LINKING SOCIAL CASH TRANSFERS AND CHILD HEALH

Development Partners Group on Health (DPG-H)
13 June 2012

OUTLINE

1. **Common features of CT programs and links with MCH**

2. **Evidence of impact of CT programs**

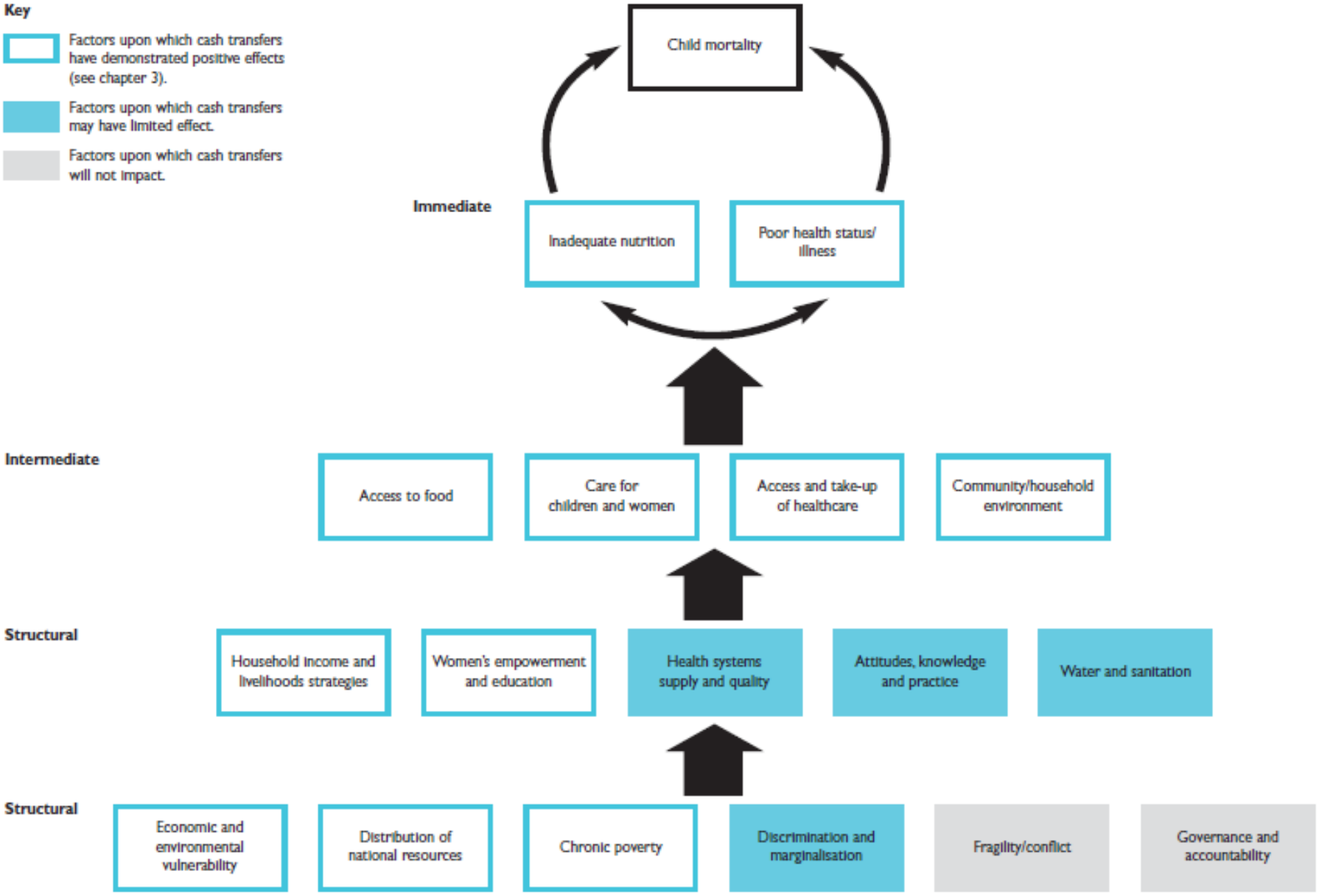
3. **Key design features of TASAF/PSSN**
   - ✓ Background
   - ✓ Target population
   - ✓ Benefits and conditions
   - ✓ Institutional and management arrangements

4. **Entry points and challenges**

Common features of CTs

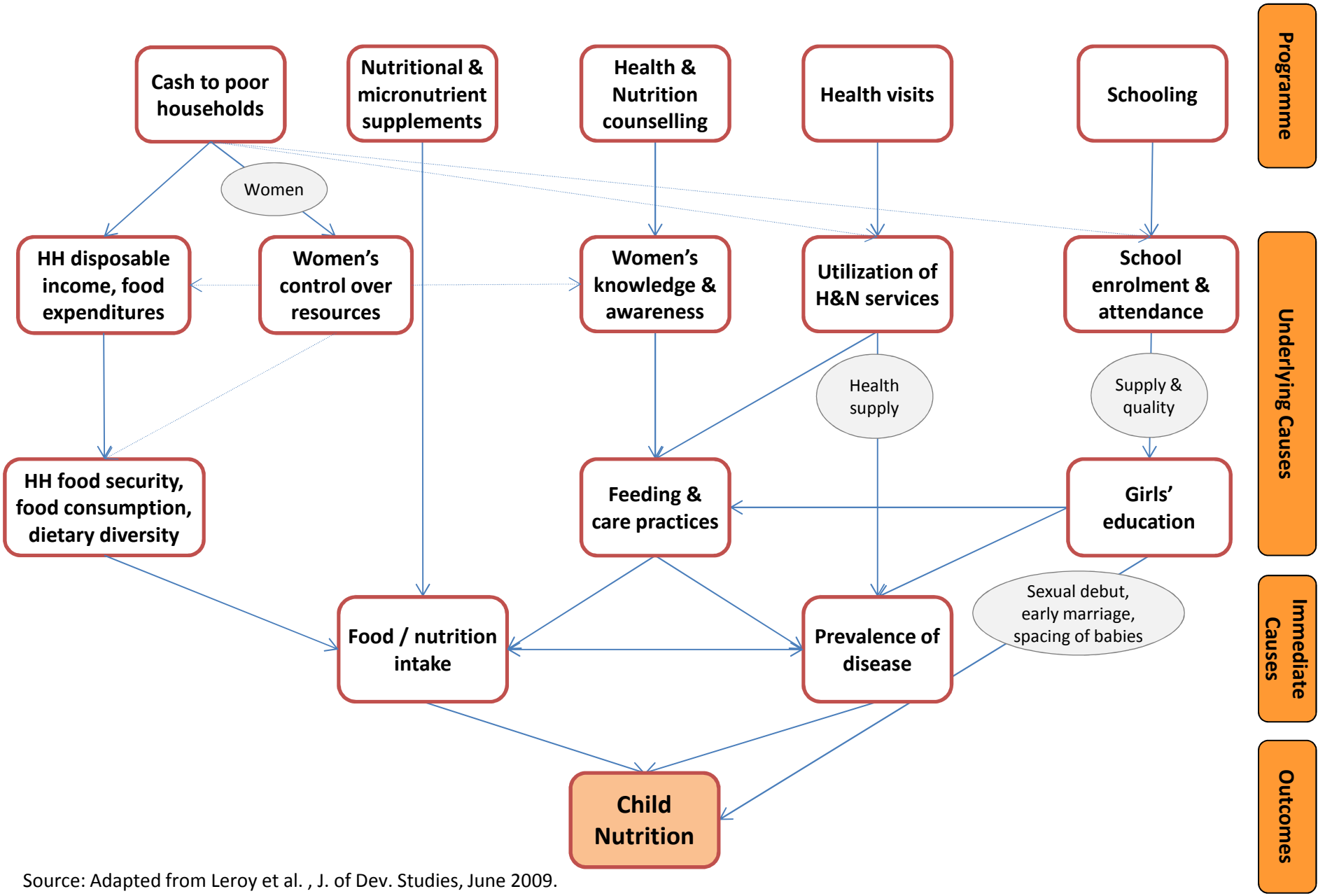
- Programs **targeted** at poorest HHs (typically with pregnant women, newborns, infants and school-age children) in poorest communities
- Provide **cash** to beneficiaries, usually the mother or primary caregiver
  - ✓ Some provide in-kind transfers (**nutrition supplements**, e.g. MEX: 20% of daily calorie requirements and 100% of micronutrients to children between 4-24 months and between 2-5 years if malnutrition detected)
- **Co-responsibilities** in return for the transfer:
  - ✓ School attendance, regular health check-ups, vaccinations and growth monitoring
  - ✓ Regular H&N education workshops
- Some include a supply-side component to improve **quality of schools and health facilities** used by beneficiaries
- Expected impacts on **health**: greater uptake of services, positive health outcomes through financial resources and new knowledge to mothers

Determinants of child mortality



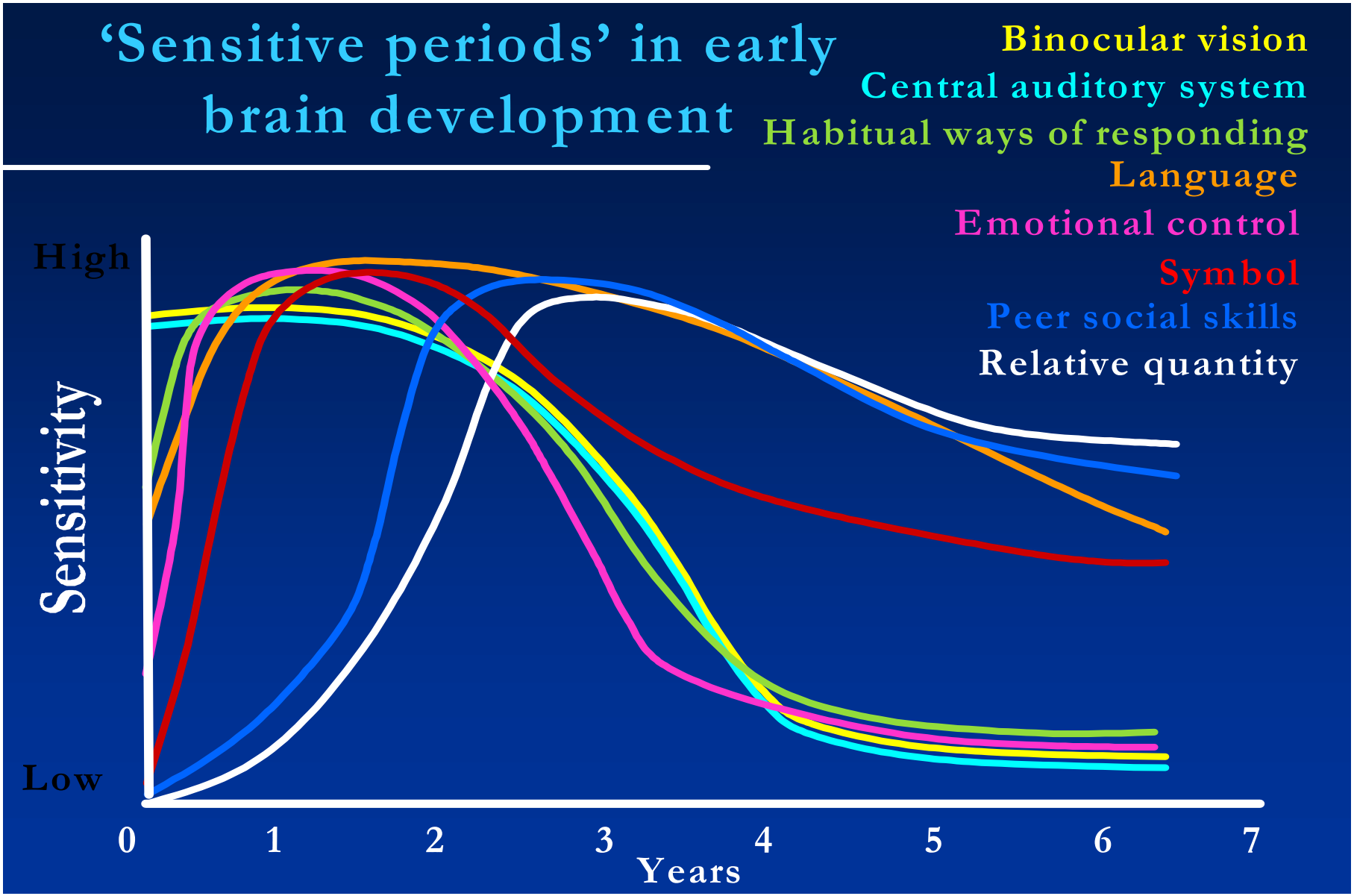
Source: SCF UK, 2009, Lasting Benefits, The role of cash transfers in tackling child mortality.

Causal pathways

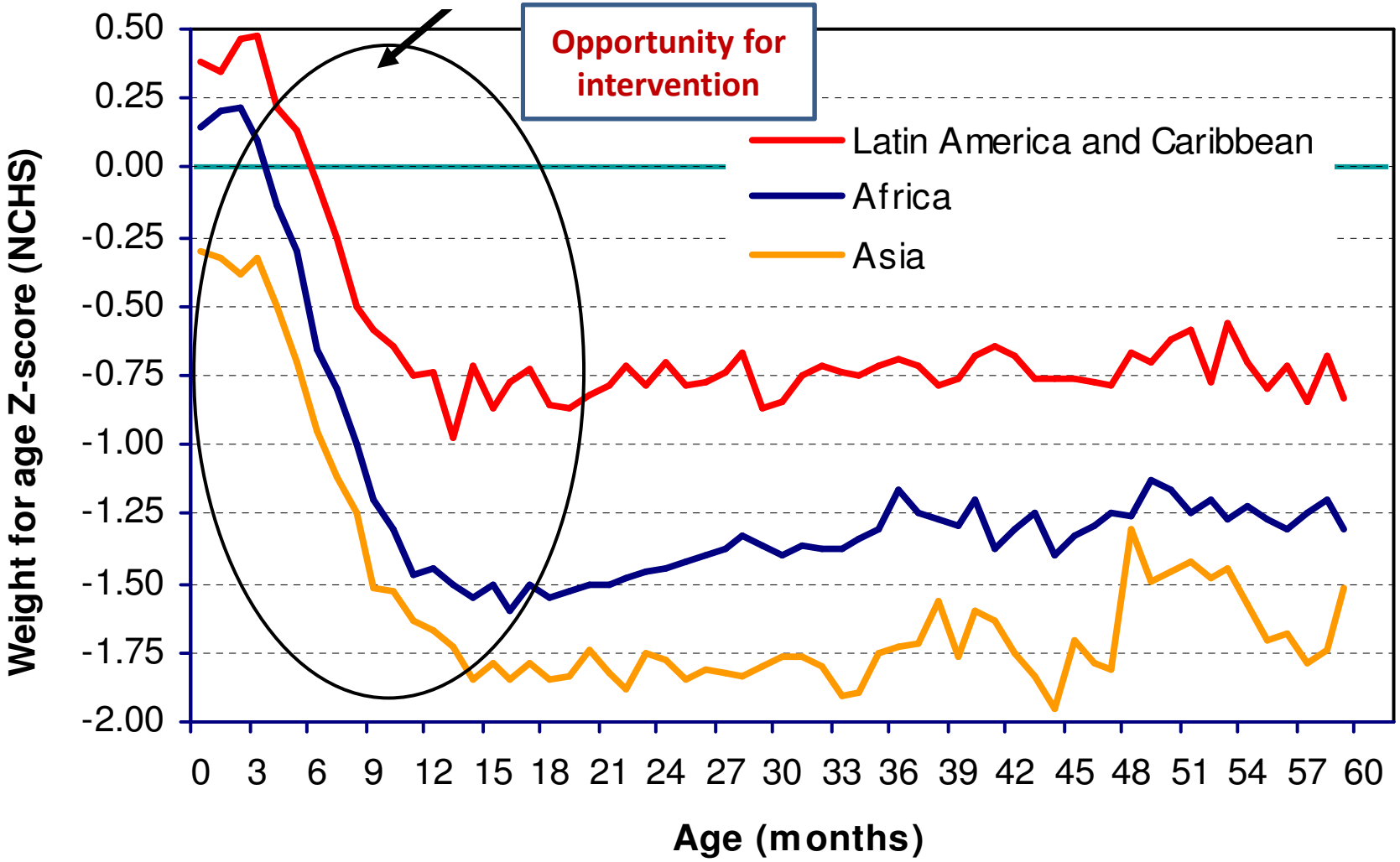


Source: Adapted from Leroy et al. , J. of Dev. Studies, June 2009.

The Early Years

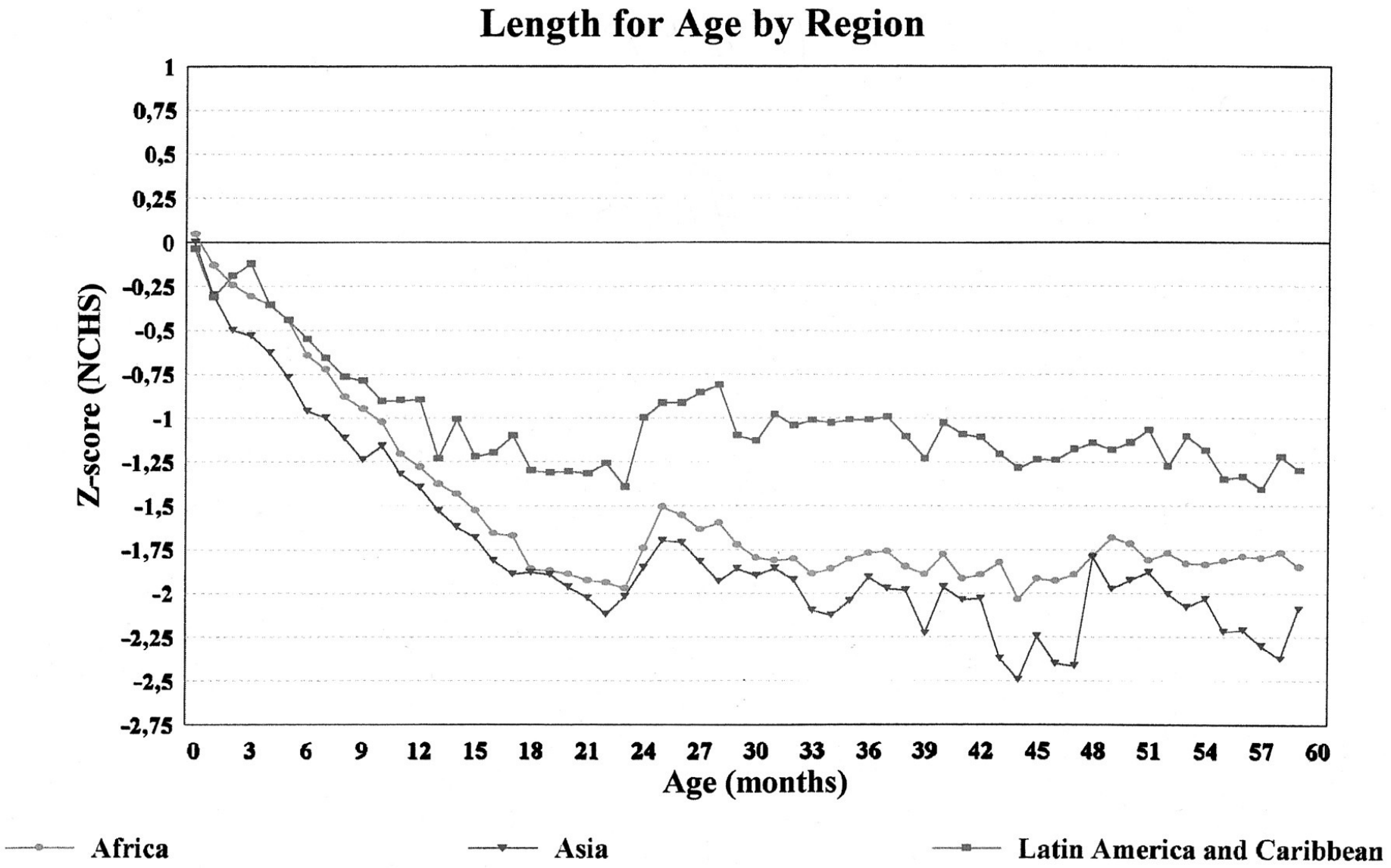


Underweight prevalence



Data Source: Shrimpton et al (2001)

Child stunting



Source: Shrimpton, R. et al. Pediatrics 2001.

Health & Nutrition co-responsibilities

Country	Program	Health Check-ups	Growth Monitoring*	Education Workshops	Micronutrient Supplementation
Argentina	Programa Familias	✓children & pregnant women			
Brazil	Bolsa Alimentação	✓ children 0-15 & pregnant women	✓	✓	
	Bolsa Familia	✓ children 0-6 & pregnant women	✓		
Chile	Subsidio Unitario Familiar	✓ children 0-6			
Colombia	Familias en Acción	✓ children 0-6	✓	✓encouraged, but not required	
Dominican Republic	Solidaridad	✓ children 0-5	✓		
Ecuador	Bono de Desarrollo Humano	✓ children 0-5	✓		
El Salvador	Red Solidaria	✓ children 0-5 & pregnant women	✓	✓	
Honduras	PRAF II	✓ children & pregnant women	✓		
Indonesia	Program Keluarga Harapan	✓ children 0-6 & pregnant women			
Jamaica	PATH	✓ children 0-6 & pregnant women			
Kenya	Cash Transfer for OVC	✓ children 0-5	✓		✓ (vitamin A)
Mexico	Oportunidades	✓ children & adults	✓	✓	✓ (iron & *papilla* nutritional supplement)
Nicaragua	Red de Protección Social	✓ children 0-5	✓	✓	✓ (iron)
Panama	Red de Oportunidades	✓ children 0-5			
Paraguay	Tekopora Program	✓ children 0-14 & pregnant women	✓		
Peru	Juntos	✓ children 0-5 & pregnant women	planned	✓ (hhs with children 6-36 mos)	
Philippines	Ahon Pamilyang Pilipino	✓children 0-5 & pregnant women			
Turkey	Social Risk Mitigation Project	✓ children 0-6 & pregnant women			
Uganda	Cash Transfer pilot	✓ infants			

Source: Bassett, L., World Bank, SP Discussion Paper No. 0835, October 2008.

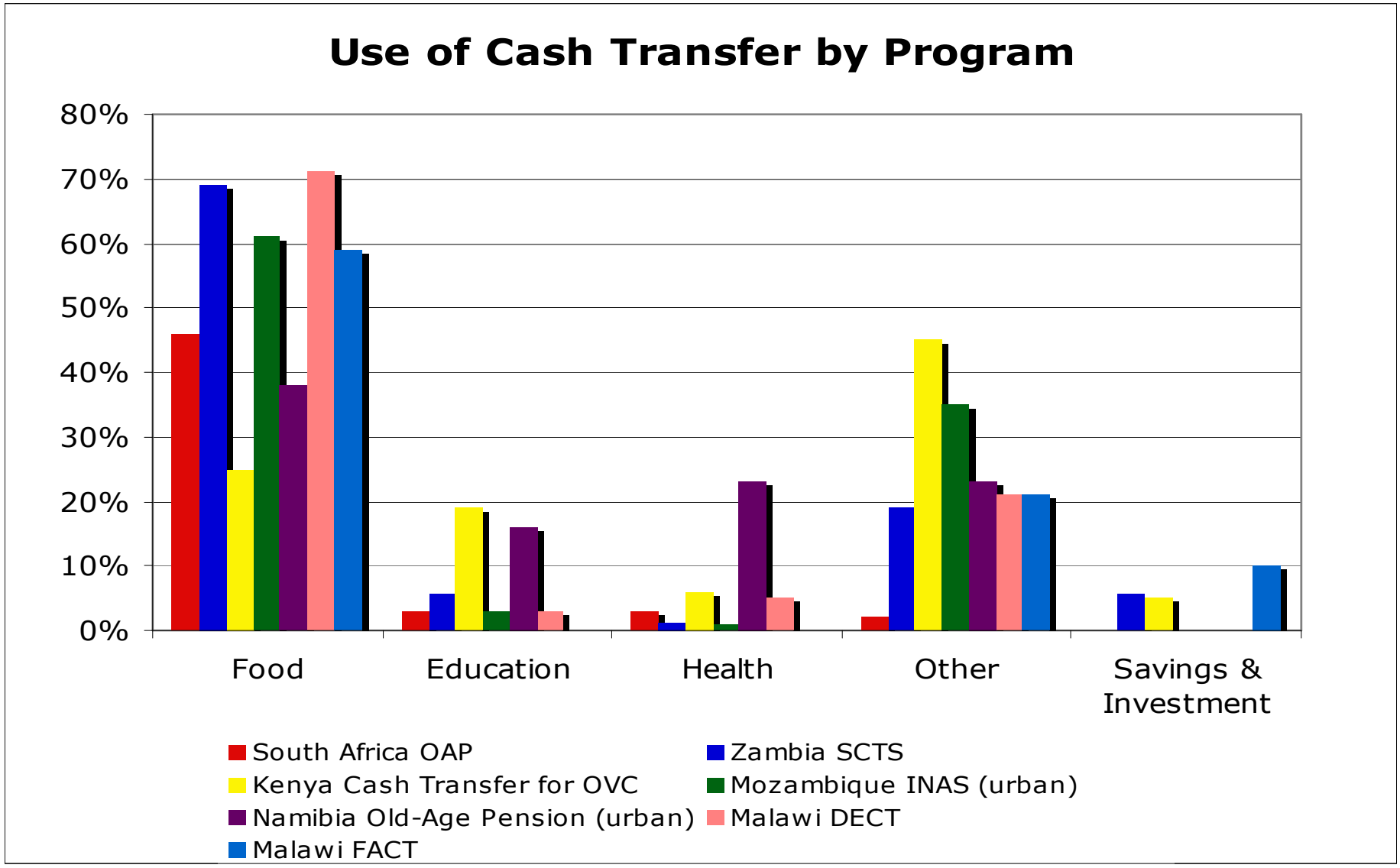
Impact of CT programs on MCH & Nutrition

"Cash transfers have demonstrated impressive impacts on factors that lead to unnecessary child deaths. And in many cases, these impacts are greatest among the poorest children."
Save the Children: Lasting Benefits. The role of cash transfers in tackling child mortality, 2009.

"CCTs are an effective way to provide basic income support to poor families while strengthening children's health, education and nutrition.
Resilience, Equity & Opportunity: The WB's Social Protection and Labor Strategy 2012-2022.

"There is evidence of cash transfers having strong impacts on the main determinants of child mortality… Social protection interventions to increase access to key services can directly and indirectly contribute to improvements in children's nutritional status by addressing the underlying causes of health- and nutrition-related vulnerabilities."
UNICEF, Integrated Social Protection Systems: Enhancing Equity for Children, 2012.

Impacts: Household expenditures



Source: IFPRI, 2005.

Impacts: Uptake of services and outcomes

MULTI-COUNTRY: A review of several studies and evaluations found **strong evidence of a positive impact of CCT programs on the use of health services, nutritional status and health outcomes**, assessed by **anthropometric measurements and self-reported episodes of illness** (Lagarde et al, October 2009).

MEXICO: Multivariate analysis based on retrospective reports from 840 women in poor rural communities randomly assigned to incorporation into the CCT program: 127.3 g higher birth-weight among participating women and a **4.6 percentage point reduction in low birth-weight** (Barber & Gertler, 2008a).

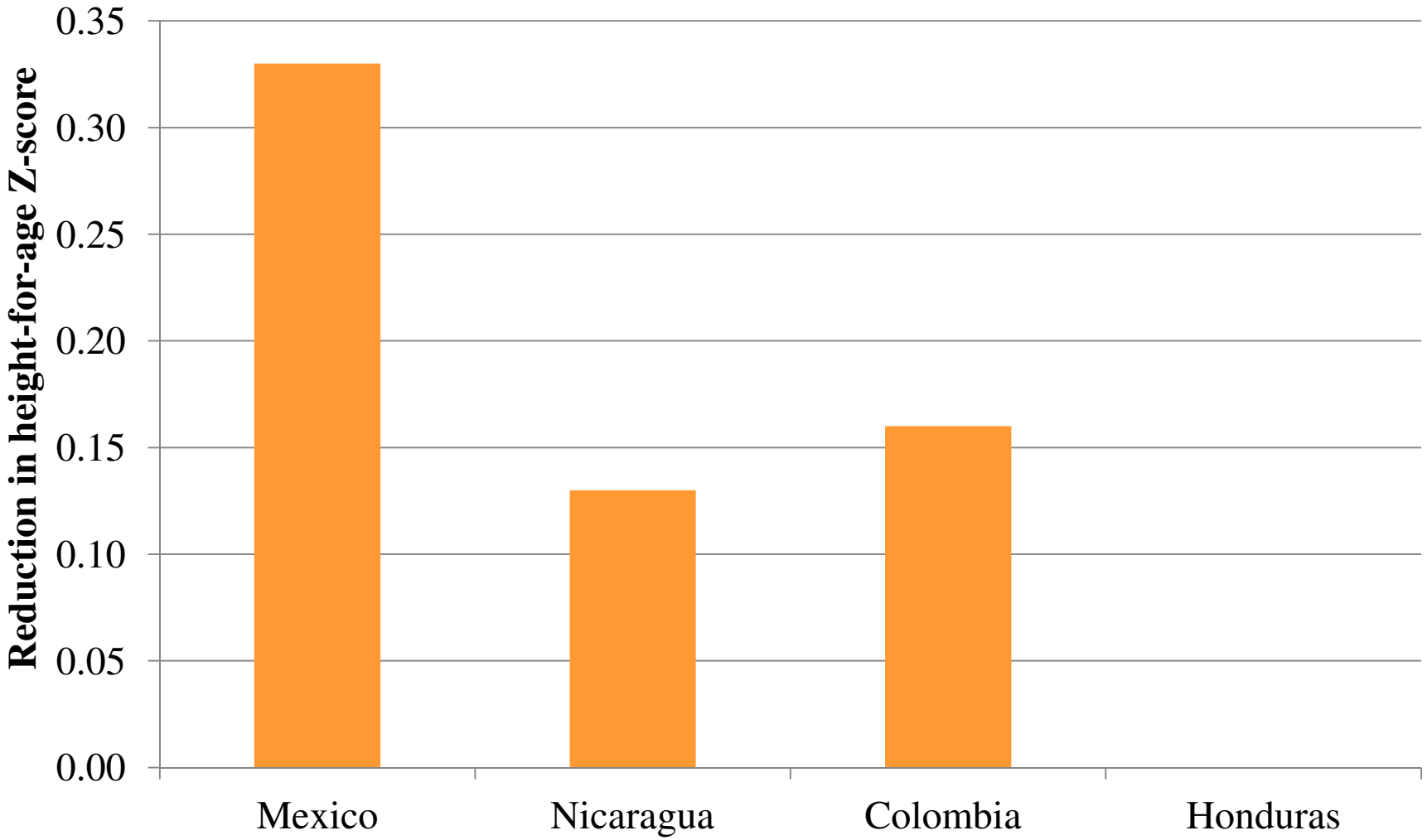
MEXICO: Regression analysis of 2,449 children aged 24-68 months found that the CCT was associated with better **outcomes in child health, growth, and development**: higher height-for-age *Z* score, lower prevalence of stunting, lower BMI for age percentile, and better performance on a scale of motor development, 3 scales of cognitive development, and on receptive language (Fernald et al., *The Lancet*, 2008).

MEXICO: CCT beneficiaries received **better quality prenatal care** (measured by the number of prenatal procedures received that correspond with national clinical guidelines) compared with non-beneficiaries: 12% more prenatal procedures (Barber & Gertler 2008b).

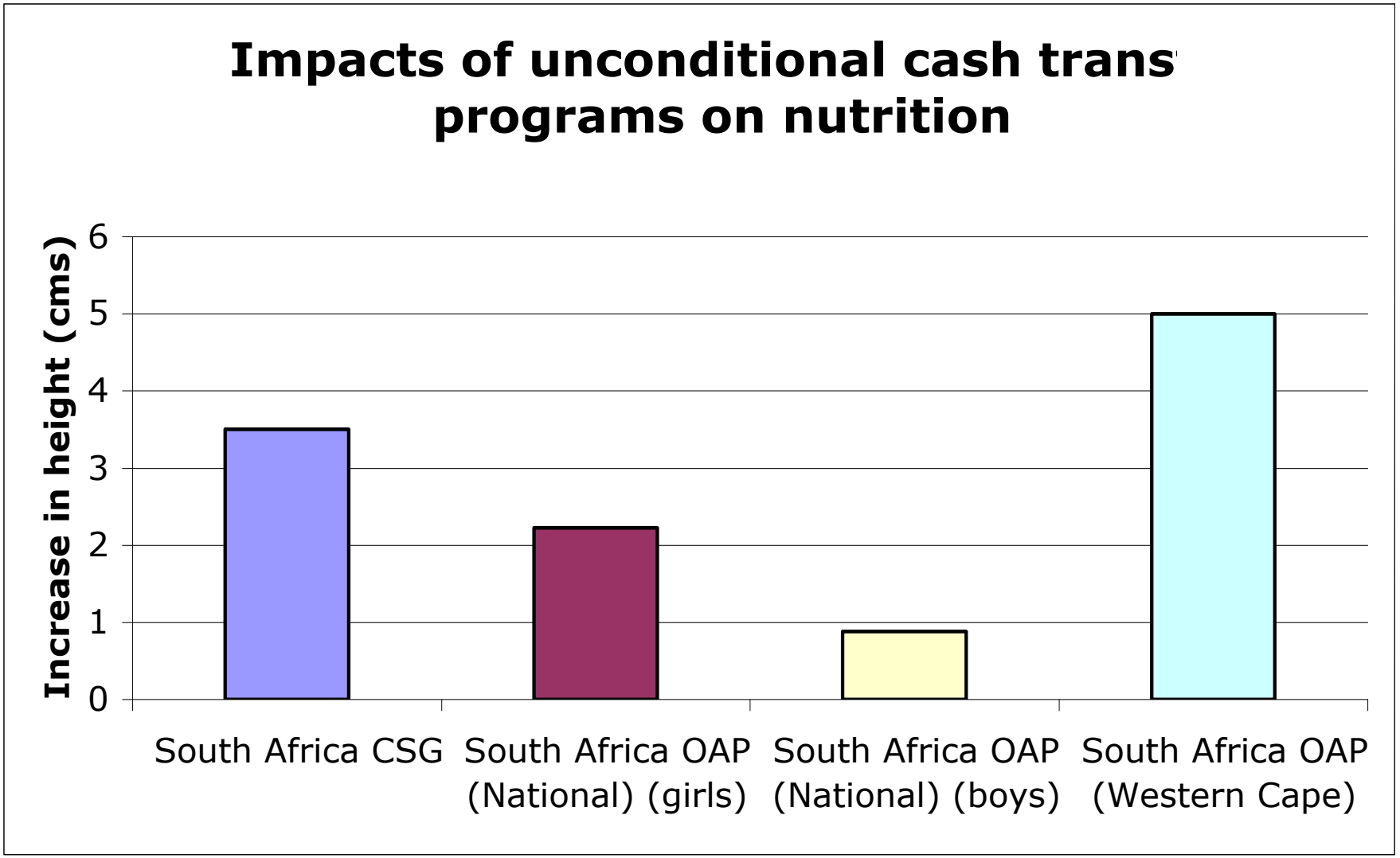
INDIA: Assessment of a CCT program introduced by the Government in 2005 found that it had a significant effect on **increasing antenatal care and in-facility births**, and in **reducing perinatal** (3.7%-4.1%) and **neo-natal deaths** (2.4%) per 1000 pregnancies / live births (Lim et al, *The Lancet* 2010).

MALAWI: Cash incentives to school girls and recent dropouts to stay in/return to school have led to significant **declines in early marriage, teenage pregnancy, and self-reported sexual activity** among beneficiaries after just one year of program implementation. For program beneficiaries who were out of school at baseline, the probability of getting married or becoming pregnant declined by more than 40% and 30%, respectively. More than a third of program beneficiaries delayed the onset of sexual activity by a full year (Baird et al. 2009).

Impacts: Stunting



Impacts: Unconditional transfers



Source: Agüero et al. 2007; Case 2001; Duflo 2003; Samson et al. 2004.

TASAF / PSSN

Objective: To increase income and consumption of poor HHs while enhancing and protecting the human capital of their children

Duration: 2012-2022

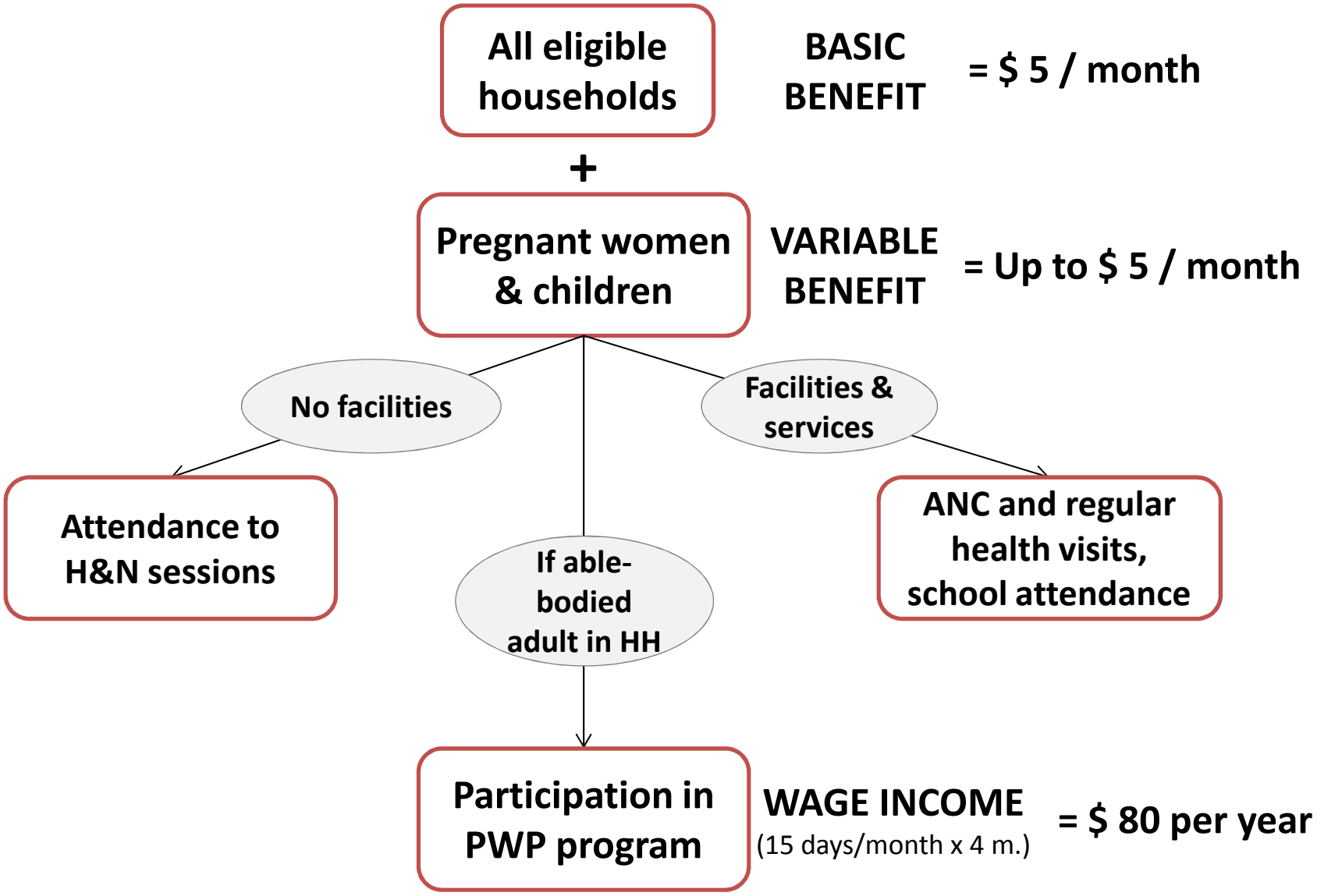
Coverage: Est. at 250,000 HHs (1.2 million)

Funding: Approx. $341 mn (2012-17) - WB $ 220 mn; DfID $ 90 mn; GoT $ 30 mn; Spain $ 6 mn; USAID $ 0.75 mn

Components:

- **CT** (extremely poor HHs with pregnant women, children 0-18 years, elderly, disabled)
- **PWP** (labour-intensive PWs during lean season)
- **Targeted infrastructure** (schools, health dispensaries, etc.)

Benefits & Conditions



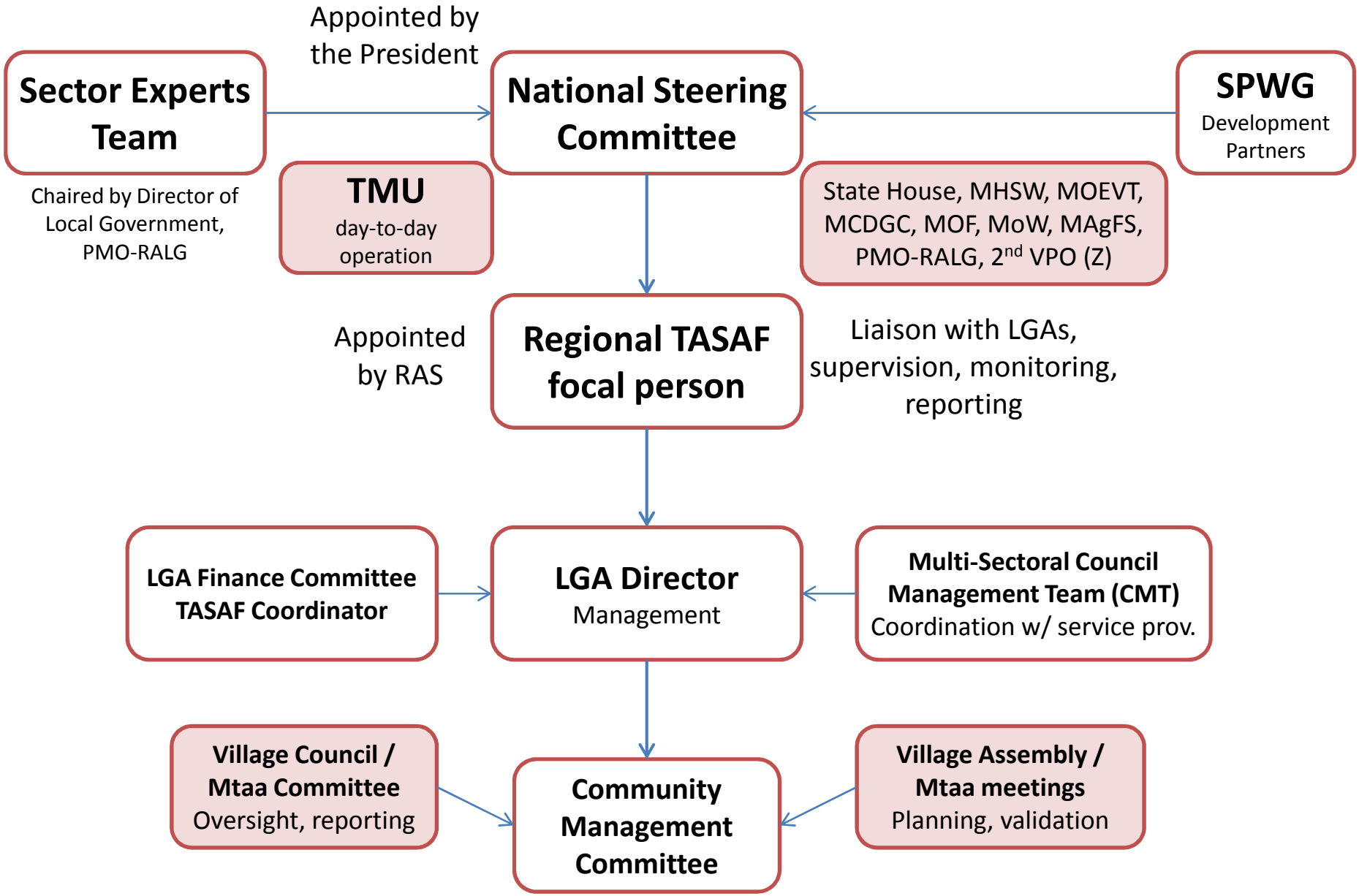
Co-responsibilities

HH member	Co-responsibilities
Children	In areas where health services are available, all children <24 months attend routine health services once per month
	In areas where health services are available, all children 24-59 months attend routine health services at least once every six months
	In areas with no health services, primary caregivers of children ≤59 months attend community health and nutrition sessions every two months
	In areas where primary education is available, children between ages 6-18 who have not completed primary education attend school 80% of the time
Pregnant women	Where health services are available, all pregnant women in the household must attend 4 prenatal exams
	Where health services are not available, pregnant women in the household must attend community health and nutrition sessions every two months

For households failing to comply, every effort will be made to ensure adequate follow-up and support to help them meet program requirements without risking a loss of the benefit.

Adequate follow-up and support will require close coordination with other Government departments at central and local level, especially social welfare officers in the LGAs.

Institutional & management arrangements



Entry points & opportunities

- Improving income / consumption of poorest HHs, including food and health expenditures
- Addressing financial access barriers by providing extremely poor families w/ an incentive and the means to access services
- Bringing hard-to-reach children to facilities & services (ANC, schools, health dispensaries, CTCs)
- Building schools, latrines, teachers' dorms, dispensaries, water points, etc.
- Linking cash with micronutrient interventions (sprinkles) and services
- Providing a captive market for C4D interventions
- Mapping schools/health facilities through supply side capacity assessment
- Developing & utilizing the Unified Registry of Beneficiaries

Challenges & issues to be explored

- Determining the size of the transfer
- Targeting: Who, how, when?
- To condition or not to condition
  - ✓ Availability and quality of services
  - ✓ Administrative costs
  - ✓ Monitoring compliance
  - ✓ Income effect
  - ✓ Soft conditions plus C4D interventions
- Matching supply with demand
- How to link cash transfers with *BCC (H&N counselling) and nutrition services* (e.g. 'sprinkle' sachets of micronutrients)
- Whether to link payments to participation in *MNCH programs, safe delivery of babies* at health facilities, *starting school at the appropriate age*, or *girls staying in school*
- How to realize the potential for PWP to strengthen service provision