

# Cash Transfers and Child Nutrition: what we know and what we need to know

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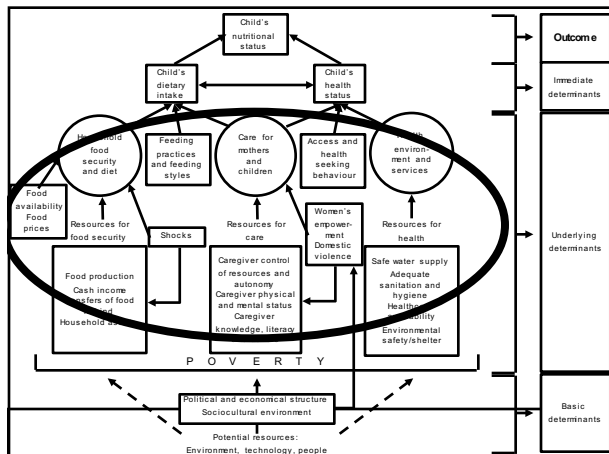
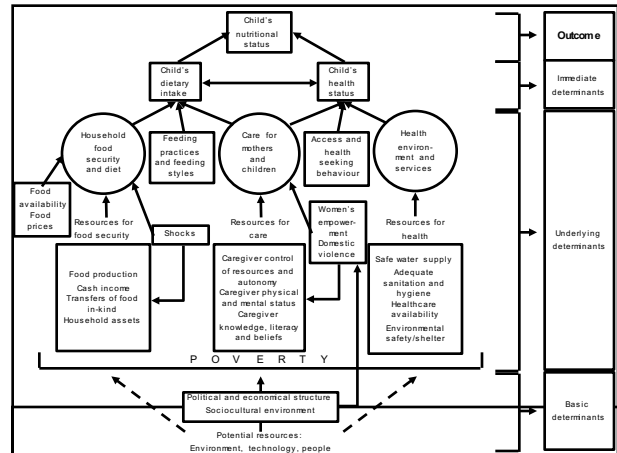
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## Cash Transfers and child nutrition

Impact	Pathways	Heterogeneity
<ul style="list-style-type: none"> <li>What are the impacts of CT programmes on child nutrition?</li> </ul>	<ul style="list-style-type: none"> <li>Through which pathways do these impacts occur?</li> </ul>	<ul style="list-style-type: none"> <li>What factors explain heterogeneity of effects?</li> </ul>

Not a systematic review, but covers many programmes and countries



## What do we know Underlying determinants

Food security	Evidence
Household consumption	+
Household diet diversity	+
Household food security	+

Examples:

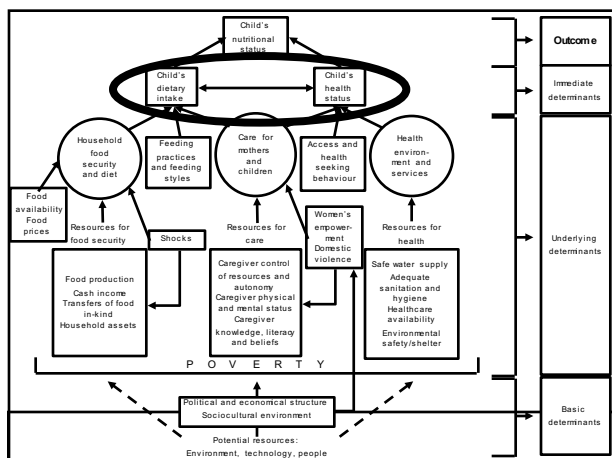
- Kenya, Malawi, South Africa, Zambia
- Brazil, Colombia, Ecuador, Mexico and Nicaragua

## What do we know Underlying determinants

Health care	Evidence
Preventive care visits	+ Jamaica, Mexico, Honduras, Nicaragua and Colombia
Water, sanitation & hygiene	* Malawi (increased bathing), South Africa (improved sanitation), Palestine (purchasing drinking water)
Caregiver physical health	+ Honduras, India, Guatemala, Mexico and Uruguay (effects on prenatal care)

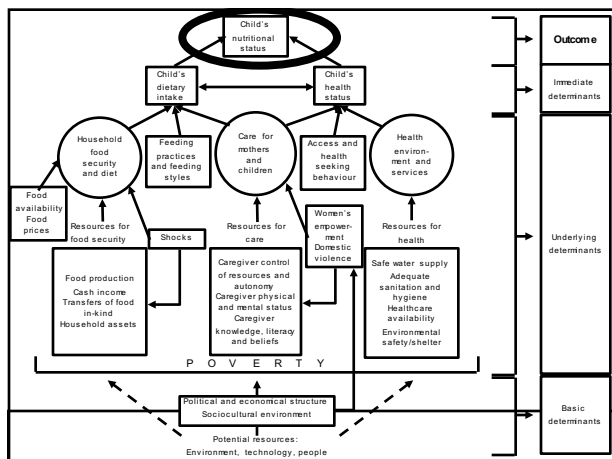
## What do we know Underlying determinants

Care Practices	Evidence
Feeding practices	* Zambia (increased meal frequency)
Psychosocial care	*
Caregiver empowerment	+/- Ecuador (no impact), Mexico (small impacts), Brazil and Nicaragua (negative impact), Kenya (mixed)
Intimate partner violence	* Mexico and Peru (short-term effect), Ecuador (effect dependent on relative level of schooling), Kenya (non-significant positive effect)
Caregiver stress & mental health	* Ghana, Kenya, Malawi, Zambia (improved subjective wellbeing), Kenya (lower cortisol levels)



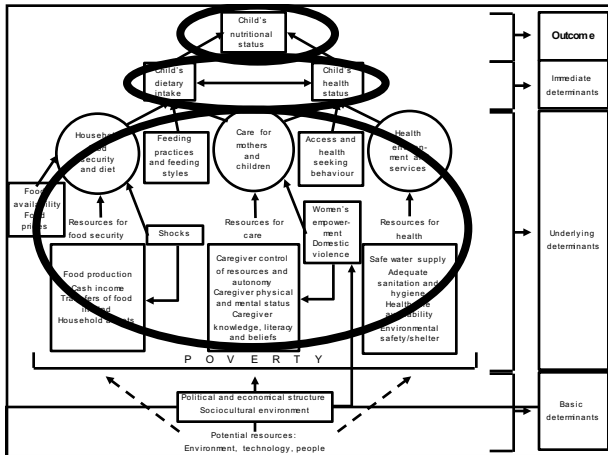
## What do we know Immediate determinants

Immediate determinants	Evidence
Child dietary intake	* Bangladesh (no impact on caloric intake), Nicaragua (more often nutritious food)
Health status	+/- Zambia, Colombia (reduction diarrhea), Mexico, Malawi, South Africa (fewer illnesses), Mexico, Kenya, Nicaragua, Palestine (no robust impact), Zimbabwe, Jamaica, Nicaragua, (no impact on immunization), Brazil, India, Honduras, Colombia (increased vaccination rates)



## What do we know Outcome

Outcome	Evidence
Child nutritional status	+/- Positive: South Africa, Zambia, Sri Lanka, Mexico, Nicaragua (RPS) and Colombia No effect: Kenya, Bangladesh, Honduras, Ecuador (BDH) Mixed: Malawi, Brazil, Bangladesh (PES), India, Nicaragua (AC), Ecuador (BS)



### Heterogeneity of impacts

- Size of transfer
- Young children
- Targeting
- Supply side
- Duration of programme exposure
- Irregular implementation

### Unintended consequences of CTs


- Women's time burden and traditional roles (in CCTs)
- Intrahousehold dynamics
- Perverse incentives
- Reduction of labour supply
- Negative spillovers

### Conclusion: What do we need to know?

- Pathways of impact and non-impact are unclear
- Much of the evidence on health is from conditional programmes
- Key indicators of interest:
  - Children's diet diversity
  - Caregiver's behavior towards infants
  - Intimate partner violence
  - Stress


### What is LEAP 1000?

- Expanding CTs to a new group:
  - Approx. 75% of children in UER and 54% in NR are poor;
  - 70% of stunting occurs in the first '1000' days of a child's life (2 years old);
- LEAP 1000 provides CT to 6200 poor Households with pregnant women and children under 1 year;

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### LEAP 1000: Incubator Experience

- Use experiences to improve mainstream LEAP:
  - New category for LEAP: DONE!
  - Use of innovative data collection methods
  - Improve targeting operations
  - Improve payment methods
  - Generate knowledge and understanding of CT's and child health in Ghana

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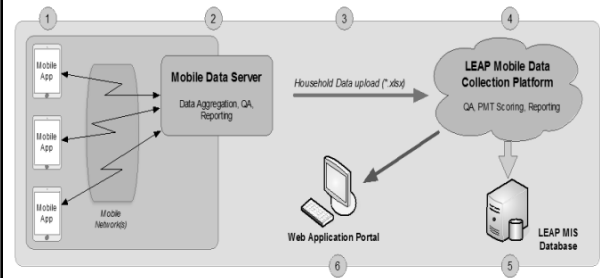
## Innovations from LEAP 1000:

- Use of tablet technology for data collection
- Mobile targeting units
- E-payment
- Research and Evaluation

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## Tablet Technology: Data Flow



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## Mobile Application

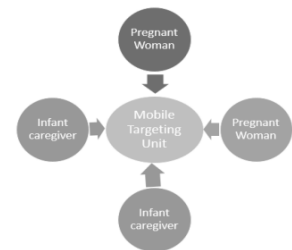
- Digitalized PMT questionnaire on tablets
- Programmed tablet to ensure certain questions needed for PMT scoring were mandatory
- Held trainings for enumerators on the tablet, survey application, and LEAP 1000
- Conducted a pilot testing in Kumbungu district (NR) to help test materials, enumeration structures, etc.
- Continuous consultations and feedback processes to improve data collection platform, and QA mechanisms

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## Mobile Targeting Units:

- Each MTU is composed 2 enumerators and 1 tablet - supported by CFP
- At least 1 enumerator/team is from Northern regions to help in language barriers
  - Interpreters hired on ad hoc basis, when needed
- Promotes demand-driven self-selection

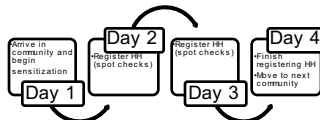


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## Mobile Targeting Units

- Initially, MTUs were to stay in communities for 4 days on average:
- But, depending on size of community, MTUs spent 2-7 days per community;
- Sometimes, teams would move to support other teams in larger communities



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## E-payments

- In 2013, E-payment was piloted in 9 LEAP districts;
- 2014 Assessment concluded roll-out of e-payments nationwide;
- EOI for e-PSPs advertised recently;
- All 10 LEAP 1000 districts will be in the Phase 1 roll-out, expected towards the end of 2015

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## Research and Evaluation

- Collaboration with Office of Research on CT and social protection research (together with Canada funds)
- Evaluation approach (RDD) to determine the extent CT influence child nutrition (Quan and Qual longitudinal)
- 'Visual' Evaluation
- Linking CT to broader Social Protection research agenda

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## Tweets to retweet: what is LEAP 1000 about?

- LEAP 1000 is about 6200hhs in 10 districts
- LEAP 1000 is about expanding mainstream LEAP
- LEAP 1000 is about improving the effectiveness & efficiency of the mainstream LEAP
- LEAP 1000 is about generating evidence on global knowledge gaps as well changing perception on the role of CT, nutrition and development

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