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Promoting healthy behaviours and improving health outcomes in low and middle income countries: A review of the impact of conditional cash transfer programmes

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ABSTRACT

Objective. To provide an overview of Conditional Cash Transfer (CCT) programmes in low and middle income countries and present the evidence to date on their contribution to improvements in health and the encouragement of healthy behaviours.

Methods. Several bibliographic databases and websites were used to identify relevant studies. To be included, a study had to provide evidence of effects of a financial incentive conditional upon specific health-related behaviours. Only experimental or quasi-experimental study designs were accepted.

Results. We identified 13 CCT programmes, whose effects had been evaluated, mostly in Latin-American countries. Their results suggest that CCTs have been effective in increasing the use of preventive services, improving immunisation coverage, certain health outcomes and in encouraging healthy behaviours.

Conclusion. CCTs can be valuable tools to address some of the obstacles faced by populations in poorer countries to access health care services, or maybe to modify risky sexual behaviours. However, CCTs need to be combined with supply-side interventions to maximise effects. Finally, some questions remain regarding their sustainability and cost-effectiveness.

Introduction

Conditional Cash Transfers (CCTs) are considered a particular form of performance-based payments, which make regular cash payments to individuals (or households) contingent on a set of behavioural requirements, such as attending regular health check-ups or sending one's children to school.

Historically, the first CCT programmes from Latin America were designed to act as social transfer mechanisms, aiming to provide a safety net to its recipients. *Progresa*, the seminal Mexican CCT programme (subsequently named *Opportunidades*) was developed during an economic crisis to replace a former social transfer mechanism, which included subsidies to the poor (mainly in the form of food subsidies) and was viewed as being administratively expensive (Grimes, 2008). The innovation proposed by *Progresa* was to use public money to target fewer and more needy households initially. The strings attached to the money given to beneficiaries ensured that it was an investment into the future development of the country, through an investment in the poor population's 'human capital'.

By transferring cash to the beneficiaries on the condition that they comply with a set of requirements (sending their children to schools and regular health check-ups, attending prevention workshop, etc.), the objectives of the programme were twofold. In addition to a short-term poverty reduction created by the increase in income, it was designed to act as powerful incentives for households to adopt a behaviour that will positively impact on their well-being and break the cycle of poverty in the long run (Gaarder et al., 2010).

Initially implemented in some areas only, *Progresa* was soon rigorously evaluated and found to be an effective mechanism, leading to the scaling-up of the programme at the national level. Its principles were soon emulated by other Latin American countries, and more than ten years later, very similar national programmes have flourished in almost every Latin American country (Fiszbein and Schady, 2009).

In parallel, the successful use of financial incentives in promoting changes in health-related behaviour in the area of addictions (Lussier et al., 2006; Pilling et al., 2007) provided the scientific base for the growing popularity of Results-Based Financing (RBF) mechanisms amongst policy-makers and funders in low and middle income countries. RBF mechanisms refer to financial transfers linked to meeting particular outcomes (Oxman and Fretheim, 2008). On the supply-side, they target health care providers and propose incentives for improved performance on measures of quality and efficiency. On the demand side, RBF mechanisms pay beneficiaries (patients) money contingent on their meeting certain behavioural requirements.

As RBF schemes were gaining momentum in low- and middle-income countries, African and Asian countries have seen the development of CCTs that have moved away from being used as a broad safety net mechanism, with multiple conditionalities (as they were traditionally designed in Latin-American countries) to being more

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Table 1
Description of CCT programmes with health components.

Country, programme name and reference	Target population	Transfer size	Conditionalities	Parallel intervention(s)	Study design
Brazil — *Bolsa Alimentação* (Morris et al., 2004b)	Poorest households from selected municipalities (chosen according to infant malnutrition prevalence).	Up to maximum of US$18.25. US$6.25 per person beneficiary/per month in the household (pregnant women or children under 7).	For pregnant and lactating women: attending educational workshops, regular check-ups, and vaccinations up-to-date. For children under 7: maintaining vaccinations up-to-date and growth monitoring.	Children received nutrition supplements.	Cluster randomised controlled trial
Chile — *Chile Solidario* (Galasso, 2011)	Poorest households in extreme poverty (identified through proxy means testing)	The direct transfer is set at US$22.73 per month for the first six months of the program; decreases to US$ 17.32 in the second six months of the program. In the second year it decreases to US$ 11.9 and finally to US$7.57 for the last six months, an amount equivalent to the family allowance (SUF), one of the main cash assistance transfers.	Through psychosocial support and cash, households need to meet minimum level of well-being along different dimensions (such as family dynamics, education, health, housing, employment, income)	Strengthening supply side of public services. Chile Solidario works directly with municipalities (local providers of services) to make sure local needs are met	Panel Survey with matched comparison group using propensity score matching
Colombia — *Familias en Acción* (Attanasio and Mesnard, 2005; Attanasio et al., 2004)	Poorest households from selected municipalities (also chosen on poverty criteria).	US$50 on average US$20 per family; US$6 per primary school child per month; US$12 per secondary school child. Approximately 30% of household consumption.	For children under 7: attending health and nutrition check-ups. For children aged 8–18 year old: attending school. For mothers: attending health education workshops.	n/a	Controlled before and after design
Honduras — *Programa de Asignación Familiar* (Morris et al., 2004a)	Children and women from poor households, living in designated beneficiary municipalities (chosen on socio-economic criteria).	US$17 on average (US$4 per family, US$5 per child) per month. Approximately 10% of household consumption.	Attending primary school and regular health visits.	n/a	Cluster randomized controlled trial
India — *Janani Suraksha Yojana* (Lim et al., 2010b)	Pregnant women belonging to poorest households, aged older than 19 years, and for up to 2 live births (extended after the third live birth if the mother chooses to undergo sterilization immediately after the delivery).	Rs700 in rural areas and Rs600 in urban areas per month.	Attending at least 3 ante-natal and post-birth check-ups and delivering in a public health facility (programme benefits are supposed to be extended to women delivering in private facilities too).	In low-performing States (with low institutional delivery rates), an incentive is paid to the accredited health worker for each delivery (Rs600 in rural areas and Rs 200 in urban areas).	Quasi-experimental design using 3 analytical methods — exact matching, with-versu- without and differences-in-differences
Jamaica — *Programme for Advancement Through Health and Education* (Levy and Ohls, 2007)	Children under 17 years old, pregnant and lactating women, elderly over 65 years, destitute adults under 65 years.	US$9/month per child eligible for education component, US$9/month per household member eligible for the health component.	For children aged 6–17 year old: attending school. For other beneficiaries: complying with required health visits per year(number depends on beneficiary age and status).	n/a	Participant-comparison group design