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Impact Assessment of Argentina's Universal Allocation per Child

Bernardo Kliksberg*
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Summary

This publication delineates the findings of the the impact assessment performed on the Universal allocation per child (Asignación Universal por Hijo) initiative implemented in Argentina. The assessment analyzed results obtained during the 4-year period following the program's launch. The policy constitutes an effort to extend the existing family benefits system, which was previously limited to coverage for the children of workers enrolled in social security. It extends coverage to households headed by unemployed or low income, informal-sector workers and thereby constitutes tangible progress towards a universal social protection system. The new regime is a conditioned cash transfer program which includes healthcare and education co-responsibilities for children and adolescents receiving benefits.

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The assessment was performed in order to determine the impact of the initiative on well-being levels within Argentine households, improvements made in access to essential goods and the degree to which beneficiaries comply with the aforementioned healthcare and education co-responsibilities. The assessment also evaluated the program's effect on labor market strategies utilized by AUH-recipient households, in addition to the perceptions of beneficiaries with regard to the importance of the cash payment in terms of quality of life levels and consumption patterns. The assessment utilized a two-pronged quantitative/qualitative approach. The quantitative aspect involved a survey of a probabilistic sampling of recipient households, the construction of a comparison group generated utilizing statistical modeling, and the use of the nearest-neighbor technique that employed a propensity score estimation. The qualitative aspects were analyzed utilizing focus groups comprised of female participants in the *Asignación Universal por Hijo* (AUH) program, in addition to interviews with qualified respondents.

The results obtained indicate notable impacts on beneficiary households which are directly attributable to AUH. The initiative also constitutes an important contribution in terms of distributive equity within the beneficiary group, as well as in terms of the general population – especially where Argentine children and adolescents are concerned. Additionally, tangible improvements were detected in terms of school attendance and academic performance, as well as in terms of access to medical care. All of these factors were attributable to the education and healthcare co-responsibility conditions. As opposed to traditional cash-benefit programs, no adverse effects attributable to AUH were detected in terms of discouraging participation in the labor market among adults within beneficiary households. This publication includes recommendations designed to drive improvements in the implementation of the initiative as well as in terms of coverage, most of which are directed at optimizing the integration of the existing social protection system.

Introduction

Latin America possesses a fairly wide spectrum of variants in terms of the design of new social policies and programs. However, certain trends and emphases can be detected which seem to point to the presence of a new generation of social policies. In particular, there is a notable emphasis on rights: providing assistance to less-favored populations is increasingly legislated, planned and perceived as the reinstatement of a right. This tack has replaced the notion of "social welfare" which was prevalent for decades within the region.

> Within the new concept, the State is simply meeting an obligation which States possess in a democracy: to guarantee basic social rights. This is to say, individuals who receive supports also have a legitimate right to demand them. (Kliksberg, 2011)

The appearance of this new political context within Latin America has fomented a new social protection paradigm in which a tangible motivation and basis exist for the conviction that States are obligated to actively pursue the full realization of their populations' economic and social rights.

Said economic and social rights – which have also been referred to as second-generation rights – comprise needs such as access to nutrition, healthcare or knowledge (a set of basic goods and services, as it were). Additionally, States are obligated to ensure these rights through active policies; i.e., measures designed to ensure individuals are not deprived of nutrition, education or housing will always fall short if said individuals are unable to ensure access to these rights by their own means.

The *Asignación Universal por Hijo* (Universal Per-Child Allocation) initiative introduced in Argentina during 2009 fall squarely within the parameters of this new strategy designed to address the challenge of consolidating the Social Protection System and ensuring a truly integrated approach is employed to achieve same. Five years on from its launch, the initiative has been praised by a variety of international organisms that have highlighted its management systems and the significant contributions it has made to Argentine society.

However, the *Asignación Universal por Hijo* (AUH) initiative has certainly been part of the broader debate on means-based benefits policymaking. The most hotly-debated points are related to the initiative's impact on labor-market participation, gender roles and birth rates, as well as arguments regarding the legitimacy of conditioning eligibility through the use of co-responsibilities.

As a result, it is imperative to determine whether resources earmarked for a given objective arrive to targeted households and whether said resources contribute to achieving initiative objectives. This study, therefore, addresses issues related to the desirable transparency of policies which also contribute decisively to optimizing the initiative's implementation, bolstering its legitimization and permanency, and ascertaining within the near future the best way forward in terms of achieving social inclusion.

The assessment, performed by a team of specialists[1] under the auspices of the Organización Iberoamericana de Seguridad Social (OISS) and Argentina's Universidad Nacional de Tres de Febrero, was primarily designed to provide answers to four essential questions: To what degree does the income received provide improvements in quality of life levels within the most vulnerable households, particularly where children and adolescents – who are the intended recipients of benefits – are concerned? How does the new policy impact healthcare and education levels within the lives of children and adolescents? Does said income have an empowering impact on the women who administer same? Does the policy have the potential to interrupt intergenerational cycles of poverty?

[1] The team was comprised of Isidro Adúriz, Victoria Arinci, Horacio Chitarroni, Elisa Trotta and Naomi Wermus.

These are some of the questions which researchers sought to resolve in the wide-ranging urban sampling survey; an instrument which comprised 3068 households and was carried out between November 2013 and February 2014 in Argentina.

The empirical data gathered during the impact assessment refuted several critiques of the AUH initiative which are currently circulating. This publication delineates the procedures and results of the AUH Impact Assessment and is comprised of four sections: Section 1 addresses the specific characteristics of the AUH initiative and the circumstances in which it was formulated, its objectives, program co-responsibilities and coverage. Section 2 outlines the objectives and questions which provided the basis of the impact assessment, in addition to a complete survey of the methodology utilized therein. Section 3 focuses on the most significant results generated by the impact assessment in terms of income, nutrition, healthcare, gender roles and education. Section 4 provides the conclusions and recommendations generated during the authors' analysis of the assessment results.

Background and creation of the *Asignación Universal por Hijo* (AUH)

The debate on cash transfer programs is certainly not a recent issue, whether in terms of conditional cash transfers or guaranteeing an unconditional right to income – which is what the AUH initiative proposes. Since the mid-1990s, conditional cash transfer programs (CCTPs) have been utilized to address the crisis in the labor market as well as growing levels of social exclusion. As a result, several initiatives were undertaken in Argentina to address the importance of universal family benefits, which have been available to formal-sector workers in the social security system since 1957. Additionally, other initiatives were launched to provide income to citizens during childhood (Pautassi, Arcidiácono and Straschnoy, 2013).

During the 1990s and particularly in the wake of the 2001 crisis, several interventions were introduced, including *Plan Trabajar*, *Plan Jefes y Jefas de Hogar Desocupados* and *Programa Familias*, all of which may be considered the direct predecessors of Argentinian cash-transfer policy.

The AUH constitutes a qualitative leap in comparison to its predecessors whereas it was implemented within the broader framework of the social protection and social security system consolidated during the 20th century in Argentina.

The Argentine social security system was designed vis-à-vis the contributory Bismarck model. The model involves a right to receive benefits (healthcare coverage through social programs, family allotments, unemployment insurance and pensions, inter alia) which is based upon the contributions made by the individuals who receive benefits (active workers), in addition to employer contributions. Economic security was guaranteed through employment which brought with it

a wide spectrum of related rights, thus making employment the fulcrum point (Anses, 2012).

For its part, the AUH as delineated in Presidential Decree 1.602/09 dated 29 October 2009 was designed to provide coverage to the children of unemployed or informal-sector workers. The decree ordered the incorporation of a noncontributory subsystem entitled the Universal Per-Child Social Protection Allocation into *Ley 24.714* (Anses, 2012).

The AUH is a cash transfer provided to households which are selected on the basis of their vulnerability (due to an inability to find employment, which is the primary cause for lack of household income). The program guarantees adequate standards in terms of access to education and healthcare for children and adolescents through the use of co-responsibilities. As a result, the cash transfers provide immediate remediation of the most pressing needs, while serving to foment access to education and preventative health care among children. The resources also increase human capital and improve their short-term and long-term opportunities. As has been noted, "increased investment in human capital during early childhood contributes to an increased capacity in individuals to transform the access to goods and services into something which they value and are able to be or do later in life (to use the phrasing of Amartya Sen). It involves the ability to transform goods and services into skill sets." (PNUD, 2010)

The original, monthly AUH allotment was US$20 (ARS$180) per child or adolescent dependent under 18 and included a limit of five benefit recipients per household. This figure was the maximum amount allowed under the contributory scheme. In the case of individuals with disabilities, no age limit was utilized and the cash transfer was US$81 (ARS$720). The regulation which established the initiative also includes explicit exclusions: informal-sector workers earning more than federal minimum[2] wage, a measure which proved impossible to enforce, whereas it depends on self-reporting; and, self-employment taxpayers, a category which excludes individuals working in domestic service and enrolled in the *Monotributo Social* tax program (an initiative designed to provide social protection coverage to individuals historically excluded from same).[3]

In May 2014, the AUH allotment was increased to ARS$644 (US$72) per child, thus reaching its highest purchasing power to date.[4] The amount of the cash transfer is significantly higher than other nations within Latin America; i.e., vis-à-vis, for example, Brazil and Chile (Isuani, 2010).

[2] Known as the *Salario Mínimo Vital y Móvil*, the Argentine federal minimum wage was ARS$1,440 in 2009, at the time of AUH launch. It has since risen to ARS$4,400 (approximately US$300).

[3] The decree stipulated program eligibility is limited to Argentine nationals, children of same or naturalized or resident aliens living in the nation for a period of more than three years. Participants are also required to establish family ties with, or guardianship of, with children and/or adolescents receiving benefits.

[4] In June 2015, further increase was announced which raised the benefit payment to ARS$837, which was equivalent to US$90.

As of early 2015, over 3.6 million children and adolescents were receiving AUH benefits, 40% of whom were under age 5; that is, the period in which periodic checkups and vaccination programs have the most significant impact.

It should be noted that the Argentine National Social Security Service (Anses) introduced a measure in March 2013 which named the beneficiary's mother as the benefit distributor. This measure is followed even in cases involving joint custody of the minor involved. This policy is also followed with regard to the family allotments in accordance with Decree 614/13. This measure guarantees that both benefits reach the individual for whom they were intended, whereas it ensure that fathers are no longer able to arbitrarily employ the funds as they deem fit.

Assessment objectives and methodology

The AUH Impact Assessment was primarily designed to verify the degree to which objectives set during the launch phase were achieved.

Some of the objectives of the assessment included:

- Estimating the results and impacts attributable to AUH.
- Measuring changes in well-being levels of recipient households which are directly attributable to introduction of AUH.
- Identifying unexpected effects (positive or negative) attributable to the introduction of AUH.
- Recommendations for new objectives within the field of social policy.

In terms of the methodology utilized to achieve the aforementioned goals, a combination quantitative-qualitative approach was employed. The qualitative aspects of the assessment employed 12 focus groups comprised of women who were AUH[5] recipients, from which opinions and perceptions on the program were gathered. Additionally, 21 in-depth interviews with key players within the education, health care and municipal government sectors were conducted, in which interviewees provided testimony on AUH characteristics and observed impact.

Given AUH's characteristics and the manner in which it was launched, the design of the quantitative aspect of the assessment was challenging. This was due to the lack of baseline measurements from the treatment group and comparison group prior to the receipt of benefits, a factor which is of paramount importance in the traditional quasi-experimental model of research.

In consequence, the assessment employed an *ex post facto* quasi-experimental model. This strategy necessitates working from the assumption that households within the treatment group and comparison group do not differ significantly in any

[5] Six of these groups focal is conducted with pregnant women pregnant or mothers of girls or children of up to 12 years; While the remaining half was composed by women with children of 13 years or more. The focus groups, as well as interviews, were conducted in different cities of the country.

aspect at the time of program launch (where T_0 represents time period prior to launch of AUH). Although the model is in fact less robust than others which possess a baseline measurement, its use is not without precedence in the literature (Campbell and Stanley, 1973).

The baseline is arrived at by comparing the treatment group (AUH-recipient households) with the comparison group (non-recipient households) possessing similar profiles in characteristics which do not comprise indicators used to measure impact. The statistical selection process allowed researchers to presume that both groups began at substantially similar levels in the absence of a baseline measurement.

Measurements were taken later, at moment T_1, in order to determine the differences between the treatment group and the comparison group. Assuming baseline parity, this measurement is effectively equivalent to the double difference utilized in classical double-measurement models.

Below is a detailed explanation of the statistical model used, sampling design and control for effects.

Sampling design

The sample was generated at the national urban level, taking into account stratification by demographic strata. The following is a brief review of the sampling characteristics:

- Probabilistic: each household selected within the studied universe and the ages of survey subjects which were finally selected possess a known selection probability which is above zero. This type of sample provides the necessary precision in the principle results to be achieved, as well as an opportunity to calculate the accuracy of all estimations made.
- Stratified: communities throughout Argentina were sampled within three population strata (Greater Buenos Aires, communities with over 100,000 inhabitants and communities with less than 100,000 inhabitants) in order to obtain significant results on the entire nation and for each population.
- Localities within each stratum were selected in order to obtain a representative sampling (primary sampling unit).

Within each of the selected communities, benefit recipients were selected via simple random selection of recipients and non-recipients from a list provided by Anses (secondary sampling unit). Distribution was performed proportionally vis-à-vis the quantity of recipients in each of the communities comprising the stratum.

The households comprising the treatment group were identified using the list of AUH recipients provided by Anses. The preselection of the household sample performed with the aim of selecting a comparison group was achieved using an

Anses list of individuals who were suing for benefits or who have filed complaints, and who had been deemed ineligible to receive AUH benefits due to administrative issues (i.e., inconsistencies in data provided, incomplete applications for benefits, failure to provide sufficient documentation) and/or failure to make payment.

The final sample comprised 1,755 recipient households and 1,313 nonrecipient households, which were distributed throughout three geographic strata.

The survey was carried out between November 2013 and February 2014. The survey instrument was designed to be administered by a survey representative to the household respondent. In the case of the treatment group, the respondent was the administrator of record for the AUH benefit; whereas in the case of the comparison group, women identified as having filed a complaint on the Anses list were utilized.[6]

Statistical procedures

In order to construct the comparison group, a *matching* procedure was used to process the set of variables considered to be crucial (ie, variables which differ from those subject to measurement, such as expected-impact variables, with the express purpose of avoiding confusion when attributing impact levels). The nearest-neighbor procedure was utilized in order to probabilistically establish propensity scores (Rosenbaum and Rubin, 1985): non-recipients possessing a probability within the same range as recipients were selected as the comparison group.

In order to establish propensity scores, a binary logistic regression model was used vis-à-vis access, or lack thereof, to AUH as a dependent variable. A set of the households' sociodemographic characteristics were utilized as independent or predictive variables; as noted, structural variables were included, in addition to variables which could feasibly be expected to involve no concomitant impact.

In order to definitively select the comparison group, it was necessary to ensure squared differences between estimated participation probabilities for the model between the nearest neighbors within each of the two groups did not exceed 0.01, in accordance with the parameters suggested by Lazo and Phillip (2003).

The treatment group of AUH-recipient households selected via statistical procedure comprised a subsample of all households surveyed: AUH-recipient households for which at least one matching households within the comparison group was found in terms of the model's distance between estimated propensity scores. Conversely, in terms of the surveyed non-recipient households, only households which have at least one match within the treatment group were included in the comparison group. These strategies have been justified within the literature (Jalan and Ravallion, 1998). The AUH Expected-Impact Assessment, which utilized comparisons

[6] In instances of male benefit-administrators, the female spouse was interviewed. In the extremely rare case of male, single-parent heads of household, the household was simply replaced.

between the subsamples which comprised the treatment group (TG) and comparison group (CG), as well as statistical significance testing of results, was employed throughout the entire process of evaluation.

In order to evaluate the statistical significance of differences and achieve a bilateral test, Student's *t*-test was utilized in every instance to determine median differences of independent samples and sample proportions.

Control for effects

- Attribution and control of confusion effects. The eventual differences between recipient and non-recipient households attributable to prior propensities and not to AUH impacts, as well as other changes due to outside influences (e.g., effects of maturity, changes in context) were controlled for through the use of propensity scores.
- Selection bias. The statistical modeling used in the CG, which employed *propensity score matching*, allowed for effective control of selection bias. Additionally, a systematic comparison, which employed statistical significance testing, was performed between the TG and CG with regard to non-AUH variables.
- Contamination of comparison group. Eventual risks of contamination were controlled for through the use of the identification in the survey through the use of specific questions and the use of secondary sources such as national databases.
- Spillover effects. Spillover effects of the program were explored through the use of qualitative techniques.
- Heterogeneity and diversity of impact throughout population subgroups. Given the differences in co-responsibilities due to age (education and health care) and the priority for the female benefit administrator, it was expected that the impact would present variations based on gender and among age cohorts.

Results of impact assessment

This section contains the principal results which resulted from the calculation of differences between the treatment group (TG) and comparison group (CG) within several dimensions which were subject to AUH-attributable impacts. The major findings of the assessment are organized vis-à-vis the most highly-debated AUH issues as follows:

1. Impact of cash transfers upon labor market participation of recipients
2. Impact of co-responsibilities
3. Impact on gender roles
4. Impact on birth rates

Impact of cash transfers upon labor market participation of recipients

A common complaint regarding cash transfer programs – and the AUH is certainly no exception, whereas this has been a major issue in the debate surrounding this initiative – is related to assertions that this type of initiative impacts the propensity of recipients to become economically active. This argument rests primarily upon the belief that the income provided by the transfers as a potentially substitution effect in terms of the income which recipients would normally obtained through participation in labor markets. As a result, proponents of this argument assert that cash transfers de-stimulate efforts to look for work and may even have an impact on the propensity to remain employed along recipients or their relatives. This dynamic is perceived as being especially relevant in terms of those sectors which normally obtain precarious, low-paying employment, whereas the opportunity costs of remaining outside the job market are reduced.

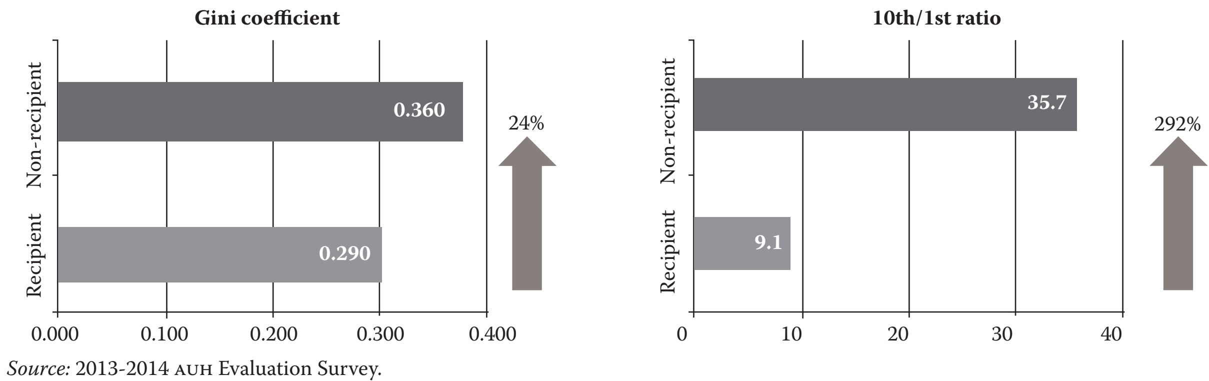
Other opinions stress the fact that these cash transfers can have positive effects whereas they serve to increase median household income levels among the most vulnerable sectors of society (for example, individuals working in domestic service). These increases serve to improve, rather than worsen, an individual's probability of escaping poverty (Matarazzo y Suplicy, 2002). Along the same lines, AUH benefits may facilitate the exit of women from the labor market whereas they serve to cover the cost of outside child or elder care (Novacovsky, 2010).

The impact assessment results would seem to completely contradict arguments to the effect that AUH benefits have a negative effect upon labor participation rates among recipients. On the contrary, positive effects were observed in terms of household finances (increases in income, decreases in social inequities) and employment rates among participants.

The AUH initiative has made a highly significant contribution in terms of REDUCING INCOME INEQUALITY[7] within recipient households as well as within urban households as a whole within Argentina. Additionally, the initiative extends an existing right to individuals previously denied same; thus delivering a leveling effect on income which is, in and of itself, virtuous whereas it contributes to social equity – a factor which is valuable based upon its own merit (Kliksberg, 2005; Dubet, 2011).

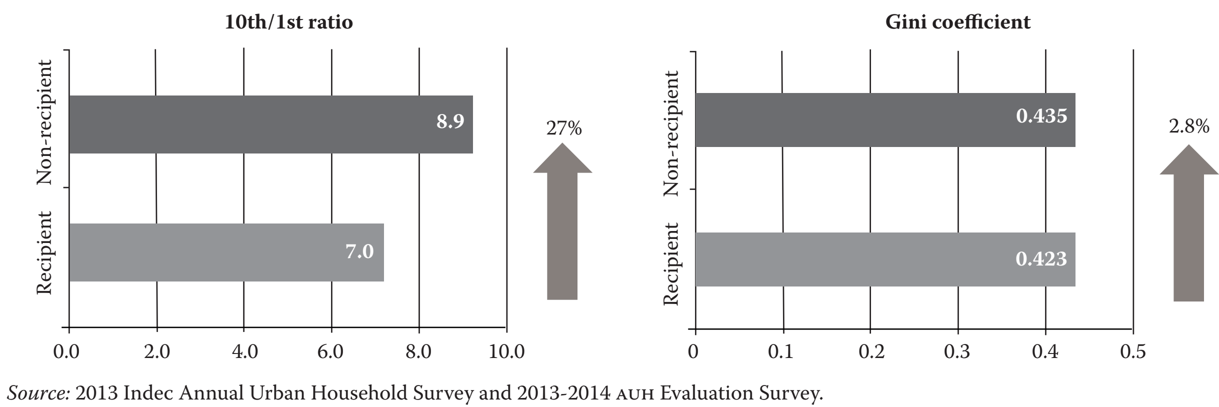
[7] Simulations were run using the Indec's 2013 Annual Urban Household Survey (*Encuesta Anual de Hogares Urbanos*), and data from the AUH Impact Assessment, by subtracting AUH income.

Figure 1
Impact of AUH on Gini coefficient and income ratio of 10th/1st PCFI deciles of AUH-recipient households



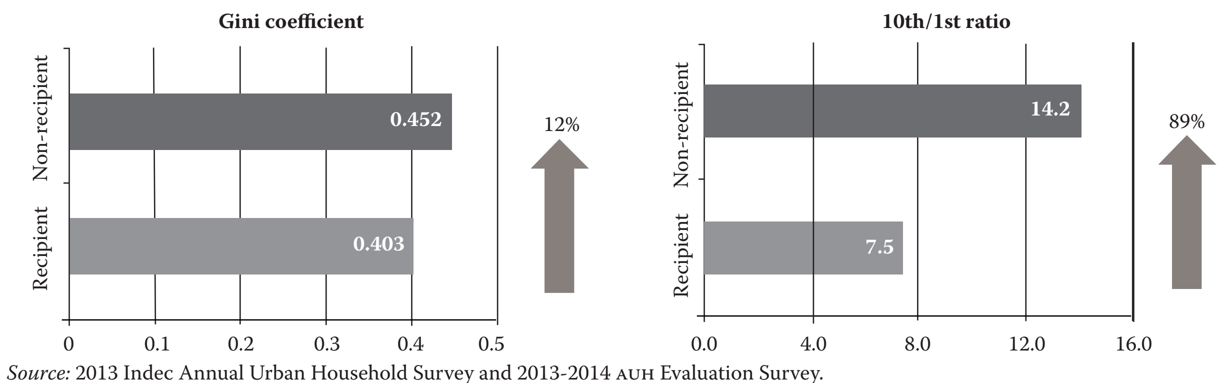
Source: 2013-2014 AUH Evaluation Survey.

Figure 2
Impact of AUH on Gini coefficient and income ratio of 10th/1st PCFI deciles of all urban households



Source: 2013 Indec Annual Urban Household Survey and 2013-2014 AUH Evaluation Survey.

Figure 3
Impact of AUH on Gini coefficient and income ratio of 10th/1st PCFI deciles of children and adolescents in all urban households



Source: 2013 Indec Annual Urban Household Survey and 2013-2014 AUH Evaluation Survey.

The initiative has been especially effective in reducing inequalities in terms of access to income among children and adolescents. This is further evidence that the AUH contributes to reducing inequality during the earliest stages of life and, as a result, has any impact on fomenting equity at a point in time when there is an ability to ensure that differences in opportunity levels do not evolved into completely insurmountable barriers.

The principal SOURCE OF INCOME WITHIN AUH-RECIPIENT HOUSEHOLDS is income earn through employment. On average, it constitutes nearly 62% of same while the cash transfer is equivalent to nearly 25% of household income. Income from pensions, therefore, represents on average 6% of total household income (Table 1).

TABLE 1
Total family income of AUH-recipient households, sources by percentage

Source of income	%
Employment	61.7
Pensions	5.8
Social programs (excluding AUH)	1.6
AUH	24.6
Other sources	6.3
Total	**100.0**

Source: 2013-2014 AUH Evaluation Survey.

In terms of income derived from AUH transfers, the proportion differs between various segments of the recipient-household population. In many cases, it represents a fairly small amount or at least not highly significant (ie, no more than 10% of total household income). While in other instances, it represents the largest proportion of income within the residence.

In nearly 6 in 10 recipient households, AUH resources do not represent more than 20% of all income; while in three quarters of this population, it represents no more than 30%. But on the opposite extreme of the spectrum, there are a small proportion of households in which the cash transfers represent an essential source of income and in nearly 5% of cases it is the sole source of income (Table 2).

In the case of single-parent homes, the capacity to increase income levels is impeded by a smaller workforce within the household. On average, the predicted AUH-sourced income comprises 32% of total household income. However, this figure increases to nearly 44% in terms of households which, in the absence of said cash transfers, would occupy the lowest urban decile in the nation. Nearly 2/3 of this decile is comprised of single parent homes, for which the AUH is a crucial source of income which constitutes nearly half of all household income (Table 3).

Table 2
Percentage of AUH-recipient households, by AUH as a proportion of total family income

AUH as a proportion of total family income	% of households	Cumulative %
Up to 10%	27.2	27.2
Between 10 and 20%	31.5	58.6
Between 20 and 30%	16.5	75.1
Between 30 and 40%	9.5	84.6
Between 40 and 50%	4.6	89.1
Between 50 and 60%	3.5	92.7
Between 60 and 70%	0.7	93.4
Between 70 and 80%	0.8	94.2
Between 80 and 96%	1.2	95.4
AUH: sole source of income	4.6	100.0
Total	**100.0**	

Source: 2013-2014 AUH Evaluation Survey.

Table 3
Single-parent, AUH-recipient households, by total-urban PCFI deciles, and AUH as a proportion of total family income

PCFI decile in absence of AUH (2013 Annual Urban Household Survey)*	% of households	AUH as a proportion of total family income (%)
1°	64.1	43.8
2°	20.1	13.4
3°	13.1	8.5
4°	2.2	5.9
5°	0.7	4.6
Total	**100.0**	**32.0**

*None of the AUH-recipient households surveyed pertained to the 6th to 10th total urban deciles.

Source: 2013-2014 AUH Evaluation Survey.

Access to AUH-provided income IN NO WAY REDUCES THE PROPENSITY TO ENTER THE LABOR MARKET on the part of adults. On the contrary. it drives labor market participation among men and women.

Among male heads of household, labor activity and employment rates are notably higher within recipient households, even as unemployment rates are lower. Where women are concerned, the activity rates are not appreciably higher, however the treatment group's employment rate was higher and its unemployment rate was lower (Table 4).

Table 4
Impact of AUH on activity, employment and unemployment rates, by selected population group: Variance between treatment and control groups

Population group	TG - CG	Significance
Population aged 18 and over		
Activity	1.6	No significance
Employment	5.0	0.01
Unemployment	-5.3	0.01
Male heads of household		
Activity	7.3	0.01
Employment	10.2	0.01
Unemployment	-3.6	0.1
Female heads of households		
Activity	1.0	No significance
Employment	6.0	0.1
Unemployment	-7.1	0.05

Source: 2013-2014 AUH Evaluation Survey.

This is to say, the heads of AUH-recipient households have a higher probability of being economically active, and their attempts to do so are more effective. They possess better skills in terms of selecting appropriate employment during job searches which translates into increased activity.

Another point of debate involves the conditions under which AUH recipients enter the labor market. It has been suggested that the cash transfer program engenders an incentive to remain within the informal-sector labor market, thereby de-incentivizing the type of formal sector employment which would result in the loss of AUH benefits.

According to this argument, there is a likelihood of this dynamic among self-employed workers who would ostensibly avoid reporting income – especially in the case of programs such as the aforementioned *Monotributo Social* initiative – whereas their work activities normally involve highly unstable demand and, in consequence, highly volatile income levels. The logic goes that this scenario may contribute to a preference among individuals to remain within the informal sector and ensure that the AUH income continues to flow into the household.

Another way of analyzing the foregoing dynamic involves questioning the underlying logic that individuals freely choose whether or not to remain within the informal sector. It is highly plausible to assume that in the majority of cases their presence within the informal sector is the product of a sector-wide strategy to reduce labor costs. For example, Bertranou and Casanova (2013) indicate that several empirical studies carried out within the Buenos Aires Metroplex (Banco Mundial-MTEySS, 2008) demonstrated that an individual's presence in the informal sector tended to be involuntary and simply an alternative to unemployment in the face of insufficient income.

The assessment of this impact was performed through the use of collected qualitative data whereas – given the fact that AUH eligibility is based on the fact that an individual does not possess formal sector work – there was no possibility of testing this condition through a quantitative model. The perceptions of AUH benefit administrators regarding the advantages of formal sector employment were gathered through qualitative methods. The testimonies demonstrate the enormous value of these individuals often place on formal sector employment, whereas said jobs involve an endless number of advantages in terms of job security and benefits:

> If I had the choice, I would opt for a (formal sector) job.
>
> …because I would have benefits. If I got sick, I would have access to sick leave. I could recuperate at home and not lose money… the benefits are the most important factor involved.
>
> We now have access to the national health care system. And at the end of the month, you know you're going to receive a set amount.
>
> I would love to work, for example, as a security guard at a school. A proper job, and not under the table. But nowadays you have to meet certain minimums: high school education or computer skills… and I only finished grade school.
>
> I wish I was as lucky as those women whose husbands are employed and to have access to the national healthcare system… this really makes things a lot easier. Salary that lasts the entire month. Our ARS$700 or ARS$1,000 just doesn't get us through the month.
>
> I wish I was able to find steady employment and not have to depend on the AUH (benefits program). I worked all my life and never had to ask for handouts. Everything I have, I earned.
>
> I wish I had a good salary.
>
> [Regarding formal-sector work] It's the best. You have a pay slip which indicates exactly what you make in which you can use to obtain credit… and in the case of accidents, you're covered. You are not simply at the mercy of the market place.

Additionally, individuals understand that the progression from informal to formal-sector work does not necessarily mean they lose their access to benefits. Formal sector workers, as has been mentioned, are eligible to receive AUH benefits as well as qualifying for an entire litany of programs, to include pensions, vacations and universal healthcare.

With regard to the impact AUH has on the labor market participation rates of recipient households, a positive effect has been observed in terms of child labor indicators. When children are forced to work, many serious problems can arise in terms of their personal development. These may include major impacts upon their health, as well as personal and academic achievement levels.

Within AUH-recipient households, child labor is practically nil among children aged 5 to 13 years. Among adolescents, the activity rates are even more significant. AUH has been demonstrated to reduce an adolescent's propensity for early entry into the labor market. The impact has been identified as reducing said propensity by 4.7% among 14 to 15-year-olds, and by 3.8% among 16 to 17-year-olds (Table 5). In terms of consumption and in-home chores, no significant differences were detected between the TG and CG.

Table 5
Impact of AUH on economic activity of children and adolescents, by age group: Variance between treatment and control groups

Economic activities	Age group			Total
	5 a 13 años	14 y 15 años	16 y 17 años	5 a 17 años
TG-CG	0.1	-4.7	-3.8	-1.4
Significance	No significance	0.15	0.15	0.15

Source: 2013-2014 AUH Evaluation Survey.

Decreased participation by children and adolescents in economic activities is an especially promising indicator. This dynamic is seen as being the result of the cash transfers which the recipient households receive, as well as the co-responsibilities which are analyzed next.

Impact of co-responsibilities

Similar to the majority of the conditioned cash transfer programs in Latin America, the AUH's primary objective is to reduce inequality gaps by increasing access to opportunities; particularly with regard to the education and health care of children and adolescents, which are factors which comprise the fundamental pillars of the initiative.

The conditions were set vis-à-vis the notion that access to quality education and healthcare is a fundamental right of all children and adolescents which must be guaranteed and protected.

The use of conditions is designed to ensure that the target population acquires the educational credentials and health it will need to break free of the intergenerational cycle of poverty.

The legitimacy and equity of the AUH initiative has been called into question, citing the supposed asymmetry which the contributory family transfers possess.

Workers enrolled in the Argentine social security program are required neither to prove their children are enrolled in school nor provide evidence of regular medical checkups. On the contrary, they are eligible to receive an additional school-attendance allotment which is paid out on an annual basis, although it does require evidence of enrollment in the educational system. There are no punitive measures for individual benefit recipients whose children are not enrolled in formal education (Mazzola, 2012).

As a result, it has been said that there is an underlying effort to "oblige" the sectors which receive benefits to meet certain preconditions. The conditioning of the cash transfers is purported to presuppose an effort to stigmatize which demonstrates the paternalism of the State which introduces such conditions. Additionally, there is a perceived punitive nature whereas that transfers are suspended in cases of failure to comply.

The fact that the AUH has been put forth as access to a right upon which conditions are then imposed is viewed as problematic, whereas "one cannot place conditions (on access) to a right" (Zibecchi, 2008).

Another argument states that in the absence of conditions, cash transfer programs in general – and the AUH initiative in particular – might be open to critiques that they are "attendance-based" policies, whereas they failed to guarantee increases in the future abilities of benefit recipients (CEPAL, 2012).

Other authors indicate that, in practice, these contradictions seem to be resolved by the fact that AUH-beneficiaries have expressed positive reactions to eligibility conditions; an issue which has been demonstrated through the opinions expressed by individuals involved in the program (Pautassi, Arcidiácono y Straschnoy, 2013; Mazzola, 2012). As Mazzola (2012) indicates: "The school enrollment and vaccination prerequisites are not perceived by those required to comply with same as a loss of autonomy. On the contrary, they view them as an *obligation-benefit*". In this sense, beneficiary households view the initiative's conditions as providing a social legitimization whereas they provide an opportunity to earn a benefit rather than being forced into compliance.

One perspective which at least partially seems to address this question in theoretical terms used to refer to these exigencies as co-responsibilities rather than as conditions. As Mazzola (2012) states: "One cannot place conditions upon rights. Therefore, one should refer to CO-RESPONSIBILITY rather than conditionality. The notion of coal responsibility presupposes the fact that the individual member of society is not alone, whereas (in this scenario) the State also shoulders responsibility: the State must sufficiently guarantee the supply healthcare and educational services."

The demand for said services activated by conditioned cash transfer programs must be met by a supply of educational and healthcare services which often fails to receive additional resources or which does not actively coordinate activities with CCTPs.

In response to these issues, Novacovsky (2010) suggests that

> program conditions leverage increases in the public supply via the same pressure which individuals exercise and the suppliers of public services vis-à-vis the disconnect of failing to offer a given benefit or the risk of losing same. This simply compounds the problem. CCTPs also served to highlight the lack of supply and problems associated with excluding individuals from healthcare and education services, thus serving to drive increases in supply.

In terms of empirical data available on health care and education issues, the AUH Impact Assessment results are extremely heartening on both points. Progress made on these issues serves to address questions regarding AUH co-responsibilities, whereas the indicators are improving and increased demand within the two sectors is generally being met successfully.

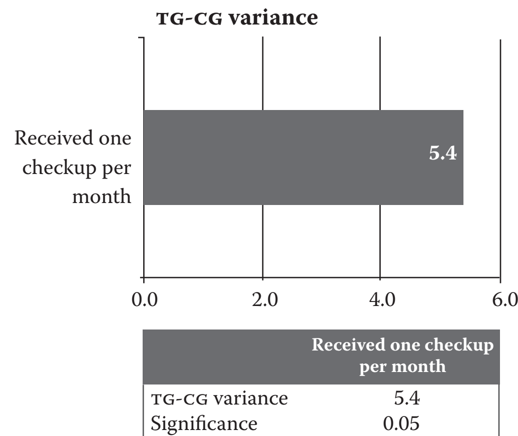
The use of REGULAR HEALTH-CARE CHECKUPS as requisites for eligibility and compliance within the AUH initiative highlights the fact that an individual's health status is a key factor which appears to drive improved living conditions within the households and efforts to sustain same.

The co-responsibilities included in the AUH and *Asignación por Embarazo*[8] initiatives help achieve the broader objective of ensuring regular health-care checkups during pregnancy (Figure 4). The increase of 5.4% in terms of checkups performed, which can be seen below, is the result of differences reported among women with children under age to within the treatment group and their counterparts within the comparison group.

Checkups during the early phases of pregnancy are essential to ensuring accurate monitoring is performed. Expectant mothers were surveyed regarding the month of pregnancy in which they received their first OB/GYN checkup. 95.7% of AUH recipients with children under age 2 reporting having had their first checkup during the first trimester of their last pregnancy. In terms of impact, we can confidently assert that AUH contributed to an increase in early-phase checkups of 4.5%; a factor which contributes greatly to the increased well-being of both mother and child during pregnancy (Figure 5).

[8] In early 2011, the coverage for pregnant women was expanded through Decree 446/11. "Women eligible to receive benefits via the *Asignación por Embarazo para Protección Social* (Social Protection Pregnancy Benefit) initiative shall include women who are unemployed, women enrolled in *Monotributista* programs who receive neither contributory nor noncontributory benefits, women working in the informal sector or domestic service, and to receive monthly wages equal to or below the federal minimum wage [...] The objective of said initiative being to reduce deaths during childbirth and newborn death rates, issues which are avoidable through access to specialized medical care services. The benefit shall comprise a monthly cash transfer paid to the expectant mother during the period beginning in the 12th week of pregnancy until birth or pregnancy is terminated" (Anses, 2012: 17).

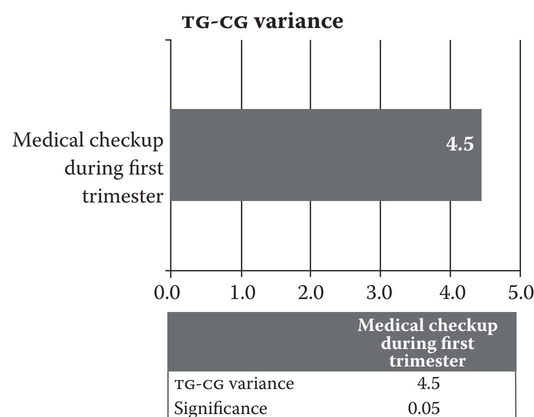
Figure 4
Medical checkups performed on AUH-recipient mothers with children under age 2: Variance between treatment group and control group (in %)



	Received one checkup per month
TG-CG variance	5.4
Significance	0.05

Source: 2013-2014 AUH Evaluation Survey.

Figure 5
Medical checkups performed on AUH-recipient mothers with children under age 2 during first trimester of pregnancy: Variance between treatment group and control group (in %)



	Medical checkup during first trimester
TG-CG variance	4.5
Significance	0.05

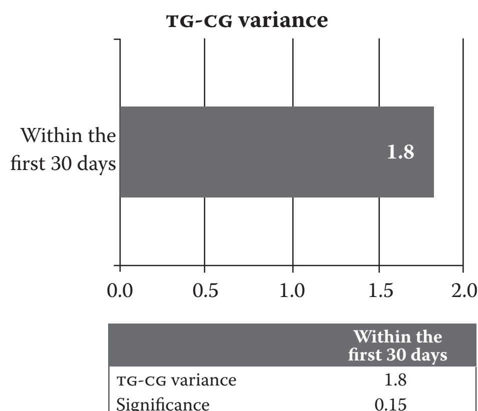
Source: 2013-2014 AUH Evaluation Survey.

Medical checkups on newborns are a fundamental part of strategies to ensure early detection of disease (Argentine Federal Law 25.415)[9]. Comparisons with the CG determined that a positive impact was made in terms of medical checkups

[9] The first medical checkup shall be performed during the infant's first week of life. During said checkup, an examination shall be made of the child's ability to hear and detect symptoms of hearing loss. Additionally, within 72 hours of birth a blood test shall be performed to detect and ensure timely treatment of congenital metabolic diseases. The aforementioned medical services shall be provided within the auspices of the *Plan nacer/Programa sumar* national health plans administered by the Argentine Ministry of Health.

during the child's first week of life. The AUH contributed to a 1.8% increase in newborn medical checkups; a change which contributed to improved early care and reductions in the levels of vulnerability in terms of neonatal death rates (Figure 6).

Figure 6
Impact of AUH on newborn first-checkup date:
Variance between treatment group and control group (in %)



	Within the first 30 days
TG-CG variance	1.8
Significance	0.15

Source: 2013-2014 AUH Evaluation Survey.

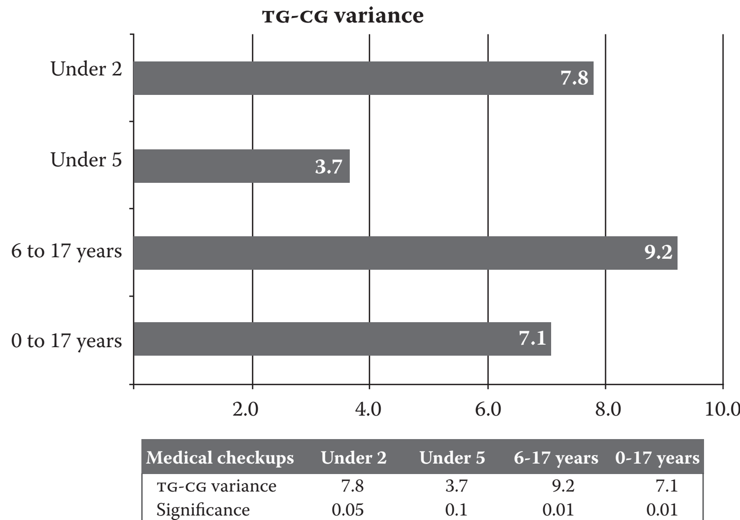
The vast majority (94.2%) of AUH-recipient children and adolescents receive the medical checkups which are appropriate for their age group. [10] In terms of impact, important contributions are observed: the effect of AUH explains the increase of 7.1% in medical checkups among 17-year-olds, and is highly significant among children under age 2 (7.8%), which contributes strongly to psychomotor development of children, and guarantees the application of the respective vaccination schedule. Additionally, among children and adolescents aged 6 to 17, the impacts are also very strong. AUH demonstrates an increase of 9.2% in medical checkups within this age group (Figure 7).

Impacts on health are evidenced in terms of improved nutrition, which contributes to better health among AUH-recipient children and adolescents. Household income is the principal determinant in consumer patterns. As a result, increases resulting from AUH cash transfers can be expected to produce a transformation in household spending patterns.

[10] Health checkups and complying with vaccination schedule are prerequisites to entering and remaining within AUH. Children and adolescents must receive medical checkups as per the following:

- Up to six months: monthly.
- Between six and 12 months: every two months.
- Between first and second gear: every three months.
- Between two and three years of age: biannual.
- After three years of age: annual.

Figure 7
Impact of AUH on medical checkups among children and adolescents, by age group: Variance between treatment group and control group (in %)



Medical checkups	Under 2	Under 5	6-17 years	0-17 years
TG-CG variance	7.8	3.7	9.2	7.1
Significance	0.05	0.1	0.01	0.01

Source: 2013-2014 AUH Evaluation Survey.

The comparison between AUH-recipient households (TG) and the comparison group yields favorable differences in terms of food consumption. The percentage of households increasing the consumption of food items consider indispensable in terms of ensuring balanced nutrition – i.e., meet, fruit, vegetables, milk and other dairy products – is significantly higher within the treatment group than in the comparison group. Variances oscillate between 4.7% and 8.4% in terms of impact made on increases in consumption (Table 6).

Table 6
Impact of AUH on food consumption, by food type:
Variance between treatment group and control group (in %)

Consume more since receiving AUH...	TG - CG (%)	Significance
Meat, fish or chicken	7.6	0.01
Milk	7.9	0.01
Fruits	5.8	0.01
Vegetables	8.4	0.01
Dairy products (yogurt, cheese, etc.)	7.1	0.01
Desserts for children	4.9	0.01
Candy	4.7	0.01
Cookies	5.9	0.01

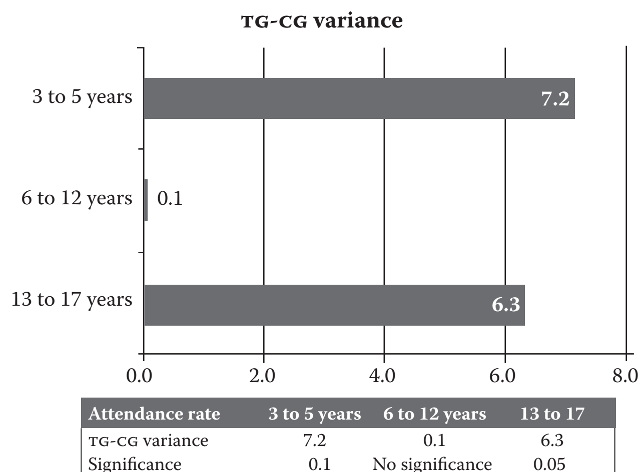
Source: 2013-2014 AUH Evaluation Survey.

AUH has also been determined to provide strong support to improvements in childhood health and reductions of nutritional risks within this age group, thus helping to achieve the significant progress which Argentina has made in this area during recent years according to a 2013 report published by the UN Food and Agricultural Organization (FAO).

As has been noted, a primary objective of the AUH involves breaking the cycle of intergenerational poverty. In order to achieve said aim, the initiative prioritizes ACCESS AND PERMANENCY WITHIN THE FORMAL EDUCATION SECTOR ON THE PART OF CHILDREN AND ADOLESCENTS. As a result, AUH results in terms of its impact throughout the educational sector are presented below.

In terms of early childhood education, a fair degree of impact has been made among children aged 3 to 5 years. AUH has contributed to a 7.2% increase in attendance among these youngsters (Figure 8).

Figure 8
Impact of AUH on medical checkups among children and adolescents, by age group: Variance between treatment group and control group (in %)



Attendance rate	3 to 5 years	6 to 12 years	13 to 17
TG-CG variance	7.2	0.1	6.3
Significance	0.1	No significance	0.05

Source: 2013-2014 AUH Evaluation Survey.

Therefore, we can confidently assert that the introduction of AUH has contributed to ensuring access to education from early childhood on, by improving these individuals' chances for academic achievement, improved health and higher probabilities of labor market insertion in the future.

However, access to kindergarten is still not assured for all children within the nation whereas there is currently an insufficient supply of State-run facilities. This dynamic primarily impacts children under five living in Argentina's most vulnerable households, whereas it limits their opportunities for early stimulation. This situation also generates a conditioning among their mothers or other adult relatives within the household who are obliged to remain at home in order to provide child care. As a result, the possibility of earning additional income which would contribute

to improved conditions within the household are curtailed, and only served to exacerbate exclusion issues faced by the family.

In terms of children aged 6 to 12 years who are AUH recipients, attendance at school is nearly universal (99.9%). It should be noted that this figure reflects attendance before AUH was implemented, therefore no link between AUH and school attendance could be established.

In terms of adolescents, the impact of AUH is highly significant whereas dropout rates within this age group are much higher, AUH recipients registered a 6.3% higher attendance rate than their counterparts.

As a result, it can be asserted that in the critical age groups (3 to 5 years and 13 to 17 years) attendance rates are between 6% and 7% higher within the treatment group than in the comparison group. In the absence of AUH cash transfers, 7% of children in kindergarten or preschool, and 6% of adolescents attending high school, would not be seated in class (Figure 8).

As a result, AUH transfers unquestionably contribute to a reduction in inequality during schooling. They compensate for cultural capital deficits within the home and, during adolescence, ensure young people possess the minimum credentials required to obtain better jobs within the labor market.

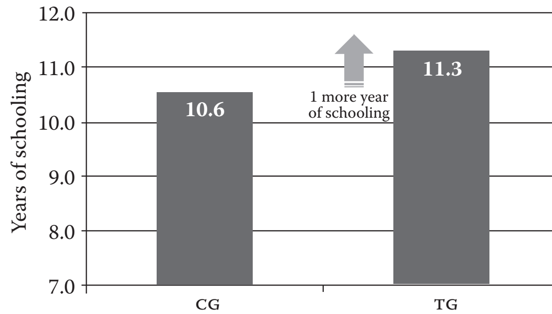
The impact of the AUH initiative within the educational sector can also be measured by another indicator: Years of schooling. Years of schooling were calculated among adolescents aged 14 to 17. Data from the treatment group was then compared with data from the comparison group. This analysis indicated that AUH recipients stayed in school nearly one school year (0.73) longer than their counterparts within the control group. This difference amounts to a gain of nearly 132 days of additional classes (Figure 9).

This finding is especially heartening, whereas *years of schooling* is considered to be a major factor in terms measuring the probability of future success for young people.

The AUH education co-responsibilities have made graduation much more plausible for young people age 18 to 24. If one analyzes the impact of the initiative within the treatment group and the comparison group, AUH achieved a reduction of 7.8% in terms of young people who either failed to attend or dropped out of school (Figure 10). It is reasonable to expect that the effects of the PROG.R.ES.AR[11] initiative will only serve to further improve the educational achievements of this population who live in vulnerable households.

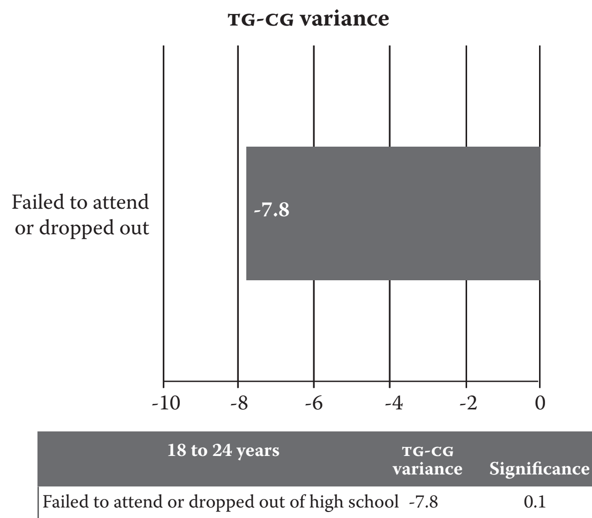
[11] The initiative entitled *Programa de Respaldo a Estudiantes de Argentina* was designed to support students aged 18 to 24 in their efforts to pursue their education goals. The underlying legislation, *Ley de Educación Nacional 26.206*, seeks to foment attendance to Ministry of Education-approved schools, as well as vocational training institutes which are duly authorized by the Ministry of Labour, Employment and Social Security.

Figure 9
Impact of AUH on years of schooling among adolescents aged 14 to 17: Variance between treatment group and control group (in %)



Source: 2013-2014 AUH Evaluation Survey.

Figure 10
Impact of AUH on years of schooling among adolescents aged 14 to 17: Variance between treatment group and control group (in %)



18 to 24 years	TG-CG variance	Significance
Failed to attend or dropped out of high school	-7.8	0.1

Source: 2013-2014 AUH Evaluation Survey.

There is a wealth of anecdotal evidence which provide qualitative evidence of the important contribution that the AUH makes in terms of driving school attendance and healthcare indicators. The following comprise a variety of comments which illustrate this fact, as well as the manner in which recipients value the AUH initiative:

> Now mothers are able to take their children to school. Do you realize how many of us were unable to do this, or how many mothers failed to ensure this occurred?

The initiative has forced women to consider: "If I don't take the child to the checkup, I won't get paid."

One has to be more attentive to children's checkups. In times past, sometimes we used to say, "I'll make sure to take them next month."

Things are better now because they also track our children's education. My sister has five children who she didn't take to school or the doctor. (Whereas transfers are now conditioned), she has started to.

Many mothers did not used to keep track of their children who were basically raising themselves. Now that they receive the monthly transfers, they are able to put more time into their children.

Before you didn't see any mothers around. Now they are all at home in the living room. Children are now being vaccinated. Youngsters are eating better.

I can tell you that thanks to the AUH, there is not an empty seat at school. A lower income neighborhoods people were ensuring their children made it to class. Nowadays, if they miss class, the family misses out on benefits. It is difficult to enroll your child in school now.

There are many children in class today who were going to school before. The main issue here is that it is great for the kids to go to school, even good meal and have a chance to learn. They are definitely going to outstrip their parents, who don't have a clue.

As a youngster in high school, sometimes my old man didn't have any money to give me for photocopies or the bus. So I stayed at home. Nowadays, there isn't much excuse for this type of scenario to occur…

The initiative motivates the children to get to class.

AUH obligates me to, in turn, obligate my daughter to go to school. I did not raise our 12-year-old, but now she is my responsibility. And my youngest is more conscious of this necessity than I am: "I have to go to class because, otherwise, they will not pay you." She says that it's like going to work because she shows up and they pay her.

I truly feel that our kids feel responsible for making it to a class because it's the only way we will receive the transfer.

My son has a 17-year-old friend who says: "I've got to go to class because my mother needs that money."

Lastly, AUH co-responsibilities have an impact on social mobility and the intergenerational cycle of poverty. The initiative has had an impact on this vicious circle wherein the educational level of the mother largely determined the frequency with which medical checkups were performed and classes were attended. There was also a spillover effect on the academic achievement levels of the children involved. However, it is now possible to identify improvements among grade levels in terms of attendance and total years of schooling achieved. One third of all adolescents who receive AUH benefits demonstrate higher levels of educational achievement than that of the individuals view administer said benefit within the household. In practical terms, there has been a 6% improvement vis-à-vis the comparison group (Table 7).

Table 7
Impact of AUH on years of upward educational mobility of adolescents aged 15 to 17 vis-à-vis household benefit administrator: Variance between treatment group and control group

	TG-CG	Significance
Upward mobility	6.1	0.15

Source: 2013-2014 AUH Evaluation Survey.

The AUH clearly drives upward mobility within the households which receive these cash transfers. The initiative possesses the ability to break the intergenerational cycle of poverty, as can be seen by changes in this indicator.

Impact on birth rates

It has been asserted that cash transfer programs may induce increased birthrates among families who receive state benefits whereas such initiatives are pegged to the number of children within the household. This dynamic, in turn, drives increases in poverty rates whereas it results in in increased "demographic load". Additionally, this scenario could conceivably drive early parenthood rates among both sexes within these sectors.

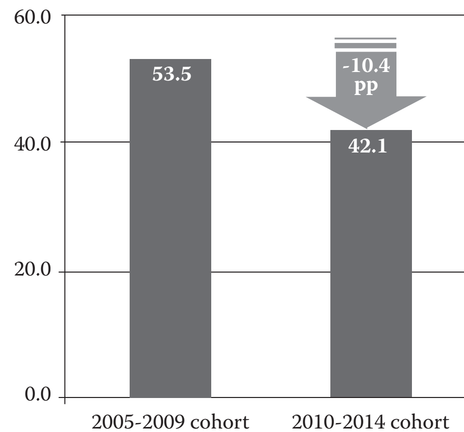
> Young mothers who comprise an important proportion of the lowest income sectors of society face a much higher degree of risk than the average mother within the population. [...] Their levels of vulnerability during pregnancy and childbirth are considerably higher than on average. This has a significant impact upon death rates during childbirth among these vulnerable, young mothers; in addition to contributing to increases of complications during delivery. (Kliksberg and Sen, 2007)

However, these suppositions are unfounded whereas there is no empirical evidence to support their underlying logic. The global birth rate within Argentina has

steadily declined during the last two censuses. In fact, the decrease was especially marked in provinces containing higher amounts of AUH-recipient households.

In terms of ADOLESCENT MOTHERHOOD, half of all AUH-benefit administrators within the household were adolescent mothers. However, if this scenario is analyzed by cohort, adolescent-motherhood rates have dropped among AUH-benefit administrators and recipients since the launch of the initiative. Between 2005 and 2009, 53.5% of recipients were mothers under the age of 20. This figure dropped to 42.1% during the period comprising January 2010 to February 2014. In other words, adolescent motherhood rates dropped by more than 10 percentage points among the AUH-recipient population from one period to the other (Figure 11).

FIGURE 11
Adolescent motherhood among AUH recipients to age 19, by age cohort (in %)



Source: 2013-2014 AUH Evaluation Survey.

This significant decrease among the two cohorts is associated with the fact that said adolescents and young adults who receive AUH benefits are now more educated and possess improved access to health care services in terms of medical checkups to obtain information and access to contraceptives which facilitate family planning.

Impact on gender roles

Criticisms have been made regarding cash transfers under the logic that such initiatives contribute to the reinforcement of traditional gender roles and to the "maternalization" of women, whereas they are perceived as inducing females to cease efforts to enter the labor market, dedicate themselves to childcare and motherhood as opposed to pursuing economic independence through employment and personal development (CEPAL, 2012).

The assumption is that, instead of empowering recipients by appointing them as benefit-administrators within the household, cash transfers serve to reinforce the traditional role of women within the household as well as the broader community (López, 2004; Daeren, 2004; Adato *et al.*, 2000: González de la Rocha, 2005; Arriagada and Mathivet, 2007).

The dynamic, however, would appear to be quite the opposite whereas AUH benefits seem to reengineer the "negotiating paradigm" within the family, whereas they serve to diversify available income sources which, in turn, are clearly a power base within said unit of society ((Wainerman, 2002). As a result, it is possible to analyze the comparison group in order to detect possible impacts made by AUH on financial decision-making processes within the home; a factor which is of paramount importance in family dynamics.

The testimony of AUH-benefit administrators and women within the comparison group (potential benefit administrators) regarding the member of the household who provides income and manages the decision-making processes related to family expenses. In terms of the provision of economic resources, the proportion of AUH-benefit administrators who self-report as the principle source of income within the household is significantly higher (8.5%) than among their female counterparts within the comparison group (Table 8).

In terms of the EMPOWERMENT which may be derived through the management of economic decision-making processes within the home, the proportion of households in which money management is performed by women is significantly higher in AUH-recipient households. The initiative contributes 8.8% more empowerment to women in this regard (Table 8).

The empirical evidence, therefore, supports the hypothesis that the AUH initiative contributes to increased empowerment of women benefit administrators by delivering increased control of economic resources within their households.

TABLE 8
Impact of AUH on identification of primary income provider and economic decision-maker within household: Variance between treatment group and control group

Who provides the majority of income within your household?	**TG-CG variance**	**Significance**
Current or potential benefit administrators	8.5	0.01
Who decides how, and on what, funds are spent within your household?	**TG-CG variance**	**Significance**
Current or potential benefit administrators	8.8	0.01

Source: 2013-2014 AUH Evaluation Survey.

Conclusions, recommendations and challenges

After only five years since its launch, the AUH initiative has demonstrated an extraordinary capacity to reduce inequality gaps among children and adolescents (in terms of income, nutrition, education and healthcare) who come from vulnerable homes or who are excluded from their peers in other sectors of society.

The AUH constitutes a highly significant contribution in terms of reducing income inequality within benefit-recipient homes as well as throughout the entire urban demographic. In particular, it is effective in reducing inequality in terms of access to income among children and adolescents. As such, it is extremely effective in introducing equity at the start of an individual's life, which is where resources can have the most impact in terms of impacting a person's future achievement and opportunity levels.

The additional and stable income provided through the AUH initiative represents, on average, 25% of all household income; and among the poorest sectors, it constitutes 40%. This dynamic has ensured access to basic nutrition, in addition to providing an increase in the quality and quantity of food available to AUH recipients.

It is important to note that access to the cash transfers provided within the initiative in no way reduce an individual's propensity to become employed. On the contrary, the added resources drive labor market insertion among males as well as females.

The AUH resources ensure the availability of the most critical nutritional elements (proteins, dairy products, fruits and vegetables), which are indispensable to a well-balanced and healthy diet.

All empirical evidence generated by the impact assessment points to the hypothesis that AUH income surged to empower women within recipient households by giving them increased control over family resources. While it is true that entire lion's share of reproduction tasks continue to fall disproportionately upon women, no empirical evidence exists to support the view that AUH engenders traditional gender roles within the household; especially with regard to the source and crystallization of said gender issues.

When measured by the co-responsibilities which obligate medical care (including prenatal checkups and coverage for deliveries included within the purview of the Social Protection Pregnancy Benefit (*Asignación por Embarazo para Protección Social*), children have universal access to appropriate and regular healthcare vis-à-vis national and international standards.

A significant finding of the impact assessment was that, far from simply ensuring compliance with the school attendance criteria included within the initiative (for preschool, primary and secondary education), the AUH initiative has demonstrated an enormous capacity to stimulate the youngest recipients (4-years-old) to participate, whereas eight out of 10 children within this age group attend classes.

This dynamic has clear implications for the children as well as their mothers who have more free time to dedicate to other (primarily work-related) activities. Therefore, the initiative contributes to reducing the inequality gap in other sectors of society by reducing early childhood stratification.

Among adolescents aged 14 to 17, the return to secondary education and improved attendance implies a gain of nearly 1 school year. This impact translates into improvements in educational capital for households within this group and improves their possibility of improving conditions within the home now and in the future. In effect, improvements in educational levels among adolescents allow them to increase their participation within society, even as they increase these individuals' possibilities for finding quality work in the future. Better-educated young adults are less likely to be forced into early and precarious insertion into the labor market (particularly where males are concerned), less likely to perform intense domestic tasks which are traditionally performed by adults (especially in the case of females), and less likely to have an unwanted pregnancy or become an adolescent mother or father. In terms of this last issue, the comparison of generational cohorts of AUH-recipient mothers both before and after initiative launch, demonstrate that adolescent motherhood dropped by 10%. This is universally accepted as being a key factor in interrupting the injured generational cycle of poverty.

The multiplier effect of the initiative's co-responsibilities has resulted in many more young adults between the ages of 18 and 24 finishing their high school education. This has a doubly-positive effect. On the one hand, it gives these young people – who are often parents – a wide spectrum of tools to meet the demands of the labor market which is increasingly credential-oriented. Additionally, it guarantees that their children will have an easier journey through the educational system and less likely to be hampered by the same issues which their parents had to overcome as children. It comes as no surprise that, within this context, benefit administrators nearly unanimously support the co- responsibilities contained within the AUH initiative.

The cash transfers also undoubtedly foment upward mobility, a factor which is beginning to take hold in recipient households. This is important evidence for how the initiative has demonstrated its ability to break the intergenerational cycle of poverty.

However, challenges still remain in terms of expanding and strengthening the coverage provided by the Argentine social protection system. To ensure AUH results and impacts continue apace, it is imperative to ensure that the benefit amount is regularly adjusted; to date, this has been the case.[12] And yet, no permanent in automatic mechanism has been put forth to execute said adjustment. Therefore, it is imperative that measures be taken to ensure a federal regulation automates these increases.

[12] In June 2015, the Office of the President announced it was sending a bill to Congress designed to automatically adjust the amount of the AUH allotment.

In terms of health care, there is a fair degree of disconnect between the public supply of medical care and the demand generated by the AUH initiative. The access to regular checkups stimulated by the co-responsibilities should be the starting point of the exercise of quality preventative medicine, as well as other aspects of healthcare (including access to sexual and reproductive health information and medical services).

In terms of the education sector, although a great deal of headway has been made in terms of kindergarten attendance among four-year-olds, a great deal remains to be done in terms of guaranteeing no-cost, universal access to early childhood education. Given the lack of State-run infant facilities (including *jardines maternales*, for infants and toddlers), strategies need to be generated which will ensure demand is met.

In terms of primary education, the most notable indicator is that attendance is universal. However, this is limited to half-day students, whereas the full-day programs are much less common due to a lack of supply. This issue is a significant challenge, whereas offering children the possibility of being in class for longer periods of time would have a positive impact on their future opportunity levels common even as it would reduce the load on women who are frequently obligated to sacrifice study and/or work time to childcare. It is also a legal obligation, because Article 28 of *Ley 26.206 de Educación Nacional*, passed in 2006, requires full-day services to be available.

Where secondary education is concerned, a major challenge involves successfully accompanying a large number of adolescents through their schooling, whereas many experience setbacks in terms of being held back a grade level and expanded attendance lapses. Academic support and inappropriate benefit amount for adolescents aged 15 to 17 will prove to be of paramount importance in any strategy designed to stimulate attendance and ensure young people do not opt for early entrance into the labor market.

In terms of addressing the supply issues, strategies need to include measures which provide priority entry to AUH-recipient families to, inter alia, the following services: infant and toddler childcare centers, full-day schooling, academic counseling and support, sporting cultural activities, programs designed to help adolescents and adults complete their secondary education, employment programs, microloans, housing plans, provision of services and infrastructure, and Internet access. In terms of public outlays and initiatives, this tactic may be approached using a variety of parallel strategies which prioritize individual recipients and/or geographic areas, schools and health centers where AUH recipients comprise a significant proportion of the population.

In terms of strategies designed to optimize the impact of the wider social protection system within Argentina, it is imperative to ensure that a cost-cutting approach is used when serving AUH-recipient households; i.e., ensuring coordination between ministries and jurisdictions, and employing focused approaches which

address specific groups or issues such as large-family households, childcare, adolescent pregnancy, child labor, adolescent dropouts.

To summarize, the AUH initiative comprises a gateway to the social policy system due to its characteristics, impact and ability to reach the most vulnerable members of society. It has successfully integrated contributory benefits with non-contributory transfers, and thereby comprises a true *social protection system*. The challenge of inequality and poverty necessitates an integrated approach to problem-solving, whereas a wide spectrum of factors are at work that simultaneously produce causes and effects in terms of producing and reproducing this cycle. In consequence, a two-pronged approach must be employed to overcome the challenge. Firstly, the integration of public policy, programs and benefits must be optimized. Secondly, the issue of ensuring supply for said services must be met; this is to say that guidelines, procedures and specific circuits must be utilized to institutionalize the *social protection and inclusion network* with the aim of overcoming outmoded conceptions of traditional social programs operating on the basis of a conjuncture of needs.

Lastly, the results obtained from this assessment are heartening in terms of the AUH trajectory during its first five years. The progress achieved thus far – in terms of educational, healthcare, income and social inclusion indicators, as well as in terms of bolstering and expanding social security coverage – speaks for itself.

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