

# The impact of unconditional cash transfers on morbidity and health seeking behavior in Africa

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# Introduction (1)

- Sub-Saharan African countries continue to face significant health challenges
- Poor health places additional burden on individuals and governments in general
- Only 6/47 countries in the region achieved the health-related MDG targets (WHO, 2015).
- Demand-side barriers include ability to pay; supply-side barriers include distance to and quality of healthcare facilities



# Introduction (2)

- Recognition of poverty as a structural driver of poor health outcomes warranted emergence of several recent policy efforts in the region
- In recent years cash transfer (CT) programmes have rapidly increased in sub-Saharan Africa, with health and nutrition as secondary objectives sometimes
- Hypothesized pathways of impact:
  - Improved food security, nutrition
  - Improved sanitation
  - Increased access to preventive and curative health services
- Evidence to date on CTs and health: mixed, largely from Latin America



# CTs and Health: The evidence

## Protective impacts:

- Clinic visits (CCTs Latin America)

## Mixed evidence/impacts only on sub-groups:

- Immunizations
- Birthweight, nutritional status (growth, stunting, wasting, underweight)
- Morbidity (diarrhea, sick days)
- Skilled attendance at birth
- Clinic visits (UCT in Kenya, CCT in Tanzania)

## Adverse impacts:

- Weight-for-age (Brazil)
- Adult BMI, diastolic blood pressure, obesity (Mexico)

**References:** LaGarde et al. 2007; Owusu-Addo and Cross, 2014; Evans et al. 2017, Morris et al. 2014, Fernald et al. 2008, Huang et al. 2017



# Study aims

Estimate the impact of UCT programs on health and health seeking behavior in selected countries in SSA



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# Data summary

Country	Design	Target	Sample	Waves
Kenya CT-OVC	Cluster-RCT	Poor households caring for orphans and vulnerable children	3161 households	Baseline (2007) Follow-up (2009)
Malawi SCT	RCT	Ultra-poor and labour-constrained households	3,531 households	Baseline (2013), 17 m (2014-15), 24 m (2015)
Zambia CGP	RCT	Households with children under age five	2,515 households	Baseline (2010), 24m (2012), 36m (2013), 48m (2014)
Zambia MCT	RCT	Female, elderly headed households, and households with persons living with disability	3,076 households	Baseline (2011), 24m (2013), 36m (2014)
Zimbabwe HSCT	Cluster-RCT	Ultra-poor and labor-constrained households	3,063 households (2,029 treatment & 1,034 comparison)	Baseline (2013), 12m (2014)



# Analysis

- Program impact evaluated for different measures of health outcomes and health seeking behavior.
  - But these measures were not consistent across countries
  - Different measures used for children under age 5
- Analysis was conducted for different age groups
  - Under 5 years; 5-19yrs; 20-59 and above 60
- Attrition analysis suggest no or minimal differential attrition across countries
- In general, balance test results also suggest treatment and control groups were sufficiently balanced to attribute impact to the programs



# Results: Illness/Sick days

Age range	Kenya	Malawi	Zambia CGP	Zambia MCT	Zimbabwe
All ages	✓	✓	✓	✓	✓
Ages 5-19	✓	✓	✓	✓	✓
20-59	✓	✓	✓	✓	✓
Above 60	✓	✓	✓	✓	✓
Under 5	✓			✓	✓

✓ No impacts

✓ Protective impact

✓ Adverse impact



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# Results: Sought care for illness

Age range	Kenya	Malawi	Zambia CGP	Zambia MCT	Zimbabwe
All ages	✓	✓	✓	✓	✓
Ages 5-19	✓	✓	✓	✓	✓
20-59	✓	✓	✓	✓	✓
Above 60	✓	✓	✓	✓	✓
Under 5	✓	✓	✓	✓	✓

✓ No impacts

✓ Protective impact

✓ Adverse impact



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# Results: Self-reported health

Age range	Kenya	Malawi	Zambia CGP*	Zambia MCT	Zimbabwe
All ages	✓	✓	✓	✓	✓
Ages 5-19	✓				✓
20-59	✓	✓	✓	✓	✓
Above 60	✓	✓	✓	✓	✓
Under 5	✓				

✓ No impacts

✓ Protective impact

✓ Adverse impact



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# Results: Fever/malaria

Age range	Kenya	Malawi	Zambia CGP	Zambia MCT	Zimbabwe
All ages	✓	✓	✓	✓	✓
Ages 5-19	✓	✓	✓	✓	✓
20-59	✓	✓	✓	✓	✓
Above 60	✓	✓	✓	✓	✓
Under 5	✓			✗	✓

✓ No impacts

✓ Protective impact

✗ Adverse impact



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# Results: Respiratory illness

Age range	Kenya	Malawi	Zambia CGP	Zambia MCT	Zimbabwe
All ages	✓	✓	✓	✓	✓
Ages 5-19	✓	✓	✓	✓	✓
20-59	✓	✓	✓	✓	✓
Above 60	✓	✓	✓	✓	✓
Under 5	✓			✓	✓

✓ No impacts

✓ Protective impact

✓ Adverse impact



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# Results: Diarrhea

Age range	Kenya	Malawi	Zambia CGP	Zambia MCT	Zimbabwe
All ages	✓	✓	✓	✓	✓
Ages 5-19	✓	✓	✓	✓	✓
20-59	✓	✓	✓	✓	✓
Above 60	✓	✓	✓	✓	✓
Under 5	✓	✓	✓	✓	✓

✓ No impacts

✓ Protective impact

✓ Adverse impact



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# Results: Health Expenditures (local currency)

Age range	Kenya	Malawi	Zambia CGP	Zambia MCT	Zimbabwe
All ages	✓	✓	✓	✓	✓
Ages 5-19	✓	✓	✓	✓	✓
20-59	✓	✓	✓	✓	✓
Above 60	✓	✓	✓	✓	✓
Under 5	✓	✓		✓	

✓ No impacts

✓ Protective impact

✓ Adverse impact



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# Conclusion

- Few impacts on morbidity
  - No endline impacts on sick days, respiratory illness
  - Mixed evidence on diarrhea by country, age
  - Self-reported health improved in 1/5 countries
  - Epidemiologic transition: should we be measuring obesity, diabetes, sugar intake among adults?
- Positive impacts on care seeking when sick in 2/5 evaluations
  - Increased expenditures in 1/5 countries
- **Determinants of health are complex:** sanitation, environment, health knowledge and practices, quality of services
  - Addressing cost barriers **may increase utilization when sick** or for preventive services (based on broader literature), but unlikely that cash alone will improve health status
  - **Complementary interventions including expanding/improving health infrastructure, behavior change** should be encouraged



# References

- Huang, Carolyn, et al. "Investments in children's health and the Kenyan cash transfer for orphans and vulnerable children: evidence from an unconditional cash transfer scheme." *Health Policy and Planning* (2017).
- Lagarde, Mylene, Andy Haines, and Natasha Palmer. "Conditional cash transfers for improving uptake of health interventions in low-and middle-income countries: a systematic review." *Jama* 298.16 (2007): 1900-1910
- Morris, Saul S., et al. "Conditional cash transfers are associated with a small reduction in the rate of weight gain of preschool children in northeast Brazil." *The Journal of nutrition* 134.9 (2004): 2336-2341.
- Evans DK, Hotemeyer B, Kosec K. (2017). "Cash Transfers and Health: Evidence from Tanzania." *The World Bank Economic Review*, 2017: 1-19.
- Owusu-Addo, Ebenezer, and Ruth Cross. "The impact of conditional cash transfers on child health in low-and middle-income countries: a systematic review." *International journal of public health* 59.4 (2014): 609-618.
- WHO (2015). World health statistics: Health-related Millennium Development Goals. Geneva, WHO





# Thank You!



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