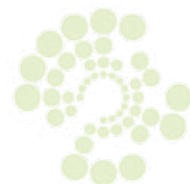


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# DESIGNING CCT PROGRAMS TO IMPROVE NUTRITION IMPACT: PRINCIPLES, EVIDENCE AND EXAMPLES

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# DESIGNING CCT PROGRAMS TO IMPROVE NUTRITION IMPACT: PRINCIPLES, EVIDENCE AND EXAMPLES

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# DESIGNING CCT PROGRAMS TO IMPROVE NUTRITION IMPACT: PRINCIPLES, EVIDENCE, AND EXAMPLES<sup>1</sup>

James Garrett, Lucy Bassett, Alessandra Marini

## INTRODUCTION

At least 33 countries have conditional cash transfer programs (CCTs) in place (Bassett 2008). Although various studies have concluded that such programs – which provide an income transfer to beneficiaries conditional on completion of certain behaviors or actions – can reduce malnutrition, few of these programs actually had improving nutrition as their primary aim. Instead, most of these programs focused broadly on improving human capital, including health, education, *and* nutrition. This chapter considers how governments might strengthen the impact of CCTs on nutrition, if they choose to do so. One key observation is that CCTs alone cannot undertake all the actions required to reduce malnutrition. Rather, governments must carefully consider the most effective place for a CCT as part of a broader nutrition or social protection strategy.

This chapter begins with a brief discussion of the role of a CCT in a strategy for social protection and then develops a categorical scheme to analyze program options to improve nutrition impact. The chapter then reviews the potential pathways of impact and discusses how program design and operation can support these pathways. Finally, using a country case study from Peru, the chapter illustrates how one country is developing its own nutrition-focused CCT.

## CCTs in a strategy of social protection

CCT programs can differ in terms of their objectives. They may focus, for example, on the short term or on sectoral issues. They may aim to meet immediate needs of the unemployed, for example, or to improve school attendance or visits to health clinics. Some argue that the objectives are longer term and more broad (Soares n.d.). They argue that a primary purpose of a CCT is to encourage the State to deliver the array of services needed to improve human capital more effectively. The CCT not only boosts demand for “unfelt” needs for health, nutrition, and education but uses that demand to force the State to integrate key services, or at least improve their quality and coordinate across sectors. Programmatic tension can emerge if policymakers are not clear how the CCT works in coordination with other programs or as part of a larger strategy to achieve these objectives.

A systems perspective is helpful to think about a CCT as one element of an overall strategy to reduce malnutrition. For improvements in nutrition, which requires coordinated, integrated action across multiple sectors, actors, and levels, a systems analysis would take into account all the components of the “system” that influence nutritional outcomes and determine how these components relate to one another. The analysis also would consider how the program could promote needed complementary actions. For instance, even with additional cash, mothers may not know the best practices for care and feeding, or the distance to the health care center may still be too far. A systems analysis would consider how to relieve operational constraints at various levels and among various actors through the use of cash, other incentives, or coordination mechanisms.

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## CCTS IN LATIN AMERICA: THE LOGIC OF IMPACT ON NUTRITION

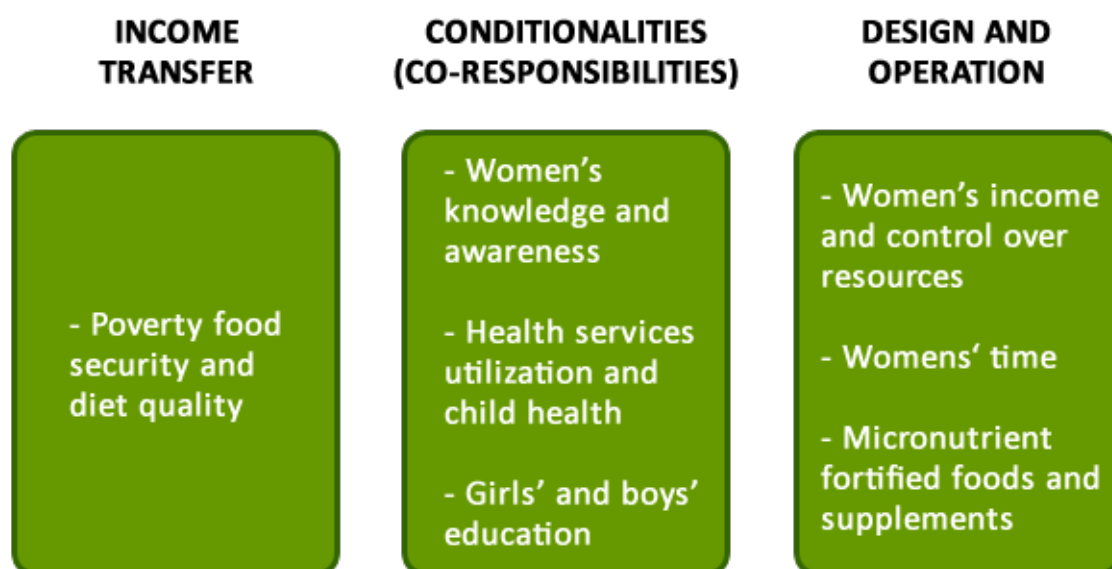
Assuming a government wants to have a CCT as an element of its nutrition strategy, what factors should be taken into account to improve program impact?

One way to think about this is to trace pathways through which CCTs can have effects on nutrition. Building on the UNICEF conceptual framework (1990), Leroy et al. (2008) note CCTs can affect child nutrition by:

- alleviating poverty and household food insecurity and improving diet diversity
- improving knowledge and awareness of the mother about health and nutrition
- enhancing utilization of health services
- increasing girls' (and boys') education
- impinging on women's time
- increasing women's income and control over resources
- providing micronutrient fortification and supplementation

It is helpful to note that the effects of these pathways, and thus the points of intervention for design, occur in two ways: through an effect on income (generally the transfer itself) and through price effects (incentivizing specific changes in behaviors by using a tax or a subsidy and affecting their explicit or opportunity cost). For our analysis of design, we can divide these pathways into categories that have to do with the provision of the transfer itself (income); the conditionalities imposed on the participants; and the way the transfer is provided (design and operational components) (Figure 1).

**FIGURE 1: CATEGORIZING PATHWAYS: STRUCTURING CCT DESIGN FOR NUTRITION**



### Increasing Incomes

As explained above, a cash transfer will produce an income effect in participant households. This may allow the household to purchase more and better foods, thereby increasing food security,

including diet quality, and improving nutrition (*poverty, household food security, and household diet quality pathway*).

## Conditionalities (Co-responsibilities)

Program conditionalities can shift underlying preferences. Counseling or educational sessions can provide the mother with greater knowledge about nutrition and health, diets, and caring and feeding practices. These can change the household's preferences for nutrient-rich foods, alter the intrahousehold allocation of resources to favor children, or improve child feeding and caregiving practices (*women's knowledge and awareness*).

Even if the underlying preferences do not change, the failure to fulfill conditions may come at a cost, with the change in "price" for certain (non) behaviors providing an incentive to act. For example, programs may require mothers, children, and other family members to visit health care facilities regularly. This may reduce child illnesses and lead to improved nutrition (*health services utilization and child health*).

Similarly, programs may require families to enroll and keep children in school. In the long term, more education can improve the quality of human capital, with higher incomes then contributing to improved nutrition (*girls' and boys' education*). On the other hand, fulfilling conditionalities poses tradeoffs. Travel and wait times, or time spent in counseling or training sessions, can prevent the caregiver from participating in other beneficial activities, such as earning an income or otherwise taking caring of children (*women's time*).

## Program Design and Operation

The program design itself can enhance these income and price effects. For instance, giving the cash transfer to women may increase their control over household resources. Previous studies have suggested that when women have greater control over household resources, they tend to favor investment in children's nutrition and health relative to men (*women's income and control over resources*).

Some programs supply a micronutrient-fortified food or micronutrient supplement. These products can directly improve the micronutrient status and overall nutrition of the child if actually given to the child, or of other household members if the products are shared (*micronutrient-fortified food and supplement for the child*). This sort of intervention effectively lowers the price of food for the participant household.

## Considering Impacts

In general we know that the effects of CCTs on end-outcomes, like poverty and child growth, are positive. Tables 1a and 1b summarize information on program design and impacts for five programs in Latin America for which we have rigorous evaluations (Brazil, Colombia, Honduras, Mexico, and Nicaragua). Since these programs were not specifically designed to maximize impact on nutrition, most likely these are the minimum impacts of such programs.

Which specific pathways led to these outcomes, or which had the greatest relative impact, remains largely unknown. Reviewing evidence from selected Latin American countries with rigorous impact evaluations, Leroy et al. (2008) found that information on the overall impact of pathways or their particular elements was limited, and often available for only one or two countries if at all. The actual mechanisms that produce impact or the magnitude of effects at the different steps in the “impact chain” are not fully established.

In any case, given the complex and interactions among causes of malnutrition, none of these pathways is a “silver bullet” meant to be pursued alone. Some pathways may be more needed or have larger impacts than others under certain conditions or designs.

**TABLE 1A: CCT PROGRAM DESCRIPTION SUMMARY**

COUNTRY PROGRAM	TARGETING		PROGRAM CONDITIONS	BENEFITS			PROGRAM ADMINISTRATION
	POPULATION	METHOD		PAYEE	METHOD	FREQUENCY	
Brazil <i>Bolsa Alimentação</i>	Poor families with pregnant/lactating women and children 0-6 years with monthly per capita income below specified threshold	Geographic targeting and means test	<ul style="list-style-type: none"> <li>• Minimum schedule of prenatal and postnatal care visits</li> <li>• Child growth monitoring</li> <li>• Up-to-date vaccinations</li> <li>• Participation in nutritional education seminars</li> </ul>	Mother	Transfers credited to a magnetic card used to withdraw cash at bank offices, or, in very isolated municipalities, with lottery agents	Monthly	Ministry of Health
Colombia <i>Familias en Acción</i>	Extremely poor families with children 0-6 years not participating in other programs (health) and/or children 7-17 years enrolled in school (education)	Geographic targeting and proxy means test	<ul style="list-style-type: none"> <li>• Growth control and development check-ups (children 0-1: every 2 months; children 1-2: 3x/year; children 2-7: 2x/year)</li> </ul>	Mother	Social security offices and other payment points	Bimonthly	Presidential Agency for Social Action and International Cooperation, local program offices
Honduras <i>PRAF</i>	Poor households with pregnant women and/or children under 3 years (health) with children 6-12 years who have not yet completed the 4th grade of primary school (education)	Geographic targeting	<ul style="list-style-type: none"> <li>• Check-ups at health center (children 0-2: once a month; children 2-5: every 3 months)</li> <li>• Growth monitoring and promotion control for mothers with children under 2</li> <li>• At least 5 prenatal checkups and verification of delivery at a public facility</li> <li>• Attendance in at least 4 training courses/year (main beneficiary)</li> </ul>	Mother	Vouchers cashed through local bank offices	Every six months (payments are made irregularly)	Presidency of the Republic <sup>a/</sup>



COUNTRY PROGRAM	TARGETING		PROGRAM CONDITIONS	BENEFITS			PROGRAM ADMINISTRATION
	POPULATION	METHOD		PAYEE	METHOD	FREQUENCY	
Mexico <i>Progresa</i>	Extremely poor households	Geographic and proxy-means test	<ul style="list-style-type: none"> <li>Compliance by all household members with required number of preventative health check ups</li> <li>Attendance at health and nutrition lectures (family member older than 15)</li> </ul>	Mother	Cash at payment points and payment through bank savings accounts	Bimonthly	Secretariat for Social Development (SEDESOL), national and state coordination agencies of the program, and education and health service providers
Nicaragua <i>RPS</i>	Poor households with children 0-5 (health); poor households with children 7-13 enrolled in primary school grades 1st to 4th (education)	Geographic	<ul style="list-style-type: none"> <li>Monthly health education workshops (all households)</li> <li>Attendance at prescheduled health care visits (children 0-2: every month; children 3-5: every 2 months)</li> <li>Up-to-date vaccinations (children 0-5)</li> </ul>	Child's caregiver (generally the mother)	Cash at payment points	Bimonthly	<ul style="list-style-type: none"> <li>Funding and administrative oversight by FISE (social fund).</li> <li>Municipal planning and coordination: committees of delegates from the health and education ministries, representatives from civil society, and RPS personnel.</li> <li>District-level: RPS representatives and local school and health-care service providers</li> </ul>

Note: Brazil's Bolsa Alimentação has merged into Bolsa Familia, and Mexico's Progresa is now known as Oportunidades.

Source: World Bank 2008a.

<sup>a/</sup> From Ayala 2003.

**TABLE 1B: CCT PROGRAM IMPACT ON CHILD GROWTH (STUNTING)**

COUNTRY AND PROGRAM	CHILD GROWTH	
	HEIGHT OR HEIGHT-FOR-AGE	STUNTING PREVALENCE
Brazil <i>Bolsa Alimentação</i> <sup>1</sup>	-0.11 z-scores (not statistically significant)	Not calculated
Colombia <i>Familias en Acción</i> <sup>2</sup>	+0.16 z-scores (children 0-2)	Not calculated (but 6.9 percentage point reduction in the probability of stunting for children 0-2)
Honduras <i>PRAF</i> <sup>3</sup>	No significant impact	No significant impact
Mexico <i>Progresa</i> <sup>4</sup>	+0.14 z-scores (children 0-5)	-6 percentage points (children 0-5) <sup>3</sup>
Nicaragua <i>RPS</i> <sup>5</sup>	+0.13 z-scores (children 0-5)	-5.5 percentage points (children 0-5)

<sup>1</sup> Morris et al. 2004; <sup>2</sup> Attanasio et al. 2005; <sup>3</sup> IFPRI 2003; <sup>4</sup> Hoddinott and Bassett 2008; <sup>5</sup> Maluccio and Flores 2005.

### *Poverty and household food security*

The review by Leroy et al. (2008) found that generally CCTs reduced poverty and increased incomes and expenditures on food. Household-level diet diversity also increased, as did consumption of animal-source foods and fruits and vegetables. Of course, increases in expenditures on food goods can also contribute to increases in food “bads.” In Nicaragua and Colombia, for instance, fat consumption increased.

### *Women’s income and control over resources*

CCTs generally give the transfer to women, based on the assumption that this way a greater proportion of the transfer will reach the child. A secondary, implicit objective is that giving the transfer to women may promote their empowerment. Adato et al. (2000) concluded that women did benefit from participation in the Mexico CCT. The program contributed to increased self-confidence, which included more independence in making expenditure decisions, speaking up in meetings, and decisions about going outside the house for visits or errands. The program appeared to reinforce recognition of the importance of women to all family members. The domains of decisionmaking did not appear to change much, with women still making most decisions about food expenditures and the man or the couple deciding on other items. This increased autonomy did not appear to increase conflict within the household, but then again women noted they took steps to reduce that possibility, such as making sure that normal household tasks were done before leaving to attend health education sessions. Likewise, CCT staff said they sometimes made judgments about what to ask a beneficiary to do based on their home situation.

### *Fortified food or supplements*

In Mexico, the food supplement, a micronutrient- and energy-fortified product, appears to have had some positive impact on children’s growth and micronutrient status, including iron, zinc, and vitamin A (Leroy et al. 2008; Rivera et al. 2004). The differences between the beneficiary children and the control group were, however, perhaps smaller than expected. For example, despite improvement, rates of anemia remained high even for the beneficiary children. This was perhaps due to the fact that reduced iron, which is not absorbed well, was used for fortification of the supplement (Rivera et al. 2004). Additionally, the supplement was often diluted or shared with others, with some leakage to the intended control group. This would have diminished the observed differences between the groups (Adato, Coady, and Ruel 2000). The evaluation of the program in Nicaragua also noted problems with delivery of the supplement, and this could have been one of the main reasons the program had no impact on hemoglobin levels or anemia (Maluccio and Flores 2004).

### *Women’s knowledge and awareness*

As Leroy et al. (2008) note, the impact of the health and nutrition education component was assessed only in Mexico. While the study (Duarte Gómez et al. 2005) found a positive impact on general health knowledge and practices, it did not evaluate knowledge or practices specifically related to child nutrition and health.

### *Girls' and boys' education*

Much evidence suggests that improved maternal (and paternal) education is associated with benefits to the child (Caldwell 1979; Cleland and van Ginneken 1988; Bicego and Boerma 1993; Semba et al. 2008), and so in the long-term CCT programs should improve the nutritional status of the children of the children who participate in the program. However, the reasons for these effects are not precisely known. Education may directly teach mothers about causes, prevention, and treatment of disease and malnutrition, or provide them with the analytical skills and openness to be able to acquire such knowledge from other sources (Glewwe 1999).

Some researchers have raised questions about such causal links between parental education and improved nutrition and other aspects of human-capital development. This well-established association may in fact be due to socioeconomic status, community of residence and availability of services, or genetic factors, rather than the education itself (Desai and Alva 1998; Behrman and Rosenzweig 2002; Plug 2004). These associations, and so the pathway, may still be particularly important in developing-country contexts with limited school choice and quality.

### *Health services utilization and child health*

Studies in Mexico, Colombia, Honduras, and Nicaragua found that CCTS were associated with an increased number of well-baby clinic visits, but had a more mixed result with regard to immunization rates and health-care seeking behaviors. The studies concluded, however, that the positive effects on utilization diminished over time, and suggested impact on immunization rates may have been limited because immunization rates were already high across both beneficiary and non-beneficiary populations (Leroy et al. 2008).

### *Women's time*

Few studies have looked at the impact of CCT programs on women's time. Adato et al. (2000) noted that women participating in Mexico's CCT said the program did place additional time burdens on them, as they had to travel to receive the transfers and attend appointments and meetings. Women may also have had to take on household work previously done by children now attending school. Only a few women described this as a problem, however. Participants explained that they managed their time to continue to meet household responsibilities and noted the effort was worthwhile in order to benefit their children.

## **DESIGN FOR NUTRITION: SOME CONSIDERATIONS<sup>2</sup>**

The previous section identified the main pathways through which CCTs are assumed to have impact on nutrition. But what specifically should the content be? And, using the design-analysis framework to categorize the discussion to look at issues relating to income, conditionalities, and design and operation, what are the key elements to consider?

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<sup>2</sup> This section is adapted from Bassett (2008) to reflect the analytical structure described in Figure 1, and also to provide some additional information.

## **An Unconditional Transfer?**

One potential design change is to remove the conditionalities. Applying conditionalities can be complex, cumbersome, and expensive. One study (Caldés et al. 2006) found that compliance verification costs ran from 2 to 24 percent of the total budget.

But would an unconditional transfer be as effective as a conditional one? In its simplest form, an unconditional cash transfer assumes society can achieve preferred expenditure allocations simply by increasing incomes, rather than by altering prices or changing underlying preferences. This may in fact be possible, as in Haiti where studies suggest that parents highly value education, but good education is costly. In that situation, low incomes are a constraint to education, and a conditionality might not be necessary to ensure that parents send their children to school (Cohen et al. 2007). But in other cases individuals or households may largely undervalue certain goods or services, such as health or nutrition. Or individuals do not take (or are not able to take) economic externalities into account. For these and other reasons explained below, conditionalities are probably needed for a cash transfer program to significantly improve nutrition.

A study of the South African cash transfer program, however, provides an intriguing counterpoint to this assertion. Agüero, Carter, and Woolard (2007) found that an unconditional transfer given to women resulted in increases in child height that appear to rival those of CCTs in Mexico and Nicaragua. The South African study compared similar subgroups of households, based on whether the household took advantage of the program more quickly or more slowly, instead of simply comparing children who participated in the program with those who did not, as most evaluations do. In fact, the researchers found that if they had used such a binary approach, they would have indeed found no impact. This suggests that, if these other CCT programs could also take such “adopter enthusiasm” into account, they might find even larger effects, and in any case the results do not obviate the hypothesis that conditionalities can enhance impacts of a cash transfer on nutrition. Still, given the implications for program administration and costs, the potential impacts of unconditional cash transfers should be investigated further.

## **What is the Role of Income?**

Income transfers from CCTs can seek to overcome income-related constraints but also increase demand for services that will reduce malnutrition, where demand is low because malnutrition is “hidden” or accepted (Bassett 2008).

The experience in Honduras, where the relatively small amount of the transfer (about 4 percent of household income) may have had something to do with the lack of apparent impact in the program (IFPRI 2003), suggests that the amount of the payment can indeed make a difference to impact of the program. But what should that amount be? The exact amount will necessarily be a judgment call, and depend on specific program and political objectives as well as on budget constraints.

One suggestion would be to provide a transfer that compensates for actual expenses related to program participation as well as other implicit or opportunity costs, which could include transport to health clinics or educational sessions or lost income or time that could otherwise be spent on home tasks (by the transfer recipient or the children). Some analysts suggest that to make a difference the payment amount should be approximately 20 to 40 percent of the per capita poverty line (Handa and Davis 2006). Viewed as an incentive, rather than additional income to lift the household out

of poverty, the amount should be at the place where the marginal benefit of acting outweighs the marginal cost of not acting.

At the same time, we note that changes in incomes do not have a strong effect on child nutritional status, so a large effect on nutrition due to the income transfer alone would seem unlikely. Malnutrition, as expressed by anthropometric measures such as stunting, does decrease significantly as income rises, but these income rises are correlated with the other aspects of demography and living conditions that also matter to nutrition (such as better housing, water and sanitation, and education). The impact of income alone on nutritional status (as measured by anthropometry using z-scores) is actually fairly weak, with an elasticity of about 0.10 to 0.15 (Haddad et al. 2003). In addition, micronutrient deficiencies often remain among children and adults even at higher income levels. And, for the smallest children, the most appropriate practices actually do not require significant expenditures. From 0 to 6 months old, children should be exclusively breastfed, and the quantity of food required by children from 6 to 24 months would rarely be a large part of household expenditures. Income alone, therefore, is unlikely to be the constraining factor to improved child nutrition.

In addition, CCTs are not set up to address expenditure patterns or behaviors directly (Bassett 2008). In fact, generally speaking, this income transfer is entirely fungible. There is no requirement that the mother spend the transfer on the children, nor on health or education. From a nutritional standpoint, in fact, what the households spend their income on may not be considered optimal. In the studies above, for instance, some countries saw increases in consumption of fats and sweets.

Thus, if decreasing malnutrition is the prime objective of the program, providing an income transfer alone may not have much effect, and targeting on income alone may exclude many in the target group. The cash transfer probably is best seen as an incentive to comply with conditionalities and influence the use of income or address behavioral or knowledge constraints. Impacts may also be augmented through design features, such as providing the transfer to women or supplying food supplements.

## What About Conditionalities?

What, then, are some of the conditionalities and incentives a program could impose to promote a focus on reducing nutrition? One way to think about content is to develop a sort of checklist, based on international consensus of what is needed to promote good child nutrition (Bhutta et al. 2008; Bryce et al. 2008; Maternal and Child Nutrition 2008; Allen and Gillespie 2001). Although some disagreements do exist, six Essential Nutrition Actions identified by the BASICS II project largely capture this agreement (Archarya et al. 2004):

- Exclusive breastfeeding for infants for 6 months
- Adequate complementary feeding from 6 to 24 months, with continued breastfeeding for at least 2 years
- Appropriate nutritional care of sick and severely malnourished children
- Adequate intake of vitamin A for women and children
- Adequate intake of iron for women and children
- Adequate intake of iodine for all members of the household

There are a number of ways to achieve these goals, but actions tend to fall into two categories: those that seek to change behaviors via communication and education (appropriate behaviors, including care and feeding practices, dietary choices, compliance, service usage); and those that provide material resources (micronutrient supplements, Oral Rehydration Therapy (ORT), soap, services) (Bassett 2008).

Bassett (2008) notes that many CCTs already undertake activities supporting these interventions, including:

- Nutrition education workshops: Group learning sessions for beneficiaries (usually mothers), providing information about health, nutrition, and sometimes other themes (e.g., reproductive health, hygiene, community participation). General education and counseling for other household or community members is also possible.
- Growth monitoring and promotion (GMP): Periodic weighing of young children to determine adequacy of child growth. Standardized or individualized counseling for children can help mothers understand and improve their child's growth.
- Micronutrient supplementation: The provision of essential micronutrients (vitamins and minerals) lacking in the diet can contribute to improved health outcomes and nutritional status.
- Nutritional supplementation: The provision of food to supply vitamins, minerals, protein, and energy that is missing or not consumed in sufficient quantity in the diet.

Table 2 summarizes how CCTs in Latin America have incorporated these nutrition-related services and conditionalities. This analysis did not examine the contents of service or conditionalities to see that these programs fully reflect the Essential Nutrition Actions, but CCTs cover most of them in some way. Interestingly, in general, CCTs appear to leave actual provision of preventive and curative health services (including prenatal health care, institutional births or use of skilled birth attendants, immunization and therapeutic care for severely malnourished children) and sanitation and safe water to other agencies. Clearly a single program cannot be responsible for the entire gamut of services needed to reduce malnutrition. Still, CCTs appear able to deliver or provide incentives to deliver many, if not all, of the recommended interventions, or provide a clear point of entry or interaction with other sectors to do so. A systems perspective can identify what actions the CCT should be responsible for, what other programs should do, and how they should link.

This discussion emphasizes the importance of motivating all the actors across the “system” that produces good nutrition. Because the list of actions focuses on individual behaviors, we may fail to consider how “conditionalities” could be used to motivate other actors in the system to fulfill their responsibilities and make the program “work.” Just as beneficiaries must fulfill their responsibilities, government and other service providers must deliver high-quality services and ensure that they are affordable and accessible to beneficiaries. “Conditionalities” for actors other than beneficiaries can function as incentives to pull them together to cooperate, collaborate, and integrate as needed.

Programs are beginning to pay more attention to the mutual or co-responsibilities of other actors, holding program staff and other service providers accountable, monitoring actions, and setting up complaint mechanisms. Some programs are thinking of how to motivate different actors in the system, such as giving bonuses to teachers or development funds to communities. Other programs have moved the entire focus of responsibility from individuals or households to communities as a whole.

**TABLE 2: NUTRITION-RELATED SERVICE AND CONDITIONALITIES  
IN CCT PROGRAMS IN LATIN AMERICA**

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	✓		
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)	

\* Indicates growth monitoring either with or without counseling.

Source: Bassett (2008).

## Design and Operation

We cannot escape the fact that CCTs are administratively demanding, and that poor administration will undermine program effectiveness. Yet analyses of these programs often focus only on the effects of income or conditionalities, as if they existed separately from design and administration. Because they have to do with the way of doing things (operational design and management, institutional arrangements), and not what (income transfer, conditionalities), program evaluations often overlook these aspects of the program, although design and operation can critically influence whether the transfer or conditionalities have any impact whatsoever.

The following are key aspects of design and operation that can enhance or inhibit the effects of income or conditionalities:

- targeting criteria and mechanisms
- the time burden on participants
- the size and composition of the transfer (already discussed above)
- delivery of the transfers and other services
- quality of supply-side services
- coordination and integration with supply-side services

### **Targeting: Groups, Agents, Behaviors**

CCTs for nutrition are most likely to focus on the nutritional status of children, although in general which group to target depends on the objectives of the CCT. It is now generally agreed that the period from gestation to two years old is the critical window for linear growth of a child. If children fall behind during this period, and become stunted, they are unlikely to ever recover physical and intellectual growth lost during this period (World Bank 2006).

Although the children are the ultimate beneficiaries, the children themselves are too small to act. Who are the appropriate agents to target to act on their behalf, by changing behaviors and responding to conditionalities? Most programs assume this should be the mother, and evidence does show women are more likely to prefer expenditures on child welfare. But there is little empirical evidence of what would happen if the transfer went to someone else. A program might choose to target the father, the caregiver, or the community, independently or in some combination. Evaluations in Burkina Faso, Morocco, and Yemen are now trying to compare the impact of delivering cash to men (fathers) or women (mothers) (World Bank 2008a).

Once we know the target agent, how do we select from among them? The program may also target on type of community, geographical area, or selected household characteristics. Each has potential drawbacks. Some propose community-level targeting, since improving nutrition requires a community effort and all residents will benefit from supply-side improvements. But targeting by community alone could exclude many of the malnourished, especially in urban areas which can be highly heterogeneous, with variation in services, educational levels, or even incomes (Morris 2001). Because of such heterogeneity, targeting by community alone (for example, only slum communities, which may serve as a proxy for income) may exclude many of the malnourished.

Targeting the nuclear family alone may be out of step with how households and social support networks form at the local level. Such targeting may unwittingly exclude the extended family or household members who are not technically part of the “family” (de la Briere and Rawlings 2006). In Haiti, for instance, about 10 percent of children less than 18 years old are *restaveks*, young children (mostly girls) who have left the rural areas to get a job as domestic worker and, their parents often hope, have a chance to get a better education (Cohen et al. 2007).

Programs might also use a complex algorithm (as in Mexico) to deal with some of these issues and select participants based on a number of characteristics. But the program must also consider the capacity of government institutions and staff to administer the analysis fairly and efficiently; the precision and expense of the mechanism; and the ability to update it with new information fairly frequently.



### *Time Burdens*

The payment mechanism may not initially appear to have much to do with the “nutrition orientation” of a program. But whether the mother can easily access payments, take time to attend educational classes, receive fortified foods, and consistently seek health care are indeed pertinent aspects of design. All these activities may end up taking time away from other productive and reproductive activities. Or the woman may simply see the time cost itself as a barrier.

Programs can reduce the time needed to collect the transfer by using newer electronic technologies and a variety of financial intermediaries. Payments may be made through banks (including mobile banks and ATMs), post offices, clinics, or schools, or the program may partner with microfinance organizations or local NGOs with a presence in remote rural areas. The program could make deposits directly into a bank account or recharge “smart cards” automatically. Checks or vouchers are also possible, but may not reduce the time burden much if the recipient has to go through an additional process to cash the check or use the voucher. On the other hand, some of these less burdensome transfer delivery mechanisms may be unable to guarantee that the transfer goes directly to the woman (del Ninno, Datta, and Ayala 2006).

The program could also reduce the time burden by using mobile clinics or making sure hours of nearby clinics or education sessions are convenient. In urban areas, for instance, many women work outside the home during the day so the optimal time for activities may be in the evenings or on the weekends.

### *Service Delivery*

A program’s effect is likely to be minimal if the CCT or partner organizations providing services are not effective. They need to have strong capacities for planning, coordination, and delivery, including standardized protocols, skilled volunteers or staff, a well-functioning supply chain, and appropriate infrastructure. They also need to have sufficient presence in the areas where the CCT operates, including hard-to-reach rural areas.

In the past 20 years, numerous development organizations have come up with detailed, effective strategies to improve the content and delivery of services relevant to nutrition-focused CCTs. Given the breadth and depth of this experience and knowledge, this paper will not cover this topic in detail but simply point out its importance and potential sources of experience. UN organizations, such as World Food Programme, and international NGOs, such as CARE, excel at supply logistics. UNICEF and USAID, among others, in partnership with local and international NGOs, have developed strong programs in health and education, particularly Information, Education, and Communication (IEC) activities (Sternin, Sternin and Marsh 1998; Dearden et al. 2002.; Positive Deviance Initiative 2008). In addition, many private sector companies have excellent distribution networks, and the government itself usually has health clinics or other program agencies scattered throughout the country. Creative collaboration in public-private or government-community partnerships could also enhance delivery performance.

Often supply-side providers have little incentive to perform at a high level. In contrast to participants, they have no “conditionalities.” Reimbursing based on performance may improve management within an organization but not address issues of interagency coordination critical to impact of a nutrition-focused CCT. In Peru, for example, the CCT program initially set aside about one-third of its budget for collaborating national ministries (Health, Education, Agriculture) to ramp up the required

services. An operational review about a year later found that the ministries had spent only a fraction of their allocation. Programs thus may need to monitor the supply side closely and provide stronger direction or incentives for expenditure and performance. Alternatively the program could choose to go outside the normal providers entirely to fund activities through local or regional organizations, including subnational governments (as in Peru) or with local NGOs (as in Nicaragua).

If empowered, communities themselves may be able to hold providers accountable and improve service quality. For example, strategic communications involving personal contact as well as mass media at the community level can educate residents about their rights, responsibilities, and expectations for the availability and quality of services. Such an approach has been successful for education in Peru, and a similar approach is now being undertaken for nutrition (Cotlear 2008).

### *Interagency Coordination and Integration*

Much of making a program work effectively, especially in terms of the supply side, will depend on successfully achieving interagency coordination and integration. Yet few studies have looked at what institutional arrangements or incentive structures work best. Adato and Hoddinott (forthcoming), the World Bank (2008a), Levy (2006), Samson, van Niekerk and MacQuene (2006), and Mathauer (2004) are among the few that explicitly consider issues of institutional structures.

The nature of institutional arrangements and connections obviously depends on the overall policy objectives as well as the capacities of the CCT program itself and potential partner agencies. One option is that a CCT program could be a core or “foundation” program for social protection, instead of the sole or preponderant program to fight poverty or malnutrition. Given its reach, the program could serve as a point of entry for a range of potential beneficiaries, and direct them to other social programs and services.

Such a program would have to be able to work effectively in cross-sectoral, multi-actor partnerships as complementary services may come from different ministries and agencies, or from civil society (local NGOs, for instance) or the private sector. The program would have to work hard to promote ownership and operational efficiency, being sure to include partner agencies (ministry representatives, secretariats, and other operating partners, including municipal and community actors) in decisionmaking (Bassett 2008).

Institutional arrangements also need to consider the often-limited operational capacities of partner agencies, to know what can be expected from them and how to interact with them. Some countries may decide to set up the CCT as a separate integrated program, outside the line ministries. Such autonomous arrangements, such as Mexico’s, may smooth operation for the program, but they also remove the program somewhat from integration with other government programs and downplay the need for capacity building across the State.

Such independence may result in duplication of existing services. One approach is to require participants to stop receiving benefits from other programs (Mexico, Nicaragua), and receive benefits only from the CCT (Skoufias 2005). This may make vertical management easier, but it is not likely to overcome the problem of duplication because the government must still provide those services to other participants who do not belong to the CCT. Other ministries may also perceive that consolidation causes them to lose operations and resources to the CCT. Problems can arise if the CCT must then coordinate with these other agencies to fulfill conditionalities (Bassett 2008).

Effective interagency collaborations depend to a great extent on the ability of the lead agency to “lead laterally” and develop genuine partnerships. The agency must be able to allow adaptation of the program to the local context and provide incentives for horizontal and vertical collaboration among actors (individual, community, local and national governments and agencies) (Garrett and Natalicchio, forthcoming).

Some countries have experience in providing such incentives as part of a CCT. At the individual level, for example, Nicaragua made a small payment to teachers to compensate them for the time needed to comply with additional reporting requirements and to deal with anticipated larger classes (due to attendance conditionalities). As suggested, programs should also consider incentives for the range of actors in the program. For instance, the program could give health staff, volunteers, and facilities a bonus for each child weighed. A potential downside is that this could undermine the commitment of the volunteers, lead to a tug-of-war between staff and the facility, or give a perverse incentive to the staff to focus on the mothers who participate in the program (Bassett 2008).

Monetary incentives at the community level could encourage the entire community to support the program, increasing social pressures on participants to comply or providing rewards for action. For example, the CCT could fund learning and strategic communication activities in the community, or provide a bonus to finance community projects if the community, say, improves program compliance or reduces malnutrition to target levels (Bassett 2008). Currently a pilot CCT in Indonesia and pilots planned for Tanzania and Sierra Leone aim to test the use of such community-level conditionalities (Grosh, personal communication 2008).

Having a national health and nutrition strategy is helpful for identifying the appropriate role of the CCT and the design and integration of its components with other programs. Unfortunately, national nutrition plans often exist but are not operational, and they may not have been updated to take account of the new possibilities of coordination with the CCT.

## **JUNTOS: PERU’S INITIATIVE TO BUILD A NUTRITION-FOCUSED CCT**

Peru’s JUNTOS program provides a contemporary illustration of how one might think about these issues in designing a nutrition-focused CCT. Peru’s conditional cash transfer program, JUNTOS, began in 2005. It initially began operating in 110 districts, covering about 37,000 households. It now operates in 638 districts and about 454,000 households. The program ultimately plans to expand to 880 districts (of 1833 total) and about 660,000 households (Government of Peru 2008). In 2007, the Government decided to modify JUNTOS to strengthen its focus on actions to reduce malnutrition.

Many of the design and operational concerns that have surfaced during this restructuring reflect issues described earlier in this chapter (Government of Peru 2008, World Bank 2008b, World Bank 2008c, World Bank 2008d). A multisectoral team composed of government representatives from JUNTOS, the Ministry of Health (MINSA), the Integrated Health Insurance program (*Seguro Integral de Salud*, SIS), and Ministry of Economy and Finance (MEF) is now working with a team from the World Bank to identify a series of bottlenecks in program implementation at national and local levels. Unsurprisingly, at this moment improving effectiveness has more to do with shaping the program operationally than in changing its technical content.

We can analyze some specific programmatic challenges faced by JUNTOS using the design-analysis framework developed earlier that looks at income, conditionalities, and design and operation.

## Incomes and Conditionalities

As noted above, the greatest impact in a nutrition-focused CCT is likely to come from complying with conditionalities. Some recent assessments have found that JUNTOS has overestimated the degree of compliance with conditionalities, moving JUNTOS in the direction of an unconditional cash transfer and likely reducing impact (World Bank 2008b). One reason for overestimation of compliance appears to be that responsibility for verifying compliance is not always independent of responsibility for program operation. In many cases JUNTOS promoters are responsible for making sure the program works well at community-level, yet they are also verifying compliance, often compensating for the failure of health staff (who say they do not have the time) to do so. Clearly the promoter has an incentive to keep up the numbers of compliant households, in order to make the program and her own efforts look good.

The program further requires that the household meet *all* conditionalities in order to receive the transfer, and a promoter may sometimes overlook a gap in compliance to allow the household to keep receiving the payment during the next 3-month period. Given what appears to be a fairly personal relationship between community residents and the promoter, and understanding how difficult it might be for a household to meet all the conditions in a particular month, one can appreciate how a promoter might “excuse” any misses in compliance.

To deal with these issues, the team has recommended that JUNTOS enforce conditionalities, but that 1) only the service provider should verify compliance; and 2) payment should depend on completion of separate individual conditions, so the household receives an amount that varies depending on the number of conditions completed (World Bank 2008d). This sort of payment structure would be easier if the conditionalities for education and health were separate, thus making the objectives of each program clearer and generating differential incentives for different critical age groups, such as children under two and children in secondary school.

The team has also recommended redefining health- and nutrition-related conditionalities for children less than 3 years old to make them more appropriate for that age-group. Other co-responsibilities could be defined for older children (3 to 6 years old). These sorts of actions reflect the recommendation to tie conditionalities to the needs of the specific target population more closely.

## Design and Operation

Following the structure in the Design and Operation section above, we will now consider the same issues here, looking more closely at the issues JUNTOS faces with regard to targeting, time burden, efficiency of service delivery, quality of supply-side services, and interagency integration and coordination.

## *Targeting*

JUNTOS has three steps in its targeting process: geographic, individual, and community. First, districts where the program will operate are identified. Second, within those districts, the program identifies eligible households. A quantitative algorithm is used to select households based on a “needs score”. This method is different from the selection algorithm used by other social programs, which is called the Household Targeting System. In order to improve institutional integration, JUNTOS is considering adopting the same system used by others. As a third step, community residents and leaders verify the list, adding or eliminating households as needed (Government of Peru 2008).

This procedure may miss some of the target population, however. JUNTOS has no structured way to update this list once the validation exercise ends. Children born after the initial district registration are often not incorporated later. And households have no incentive to press for their inclusion because the program gives 100 soles per month to the household, regardless of the number of qualifying children. Informing JUNTOS about additional children would only increase the number of conditionalities to comply with, without changing the amount of the transfer the household receives.

JUNTOS has identified a number of ways to improve targeting. As part of the restructuring, JUNTOS is now planning to adjust the value of the payment to reflect the number of the qualifying children (World Bank 2009, Government of Peru 2008). JUNTOS can also coordinate more closely with SIS, the social program that finances health services for many of the poor. The poor are likely to use SIS when they receive health services, including births. By cross-checking lists between JUNTOS and SIS, both agencies can make sure they have complete household lists and, using health system records, can perform automatic verification of the health conditionalities (Government of Peru 2008, World Bank 2008b).

## *Time Burden and Transfer Efficiency*

Except for travel time, technology and institutional presence have made the time burden on beneficiaries relatively low. The program opens a bank account in the government’s bank for each beneficiary. This bank has branches throughout Peru, including rural areas. Each recipient receives a payment card with her name and a digitized photograph.

The current payment schedule, however, causes some difficulties. Currently the program has only six days between when the community promoters turn in their documentation to verify compliance and when the next monthly payment is due. In order to avoid not paying a household that should receive the payment, program staff have an incentive simply to accept reports of compliance without rigorous verification (Government of Peru 2008). Peru is now considering moving to a system that gives staff more time to verify and report compliance. The program is also considering saving administrative and time costs by making the transfer only once every two months, instead of monthly (Government of Peru 2008).

## *Service Delivery*

Operationally, JUNTOS generally does not have any major problems in delivery of transfers or services. However, consistency and quality of delivery have sometimes suffered. The health appointments, for example, are sometimes not well-spaced out throughout the month, causing long waits for

some program participants on appointment days. And the current operational manual has not been updated regularly. JUNTOS is now developing a new operational manual that will make organizational roles and responsibilities of JUNTOS and its partners clearer and will clarify program procedures.

### *Assuring Supply-Side Quality*

An important component of the restructuring process has to do with efforts to identify and address supply-side weaknesses. This includes issues having to do with cross-institutional linkages (discussed in more detail below), staffing numbers and ability, information exchange, and supply chains, including lack of equipment or delays in delivery of inputs and supplies. Other issues identified include: protocols for attention that were unclear to promoters or health staff; health clinics not being open at times convenient to beneficiaries; and delays in payments by JUNTOS to SIS (World Bank 2008b).

A serious concern often raised about CCTs is that although the program enforces compliance among participants, no one holds the program itself accountable to the participants. JUNTOS is addressing this issue as well. Although currently the program does not have a participatory monitoring system, the restructuring envisions a system of operational supervision, including performance indicators. The system will establish mechanisms for periodic spot checks, possible use of citizen score cards, and a clear, accessible process for receiving and resolving complaints. In addition, JUNTOS is designing a series of operational and impact evaluations and a strategy for discussion and dissemination of results.

An important element of ensuring operational quality is making sure the process is clear and transparent to participants and partner organizations. Not only does this help everyone know what to do but also encourages them to hold each other mutually accountable. To that end, clarifying and publishing the operational guide and program procedures, which will detail roles and responsibilities of all actors, should help. This information will be available not only to the partner organizations but to donors, other parts of government, and civil society, especially local leaders and beneficiaries.

### *Interagency Coordination and Policy Integration*

Success will come not just with what JUNTOS does but with what others do as well. Establishing mechanisms and incentives for working together is essential. Although the “new” JUNTOS strongly emphasizes management coordination, previous attempts at policy collaboration have had only limited success (partly because each of the complementary programs has a slightly different target population).

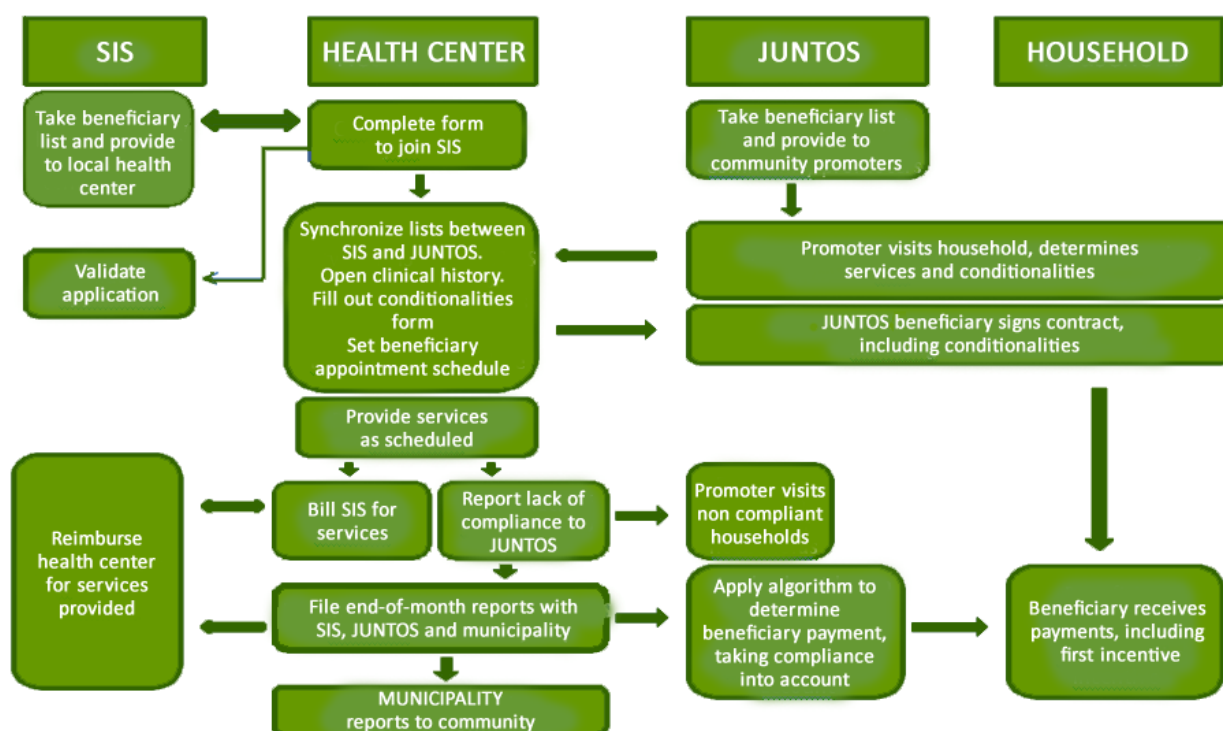
But now a number of factors are aiding the push toward institutional coordination and creating an environment for collaboration (World Bank 2008b). First, the government itself has made reducing malnutrition a national priority. The President, supported by the donor community and civil society, is prodding various ministries, agencies, and sectors to align to achieve results. For example, MEF is implementing a system of Results-Based Budgeting in order to identify and monitor the most effective nutrition-related investments. Second, CRECER, the national strategy against poverty and child malnutrition established in 2007, provides an overarching policy framework for social protection (World Bank 2008b). This interinstitutional framework allows JUNTOS and other programs to be clearer about their purpose and role within the social protection strategy. It also has helped to clarify reasonable limits of what a CCT can be expected to accomplish.

JUNTOS, as a CCT, is not intended to directly provide all services, but its integrative approach (needed for a CCT and especially so for nutrition) can catalyze efforts to improve supply through articulating actions and encouraging monitoring across actors and organizations (Government of Peru 2008). So the entire burden of delivering or integrating services for nutrition does not fall on JUNTOS. Rather, JUNTOS works to integrate and coordinate with, but not replace or duplicate, other programs and agencies and stimulate demand for an integrated package of health, nutrition, and education services.

### Incentives and Integration: Some Examples from JUNTOS

Figure 2 illustrates the complexity and importance of interagency coordination as part of a CCT by diagramming the different responsibilities for just one of the JUNTOS co-responsibilities: providing health services to beneficiaries (Government of Peru n.d.). This process involves three different national-level government agencies, as well as various actors at the community level, operating both horizontally and vertically. Impact clearly also depends on both demand- and supply-side actions. For example, beneficiaries must meet scheduled health appointments, but the State must provide the services.

**FIGURE 2: JUNTOS: PROVIDING SERVICES TO THE BENEFICIARY POPULATION**



Source: Government of Peru (n.d.)

This figure clearly illustrates the institutional challenges posed by a CCT for nutrition, especially as many parts of the system intended to produce “good nutrition” are beyond JUNTOS’ direct control. For example, SIS has to validate applications and reimburse the health center for services provided. JUNTOS is not directly involved. And the *local* health center must complete forms, check lists, provide services, bill services, report lack of compliance – and then prepare end-of-the-month reports for other actors in the system (SIS, JUNTOS and the municipality). If there are breaks or

delays in payments between SIS and the health center, this may lead to poorer service and reduce the program's impact. It results in a headache for JUNTOS, but JUNTOS management has little direct control over whether the situation gets resolved.

This example shows a successful CCT will need to focus on incentives for all actors in the system, not just the household. These other actors, not just the beneficiaries, also need a supportive operating environment and incentives.

But what is the incentive for these other actors to work with JUNTOS? Just that they should? What authority does JUNTOS have over them, or their lead ministry? Some efforts are already underway to generate greater cooperation and integration in design, planning, and operation (Government of Peru n.d., World Bank 2008b, World Bank 2008c, World Bank 2008d). Incentives to make the system work for JUNTOS and the beneficiaries may involve tangible rewards and penalties but also eliminating disincentives, such as conflicting data systems across different agencies.

Overall, working collaboratively to establish integrated and coordinated operations is key, so that each actor understands the rationale and procedures of the program, and their role in it. For example, JUNTOS and the Ministry of Health are working to make information systems more compatible, including automation and consolidation of forms. This should make it easier for JUNTOS, SIS, and Health Center staffs to input and share beneficiary information across their management information systems.

Health centers may also face increased demand for services. To make meeting this demand easier, JUNTOS could work with the Ministry of Health and the health centers to make sure that forms and operating procedures are shared and standardized.

A new operational guide, developed jointly with the MINSAs and MEFs, will smooth coordination as well. JUNTOS had developed the previous guide independently of its operating partners, and developing the new guide collaboratively will not only assure that the guide is technically sound but also that the operations and conditions will mesh with different agency procedures and protocols. Joint production will also reduce the tendency of local health staff to see JUNTOS requirements as an additional – and differentiated – burden.

Even though the national agencies are important for setting tone and providing guidance, much of success in interagency collaboration depends on what happens at the local level. Local actors are ultimately responsible for implementation, and are also more capable of seeing needs and of promoting integration (as the institutional silos begin to break down in implementation on-the-ground). JUNTOS seems to be taking this into account as well, and is working to promote action and ownership at the community level. A communications strategy, group presentations, demonstration sessions, and agreement on strict verification of compliance with conditionalities are being developed with community leaders, residents, and staff.

Some gaps remain. Figure 2, for example, shows a mechanism for reporting to the community, but no mechanism exists for the community to give comments back to the municipality, or for the municipality to report back and affect what higher-level agencies are doing. Strategic communications and monitoring and feedback systems could help the community pressure for higher-quality services and see where service provision needs to be tweaked.



Some difficult issues remain, including how to set up a recertification process that will not impose significant operational time or costs or time burdens on beneficiaries. And despite interagency collaboration, it is not entirely clear what should happen to households or individuals who may qualify for more than one program.

### *Promoting Change*

In modifying operations and strengthening its focus on nutrition, JUNTOS is following lessons from what we know about leading and managing change and working multisectorally (Garrett and Natalicchio, forthcoming; McLachlan and Garrett 2008; Kotter 1996). The joint development of procedures and activities noted above is an example of the sort of approach necessary to make sure changes are enduring and operationally feasible. Another is promotion of ownership by operating partners.

Once the decision to modify JUNTOS to be nutrition-centered had been made, the government and the World Bank began to work together to build a shared understanding and vision among the key political and institutional partners. A multi-stakeholder, cross-sectoral group was established with support from the World Bank to lead the initial assessments and analyses to identify problems, challenges, and potential changes (World Bank 2008b). Over time the group expanded to other key stakeholders and actors, including the Interamerican Development Bank and UN organizations such as UNICEF. The group also began to reach beyond upper management and technical staff in the agencies already participating to include other staff, especially those responsible for regional operation and coordination with other sectors.

These groups discussed the available evidence but also identified knowledge gaps, and determined what other information was needed. Chief among these were ways to improve operations, including staffing arrangements, capacity, and salaries; more synergistic cooperation among partner organizations; streamlining data collection and use; and studies on conditions, design, operations, and impact.

The group also determined they needed concrete experience with these ideas, to see how the new arrangements would work on the ground. As a result, they decided to test these changes in one pilot district in Peru. The district is now serving as a “laboratory” to introduce and evaluate changes in management and delivery, including coordination among the various components and institutional actors (World Bank 2008b). As with Rapid Results Initiatives undertaken in other countries for nutrition (Rapid Results Institute and Micronutrient Initiative 2008), this sort of results-focused, short-term effort helps normally rather disparate players quickly identify organizational and operational bottlenecks. The collaboration required to get issues resolved promotes a sense of ownership and accomplishment, and allows partners to see what institutional, normative, and operational processes are needed to make the program work effectively – and informs how to roll out the program to other areas.

Another significant change is one of philosophy and perspective. In line with the government taking responsibility for fulfilling social obligations and for delivering high-quality services, JUNTOS is now more likely to talk about “co-responsibilities” than conditionalities. Rather than an externally imposed “condition” on one of the actors (usually meaning the household), this term makes it clear that all the participants in the system have roles to play: they have rights but also responsibilities. In sum, some of the guiding principles for reorienting JUNTOS include:

- A clear focus on orienting operations and conditionalities to achieving impacts on health and nutrition.
- A strong focus on results and use of information for evidence-based decision-making.
- A recognition of the importance of coordinating and exchanging information with operating partners, both horizontally (sectorally, across the national level, for example) and vertically (including sub-national governments and communities, for instance).
- A strong emphasis on enforcing conditionalities.
- Attention to supply-side issues, including a system to detect problems with delivery of supply-side services.
- Inclusion and building capacity of local partners to benefit from their knowledge and create a sense of ownership. The scope of local involvement runs from using community promoters as JUNTOS staff, adapting the program to the cultural practices of each region, and implementing community-level strategic communications.

## Summary

Peru is in the initial stages of creating a “nutrition-centered” CCT. Whether JUNTOS has an enhanced impact on malnutrition among the most vulnerable, as compared to CCTs that are conceived more broadly or with different objectives in mind, remains to be seen. What does seem to the case, however, is that JUNTOS shows that operationally governments can refocus a CCT on nutrition objectives.

Interestingly the most intensive discussions around how to refocus a CCT on nutrition have had less to do with the technical content of the conditionalities (or “co-responsibilities) and the package of services, and more how to align the efforts of partner agencies and improve operations so that the government is providing an integrated operation, across those agencies, focused on reducing malnutrition. In this regard, the team behind the restructuring of JUNTOS is providing useful lessons and leadership.

The experience in Peru is providing insights into the challenges of operationalizing, supporting, and incentivizing the different pathways. The issues uncovered so far in the restructuring of JUNTOS very much mirror the insights presented above on how to design a CCT to enhance its impact on nutrition. Furthermore, their approach is not suggesting one pathway is more important or necessarily exclusive of another. Rather, they are taking a holistic, integrated approach. They are basing the restructuring of the program on sound technical concepts (taking account of the pathways of impact and the Essential Nutrition Actions, including a tighter focus on the 0-2 age group); sound concepts of policy (fitting JUNTOS within the broader framework of an integrated social protection strategy), politics (building vision and commitment, based on discussion, evidence, and consensus on a way forward), and institutional operation (working multisectorally, involving the community, and paying attention to individual and organizational incentives). Interestingly, they are in a sense reprioritizing the role of the State in making sure that the program itself operates well and actions across the pathways of impact do indeed flow easily and freely.

## CONCLUSION

Available evaluations concur that CCTs can indeed have a positive impact on poverty and nutrition. Although programs evaluated to date were designed with impacts on human-capital outcomes in mind, few were designed with a specific intent to improve nutrition. This paper suggests that programs could increase their impact on nutrition through modifications in design and operation – if a government determined that a CCT could play a cost-effective role with respect to alternative interventions and if it has clarified its role within a broader strategy for social protection or reduction in malnutrition.

The paper notes that the causes of malnutrition are indeed multisectoral. This does not mean that a nutrition-focused CCT has to take on the responsibility for addressing all these determinants, however. Rather, this paper argues for use of a more holistic perspective within an overall strategy for social protection or reducing malnutrition. Such a perspective would identify needs but also comparative advantages of the different agencies and actors that need to be involved.

A nutrition-focused CCT should be sure to promote action (alone or, more probably, in concert with others) that enhances the “action” along the pathways of impact and includes the essential nutrition interventions experts agree on. This highlights how critical good management and effective interagency collaboration will be to success. Beyond technical content, then, as the Peru experience illustrates, governments should pay special attention to design and implementation to make sure the government completes its supply-side obligations with quality services and facilitates the ability of the beneficiary to fulfill conditionalities.

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