

**Assessing the Need and Opportunities  
for Improved Linkages between  
Conditional Cash Transfers  
and Reproductive Health Programs  
in Latin America and the Caribbean**

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## SUMMARY

Conditional cash transfer (CCT) programs provide cash to poor households, mostly in rural areas, on the conditions that children stay in school until they finish a minimum level of education established by the program, and that children and mothers attend health centers and educational sessions. CCT programs are based on the assumption that poor families do not invest enough in human capital and are therefore trapped in a cycle of intergenerational transmission of poverty. Currently 14 countries in Latin America and the Caribbean (LAC) have CCT programs. Countries in Africa and Asia have also begun programs in the last few years

The objective of this project was to document the structure and functioning of CCT programs in LAC, to assess opportunities for improved linkages between CCTs and reproductive health programs, and to explore the role that operations research may have in the improvement of CCT programs. The activities conducted included: 1) a desk review of the CCT programs in the Dominican Republic, El Salvador, Honduras, Jamaica, Nicaragua and Peru; 2) a review of the literature on CCT programs; and 3) on-site visits to El Salvador, Honduras, Jamaica, Nicaragua and Peru to interview key informants and assess their perceptions of the functioning of the CCT programs and opportunities for improving them.

The greatest opportunities to improve the reproductive health outcomes of CCT programs were establishing systematic screening procedures for a minimum package of essential preventive services, including contraception. Increasing access to sterilization and the IUD for CCT program beneficiaries and establishing community-based distribution to increase access to temporary methods also have great potential. The model of offering a bonus for institutional births used in Honduras should be tested in other programs. Other opportunities include testing a reduced schedule of visits, strengthening linkages between school and health service activities and establishing positive deviance interventions to achieve better outcomes in reducing anemia in children of beneficiary families.

Operational problems faced by CCT programs included the targeting and selection of beneficiaries, monitoring compliance with conditions for receiving cash transfers, the systems used to provide the transfers, and management weaknesses. Recommendations are made for operations research and other interventions to overcome the operational problems found with CCTs. These include conducting diagnostic research on the perceptions of the participants, using illiteracy as a criterion for eligibility in the program, testing interventions to improve scholastic achievement and conditioning payments in other programs.

# INTRODUCTION

Conditional cash transfer (CCT) programs provide cash to poor households, mostly in rural areas, on the conditions that children stay in school until they finish a minimum level of education established by the program and perform specified health activities (e.g. periodic visits to the health center). CCT programs are based on the assumption that poor families do not invest enough in human capital and are therefore trapped in the vicious cycle of intergenerational transmission of poverty. Unlike other welfare programs, CCTs allow the household to spend the money they receive any way they wish, so long as the educational and health conditions of the program are met.

The first CCTs are over ten years old and the number of programs is increasing. In the Latin America and the Caribbean (LAC) region, Mexico, Brazil, Colombia, Ecuador, Honduras, Jamaica, Nicaragua, Argentina, Chile, Costa Rica, El Salvador, Panama, Paraguay and Peru have introduced CCT projects. Countries in Africa and Asia have also begun programs in the last few years.<sup>1</sup>

Evaluations indicate that CCT programs are effective in reaching the poor and improve some educational and health outcomes, but have little or no effect on others. It has been estimated that 80 percent of the benefits go to the poorest 40 percent of families.<sup>2</sup> The evaluations show that the CCT programs have helped increase school enrollment and decrease school drop-out and repetition of grades. CCTs also increase target population attendance at health centers, increase food consumption, reduce stunting and decrease the proportion of children working. Little or no improvement among beneficiaries has been found in other intended outcomes, however, such as learning, anemia, and fertility rates.<sup>3</sup>

Appendix 1 presents a summary of CCT program results that have been reported in the literature. As would be expected, the effect of CCT programs appears greater where education and health indicators are worst (e.g. the impact on school enrollment rates in elementary school was much larger in Nicaragua, where only about 60 per cent of children were enrolled prior to the CCT, than in Mexico, where at baseline enrollment was over 90%).

Very few studies have reported an impact of CCTs on reproductive health outcomes. Pregnant and lactating women are one of the target groups of CCT interventions, and one common conditionality is attendance at antenatal and postnatal care visits. CCTs appear to have increased

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<sup>1</sup> See the following websites for more information on programs around the world: <http://www.undp-povertycentre.org/cct.htm> and [http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2004/10/12/000012009\\_20041012095621/Rendered/PDF/301650PAPER0SP00416.pdf](http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2004/10/12/000012009_20041012095621/Rendered/PDF/301650PAPER0SP00416.pdf)

<sup>2</sup> Coady, D; M. Grosh and J. Hoddinot. 2004. Targeting of Transfers in Developing Countries: Review of Lessons and Experiences. World Bank Social Protection Papers, Washington, D.C.

<sup>3</sup> See de la Brière, Bénédicte and L.B. Rawlings. 2006. Examining Conditional Cash Transfer Programs: A Role for Increased Social Inclusion? SP Discussion Paper No. 0603, The World Bank; and Glassman, Amanda; J. Todd and M. Gaarder. 2007. Performance-Based Incentives for Health: Conditional Cash Transfer Programs in Latin America and the Caribbean. Center for Global Development Working Paper # 120.

prenatal visits modestly, and in Mexico small or non-existent increases in contraceptive use by beneficiaries have been reported.<sup>45</sup>

Operations research (OR) can be an important vehicle for improving CCT programs and reducing missed opportunities –from making family planning and reproductive health services more accessible to CCT clients, to improving the quality of the services offered. This report describes the findings of a desk review, a literature review of CCT programs, and on-site assessments of five CCT programs in LAC. The study had the objective of identifying opportunities for improved linkages between CCTs and reproductive health services. One of the findings of this project is that, in addition to these linkages, there are several other areas where the effectiveness of CCT programs can be improved. The report proposes concrete ways in which OR can be used to make CCT programs more effective.

## **OBJECTIVES**

The objective of this project was to document the structure and functioning of CCT programs in the LAC region to assess opportunities for improved linkages between CCTs and reproductive health programs, and to explore the role that operations research may have in the improvement of CCT programs.

## **ACTIVITIES CONDUCTED**

### **Desk Review of CCT Programs in LAC**

The Economics Department of the Universidad Iberoamericana (Ibero American University or UIA) in Mexico City conducted a desk review of CCT programs in six countries in the LAC region to assess the management structure of each program, their operating procedures, and their health results. In this review, UIA researchers searched the web for the websites of CCT programs in the Dominican Republic, El Salvador, Honduras, Jamaica, Nicaragua and Peru. They located and analyzed official documents of these programs, and prepared brief (5-10 pages) reports explaining the characteristics of each program. The countries included in this review were selected because they had a CCT program and a USAID Health, Population and Nutrition Office. The reports are presented as appendix 1 in the accompanying volume to this report.

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<sup>4</sup> Hernández, B., Hernández, M. (Eds.) (2005). Evaluación externa de impacto del Programa Oportunidades 2004. Tomo IV. Aspectos Sociales y Económicos. Instituto Nacional de Salud Pública, Centro de Investigaciones y Estudios Superiores en Antropología Social. México: Programa de Desarrollo Humano Oportunidades; Prado, B; J.Urquieta, M. Ramírez y J.G. Figueroa. 2004. Impacto de Oportunidades en la salud reproductiva de la población beneficiaria. Versión preliminar.

<sup>5</sup> Urquieta, Jose et al. 2008. “Impact of Oportunidades on Skilled Attendance at Delivery in Rural Areas,” *MEASURE Evaluation Working Paper Series* WP-08-102. Chapel Hill, NC: MEASURE Evaluation.

## **Literature Review**

An extensive literature review was conducted to understand CCT's organizational principles, their human behavioral and service delivery assumptions, and their impacts. Like the desk review, this information formed the basis for understanding how operations research could help improve CCT programs. The literature reviewed focused on three topics: i) The design, impact and implementation of CCT programs; ii) anti-poverty and social assistance programs, and iii) the development of human and social capital. The documents reviewed included articles in peer-reviewed journals, book chapters, and program reports; appendix 2 lists the documents reviewed.

## **On-site Assessment of Programs**

FRONTIERS' staff made on-site visits to El Salvador, Honduras, Jamaica, Nicaragua and Peru. Interviews with CCT and MOH staff members – including the director of the CCT program, managerial staff in charge of the health, education, and monitoring and evaluation components of the programs, and field staff – were conducted during the 2-3 day visits. These visits were also used to interview other key informants (such as consultants, staff of the World Bank and the Inter American Development Bank, and staff members of other health stake holders like UNFPA and USAID and its collaborating agencies). We also gathered printed and electronic information produced by the programs, including manuals, job aids, and program reports. The interviews focused on perceptions of the functioning of the CCT programs, their problems and needs, possible solutions, opportunities for improvement, and linkage with other social protection and health programs. Appendix 2 in the accompanying volume presents the trip reports. Appendix 3 in this report presents a summary of the characteristics of the CCT programs visited; those not familiar with CCT programs should read this appendix before the results section below.

## **RESULTS**

### **Opportunities for increasing the linkage of CCT programs and reproductive health services**

Even in countries with good reproductive health indicators, there is an inverse relationship between contraceptive use and access to reproductive health services, and socioeconomic status. In the Dominican Republic, for example, overall contraceptive prevalence for women in union is 64.7% and unmet need for family planning is 10.9%. However, women in the poorest quintile have more than double the unmet need of women in the richest quintile (8.7% vs. 4.1% for limiting, and 11.3% vs. 4.5% for spacing).<sup>6</sup> CCT programs focus on poor households with women of reproductive age who have the highest fertility, largest unmet need for contraception and highest maternal mortality rates. CCT programs offer the opportunity to provide these women with a broad range of family planning and reproductive health (FP/RH) services. Nevertheless, with only a few exceptions, programs in Latin America do not explicitly provide FP/RH. Of the programs reviewed for this study, El Salvador, Honduras, Jamaica and Peru have as a condition for cash transfers that pregnant women attend antenatal and postnatal care (see

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<sup>6</sup> UNFPA. 2008. *Country Profiles for Population and Reproductive Health* (<http://www.unfpa.org/profile/#indicartors>, accessed May 2, 2008)

Table 1), and Honduras offers an additional bonus for women who have an institutional delivery. The health components of all programs focus on the preventive care of children, regular health check-up visits, and compliance with vaccination schedules. In addition, all programs, with the exception of PATH in Jamaica,<sup>7</sup> provide regular talks for beneficiary families. Reproductive health topics such as family planning and the importance of assisted delivery are covered in these talks.

**Table 1: Health components of CCT programs in six countries**

Country	Health component				
	Antenatal care	Institutional delivery	Postnatal care	Children's check-ups	Health talks
Dominican Republic	No	No	No	Yes	Yes
El Salvador	Yes	No	Yes	Yes	Yes, but not a conditionality
Honduras	Yes	Yes, but not a conditionality	Yes, but not a conditionality	Yes	Yes
Jamaica	Yes	No	Yes	Yes	No
Nicaragua	No	No	No	Yes	Yes
Peru	Yes	No	Yes	Yes	Yes

A common assumption in the literature, and among the CCT staff we interviewed, is that even when CCT programs do not explicitly offer family planning and other reproductive health services beyond antenatal and postnatal care, these programs will contribute to an increase in the use of FP/RH services. According to these arguments, CCT programs foster demand for family planning because: (1) family planning and healthy birth spacing are covered in the health talks, (2) women who want to use a contraceptive method may obtain one when they take their children to the health center, and (3) the increased income may help households to overcome economic barriers to contraceptive use.<sup>8</sup>

In theory, the outpatient services in the health posts and centers that women need to attend to receive their cash transfer offer family planning and other reproductive health services. However, the CCT and MOH staff we interviewed during our field work had no information regarding the true availability of these services or the degree to which service providers offered these services to CCT beneficiaries. In Nicaragua, health providers said that temporary methods (condoms, pills and injectables) had been provided by the CCT program and the methods were consistently offered to participants. In El Salvador and Honduras, the outreach and community-based teams

<sup>7</sup> When we visited PATH officials, they explained that they were starting to pilot health talks in some communities. Nevertheless, they were not sure whether these would be made a conditionality in the next phase of the program.

<sup>8</sup> See for example, Urquieta et al. 2008.

providing services in rural communities only provided a limited set of child survival services to beneficiaries.

Access to long-term methods such as the IUD and sterilization was a major problem in all countries studied. This is an important oversight since beneficiaries can remain in the CCT program for only three years, putting them at risk of method discontinuation for economic or accessibility reasons (many beneficiaries live in service-poor areas) at the end of their eligibility for transfers. Additionally, because CCT programs target poor families with infants and school-age children, they include substantial numbers of older women who have achieved their desired fertility, who are likely to have a high need for permanent and long-acting methods.

Furthermore, motivating women to attend health facilities for their antenatal and postnatal care, or for their children's checkups is not enough to increase the demand for family planning and other reproductive health services. FRONTIERS studies in the Dominican Republic, Egypt, Haiti, Ghana, Kenya, Nicaragua, and South Africa have shown that, even when service delivery protocols call for family planning counseling to be given during antenatal and postnatal care visits, less than 55% of women receive this information.<sup>9</sup> FRONTIERS studies have also shown that despite the need and desire to use a contraceptive method, many women who visit a health facility do not obtain family planning services unless these are explicitly offered to them.<sup>10</sup>

Although the primary purpose of CCT programs is to increase the demand for some services, most programs have introduced at least a few supply-side components. In health, the programs in El Salvador, Honduras and Nicaragua contract private providers for some or all of health services. Thus, rather than strengthening existing services to achieve better results, the programs use resources to extend services to allow community inhabitants to receive the cash transfers. In Nicaragua, services were extended through itinerant health teams that were well equipped. In the

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<sup>9</sup> See Abdel-Tawab, Nahla, Sarah Loza and Amal Zaki. 2008. "Helping women achieve optimal birth spacing intervals: testing two models of providing birth spacing messages to pregnant and postpartum women," *FRONTIERS Final Report*. Cairo, Egypt: Population Council; Quiterio, Gisela, Maritza Molina, Marija Miric, Ricardo Vernon and Estela Rivero. 2007. "Dominican Republic: Diagnostic study of postpartum, postabortion and PMTCT contraceptive services," *FRONTIERS Final Report*. Washington, DC: Population Council; Rivero-Fuentes, Estela, Ricardo Vernon, Micaela Boulos, and Louis Marie Boulos. 2007. Haiti: Situational analysis of the use of contraception in postpartum, postabortion and prevention of mother to child HIV transmission," *FRONTIERS Final Report*. Washington, DC: Population Council; Solís, Freddy, Ana Cristina Rojas, Adilia Gadea, Estela Rivero-Fuentes, and Ricardo Vernon. 2007. "Situational analysis of the use of contraception in postpartum, postabortion and prevention of mother to child transmission (PMTCT) programs, Nicaragua," *FRONTIERS Final Report*. Washington, DC: Population Council; Warren, Charlotte, Rachel Shongwe, A. Walñigo, M. Mahdi, G. Mazia and I. Narayanan. 2007. "Repositioning postnatal care in a high HIV environment," *FRONTIERS Final Report*. Washington, DC: Population Council; Warren, Charlotte, T. Ts'ukulu, S. Phafoli and B. Majara. 2008. Extending PMTCT through family planning-Lesotho," *FRONTIERS Final Report*. Washington, DC: Population Council.

<sup>10</sup> See Vernon, R., and Foreit, J. (1999). How to Help Clients Obtain More Preventative Reproductive Health Care. *International Family Planning Perspectives*. 25 (4) pp 200 -202; Leon, F. et al. (1998). Increasing Use of Reproductive Health Services in a Peruvian Clinic. In J Foreit and T. Frejka (Eds.), *Family Planning Operations Research: A Book of Readings*. (pp. 239-245) New York. Population Council; Vernon, Ricardo; James R. Foreit and Emma Ottolenghi. 2006. *Introducing Systematic Screening to Reduce Unmet Health Needs: A Manager's Manual*. FRONTIERS Manual. Washington, DC; Population Council

case of Honduras and El Salvador, NGOs extended basic community child nutrition monitoring interventions, but beneficiaries had to attend MOH health posts for other services. The only projects that attempted to improve the skills of providers and the processes by which they provided services were the BID 1026 and BID 1568 projects in Honduras. In the latter, the design called for implementing quality improvement in health centers and posts with a standard quality assurance methodology, but according to respondents, they never understood what was expected of them, and the component was never implemented.

## **Recommendations for increasing the effectiveness of CCT programs**

To avoid missed opportunities to provide health services to clients, CCT programs should establish systematic screening procedures for a minimum package of essential preventive services. The systematic screening technique developed by FRONTIERS has been tested and adapted in different countries and could easily be implemented during the mandatory visits that CCT clients make to the health facility. The systematic screening technique could also be adapted to identify the unmet needs of women during their attendance at the mandatory health talks and referring them to a health facility. This intervention would reach families that do not have infants or pregnant women and do not have to make regular visits to the health facility as a condition for their cash transfers.

The greatest opportunity for improving linkages between CCT and family planning programs would seem to be increasing access to sterilization and the IUD. None of the CCT programs make any special provisions for this, despite the fact that many of the women enrolled are older and suitable candidates for long acting and permanent contraception.

CCT programs need to reinforce the supply-side of family planning and reproductive health services. In particular, it is important to ensure that providers in areas covered by the program are trained in a minimum package of essential preventive services, and that existing services are reinforced. As mentioned in the previous section, the few experiences seeking to test the effect of supply-side interventions have not been very successful because they have been difficult to implement. The use of operations research to introduce simple successful interventions in existing MOH services is key to make reproductive health services in a CCT framework sustainable over time. Equally important is the need to use operations research to guarantee a minimum quality of care. CCT programs should work with the MOH to define a basic package of services and insure that providers are appropriately trained to deliver them.

Linking vaginal cytology to CCT health services would also seem to be a good opportunity. One of the main problems of cervical cancer prevention programs is informing clients of the results of the test. In the case of CCT programs, the frequent contact of beneficiaries would make it easy to solve this problem. As in the case of the IUD and sterilization, family planning programs have ample experience providing outreach Pap test services that could easily be adapted to the context provided by CCT programs.

Several research projects have sought to evaluate the effect reduced schedules of visits on health outcomes (see for example, WHO's Focused Antenatal Care, and Hubacher et al, 1999, for the IUD). Given the complaints of program participants in countries such as Jamaica about the need to attend health services even if the family member is healthy, and given the demands these visits

impose on the health system, research on reducing visit requirements might have important results. Operations research could help determine the appropriate schedules, targeting methods, contents, didactic methods and filters used in health education programs.

It appears that there are few if any linkages between school and health service activities in CCT programs. Providing preventive health services in schools might be effective and reduce costs for women because many mothers already take their children to school, and because schools are usually much nearer the average household than health facilities are.

Programs have had little success in decreasing anemia; a program intervention could establish positive deviance interventions where mothers of anemic children receive advice and supervision from mothers of non-anemic children, or an adaptation of the DOTS methodology used for tuberculosis patients.

## **Operational problems faced by CCT programs**

### **a) Targeting and selection of beneficiaries**

Regardless of the evaluation results showing that a large proportion of the benefits of CCT programs go to the intended beneficiaries, in all countries visited program staff complained about inclusion and exclusion errors. In Jamaica, we were told that the targeting mechanism leaves out of the program some families in great need, especially in the Kingston area, and that the appeal process was very cumbersome. In addition, some Jamaican social workers were not adequately trained to help clients file appeals. In Nicaragua, we were told that families in need were excluded because the people conducting the surveys did not have sufficient knowledge of the communities that they visited. Many households appealed to local program staff, who were unable to solve the problems because only the central-level program authority could make changes in beneficiary status.

The practice of selecting households instead of individual families was also criticized. Often, very poor families, such as those headed by single mothers, lived in extended households whose overall characteristics excluded all members from receiving benefits. In Peru and Nicaragua, households sometimes deliberately dissolved to qualify for benefits. In Jamaica, there were information system problems that resulted in many applications being lost.

### **b) Monitoring participant compliance with conditions for receiving cash transfers**

Although the literature found in the desk review assumed that the compliance of families with payment conditions was always monitored, we found that the degree of monitoring varied greatly from program to program. The BID-1026 program in Honduras, for example did little monitoring while the program in El Salvador rigorously monitored compliance.

Several problems associated with compliance monitoring were identified. In many countries program staff believed that a large proportion of program beneficiaries were not aware of, or did not know about, all or even some of the conditions for receiving payments. This is a particularly important finding because CCT programs assume that the incentives they give promote concrete behaviors, but often beneficiaries are unaware of the behaviors they are expected to perform. In Jamaica, for example, some parents did not understand why they needed to take healthy children

to the health center. Also, in all countries the monitoring mechanism is subject to many mistakes and parents are informed of penalties only long after they are assessed. Families sometimes stop receiving benefits without knowing why. Finally, in a few countries the management information systems were insufficient for the amount of data that had to be processed and little analysis of program data was done.

### **c) Payment (cash-transfer) systems**

Payment systems suffer from many problems. In Honduras, for example, beneficiaries failed to receive payments in the BID 1026 project for more than a year, and in Nicaragua one or two month delays were common. In Jamaica, a study on payment options showed that many clients experienced delays in receiving the check. Frauds in the Jamaican checks were also detected because some persons would “wash” them and alter the amount.

To solve these problems, the Honduran and Jamaica programs changed the way in which the payments were made. Beneficiaries now have the option of receiving their payments as a direct bank deposit and receiving an ATM card to make their withdrawals. In Jamaica, the checks were also changed and are now more secure. In Nicaragua the periodicity of the payments was modified, from every two months to every three months but delayed payments continued to be experienced.

### **d) Governmental management and administration weaknesses**

In Honduras and Nicaragua, some of the key informants interviewed mentioned that the governments’ traditional managerial weaknesses affected the programs negatively. One problem was the high turnover of government officials that were the counterparts of the CCT programs and turnover among the CCT program management teams themselves. In Nicaragua, there were nine different Ministers of Health in the seven year period in which the CCT program was active. In Honduras, all but one of the top CCT program managers were changed when the second CCT program started. In Nicaragua, was that the CCT management team was moved in the middle of the project cycle from the FISE (Social Investment Fund) to the Ministry of the Family.

### **e) Sustainability**

The only CCT program visited that did not depend on foreign loans or donations was PATH in Jamaica. The Honduras and Nicaragua programs were implemented with loans from the Interamerican Development Bank (IDB). In El Salvador, the government was also able to obtain a large donation from a European donor. To date, only mid-income countries like Brazil, Chile, Jamaica and Mexico have been able to implement CCT programs mostly with their own resources. In Jamaica, PATH was funded by merging three programs that targeted three different vulnerable groups: the elderly, pregnant women, and people with disabilities. In Mexico, PROGRESA was funded by eliminating other less well targeted pro-poor programs. In contrast, the Honduras government already had programs giving cash to poor people. This program was being implemented without a bank loan when Honduras received a loan (BID 1026) to implement yet another cash transfer program. The conclusion is that many poor and mid-income countries could probably fund their own CCT programs if they re-structured their existing anti-poverty programs.

Some CCT program components were perceived by our respondents as being too expensive. Countries receiving loans from the BID often have to comply with requirements set by the banks that consume a large proportion of the CCT program's budget, such as the targeting and evaluation components. Respondents in Nicaragua were critical of the requirement to use private providers to extend health services, rather than spending money on up-grading the MOH. In most countries respondents felt that many program components could have been cheaper and would have responded better to the countries' long term interests.

#### **f) Inadequate or overly-ambitious evaluation and intervention designs**

In the BID 10-86 program in Honduras, all communities selected for participation in the program were randomly assigned to one of four conditions: (1) demand-creation (cash transfer) components only; (2) supply-side conditions (payments to school parent associations, training, quality assurance) only; (3) both demand and supply-side conditions; and (4) a control group where no activities were implemented. This design proved impossible to follow. First, there were large problems in setting up the basic payment and monitoring systems; second, disbursing cash transfers to individuals and parent associations was affected because many parents lacked adequate ID cards and the parents' organizations were not legally constituted. The baseline survey was conducted but the interventions had not been implemented by the time that the endline survey had to be conducted, and the endline was never conducted. The designs utilized by the International Food and Policy Research Institute (IFPRI) and others have often relied on random or random-like assignment of all communities rather than of small samples to determine impacts and help make decisions.

On the other hand, programs have failed to profit from opportunities to conduct research to answer important questions regarding, for example, the long-term impact of CCT programs or the impact of different inputs. In both Honduras and Nicaragua, communities participating in the first cycle of CCT projects were replaced by new ones in the second cycle, and in Nicaragua the project ceased to operate after the second cycle. In Honduras, the existence of two PRAF programs, one paid for with local funds and another funded by BID, provided an opportunity to assess the effects of different structure of incentives and conditions that was not capitalized on.

#### **g) Lack of attention to Human Capital Development and Productivity of Adults**

One of the most common criticisms of CCT programs heard during visits was the lack of attention to the development of the human capital and the lack of income-generating programs to accompany the cash transfers ("they give them fish instead of teaching them how to fish").

In terms of human capital development for adults, the only component in the programs visited were talks that health providers gave to the female heads of beneficiary households. Adult males were ignored by all programs. In Nicaragua, for example, about 30% of the beneficiary households were led by an illiterate head, and although the interviewees said that a separate literacy program was conducted, it did not seem to be integrated with the CCT program. The only program that seemed to have an income generating element was El Salvador's, which had micro-credit and agro-forestry components. However, these components were underfunded.

In Jamaica, the Ministry of Labor and Social Security (MLSS) is in the process of developing an extension to PATH called “Welfare to Work”. The program will target able-bodied adults, starting with those already in PATH households. The MLSS will work with the National Skills Training Agency (Heart) and the Jamaican Fund for Life-Long learning (JFLL) to provide adult literacy, job-skills training, soft-training (e.g. how to do an interview), and job-placement. The program is also piloting parenting workshops on health-related subjects.

#### **h) Lack of involvement of stakeholders in the design and follow-up of programs**

A frequent complaint in some of the countries visited was the lack of involvement of stakeholders in the design and follow-up of programs. This lack of involvement is present at different levels.

The impression one gets from interviews with local program staff (we were not able to interview BID officials) is that the design of programs implemented with bank loans is to a large degree decided by the banks’ team of experts. When asked about particular characteristics of the program and whether they could have opted for different alternatives, the most common response was that the loan depended on acceptance of a pre-defined package that had little room for change.

At a different level, the MOH sub-program managers (e.g. reproductive health or child survival managers) seemed to be minimally aware of the CCT programs’ existence or their activities. Typically, the teams designing CCT programs work independently from ministries of health and education. Thus, there is little use of the expertise of these sub-program managers to enrich the proposed interventions. District and regional health and education managers are also rarely involved in the implementation or supervision of programs. In several countries, CCT program staff members mentioned the importance of greater involvement of local officials to facilitate processes, provide support in terms of transportation, negotiations with the church, etc.

#### **i) Costs for users**

One feature of CCT programs not often discussed is the cost that it imposes on beneficiaries and, in particular, female heads of households. Women are required to attend educational sessions, take their children to the health center, and participate in coordination meetings. The money families get from the transfers are meant to compensate them for the direct and opportunity costs spent meeting the conditionalities, but it has not been assessed whether families are overburdened with the imposed conditions. Also, many programs use volunteer promoters. Interviewees mentioned that promoters often had problems with their partners due to the amount of time that they had to dedicate to the program and the increase in work within the home that this represented for him.

#### **j) Insufficient consideration to other social problems**

Some respondents mentioned that CCT programs should also seek to affect other prevailing social problems, in particular those related to domestic violence and petty crime. In Jamaica, it was mentioned that crime and violence (especially gang-wars) affected the performance of PATH; for example, social workers could not go into some communities and children had to miss school-days because they could not cross gang-borders.

## **Recommendations for overcoming CCTs operational problems**

### **a) Diagnostic studies and research on the perceptions of the participants**

Several respondents, particularly the top managers of CCT programs, alluded to the need for greater knowledge of the perceptions of beneficiaries and other stakeholders. Among the concrete topics mentioned were client perceptions of the functioning of program components and of the quality of services provided. Diagnostic studies are important for identifying current barriers with compliance. Plus, studying the general perceptions of citizens and politicians about the program could also help guide advocacy for the program.

A second area of diagnostic research regards those who could benefit from the program but do not do so. De Janvry et al (2006) present data showing that about one third of children of secondary school age eligible to participate in the CCT program in Mexico fail to do so (the majority of the children are not working), and reasons for not participating are not understood.

A third area of research is the participation of potential CCT program beneficiaries in program design. These studies could either take the form of interventions or formative research that asked potential beneficiaries about the attributes they would like the program to have.

### **b) Use of illiteracy as a criterion for eligibility**

Literacy of parents is strongly associated with school attendance of children and with the number of years a child completes. Illiteracy is also associated with extreme poverty and with belonging to minority ethnic groups. A potential solution that could be tested through operations research could be to make illiteracy a criterion for eligibility in communities participating in CCT programs and attendance of parents to literacy courses a conditionality<sup>11</sup>. Adopting adult illiteracy as a criterion for eligibility would help to better target scarce resources and obtain greater human capital development outcomes for the same investment. Finally, it could also help incorporate adolescents and young adults into CCT programs. School teachers in program areas could be trained and paid to provide this service for 1.5 – 2 hours per day in order to achieve basic literacy/numeracy. (Oxenham et al, 2002).

### **c) Alternative educational models and interventions to improve scholastic achievement**

As in the case of the health services described above, CCT program evaluations have shown consistently that those who attend education services in CCT program areas do not have better outcomes than those who attend services in equivalent non-program areas.<sup>12</sup> Traditional classroom training can be expensive, but there are a large number of distance learning programs,

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<sup>11</sup> Illiteracy is included as one indicator among others in some programs using several variables to create an eligibility scale, with an unknown weight in the cut-off line. What we suggest here is that illiteracy is used as a first criterion for eligibility and then that other criteria are further used to determine final eligibility.

<sup>12</sup> However, it would be expected that those attending the services do have better outcomes than those not attending them, and thus by increasing attendance to services a positive effect is achieved.

and supervision aids that programs should test using operations research.<sup>13</sup> This type of research could be complemented by related studies to solve other problems observed.

A review of the educational literature and consultations with experts showed few experiences of operations research to test simple interventions to improve scholastic achievement (see, for example, Hanushek, 1995, describing the use of radio in Nicaragua to improve teaching in math, or the examples provided by Herz and Sperling, 2004.) Schools in CCT program areas could be included in research to test small interventions to improve attendance of teachers, support for underachieving students, etc.

#### **d) Conditioning other payments**

Increasingly more programs are using cash transfers (or payments) to motivate people to engage in behaviors conducive to better environmental protection, health, education and the like.

Whether investment in the human capital of the children of participants in these programs could be required of participants in these projects could be assessed through operations research. For example, several programs provide cash payments to peasants on condition they maintain their forests. Operations research can be used for testing the feasibility and effectiveness of introducing health and education conditionalities in this and other contexts.

## **CONCLUSIONS**

The clearest opportunities that we found to strengthen reproductive health outcomes of CCT programs were increasing access to long-term contraceptive methods, establishing community-based distribution posts and introducing and/or increasing access to Pap screening. In addition, we believe that the bonus provided by PRAF in Honduras for delivery in hospitals should be evaluated and made available in other programs if effective.

In addition, we found several other opportunities that could be explored to increase the impact of CCT programs. We recommend that donor organizations make allowances for using operations research to test these and other ideas and achieve this goal.

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<sup>13</sup> Available job aids could include, for example, those for systematic screening, counseling and AIEPI.

## APPENDIX 1: RESULTS OF CCT PROGRAMS

In addition to the information collected during visits, the review of the literature confirmed that CCT programs can have important effects on health, education and other variables (Glassman, Todd and Gaarder, 2007; Handa and Davis, 2006; Rawlings and Rubio, 2003; Jones, Vargas and Villar, 2007; Lagarde, Haines and Palmer, 2007). Some notable evaluation results are the following:

### *Health and Nutrition*

- Increased attendance to public clinic visits for children (between no impact to 50% increase), to prenatal care visits (between no impact to 18.7% increase) and to preventive health care visits by families (20% in Mexico)
- Increased per-capita food consumption and expenditures (between no impact and 22% increase)
- Increased immunization rates.
- Decreased proportion of stunted children (between no impact to decrease of 29% of children more than two standard deviations from mean height-for-age); decreased proportion under weight (between no-impact and 6%); but no impact on prevalence of anemia.
- Weak, mixed or scant evidence on the impact on knowledge, attitudes and practices on many different health topics, on the supply and quality of services, on morbidity, mortality, fertility and use of family planning methods, skilled attendance of birth, domestic violence, although the trends generally seem to be in the desired direction.

### *Education:*

- Increased school enrolment and school attendance (strong where baseline enrolment figures are relatively low)
- Large increase in post-primary enrollment rates (especially for females)
- Weak, mixed or scant evidence on school achievement

### *Other variables and results discussed in the literature:*

- Gender equality: increased women status, decreased gender difference, increased participation of husband in household chores and child-rearing,
- Increased investment spending and increased economic security
- Decreased international migration (from Mexico to the USA)
- Lesser inequality
- Spillover effects of interventions to non-beneficiaries of the program
- Weak, mixed or scant evidence on the effects on child labor
- Other variables and results discussed in qualitative studies include: increased workload for women, increased attendance to work of health and education providers; community tensions and lack of participation of non-beneficiaries; increased expectations for children.

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## **APPENDIX 3: CHARACTERISTICS OF CCT PROGRAMS VISITED**

**Beneficiaries:** all programs select either families or households (Honduras and Peru) that include pregnant women, pre-school children (0-5 years), and/or school-age children (6-14 years except in Jamaica (6-17 years) and the Dominican Republic (6-16 years) attending grades 1-6 (except in Nicaragua, where eligible grades were 1-4.). Payments are given in all countries to the female head of the family or household, but single male fathers are also allowed.

**Demand-creation components:** all programs have both a health/nutrition component and an education component. The health and nutrition component targets pregnant women and pre-school children, while the education component targets children of school age.

**Conditionalities:** For the health and nutrition components, the condition for receiving payments is to comply with the number of health visits established in guidelines in each country or program: For pregnant women, between 4 and 6 antenatal care visits and in some countries one or two postnatal visits; children under one year of age, every two to four months; children over one year of age, between 2 and 3 times per year; school-aged children, two times per year.

For the education component, conditions for receiving payments are for the children to be enrolled and to attend school (in most cases, a minimum of 85 percent of school days, but also defined of a maximum number of absences (less than six in Nicaragua and a maximum of four in El Salvador.) Honduras and Nicaragua also establish the condition that beneficiaries have to be promoted to the following school grade at the end of the year (Honduras allows a maximum of one no-pass child in the household.)

In the DR, El Salvador and Nicaragua, beneficiaries need to attend health workshops/talks: in the DR, every 3 months; in El Salvador, every month; in Nicaragua, every two months.

In most countries, proof of identity is needed for receiving the cash transfer; thus, an implicit or explicit condition is to have identification papers or cards. In Peru identification is a formal conditionality and citizenship one of the goals of the program.

In El Salvador and Honduras, beneficiaries need to sign a co-responsibility document in which they agree to abide to the program conditions and the program assumes the responsibility for providing the services.

In most countries, beneficiaries stop receiving the transfers if they do not collect them on two consecutive occasions.

**Inclusion of family planning and other reproductive health information and services:** reproductive health and family planning are included in the list of health talk topics in the three countries where attendance at talks is a condition for receiving cash transfers.

In all countries, family planning services are provided in the MOH health centers covering the CCT program areas; in Nicaragua and El Salvador, temporary contraceptives were provided by the itinerant health teams that visited communities, but not in Honduras. However, family planning outcomes were not included in the evaluation indicators in any country.

Attendance to prenatal health care is a condition in all programs and part of the package of services offered to CCT beneficiaries. Postnatal care is also part of the package of services in all

countries. The only country that provides incentives for delivery and postnatal health care services is Honduras, but skilled birth attendance is not a conditionality.

**Monitoring compliance with conditions:** programs in all countries claim to monitor compliance. In reality, some are stringent in monitoring compliance (Jamaica, El Salvador and Nicaragua) and some are not (Honduras). Even in countries with stringent compliance monitoring, some conditions are not monitored.

**Targeting of beneficiaries:** in all countries, the targeting methods used included targeting the communities in extreme poverty using existing data and then conducting household surveys and selecting beneficiaries based on indicators that determine if a family is above or below the poverty cut-of line. These indicators are usually developed using large existing data sets. Jamaica is the exception: communities are first selected and then families are invited to apply for the program; applicants fill-out a questionnaire and the proxy means test is applied on the basis of the questionnaires and families are selected. Families have the right to appeal. In Peru, a community validation process is used: once the families are selected, the list of beneficiaries is presented to representatives and they can question the inclusion of families that do not meet the requirements. In almost all countries, the selection of beneficiaries is conducted at the central level (in other countries, like Brazil, the selection is conducted at the municipality level.)

**Amount of benefits:** the average amount of benefits for families or households ranges from US \$15 in El Salvador to \$ 45 in Jamaica. Most countries have separate bonuses for the health/nutrition component and for the education component. Countries have different schedules of payments: monthly, bimonthly, or quarterly.

In the Dominican Republic, the education bonus consists of around \$5 per month per child in the family and the health bonus of \$ 16 per family.

In El Salvador, the health and education bonus are US \$30 bimonthly, and \$40 in families that receive both education and health bonuses.

Honduras provides \$97 per year per household for education, in addition to a \$113 bonus at the beginning to help prepare households for school supplies, uniforms, travel and the like. The health bonus is \$135 per year per household. In addition, pregnant women can request \$60 for delivery at hospital and attendance to one postnatal health care visit.

In Jamaica, the bonus is \$ 7 per capita.

In Nicaragua, the education bonus was \$25 per year per child up to \$112 per year per family; children attending school were also given a yearly bonus of \$XXX for school supplies and uniforms; the health bonus was \$37 per capita up to \$224 per year per family.

In Peru, the bonus is \$35 per household.

**Duration of benefits:** In El Salvador, Honduras and Nicaragua, participants can remain in the program for three years and in Peru for four years. In Jamaica, participants can remain indefinitely as long as they are in the target age groups and the social workers determine that they are still in need. All countries, except Jamaica, had non-dynamic enrollment systems; potential beneficiaries were allowed to enroll only at one point in time; after beneficiaries were selected, enrollment in the program in a particular community was closed.

**Health and education supply components:** CCT programs affect the demand for health and education services by providing cash transfers for people who attend them. This often implies

that ill equipped health centers and schools have to respond to this demand. Further, since by definition CCT programs require services that allow beneficiaries to comply with the conditions established by the program, it is necessary for programs seeking to reach communities without services to make these available. For these reasons, several CCT programs have also sought to affect the supply of services in the program target areas.

In Honduras, school parent associations receive a US \$ 1000 bonus and make decisions regarding how to spend the funds to improve conditions in the school. The parent associations also receive training on management of funds. In the case of health, NGOs give health talks and are hired by the program to train and supervise community health volunteers who conduct community based child care activities. Program beneficiaries need to attend four talks per year. In Nicaragua, families were given a school bonus (equivalent to US \$ 5 per child) that they were required to pass on to the school. In El Salvador, NGOs were hired to extend health services. One physician and two nurses were hired for every 10,000 inhabitants and they visited each community once a month to provide health services. A separate NGO was hired train promoters and conduct the monthly educational sessions, coordinate payment events, receive complaints and update information for the registry system. In contrast to other countries, the government of El Salvador strengthened health services by adding personnel and by focusing resources equivalent to \$54 per child in education related activities. They also provided one ambulance to each of the 32 municipalities in the program. Further, other ministries and programs also focused on the same communities to insure that drinking water, sanitation, electricity and rural roads were built. A third component was added to promote greater long-term sustainability of families by promoting productive projects and micro-credit schemes in the targeted municipalities.

In Peru, 30 per cent of the Juntos program is devoted to strengthening health and education services (the budget was divided in nearly equal amounts. It was used for hiring new staff, improving monitoring systems and for investment in infrastructure.

No information is available about the Dominican Republic and Jamaica, where apparently the supply side was not strengthened.