

8. Cash Transfer Programmes

Cash transfer programmes, conditional (on health/nutrition related actions: CCTs) or unconditional (CTs) have expanded rapidly in recent years, and are of increasing importance for improving nutrition. They are highly complementary to other nutrition actions, and involve establishing eligibility, usually based on low income. Hence, they are positively targeted towards the poor and most vulnerable. The level of resources/head is much higher than for typical nutrition programmes – but the objectives are broader – and the scale in terms of coverage equal or higher. Their effect on nutrition is both through increasing resources (income), and, for conditional programmes, enhancing use of services such as immunization and education. The impact on nutritional status of children is potentially both through maternal nutrition and hence intra-uterine growth and development, and through infant and young child feeding, care, and use of health services.

Examples of CCTs and CTs that have been described and evaluated to some extent were drawn from the literature, agency reports, and other documents for this section. These sixteen case studies are described in **Annex 3**, and some characteristics summarized in **Table II-5**. CCTs are the usual form for these programmes in Latin America, where they have been operating for some time, while CTs are the norm in Africa.

Cash transfer programmes provide assistance in the form of money in order to increase household income. Transfers may be given without requirements that household members meet specified conditions, or be contingent upon compliance with a specified set of conditions. CCTs have increased in popularity in recent years due to their perceived ability to create long-term benefits through encouraging behaviour adoption that improves well-being, and investing in human capital (62). Provision of transfer is generally targeted to poor households. Programmes may directly affect nutrition (e.g. providing supplements), or connect to nutrition outcomes less directly (e.g. through increasing use of health services, antenatal care or education). Conditionalities may include periodic health visits, growth monitoring, vaccination when applicable, antenatal care, and attendance at education sessions by mothers (63).

Both CTs and CCTs are forms of social assistance, or safety nets, assisting beneficiaries who are vulnerable to impoverishment without support (62, 64). Public works programmes (productive safety nets) and in-kind transfers (food for work) are two other components of social safety nets but will not be described in detail here. Ethiopia's PSNP is included as cash transfers are provided to mothers. In sub-Saharan Africa overall approximately 137 programmes were in operation in 37 countries in 2009 (64). Transfer programmes in Latin American countries are mostly CCTs, which have dramatically increased in popularity in comparison to CTs, as well as expanded to other regions, in the past 10 years (63).

Several programmes, such as *Oportunidades* in Mexico, *Bolsa Família* in Brazil, and *Red de Protección Social* in Nicaragua include requirements for receipt of transfers specific to addressing nutritional concerns. Conditions intended to improve nutritional outcomes may address behaviours through group nutrition education sessions and growth monitoring and promotion, which also may be accompanied by more personalized counselling. Conditionalities aimed at improving micronutrient status may be employed in CCT programmes through provision of essential micronutrients and food or supplements to supply both macro- and micronutrients, though the latter has been limited to Mexico's *Progresá* (65).

Conditionalities in programmes with nutrition objectives may be determined based on country context and nutrition actions for which there is evidence of efficacy. CCTs that are intended to improve nutritional outcomes should be "well coordinated with the existing priorities guiding a country's nutrition policy" (65). General agreement exists as to which interventions are the most efficacious, therefore guiding conditional requirements in CCT programmes. The efficacy of these ENAs are described in Part I of this document and include: exclusive breastfeeding for six months, appropriate complementary feeding, appropriate nutritional care of sick and severely malnourished children, adequate intake of vitamin A and iron for women and children and adequate intake of iodine by all household members (65 from 66).

8.1 Mechanisms, demand and supply-side

Preference for CCT programmes over in-kind and unconditional transfers has grown for several reasons. CCTs offer greater flexibility for determination of household needs and decreased logistical costs relative to in-kind transfers. In comparison to unconditional transfer programmes CCTs are promoted as a direct investment in human capital, as well as an incentive for households to adopt behaviours that improve well-being, both offering long-term benefits (62).

Various mechanisms by which CCT programmes work to improve maternal and child nutrition have been proposed:

- As women typically receive the cash transfer, programme beneficiaries may be empowered to prioritize care for both themselves and their children during the CCT programme and even after it ends (65).
- An increase in household purchasing power for food and health services may result from CCT programmes (65). Due to the multifactorial nature of undernutrition, complementary interventions need to be supplied and maintained in addition to income provision for real improvement (67).
- Direct provision of micronutrients and/or energy supplements may be provided to mothers and children, though this practice has not been widespread in CCT programmes thus far (65).
- Conditionality such as growth monitoring for children, antenatal care for mothers, and participation in nutrition education sessions for both may improve maternal and child nutrition by addressing behavioural determinants of undernutrition (65).

An important consideration of the ability of CCTs to improve nutritional status involves determining the effects of providing both demand- and supply-side incentives. Transfers offered to families can increase demand for health and nutrition services by overcoming barriers to access such as direct costs, indirect costs (transport, food during hospitalization) and opportunity costs (loss of income due to health-seeking activities). CCTs aimed at increasing demand for preventive services may also have positive spillover effects, thus furthering long-term benefits for beneficiaries (62).

Inadequate or poor quality supply of services limits the effectiveness of demand-side CCTs. Therefore some programmes are implementing supply-side transfers in addition to those typically provided directly to beneficiaries. For example, the *Programa de Asignación Familiar* (PRAF) provides health centres with approximately US\$ 6000 annually for meeting quality improvement and service standards at rural health posts, including nutrition training for mothers (68).

8.2 Coverage and resource intensities

In CCT programmes providing both demand and supply-side incentives the effects on health and nutritional outcomes of each as well as the combination should be distinguished. For example, an evaluation of Honduras's PRAF demonstrated that demand-side transfers resulted in the largest ppt increase in healthcare visits among children under three years of age, as well as attendance at growth monitoring within the same age group as compared to controls. The combination of demand- and supply-side benefits increased utilization of both health visits and growth monitoring to a lesser extent, but supply-side incentives alone failed to increase utilization of either. The demand- and supply-side benefits individually and in combination resulted in improvements in antenatal care attendance (five or more sessions), although supply-side incentives resulted in the lowest percentage point increase (65). This example may be flawed since health facilities received slightly more than one half of their expected incentives, but it is reasonable to assume that supply-side incentives may be beneficial only when demand-side transfers are offered concurrently.

Cash transfer programmes vary in implementation stage as pilots, early or small-scale programmes or national coverage (see **Table II-5** and details in **Annex 1**). Among pilot and early or small-scale programmes, mostly CTs in sub-Saharan Africa and CCTs in Latin America, coverage ranges from approximately 4000 beneficiaries, as in Zambia's Kalomo Pilot Social Cash Transfer Scheme (69) to 165 000 beneficiaries in Nicaragua's RPS (70). This coverage represents less than 1% and 3% of the populations respectively. Large-scale CCT programmes, mostly in operation in

Latin American countries, range in coverage from about 1 million participants, as in Honduras's PRAF (68), to 45 million participants in Brazil's BF Programme (65). About 15% and 25% of the population (100% of the targeted poor) are covered with these programmes respectively.

Estimates of programme intensity are based on the amount of transfer provided to beneficiaries. Among CT programmes, transfers range from US\$ 6/household per month in Mozambique's National Institute of Social Action (INAS) Food Subsidy Programme (PSA) (71) to US\$ 25/household per month in South Africa's Child Support Grant (CSG) (72). Among CCT programmes, the lowest estimate of expenditure was US \$4/household per month in Honduras's PRAF, or less than 10% of average household consumption (73). In contrast, the highest expenditure was US\$ 60/household per month in Brazil's BF programme (65) or approximately 15% of average household consumption (73). It should be noted that among BF beneficiaries not all households receive this amount as transfers are dependent upon the level of poverty and number of children.

8.3 Effect on nutrition outcomes

Effectiveness of CCTs is estimated mostly from programmes in Latin America. It is based on data for various age groups of children and a variety of outcomes, thus making comparisons with large-scale nutrition programmes themselves (as in this document) problematic. However, impacts on child growth, birth weight, as well as on food expenditure and consumption have been estimated (see **Annex 2**, last column).

Mexico's *Oportunidades* has multiple evaluations reporting an approximate 1.0 cm increase in height among children ages 0–6 months and 12–36 months, all as compared to controls (62). Improvement in HAZ scores as compared to controls of 0.13 (Brazil's BF, children less than 7 years of age), 0.25 (South Africa's CSG, children less than 36 months), 0.161 (Colombia's FA, children less than 24 months), and 0.17 (Nicaragua's RPS, children less than 5 years) were reported (62, 72).

Increase in birth weight of 0.13 kg was reported among beneficiaries as compared to controls in Mexico's *Oportunidades* (74). Additionally, an increase of 0.58 kg in "newborn" weight was reported for beneficiaries in Colombia's FA, although this should be interpreted with caution since the programme was targeted to children rather than mothers. Although mixed results have been found, there is evidence that CCT programmes can have a positive impact on child nutritional status. To date most CCT programmes designed to improve nutritional and health outcomes have targeted children rather than mothers, resulting in a lack of data available on changes in maternal nutritional status (65).

8.4 Linkage to direct nutrition programmes

Both types of cash transfer programmes offer a link to existing nutrition programmes within a country. Furthermore, they may work to bolster both demand- and supply-side improvements in nutrition services at the community level. When considering implementation of a cash transfer programme designed to improve undernutrition, several rules for determining appropriateness of using nutrition-related conditionalities have been proposed. An unconditional CT programme should be used when nutrition programmes of good quality are in place and utilized extensively. In contrast, a CCT programme is more useful when current nutrition programmes are not well-utilized, but quality is good. CCTs in addition to supply-side incentives should be considered when both quality and utilization of nutrition programmes is poor. Finally, when a country does not have an existing nutrition programme a CCT should be considered only when both services of appropriate quality can be introduced and when beneficiaries are able to utilize the services (65).

A number of important factors are likely to affect the positive impact of CCTs on maternal and child nutrition outcomes. Programmes should focus on the window of opportunity for nutrition impact, pregnancy through two years of age, and therefore target beneficiaries in this range. Conditionalities should be specific to nutrition, based on best practices, including ENAs, for which there is evidence of efficacy. Supply-side transfers should be provided when needed in order to maintain quality and quantity of health and nutrition services, thus increasing the ability of CCTs to improve the nutritional status of mothers and children.

Table II-5 Summary of CCT/CT programmes studied

| Type | Region | No. programmes | Resources (\$/household/month): examples | Population coverage (in millions): examples |
|------|---------------|----------------|--|--|
| CCT | Africa | 1 | Republic of South Africa US\$ 25 | South Africa 8 |
| | Asia | 3 | Sri Lanka US\$ 2–9 India US\$ 130/pregnancy | Sri Lanka: 2 India: 0.6 |
| | Latin America | 5 | Brazil US\$ 30-60 Mexico US\$ 15 Colombia US\$ 17 Nicaragua US\$ 19 Honduras US\$ 4 | Brazil: 45 Mexico: 25 Honduras: 0.2 |
| CT | Africa | 8 | Ethiopia US\$ 4 Mozambique US\$ 3–6 Senegal US\$ 14 Kenya US\$ 5 Zambia US\$ 8 Malawi US\$ 4–13 | Ethiopia: 8 Mozambique: 0.2 Senegal: 0.3 Kenya: 0.3 |
| | Asia | 0 | | |
| | Latin America | 0 | | |