/02/2011
15	Female recipient	Mathula	21/02/2011
16	Village health worker	Mathula	21/02/2011
17	Village support health worker	Mathula	21/02/2011
18	Shop keeper	Mathula	21/02/2011
19	Chief of village	Mathula	21/02/2011
20	Principle of primary school	Mathula	22/02/2011
21	Nurse at clinic	Mathula	22/02/2011
22	Shop keeper	Mathula	22/02/2011
23	Village health worker	Mathula	22/02/2011
24	Village support group (3)	Mathula	22/02/2011
25	Female non-recipient	Mathula	22/02/2011
26	Village health worker	Thaba Khubelu	24/02/2011
27	Female non-recipient	Thaba Khubelu	24/02/2011
28	Female non-recipient	Thaba Khubelu	24/02/2011
29	Teachers (3), primary school	Thaba Khubelu	24/02/2011
30	Female recipient	Thaba Khubelu	24/02/2011
31	Female recipient	Thaba Khubelu	24/02/2011
32	Chief	Thaba Khubelu	24/02/2011
33	Female recipient	Thaba Khubelu	25/02/2011
34	Female recipient	Thaba Khubelu	25/02/2011
35	Chief and village health worker (husband and wife)	Thaba Khubelu	25/02/2011

36	Teacher, primary school	Thaba Khubelu	25/02/2011
37	Principal, pre-school	Thaba Khubelu	25/02/2011
38	Shopkeeper	Thaba Khubelu	25/02/2011
39	Female non-recipient	Thaba Khubelu	25/02/2011
40	Male non-recipient	Thaba Khubelu	25/02/2011
41	Nurses, public clinic	Thaba Khubelu	23-25/2/2011
42	Village support group	Semonkong	24/02/2011
43	Village health worker	Semonkong	24/02/2011
44	Teacher	Semonkong	24/02/2011
45	Chief of village	Semonkong	25/02/2011
46	Female non-recipient	Semonkong	25/02/2011
47	Shopkeeper (2)	Semonkong	25/02/2011
48	Teacher (3), two different primary schools	Semonkong	25/02/2011
49	Female recipient	Semonkong	25/02/2011
50	Village health worker/Support group	Semonkong	25/02/2011