
How to Make 'Cash Plus' Work: Linking Cash Transfers to Services and Sectors

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HOW TO MAKE 'CASH PLUS' WORK: LINKING CASH TRANSFERS TO SERVICES AND SECTORS

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Abstract: The broad-ranging benefits of cash transfers are now widely recognized. However, the evidence base highlights that they often fall short in achieving longer-term and second-order impacts related to nutrition, learning outcomes and morbidity. In recognition of these limitations, several 'cash plus' initiatives have been introduced, whereby cash transfers are combined with one or more types of complementary support. This paper aims to identify key factors for successful implementation of these increasingly popular 'cash plus' programmes, based on (i) a review of the emerging evidence base of 'cash plus' interventions and (ii) an examination of three case studies, namely, Chile Solidario in Chile, IN-SCT in Ethiopia and LEAP in Ghana. The analysis was guided by a conceptual framework proposing a menu of 'cash plus' components. The assessment of three case studies indicated that effective implementation of 'cash plus' components has indeed contributed to greater impacts of the respective programmes. Such initiatives have thereby addressed some of the non-financial and structural barriers that poor people face and have reinforced the positive effects of cash transfer programmes. In design of such programmes, further attention should be paid to the constraints faced by the most vulnerable and how such constraints can be overcome. We conclude with recommendations regarding the provision of complementary support and cross-sectoral linkages based on lessons learned from the case studies. More research is still needed on the impact of the many variations of 'cash plus' programming, including evidence on the comparative roles of individual 'plus' components, as well as the knowledge, attitudes and behaviour pathways which influence these impacts.

Keywords: Social protection, cash transfers, cash plus, linkages

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INTRODUCTION

It is now widely recognised and evidenced that cash transfers can have highly positive socio-economic impacts, ranging from poverty reduction and improved living conditions to enhanced psychosocial well-being. At the same time, the expanding evidence base also highlights that the provision of cash alone falls short in achieving long-term second-order impacts such as those related to nutrition, learning outcomes and morbidity (Attah et al. 2016; Bastagli et al. 2016). This holds true across the spectrum of social protection interventions, from child grants seeking to improve children's nutritional outcomes to graduation programmes designed to promote household asset accumulation and income generation. The term 'cash plus' is gaining considerable traction because of its potential to complement cash with additional inputs, service components or linkages to external services, that, in combination, may be more effective in achieving the desired impacts and ensuring their sustainability than cash alone (Watson and Palermo, 2016).

The theory of change of 'cash plus' programming is predicated on the notion that, while cash transfers can have impacts beyond their poverty-alleviation objectives, the 'income effect' of cash transfers can be constrained by behavioural mediators or broader moderators (Palermo, Veras Soares and Yablonski, 2017). For example, cash transfer programmes alone may not prompt sufficient behavioural change ('mediators') to reach impacts in areas such as nutrition, education and health¹. Further, cash alone may not achieve positive outcomes when beneficiaries experience exclusion from quality health facilities, schools, markets, or other services (access and supply-side constraints, or impact 'moderators'), or in the face of shocks. Indeed, this concept of exclusion is recognized in the definition of 'transformative social protection' emphasising the importance of addressing structural inequalities and barriers to inclusion (Devereux and Sabates-Wheeler, 2004).

'Cash plus' programmes can be characterized as social protection interventions that provide regular transfers in combination with additional components or linkages that seek to augment income effects. This is done either by inducing further behavioural changes or by addressing supply-side constraints. Options for so doing include the provision of information (such as through behaviour change communication [BCC] or sensitization meetings), provision of additional benefits and support (such as supplementary feeding or psychosocial support), provision or facilitation of access to services (such as through health insurance or setting up Village Savings and Loans Associations) or implementation of case management (ensuring referrals to other sectors), or strengthening the quality of existing services and facilitating linkages to these. While the need for programmes to move beyond 'cash only' has been increasingly recognised in making social protection truly transformative (Molyneux et al. 2016), relatively little is known about how these linkages can be successfully established and implemented.

This paper seeks to identify criteria for success and considers challenges in the creation and delivery of such programmes, with a focus on sectors related to health, nutrition and education. It aims to provide recommendations for more integrated service provision as part of (or linked to) social protection programming. It does so by (i) reviewing the emerging evidence base assessing the impact of 'cash plus' versus cash alone and (ii) examining case studies in three countries – the Livelihoods

1 This review focuses on nutrition, education and health. For a comprehensive review of 'cash plus' programming related to agricultural interventions, see Soares F. V., Knowles M, Daidone S, Tirivayi N (2017). Combined effects and synergies between agricultural and social protection interventions: What is the evidence so far? Food and Agriculture Organization of the United Nations: Rome.

Empowerment Against Poverty (LEAP) programme in Ghana, the Chile Solidario scheme in Chile, and the Integrated Nutrition Social Cash Transfer (IN-SCT) pilot project in Ethiopia. As such, this paper contributes to an increased understanding of how social protection interventions can enhance inclusion by steering basic services towards those most excluded in society. This improved understanding of successful strategies and lessons learned could help policymakers and implementers to improve linkages and take steps towards integrated systems.

This paper is structured as follows: Firstly, we discuss the rationale and options for 'cash plus' programming, suggesting a 'menu' of 'plus' components. Secondly, we discuss each case study in detail, including programme descriptions, discussions of 'cash plus' components, assessing success and challenges and identifying lessons learned. We subsequently identify common factors for success as well as challenges for the establishment and delivery of 'cash plus' programmes, before offering final conclusions.

1. 'CASH PLUS' PROGRAMMING: STRENGTHENING IMPACTS ON SECOND-ORDER OUTCOMES

This section provides the rationale for 'cash plus' programming and discusses options for design and implementation of these interventions, elaborating various options in a menu of 'plus' components. We build on existing frameworks and evidence from low- and middle-income countries.

1.1. The rationale for 'cash plus' programming

Cash transfer programmes have been shown to reduce poverty and improve well-being across a range of dimensions, including food security, health, schooling, child protection, productive activities, and safe transitions to adulthood (Baird, Ferreira, Özler et al. 2013; Bastagli et al. 2016; Davis et al. 2016; De Hoop and Rosati, 2013; FAO, 2015; Lagarde, Haines, and Palmer, 2007; Roelen, 2014). Households may face budget constraints that limit their ability to buy food, send children to school and seek healthcare, even if they value these activities and would prefer to carry them out. Relatedly, households may face liquidity constraints which prohibit them from investing in agricultural inputs or businesses to increase their productive capacity (Veras Soares, Knowles, Daidone, & Tirivayi, 2016). Regular cash payments can alleviate these budget and liquidity constraints and help households to smooth consumption, for example, during lean seasons. Indeed, cash transfer programmes have proved to be crucial for the achievement of positive outcomes.

Notwithstanding these positive effects, cash alone cannot alleviate non-financial and structural barriers to improving living standards and well-being. With respect to education, cash transfers have widely been found to improve school attendance but appear to have a limited effect on learning outcomes (Bastagli et al. 2016). Child nutrition is an area in which evidence of cash transfer impacts is notoriously mixed (Manley, Gitter and Slavchevska, 2013), suggesting that barriers other than lack of cash – including inadequate knowledge of feeding practices or lack of access to clean water – undermine children's nutritional outcomes. Investments in productive capacity may be hampered by structural constraints such as lack of access to services, markets, and insurance (Veras Soares et al. 2016).

Integration of cash transfer programmes with other interventions or services including the creation of linkages between demand-side and supply-side interventions has the potential to improve impacts in many areas of people's lives (and conversely, cash transfers may not have impacts among those

facing exclusion from quality services). Existing evidence illustrates how access to services enhances the impacts of cash transfer programmes. For instance, Zambia's Child Grant Programme (CGP) was found to improve skilled birth attendance – but only among women living in communities with higher quality health services (Handa, Peterman, Seidenfeld, & Tembo, 2016), and to reduce stunting among households with a protected water source (Seidenfeld et al. 2014). In Niger, Langendorf et al. (2014) identified a higher rate of reduction of acute malnutrition among households that received cash plus access to nutritional supplements, compared to households that received cash or supplementary food.

In circumstances where sub-optimal outcomes occur due to lack of knowledge (i.e. inaccurate or insufficient information), the provision of information or creation of awareness may be needed. In Latin America, Mexico's *Oportunidades* programme is estimated to have increased family planning use among women aged 20 to 24 years, most likely through the required health/information sessions (Lamadrid-Figueroa et al. 2010). In Bangladesh, a pilot project titled 'The Transfer Modality Research Initiative' (TMRI) tested five transfer options: cash; food; cash plus food; food plus nutrition behavioural change communication (BCC); and cash plus nutrition BCC. The objective was to identify which transfer or combination of transfers would have the biggest positive impact on child nutrition. A rigorous evaluation found that only one of the five options – cash plus nutrition BCC – achieved a statistically significant reduction in child malnutrition rates (Ahmed et al. 2016), which underscores the importance of adding messaging to cash transfer programmes.

Experimental evidence from Liberia highlights how intense counselling and support can improve the sustainability of impacts. In an experiment aiming to reduce violence and crime among men who were previously engaged in criminal activities, the combination of cash transfers plus cognitive behavioural therapy was found to significantly improve the long-term reduction in crime and violence. While crime and violence were reduced among all men receiving either cash alone, therapy alone or cash and therapy combined, the result was only maintained for those who received the combination of support (Blattman et al. 2017).

1.2. Options for 'cash plus' programming

Watson and Palermo (2016: 5-6) refer to 'cash plus' programmes as "[...] the programme option of combining cash transfers with other sorts of support. The rationale is that cash alone is not always sufficient as a means to reduce the broad-based and interrelated social and economic risks and vulnerabilities that the targeted beneficiary populations face, and that additional support is needed". The types and combinations of 'other sorts of support' can take many forms and can be integrated with cash transfers in different ways. We consider existing typologies of programmes offering integrated packages of support before providing our own understanding of 'cash plus' programming.

In aiming to classify social protection programmes across a continuum of service delivery, Barrientos et al. (2014) distinguish between (i) pure income transfers, (ii) income transfers combined with asset accumulation, and (iii) integrated poverty reduction programmes. The second and third categories can be considered 'cash plus' interventions, given their complementary components. Their rationale is based on the premise that poverty is broader than a mere deficit in income or consumption, but also represents deficits in productive assets and human capital and can be characterized by social exclusion (ibid). Income transfers combined with asset accumulation include programmes that aim to build physical assets and infrastructure, most notably public works programmes and programmes that focus on human capital – primarily conditional cash transfers. Integrated poverty reduction programmes can

be considered most holistic in their approach and particularly aim to address the issue of social exclusion by linking programme participants to a wide range of services.

'Graduation programmes' also represent a type of 'cash plus' intervention that has gained prominence recently. Pioneered by BRAC in Bangladesh, the graduation model transfers a package of assistance to extremely poor households over a two-year period. The package includes regular cash transfers, access to savings, productive assets, livelihood training and behaviour change communication. Following BRAC's success with its graduation programme, pilot projects were launched in eight other countries. Randomized control trials reported similarly positive results, not only in terms of graduating out of extreme poverty but on a range of indicators such as asset ownership, food security and financial inclusion. Moreover, most of these gains were sustained one year after programme support ended (Banerjee et al. 2015).

While a conceptualisation of 'cash plus' interventions from simple to more complex programming is appealing, variations of additional forms of support and the ways in which they are combined to complement cash transfers do not lend themselves to such a categorisation. For example, a scheme that complements cash transfers with the provision of health insurance cards and awareness raising by extension workers may be comparable to an intervention linking cash transfers to the use of health services through the use of conditions in terms of level of complexity. Yet, their 'cash plus' components are very different indeed.

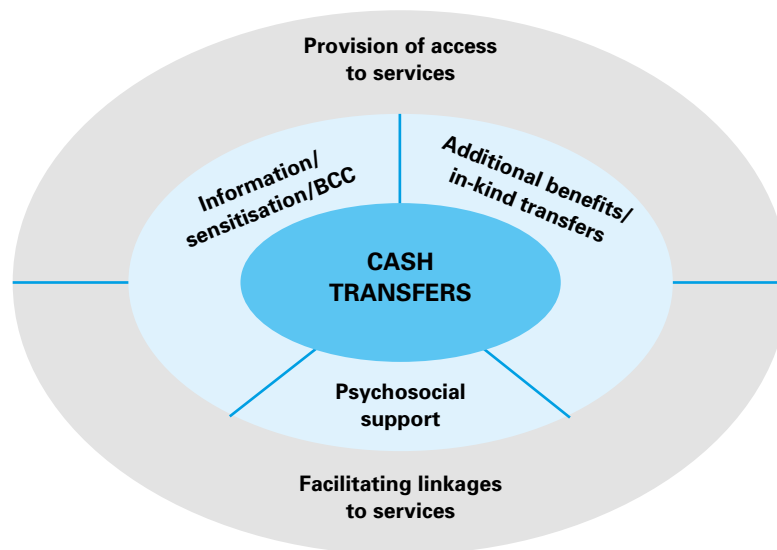
We conceptualize 'cash plus' programmes as follows:

'Cash plus' interventions combine cash transfers with one or more types of complementary support. Types of complementary support can consist of (i) components that are provided as integral elements of the cash transfer intervention, such as through the provision of additional benefits or in-kind transfers, information or behaviour change communication (BCC), or psychosocial support, and (ii) components that are external to the intervention but offer explicit linkages into services provided by other sectors, such as through direct provision of access to services, or facilitating linkages to services.

The options for 'cash plus' components, both integral and external to the specific cash transfer intervention, can be captured in a menu of 'cash plus' components (see Figure 1). The proposed components are not mutually exclusive and can be combined in various ways depending on scope and objectives. For example, programmes can seek to promote nutrition and health outcomes through a combination of supplementary feeding, BCC, the provision of health insurance cards and by making explicit referrals to health services. This menu of options suggests that 'cash plus' programmes need not develop on a progressive scale of comprehensiveness in terms of the number of services or linkages to services that they provide, but rather that they can offer a combination of components in response to needs and objectives, in line with available capacity and resources.

We discuss each component in more detail below.

Figure 1 Menu of 'cash plus' components (Authors' own)



1.3. Integral programme components

Additional benefits or in-kind transfers

The provision of additional benefits or in-kind transfers is based on the recognition that the income effect of cash transfers is often not large enough for achieving desired outcomes, or that structural factors impede the use of cash for affecting change. Often, cash transfers need to respond to multiple needs across all household members and are spread too thinly to make a significant impact in any one area. Indeed, higher transfer levels are associated with higher impacts across education, health and nutrition (Bastagli et al. 2016). Graduation programmes explicitly acknowledge the need for additional benefits over and above regular cash transfers in order to achieve the desired level of asset accumulation; the provision of asset transfers represents an investment in productive capital beyond what would be feasible on the basis of cash transfers alone (Sabates-Wheeler and Devereux, 2013). In Niger, cash transfers were complemented with the provision of fortified foods and supplementary feeding given that such foods were not locally available (Bastagli et al. 2016). The combination of support led to more significant reductions in malnutrition compared to the provision of cash alone (Langendorf et al. 2014).

Information/ sensitisation/ behaviour change communication (BCC)

This component aims to achieve positive outcomes by increasing knowledge and awareness and changing attitudes and practice (important 'mediators' of programme impacts). Many theories of change cash transfer programmes recognize that lack of knowledge may undermine programme impacts, notably in terms of nutrition and health (Browne, 2013) and child-rearing practices (Bastagli et al. 2016). With reference to nutrition, awareness raising and creation of knowledge can ensure that parents use their cash transfers to purchase more nutritious foods and improve sanitation practices that prevent diarrhoea (de Montesquiou and Sheldon, 2014). Many programmes have indeed started adding this component to the regular provision of cash (Molyneux et al. 2016) with activities ranging from the provision of information at pay points by programme staff, community-level training by volunteers or NGOs, to home visits by community volunteers or social workers.

Longstanding debates on communication for development (C4D), health communication and BCC suggest that modes of implementation are crucial in effecting change (Storey and Figueroa, 2012; Waisbord and Obregon, 2012), increasingly underscoring the need for interpersonal communication for effective messaging. With reference to the graduation programme in Burundi, the role of case managers and their strong interpersonal relationships with participants proved crucial for the uptake of messages and subsequent positive behavioural change (Roelen and Devereux, 2017).

Psychosocial support

The importance of psychosocial well-being in social protection is increasingly recognized, either as an outcome of social protection programming (Attah et al. 2016) or as an instrumental factor towards achieving transformative change (Molyneux et al. 2016). The potential for social protection programmes to link to forms of psychosocial support have emerged from discussions regarding the response to HIV/AIDS and Orphans and Vulnerable Children (OVC) (Adato and Bassett, 2012). Zambia's Social Safety Net Project, for example, included a counselling module for those affected by HIV/AIDS in recognition of the persistence of mental health problems (Miller and Samson, 2012). In South Africa, adolescents in cash transfer households which also received household visits by a home-based carer reported fewer HIV risk-taking behaviours among adolescent than those in households only receiving cash (Cluver et al. 2014). The inclusion of psychosocial support as a core component of social protection programmes is also increasingly considered in strengthening the linkages between social protection and child protection. Nevertheless, many questions remain regarding the appropriate remit and implementation of such support (Roelen et al. 2016b).

1.4. Linkages to external support

Providing access to services

This component pertains to the explicit provision of access to services in addition to the distribution of cash transfers. This can include the inclusion of beneficiaries in insurance or micro-credit schemes to provide access to health or financial services, or waiving tuition fees to specifically lower barriers to education. Participants in Concern Worldwide's Graduation Programmes in Rwanda and Burundi, for example, all received health insurance cards that granted free primary health care for all household members (Devereux et al. 2015; Devereux and Sabates, 2016). The Temporary Livelihood Protection Programme in South Korea combined cash transfers to those who had become unemployed following the economic crisis of the late 1990s with tuition fee waivers, lunch subsidies, and reductions in medical insurance premiums (Blouin et al. 2007). While the provision of such support is part of the 'cash plus' intervention, the actual take-up and use of services occurs in the health and education sectors.

Facilitating linkages to services

This component pertains to the facilitation of linkages to services (as opposed to directly providing access to services). This includes referral to services with voluntary take-up, the establishment of non-punitive co-responsibilities, or making the transfer conditional upon the use of services (such as in conditional cash transfer programmes (CCTs)). Referral to services is increasingly considered crucial for addressing multiple needs of the most vulnerable (Roelen et al. 2012). In Mozambique, case management and referral are deemed crucial for linking social protection and child protection services. Here, the Community Child Protection Committees (CCPCs) identify and assesses needs while social workers supervise and monitor support offered to children (Roelen, 2011). Case management can help identify needs of programme participants and facilitate linkages to corresponding services. Case management can be resource intensive, and the potential for this option may be limited in some

contexts without significant capacity strengthening – for example of the social welfare or social worker cadres – beforehand.

Interventions operating co-responsibilities or conditions require programme participants to comply with certain requirements, such as children's school attendance or health check-ups. Such interventions often include regular monitoring of the adherence to co-responsibilities or conditions, involving social workers, case managers or community volunteers undertaking monitoring meetings or home visits. The frequency of interaction with service providers can have powerful positive results (Jones and Marquez 2014). Indeed, a strong evidence base – primarily from CCTs in Latin America – provides testimony to the positive effects of such interventions regarding the use of services, most notably education and health, and also with respect to improved nutritional outcomes and reduced child labour (Gatenio Gabel, 2012). A systematic review of the differential impact of unconditional cash transfers (UCTs) and CCTs on schooling indicates that programmes with explicit conditions, strong monitoring and punitive action in case of non-compliance have greater impacts on enrolment. No differential impacts were observed in terms of learning outcomes such as test scores (Baird et al. 2013). On the whole, evidence does not allow for conclusions to be drawn regarding the differential impact of co-responsibilities and conditions or the extent to which a supportive versus punitive approach enhances or undermines impact.

A key factor for the successful facilitation of linkages at scale is a functioning Management Information System (MIS). Benefits of MIS include increased efficiency in targeting, improved oversight and coordination of multiple schemes, potential for establishment of a common payment system across schemes, improved fraud management, more effective emergency response, and improved ability to transition beneficiaries across schemes as their circumstances change (Barca and Chirchir, 2014). Requirements for successful MIS include strong political commitment to integration, sufficient staff availability and capacity, adequate hardware and internet connection, a solid system for national identification (such as a civil registry), and existence of a clear and high-level governance structure which can manage the process and liaise with all stakeholders (Barca and Chirchir, 2014).

In order to learn lessons from 'cash plus' interventions, we look at three case studies with varying combinations of 'plus' components. The first case study – Ghana's LEAP programme – offers access to services by automatically enrolling its participants in the National Health Insurance Scheme (NHIS). The second case study – Chile's *Chile Solidario* scheme – includes the provision of psychosocial support, facilitating access to services, adherence to conditions and case management and referrals. It should be noted upfront that in this case study, the cash transfer was not deemed the central component around which other components were framed but that it existed on par with the other programme components. The final case study – Ethiopia's Integrated Nutrition Social Cash Transfer (IN-SCT) pilot project – offers a combination of information/ BCC and a case management approach.

2. GHANA: LIVELIHOODS EMPOWERMENT AGAINST POVERTY (LEAP) PROGRAMME

2.1. Background and programme description

Ghana introduced several social policy interventions during the 2000s, including a new contributory national health insurance scheme (2003), a national school feeding programme (2005), capitation grants to expand free primary education (2005), and the flagship Livelihood Empowerment Against Poverty (LEAP) cash transfer programme (2008). As part of the review of the Ghana Poverty Reduction Strategy (GPRS I, 2003-2005), a Poverty and Social Impact Assessment (PSIA) was conducted by the National Development Planning Commission in 2004. It showed that past policies and interventions did not adequately impact the lives of the poorest, leading to rising levels of inequality. There was a perceived need to take a more holistic approach to the redesign and coordination of social intervention programmes in order to integrate the concerns of the poorest and most vulnerable segments of society into national development efforts. These observations informed the development of a National Social Protection Strategy (NSPS) under the leadership of the Ministry of Employment and Social Welfare (MESW), between 2005 and 2007.

Launched in 2008, LEAP is a social protection programme that provides bi-monthly cash transfers to households living below the national extreme poverty line. Specifically, LEAP targets poor families which also have at least one member who is aged (over 65), or who has a disability and is unable to work (PWD), or who is an orphan or vulnerable child (OVC); or who is a pregnant woman, or who is a child under one year of age. The overall goal is to increase long-term human capital development among the poorest and most vulnerable populations. More specifically, LEAP seeks to:

- (1) Improve basic household consumption and nutrition, and access to health care services among children under two years old, older persons and people with severe disability;
- (2) Increase basic school enrolment, attendance and retention of beneficiary children between the ages of 5-15; and
- (3) Facilitate access to complementary services such as welfare, livelihoods, and improvements in productive capacity (MESW, 2012).

The level of the LEAP benefit varies, depending on the number of eligible people in a household. At the time of writing, benefits range from GH¢64 to GH¢106 bi-monthly for households with one and four or more eligible members, respectively (Appiah, 2016). The number of LEAP beneficiary households has expanded rapidly over time, from just 1,654 in 21 districts in 2008, to 213,000 households in all 216 districts by 2016. Transfers are conditional or unconditional depending on the characteristics of beneficiary households.² From 2012, the programme's operational manual requires that children under 15 years of age enrol in and attend school, visit health facilities for vaccinations, and undergo growth monitoring every 3 months (MESW, 2012). Conditions are not enforced, however (Handa et al. 2013).

2 <http://leap.gov.gh/44th-payment-cycle-of-leap-social-cash-grant-212848-households-to-be-paid-for-the-months-of-july-and-august-2016/>

2.2. 'Cash plus' components

LEAP promotes an 'integrated social development approach'. This needs to be understood in reference to the NSPS, which not only gave birth to the LEAP but also marked the beginning of an integrated approach to social protection in Ghana (GoG, 2015: 23). The NSPS recognizes the multi-dimensional nature of poverty and vulnerability in Ghana, and argues that such problems cannot be effectively tackled through cash transfers alone (GoG, 2007a: 10). Consequently, the NSPS emphasises the importance of linking beneficiary households with other programmes as a way of facilitating their capacity to 'leap out' of extreme poverty (GoG, 2007a: 59). It calls for linking LEAP beneficiary households to initiatives that will help boost their productive capacities and assets, including the Labour Intensive Public Works Programme, the Agricultural Input Support Programme, the Micro Finance Scheme, the Youth Employment Programme, and the free Cocoa Mass Spraying Programme (GoG, 2007a: 53, 60). As such, the LEAP design document outlines a broad array of potential linkages between LEAP and other programmes (GoG, 2007b).

Against this backdrop, in 2010 the then MESW signed a Memorandum of Understanding (MoU) with the Ministry of Health to provide LEAP beneficiaries with free access to NHIS cards. To date, this MoU represents the only linkage to a complementary service for LEAP.³ In this section, therefore, we focus specifically on this LEAP-NHIS linkage, which is by far the most 'well established' complementarity in Ghana's social protection landscape (Ragno et al. 2016: 153).

Providing access to services: LEAP-NHIS complementarity

The NHIS was established in 2003 to remove financial barriers in accessing health services, particularly for the poor and vulnerable. The programme's ultimate goal is to provide universal insurance coverage to all Ghanaians. By 2014, the number of active NHIS members stood at 10.5 million, representing 39% of the national population (GoG, 2015: 149). The scheme is financed mainly through a combination of individual premiums, a 2.5% levy added to the value-added tax on goods and services and an earmarked 2.5 percentage point portion of social security contributions from formal sector workers. Individual premiums are charged based on each person's income or wealth, ranging from about GH¢8 for those categorised as poor, GH¢20 for middle income earners, and GH¢52 for high income earners (GoG, 2012: 67). Premium payments are waived for a wide range of vulnerable groups, including people over age 70; children under 18 years; 'indigents'⁴; pregnant women, persons with mental disorders and categories of disabled persons determined by the minister responsible for social welfare. By design, the scheme covers about 95% of the disease burden in Ghana (Schieber et al. 2012: 21). The scope of the basic benefits package is broad and includes outpatient and inpatient services – such as diagnostic testing, specialist care, most forms of surgery, hospital accommodation, maternity care services, emergency care, and drugs on the NHIA Medicine List (ILO, 2014).

LEAP beneficiaries are entitled to free health insurance through the NHIS and are encouraged to access post-natal clinics and birth registration as well as complete the Expanded Programme on Immunisation (Ragno et al. 2016). This arrangement is facilitated through the MoU with the Ministry of Health, which requires the National Health Insurance Authority (NHIA) to register all LEAP household members with

3 To a limited extent and without a formal MoU, the Labour Intensive Public Works (LIPW) programme has also been linked to LEAP Households. As of June 2016, members from 2,800 LEAP families have taken part to the LIPW (Source: LIPW Information System).

4 These are defined as those who are unemployed with no visible source of income, no fixed residence, and not living with someone employed and with a fixed residence.

no payment of premiums or processing fees. Funds to cover enrolment in health insurance are transferred directly to the local health authority, which then issues NHIS cards to LEAP households. Continued receipt of cash payments from LEAP is conditioned on acquiring a health insurance card (Handa and Park, 2012) although this has never been enforced.

Enrolment of new LEAP beneficiaries into the NHIS is carried out during LEAP payment days. District NHIS officials join District Social Welfare Officers (DSWOs) to provide information on the NHIS, distribute free NHIS cards, and update registries of beneficiaries. Additional efforts include quarterly meetings between NHIA and DSWOs to improve implementation and coordination (Gomez et al. 2016: 23).

The recognition of the importance of the NHIS-LEAP linkage became much stronger among policy-makers in light of empirical evidence on the modesty of the transfer size⁵ and LEAP beneficiaries using their transfers to pay NHIS premiums and purchase school supplies and food items. One study cited a female LEAP beneficiary in the poorer northern part of the country as remarking: "Our NHIS card has expired. I wish the LEAP payment was larger as we couldn't renew it given the cost. If we had money, we would renew the health insurance" (ODI and UNICEF Ghana, 2009, cited in Amuzu et al. (2010: 31)). Handa et al.'s (2013) quantitative impact assessment shows that LEAP households modestly reduced their out-of-pocket health expenditures by up to GH¢7 per month through enrolment in the NHIS. These findings are consistent with the overarching objective of the LEAP-NHIS complementarity, which seeks to increase access to health care services among LEAP beneficiaries by reducing their health care expenditures and thereby enabling them to use the cash grant on other productive activities (Ministry of Gender, Children and Social Protection, 2016).

2.3. Explaining success

In explaining factors for success, the history of the NHIS-LEAP linkages can be split into two broad phases, namely from 2010 to 2014 and from 2015 to date. While the first phase saw very limited efforts on the part of either the LEAP programme or NHIA in forging partnerships beyond the MoU, the second has been characterised by a deliberate push to linking LEAP households to the NHIS. The NHIS had been registering LEAP beneficiaries since the 2010 MoU but various challenges undermined its effectiveness.

First, while the MoU required that LEAP beneficiaries be registered with the NHIS before receipt of their first payments, this was not always implemented effectively. Second, there were few efforts by NHIA officials to deliberately target LEAP households during NHIS registration exercises, leading to several LEAP households not being registered with the NHIS or having invalid insurance cards (that required renewal).

From 2015 onwards, the LEAP programme office initiated engagements with the NHIA aimed at identifying modalities to facilitate the registration of LEAP beneficiary households with the NHIS. To help build broad-based consensus on the importance of improving the health status of LEAP beneficiary households through the NHIS, both the Regional Director of Social Welfare for the Greater Accra region and District Social Welfare Officers (DSWOs) sometimes participated in meetings between

5 For example, at the start of the programme, some LEAP households received as little as GH 8, at a time when about 7 was required to renew one's NHIS card.

the LEAP programme and the NHIA. These engagements proved useful in enhancing mutual understanding of the complementarity of their roles in improving the health status of LEAP households, and in overcoming NHIS enrolment constraints faced by LEAP beneficiaries.

Overcoming exclusion of LEAP beneficiaries from NHIS as a result of different inclusion criteria for LEAP and NHIS represent a case in point. While LEAP targets extremely poor households, the NHIS targets extremely poor individuals. As a result, NHIA officials would occasionally refuse to provide free NHIS cards to LEAP beneficiary caregivers on grounds that they – as individuals – did not look extremely poor. Regular engagements between the LEAP programme office and NHIA ensured that the NHIS district teams were provided with new and complete lists of LEAP household members, enabling the teams to include all the members of the LEAP households in the registration for the NHIS.

Collaboration between NHIA and LEAP programme staff is crucial; the LEAP programme does not have the direct mandate of registering beneficiary households and their members with the NHIS and therefore cannot achieve its objectives without the direct involvement of the NHIA. By the same token, NHIA experienced difficulties in meeting its targets regarding reaching the extremely poor because it did not have the internal capacity of identifying them.⁶ As a result of the growing collaboration and greater reliance on data provided by the LEAP programme, the NHIA has been able to increase the number of indigents exempted under the NHIS from a mere 1.4% of all NHIS beneficiaries in 2010 (see NHIA, 2011:18) to 5.5% by 2014 (GoG, 2015: 150). This analysis suggests that the realization on the part of the implementing institutions that the most efficient way of delivering their respective mandates is through partnerships, is central to understanding the growing improvement achieved by linking LEAP beneficiaries to the NHIS.

Indeed, the increased collaboration between LEAP and the NHIA has manifested itself in several ways, such as the establishment of a LEAP-NHIS technical committee⁷, and the joint development of a plan to increase the number of valid NHIS card-holders in LEAP households. The plan includes the sharing of a complete list of LEAP households and LEAP registration timetables with the NHIA, outlining District Social Welfare Officers' (DSWOs') and district-level NHIA representatives' visiting dates to LEAP communities, in order to provide beneficiary households with free NHIS cards.

In March 2016, a five-day pilot exercise in two districts was jointly undertaken and monitored by national NHIA officials and LEAP programme officers. It targeted three groups of LEAP beneficiaries for NHIS enrolment: (i) those who were not registered with the scheme; (ii) those whose NHIS cards had expired; and (iii) those whose cards were about to expire within a three-month period. The pilot project was considered a success, prompting the Minister of Gender, Children and Social Protection to recommend it be rolled-out nationally.

In August 2016, the Ministry of Gender, Children and Social Protection (MoGCSP), created in January 2013 with a mandate to coordinate social protection in Ghana⁸, launched a nationwide exercise aimed at enrolling 200,000 additional LEAP beneficiaries in the NHIS by December 2016. The Ministry

6 The NHIA had already partnered with the Ghana Education Service (GES) to identify and enrol children through the school system, but had not been able to capture those out of the system, or those populations from other priority groups.

7 Comprising members from the LEAP programme and the NHIA, the primary mandate of this committee was to spell out specific modalities that will ensure the enrolment of all LEAP households with the NHIS.

8 MoGCSP is an amalgam of MOWAC, the Department of Social Welfare and the Social Protection Division of the then Ministry of Employment and Social Welfare.

explained this nation-wide exercise as a way of fulfilling one of the key objectives of LEAP, which is to increase health care access among beneficiaries and ensure that the LEAP transfers can be directed at consumption and productive livelihood initiatives. As a result, an additional 80,000 LEAP households were registered with the NHIS by late October 2016. Although this pace of progress makes the achievement of the desired target by December 2016 unlikely, the LEAP-NHIS linkage nevertheless remains the most successful example of complementarity in Ghana's social protection landscape.

High-level political commitment, especially on the part of the Minister in charge of the MoGCSP from 2013-2017 (Nana Oye Lithur), is widely considered to have played a key role in facilitating this success story. While discussions about linking LEAP households to the NHIS had been ongoing for years, few practical measures were taken to operationalize this 'entitlement' until the Minister repeatedly declared it as priority. The fact that both the pilot and the nationwide registration exercises are fully funded by the MoGCSP highlights this commitment. The total cost of the registration exercises is estimated to be GH¢5 million, representing the largest project ever funded for LEAP by the MoGCSP, at a time when the project was not originally included in the budget. This raises questions as to how the Minister was able to provide substantial off-budget resources for the NHIS registration of LEAP households at a time when the national economy was in serious difficulty.

A key explanation relates to the political incentives of the current ruling National Democratic Congress (NDC) party, which assumed office in 2013. In its party manifesto for the December 2012 elections, the NDC pledged to increase the number of LEAP beneficiaries and to ensure an 'expanded coverage of the National Health Insurance Scheme (NHIS) to all 71,000 LEAP beneficiary households' (NDC, 2012: 25). The political commitment to the LEAP-NHIS linkages thus seem to have been partly influenced by the potential electoral advantages associated with this initiative, which was clearly in line with the electoral promises of the ruling party. The electoral advantages of this initiative were also enhanced by the highly visible nature of incentives to voters, entailing the provision of free transportation of households to registration centres, the provision of free snacks during the registration exercise, and the free provision/renewal of NHIS cards. Moreover, President John Mahama expressed strong commitment to the implementation of an integrated social protection system in Ghana. He demonstrated this commitment in various ways, including through the establishment of MoGCSP in 2013, the appointment of a well-respected human rights activist to head this Ministry, and the launch of a national social protection policy in June 2016.

Notwithstanding the observed success, two points of caution should be taken into account: First, registration with the NHIS is no guarantee of provision of high-quality health care. The strong increase in NHIS coverage among LEAP households has not been accompanied by a commensurate impact on the utilisation of health services, nor has it resulted in significant reductions in out-of-pocket health expenditure. Moreover, despite the large increase in NHIS coverage among LEAP beneficiaries, this did not have any impact on the curative health care seeking behaviour among households (Handa et al. 2013). Second, issues of sustainability remain a concern. Greater resource allocation will be required to fully implement this initiative. Furthermore, there is considerable uncertainty around outcomes of the 2016 elections and subsequent changes in ministerial appointments.

2.4. Lessons learned

- i. Putting in place formal agreements with the institutions charged with the responsibility of providing complementary social protection services, which spell out roles and responsibilities of each implementing institution, is crucial. The MoU between NHIA and the Ministry in charge of LEAP implementation was fundamental to laying the foundations for effective collaboration towards enrolling LEAP beneficiaries with the NHIS.
- ii. Effective operationalization of formal agreements requires the involvement of 'champions' of social protection within governing coalitions. While the MoU between LEAP and the NHIA was signed as far back as 2010, practical steps towards linking LEAP beneficiaries to the NHIS were only taken after the appointment of Minister Nana Oye Lithur for the MoGCSP – a well-known social protection activist who enjoyed substantial influence within the governing party at the time. The fact that other MoUs between the LEAP and other Ministries such as Agriculture, Local Government and Rural Development have not been followed by practical action is a demonstration of the limitations of formal agreements in the absence of effective agents of change.
- iii. Implementation of complementary services across institutions is facilitated when institutions share objectives or have overlapping mandates, as in the case of the LEAP and NHIA. Implementing institutions are likely to take the provision of complementary services seriously, when the outcomes of their efforts have direct bearing on their ability to deliver on their core mandates.
- iv. Political economy dynamics – including electoral incentives – should be taken into account when aiming to forge linkages. Forging effective complementarities generally requires additional resources and the ruling political elites are likely to make such resources available if they deem such complementarities compatible with their own political survival strategies. In this respect, politics and political economy dynamics are just as important as technocratic factors in the coordinated delivery of social protection.

3. CHILE SOLIDARIO

3.1. Background and programme description

Chile Solidario was launched during Ricardo Lagos's presidency (2000–2006) and implemented from 2002 to 2012⁹. The programme was established following an intense public and political debate, putting Chile's economic and social development model under scrutiny and calling for new policy solutions. While conditional cash transfers (CCTs) quickly became very popular in the majority of Latin American countries, the Chilean government tried to follow a different strategy by implementing an innovative anti-poverty programme based on a multi-sectoral and integrated approach, combining demand- and supply-side interventions targeted to the most vulnerable families (MIDEPLAN, 2002). When President Ricardo Lagos came into office in 2000, he considered the reduction of extreme poverty to be a priority, assigning an expert in poverty eradication policies as the new Minister of MIDEPLAN (Ministry of

9 The programme has since been transformed into the *Ingreso Etico Familiar* programme, expanding the set of transfers and conditions in comparison to Chile Solidario (no longer exclusively targeting families living in extreme poverty) and including a more central focus on labour market and productive inclusion features (Cecchini, Robles and Vargas, 2012).

Planning and Cooperation). The establishment of the *Chile Solidario* programme was directly overseen by the Office of the President.

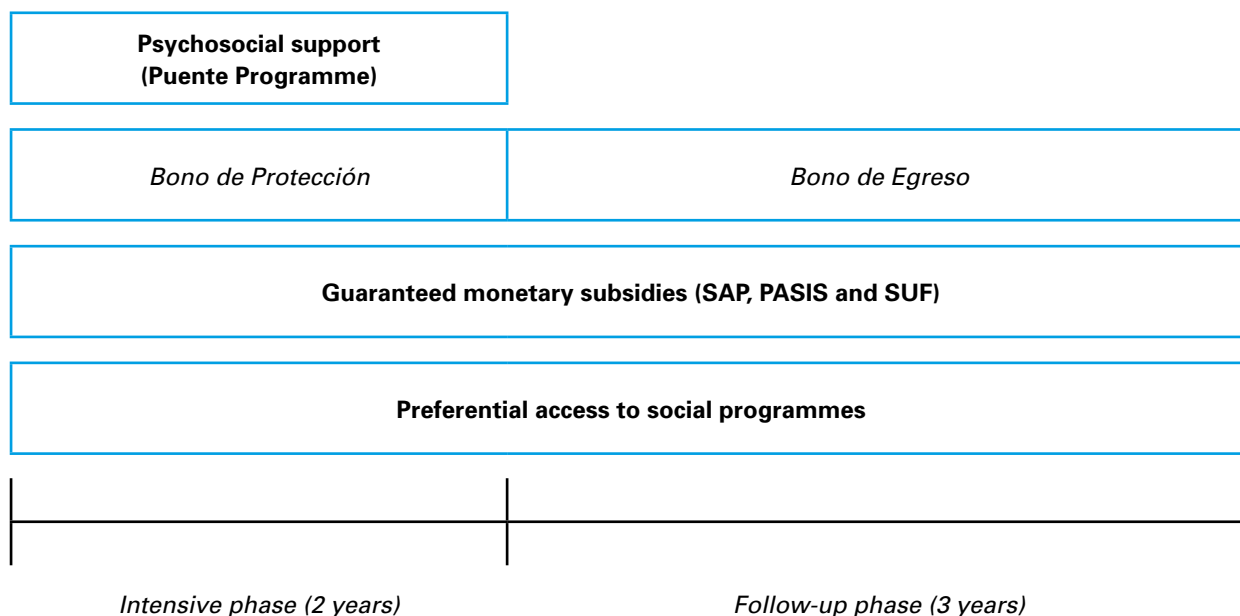
Chile Solidario was based on the premise that poverty has multiple and interacting dimensions that tend to interact with one another, often in accumulating and self-reinforcing ways, thereby provoking a vicious cycle of poverty. As a result, only multi-sectoral policy actions directed at these different dimensions were thought to be effective in tackling poverty. In addition, while cash transfers were considered useful for protecting the most vulnerable groups and improving their living conditions in the short term, it was recognized that cash transfers had to be integrated with other interventions promoting opportunities and rights. In fact, cash transfers and compliance with conditions was only considered secondary to psychosocial support and linkages to services (Cecchini, Robles and Vargas, 2012).

Eligibility for *Chile Solidario* was based on a proxy-means test in four principal domains, namely education, income, health and housing. The eligibility threshold varied by municipality in order to reflect geographical diversity. Participation was voluntary and during the period 2002–2012 some 480,000 families (around 2 million people) were invited to participate. Take-up was high with only 2.2 per cent refusing to participate in the programme and 5.6 per cent not fully completing the application (Camacho et al. 2014). Conditions were defined by households and social workers to fit their respective situations, with access to cash transfers being conditional upon satisfaction of those conditions, as set out in a contract agreement between beneficiary households and social workers (Galasso, 2006).

Programme participation was limited to a period of five years, divided into two distinct phases: (i) an intensive phase of two years and (ii) a follow-up phase of three years. The main components of support included cash transfers, additional monetary subsidies, psychosocial support and preferential access to social programmes (see Figure 2). Beneficiaries received a monetary transfer (*Bono de Protección*) on a sliding scale over time: 10,500 pesos (USD 15.45) per month for the first 6 months, which was gradually decreased to 3,500 pesos (USD 5.15) per month between months 19 and 24. From the third year onwards, participants only received an unconditional cash transfer (*Bono de Egreso*) with an amount equivalent to the last (*Bono de Protección*) transfer, i.e. 3,500 pesos (Schulte, 2007) and no longer benefited from psychosocial support. The purpose was to stimulate and promote households' efforts in the process of graduation from the programme after five years, reducing the dependence on public transfers as much as possible. Indeed, this transfer was considered purely as compensation for participation in the programme (Carneiro et al. 2015).

The most innovative parts of the programme were related to the interactions between the psychosocial support intervention (*Puente* programme) and the network of social services. In particular, the psychosocial support was considered crucial for bringing vulnerable groups into the network of social services through tailored interventions (Cecchini et al. 2012). Beneficiaries received 'preferential access' to services, which was believed to be crucial for making the target population 'visible' to municipalities and service providers (Amior et al. 2012). Moreover, participants benefited from monetary subsidies for which they were eligible (but in many cases had not previously taken advantage of) such as the *Subsidio Único Familiar* (SUF), the *Pensiones Asistenciales* programme (PASIS) and the *Subsidio de Agua Potable* (SAP).¹⁰

10 The *Subsidio Único Familiar* (SUF) is a family allowance targeted at poor families with children under 18 years, people with disabilities and pregnant women. The *Pensiones Asistenciales* programme (PASIS) is a non-contributory system of social

Figure 2: Components of Chile Solidario programme (Martorano and Sanfilippo 2012)

3.2. 'Cash plus' components

We discuss two major 'plus' components of *Chile Solidario* – one that is inherent to the programme, namely psychosocial support – and another that is external to the programme, namely preferential access to other social programmes. The discussion demonstrates the overlap and synergetic effects between both components given the role of social workers in providing psychosocial support and facilitating linkages to services.

Psychosocial support

Provision of psychosocial support was considered crucial for bringing vulnerable groups into the network of social services through tailored interventions (Cecchini et al. 2012). In the first phase of programme participation, psychosocial support consisted of intensive working sessions aimed at addressing the specific needs of each beneficiary household (Government of Chile, 2004). This component was called the *Puente* programme and was thought of as the 'entrance' into the overall *Chile Solidario* programme.

The initial period was based on an intensive relationship between social workers and families in order to build trust, understand each family's current situation and develop an action plan (*Apoyo familiar*) in 7 dimensions – identification, health, education, family dynamics, housing conditions, work and income – along with 53 minimum conditions considered strategically important to evaluate quality of life. This action plan represented the basis for evaluating the households' progress during the following 16–18 months (until month 24), identifying their weaknesses, ensuring their access to monetary subsidies and providing access to services that better responded to the needs of each household.

pensions which provides benefits for people over 65 years (who do not receive contributory pensions) and for disabled and mentally ill people living in poverty. The *Subsidio de Agua Potable* (SAP) is a transfer amounting to 100% of water bills for up to 15 cubic meters of the monthly consumption.

The component of psychosocial support consisted of 21 home visits of 40–45 minutes each. These home visits were made by social workers and were more frequent during the first 6–8 months, but decreased over time. Social workers were located at the municipality level and professionally trained as Family Counsellors (Camacho et al. 2014:14).

Facilitating linkages to services

Promoting access to social services was considered instrumental to improving living standards of the poor, particularly as various vulnerable groups experienced problems in accessing services or programmes. Before the introduction of the *Chile Solidario*, only 4 out of 10 among the poorest and eligible households benefitted from the *Subsidio Unico Familiar* (SUF) (Amior et al. 2012). Lack of information, high transaction costs and psychological factors were identified as barriers to the access of services (Clert, 2000; Amior et al. 2012). The programme therefore tried to reconnect participants to the network of social services and to rebuild social capital at the local level by promoting an active engagement of beneficiaries. In order to do this, it was important that (i) the government put in place the necessary conditions and opportunities for the families to get access to the network of social programmes and services; (ii) families had sufficient and timely information on existing resources; and (iii) social workers acted as intermediaries between families and the institutional network of social services.

In the first two years of programme implementation (2002-2004), the government worked to ensure an adequate supply of social services. Many programmes for vulnerable groups already existed before *Chile Solidario*, but no mechanisms were in place to assure the integration and synchronization of programmes and services. *Chile Solidario* promoted the coordination of services at the municipal level with the aim of assuring that the supply of services matched the demand of participating families. Evidence highlights that the programme was able to facilitate access to health and education services and social programmes (Chamaco et al. 2014; Carneiro et al. 2015; Galasso, 2006; Martorano and Sanfilippo, 2012; Peticara, 2007) especially in urban areas (Galasso and Carneiro, 2007). New programmes were created in subsequent years of programme implementation, including labour market access, skills training and micro-finance interventions that exclusively targeted families participating in *Chile Solidario* in order to promote employment (Government of Chile, 2004).

Social workers played a crucial intermediary role among participants, existing social services and local communities. They provided the families with the necessary information and suitable guidance, thereby ensuring their access to the existing programmes and services. They were also pivotal in supporting families to autonomously navigate the social service network and to sustain improved living conditions in the long run. This was done through the development of skills, capabilities, information as well as autonomy and self-efficacy.

3.3. Explaining success

Various factors can be identified to have played key roles in facilitating the implementation of the 'plus' components of *Chile Solidario*.

A crucial factor in facilitating coordination of services at the municipal level and overcoming initial frictions (CEPAL, 2003) was the promulgation of the Law 19,949 in 2004 and its associated regulations (Palma and Urzúa, 2005). This law contributed to clarifying the procedural norms as well as improving the management of the *Chile Solidario* system in addressing potential institutional conflicts (ibid). In particular, the law charged the Ministry of Planning and Cooperation (*Ministerio de Planificación y Cooperación* – MIDEPLAN) with administration, coordination, supervision and evaluation of the programme. One of the consequences was that the different institutions operating in areas such as education, health, housing, justice and labour had to work in cooperation with MIDEPLAN to provide preferential access to programme beneficiaries.

A second factor pertains to the devolution of programme implementation to sub-national and local levels and the focus on addressing supply-side constraints. Direct responsibility for implementation of the Puente programme at central, regional and municipal levels was transferred to the *Fondo de Inversión Social* (FOSIS),¹¹ while responsibility for programme execution at local level was transferred to the Family Action Unit. This unit played a crucial role in ensuring and promoting coordination within the existing institutional supply of public and private services at local level. A Local Action Network convened by the municipality and composed of public and private service providers supported the Family Action Unit to better identify gaps and to promote solutions to achieve the targeted population (Ruz and Palma, 2005). Qualitative indicators were collected regularly on the local supply side (Carneiro et al. 2009) as well as on the social and demographic characteristics of each family participating in *Chile Solidario*, and progress and problems over each period (Larrañaga et al. 2015); this was aimed at facilitating creation and re-orientation of programmes. If the existing supply of services was insufficient for meeting minimum conditions, municipalities could turn to the provincial and regional levels for resources to address the constraints (Schulte, 2007). The reorganisation of public services at the local level also moved psychosocial support from its traditional position of a single stand-alone intervention to its integration into a comprehensive and coordinated system of social protection.

The strong role of well-trained social workers at the municipal level can be considered another key factor for success of the *Chile Solidario* programme. The contribution of social workers was strategically important in achieving good results in education and health because they worked closely with the families. This highlights the importance of health system enrolment or school attendance for the facilitation of physical and cognitive child development (Martorano and Sanfilippo, 2012). In addition, the activity of social workers was crucial in promoting the take-up of additional monetary subsidies that were available to beneficiary households (Hoces de la Guardia et al. 2011).

Analyzing the case of the *Subsidio Unico Familiar*, Amior et al. (2012) explain that the increasing access to this benefit by poor people was due to the increasing flow of information as well as the decreasing application costs. Social workers operated at the municipality level and were incorporated into the local Family Intervention Unit (UIF). The number of social workers for each municipality was based on the

11 FOSIS was created in 1990 with the aim to design, finance and implement programmes for promoting employment and social development. FOSIS also designed the Puente Programme (Palma and Urzúa, 2005).

number of participating families in the area. Between 2002 and 2006 there were around 2,400 social workers, half of whom were municipal employees while the others were contracted through competitive public bids within the municipalities and under mutual agreement between the FOSIS and the UIF (Schulte, 2007). Social workers were professionally trained as Family Counsellors (95% were university graduates) and each had a case load of 60–100 families (Camacho et al. 2014: 14).

3.4. Lessons learned

- i. Legislative frameworks are important for setting out roles and responsibilities across implementing agencies, especially when many sectors are involved. In the case of *Chile Solidario*, the promulgation of the 2004 law institutionalized the content of the programme transforming political will into a legal mandate. It clarified the specific role of the different actors facilitating the management and the implementation of the programme, reducing potential conflicts among participating agencies and promoting the coordination of institutional activities across levels and sectors.
- ii. Addressing supply-side constraints is vital for achieving positive change. The programme's success in facilitating access to services and social programmes was enhanced by the ability of the programme to work on the supply-side, improving the quantity and quality of services. A larger impact was achieved when the expansion of the supply of social services was effectively implemented and services were tailored to the needs of the targeted population. By contrast, *Chile Solidario* was less effective when policy interventions were rationed, as in the case of housing programmes.
- iii. Social workers play crucial direct and indirect roles. Their close work with families directly promotes children's physical and cognitive development and psychosocial well-being. The programme registered positive impacts on participants' subjective well-being (Chamaco et al. 2014) in terms of high aspirations (Trucco and Nun, 2008) and optimism (Carneiro et al. 2015), better future expectations (Galasso, 2006) and positive attitudes for dealing with problems (Peticara, 2007). Qualitative evidence shows that the activity of social workers was important in promoting a forward-looking orientation and restoring the confidence and self-image of individuals (*Universidad de Chile*, 2004; *Asesorias para el Desarrollo*, 2005, Trucco and Nun, 2008). Social workers also proved vital for linking beneficiaries to services to which they have preferential access. They were crucial in promoting the take-up of subsidies (Hoces de la Guardia et al. 2011). It should be noted that the programme was less able to activate the demand for public services among certain groups, particularly the poorest (Trucco and Nun, 2008). In some cases, lack of improvement in employment or income generated dissatisfaction and mistrust directed at public institutions and social workers (ibid).

4. ETHIOPIA: INTEGRATED NUTRITION SOCIAL CASH TRANSFER (IN-SCT) PILOT

4.1. Background and programme description

In 2005, the Government of Ethiopia launched the Productive Safety Net Programme (PSNP) as an innovative approach to address food insecurity and hunger, especially in the historically famine-prone rural highland areas. Before the PSNP, Ethiopia made annual emergency appeals for food aid, which addressed immediate food needs but left millions of households chronically food insecure and dependent on further food aid appeals the following year. The theory of change behind the PSNP was that providing food insecure households with a sustained package of support for several years would enable them to accumulate productive assets and achieve self-reliant livelihoods, where self-reliance was defined as the ability to cover household food needs all year round and to withstand moderate shocks (FSCB, 2007). Households were eligible for the PSNP provided they were chronically food insecure. A chronically food insecure household was defined as a food aid recipient for the previous three years¹². Eligible households with labour capacity were assigned to Public Works (temporary employment on labour-based community infrastructure projects), and those with no labour capacity received Direct Support (unconditional food or cash transfers for six months every year).

Since its inception the programme has been widely expanded, has undergone a number of reforms and has been subject to rigorous mixed-method programme evaluations. The programme has been found to reduce household vulnerability, food insecurity, and distress sale of assets (Berhane et al. 2011). However, the programme has had little effect on child nutrition and use of health services has remained low (UNICEF, 2016).

In 2015, the government launched Phase 4 of the PSNP. PSNP4 includes several innovations designed to strengthen the programme and improve its outcomes, particularly with respect to nutrition and health (UNICEF, 2016). Changes include increases in quantity and duration of transfers and greater integration with delivery of social services such as health and nutrition services. Food and cash transfer payments were raised for Public Works and Direct Support participants, in response to evidence from previous evaluations demonstrating that payments were too small to achieve any significant impact. The duration of transfers was also extended from six months to twelve months for Permanent Direct Support (PDS) beneficiaries. A new category of Temporary Direct Support (TDS) beneficiaries was created for pregnant and lactating women (PLW) or malnourished children's caregivers, who were Public Works participants. Pregnant and lactating women (PLW) and malnourished children's caregivers will temporarily move from Public Works (PW) into Temporary Direct Support (TDS).

The new round of PSNP also introduces co-responsibilities for TDS beneficiaries, aiming to improve their take-up of health and education services. Finally, PSNP4 also allows malnourished children's caregivers from outside of the programme to move into TDS for duration of the period during which the child is assessed as malnourished.

The Integrated Nutrition Social Cash Transfer (IN-SCT) pilot project is embedded within PSNP4 and aims to test a case management model to optimise the innovations within PSNP4 and maximize impacts for DS beneficiaries, particularly with respect to child nutrition. The pilot is supported by

12 The full targeting process includes geographical targeting of food insecure districts by the Ministry of Agriculture and Food Security Directorate, followed by community-based targeting of food insecure households within selected districts.

UNICEF and is implemented in collaboration with the Ministry of Agriculture (MoA), Ministry of Education (MoE), Ministry of Health (MoH) and the Ministry of Labour and Social Affairs (MoLSA) in two *woredas* (districts) in two regions in Ethiopia, namely Oromia and SNNP. It involves social workers and community-based structures in providing case management and setting up linkages between services for PDS and TDS beneficiaries. The pilot commenced in early 2016 and aimed to develop and test the coordination between the three parties (MoA, MoH and MoLSA) at different administrative levels in terms of information sharing, case management and capacity building. It also includes the implementation of nutrition-sensitive interventions such as the rehabilitation of existing Farmer Training Centres (FCTs), establishment of nutrition clubs at schools and school gardens. These interventions are implemented Concern Worldwide. The lessons drawn from this pilot will inform the design and implementation of the future National Nutrition Programme (NNP), the next phase of the PSNP and the National Social Protection Policy and Strategy (UNICEF, 2014).

In so doing, the IN-SCT pilot aims to achieve increased uptake of social services by PDS and TDS households; improve knowledge, attitudes and practices of PDS and TDS households regarding nutritional, sanitary, health, child protection and educational behaviour; and increase understanding of the roles and responsibilities of actors such as social workers and community-based committees in achieving improved outcomes (Schubert, 2015).

In terms of this case study, we explore the 'plus' components as introduced within PSNP4 and in light of the specific implementation modality of IN-SCT.

4.2. 'Cash plus' components

PSNP4 and the IN-SCT pilot include a comprehensive package of 'plus' components in recognition of the need for a comprehensive approach to achieve positive impacts, including participation in nutrition-sensitive activities, supplementary feeding, psychosocial support and coordinating linkages to services (Schubert 2015). We discuss two main components – one that is integral to PSNP4 at large, namely Behaviour Change Communication (BCC) and improvement of knowledge – and one that is specific to the IN-SCT pilot, namely the implementation modality predicated on a system of case management and referrals.

BCC and improvement of knowledge

An important component of the programme's theory of change focuses on increasing participants' knowledge in order to change attitudes and practices towards improved outcomes for children, particularly with respect to nutrition but also sanitation, health and child protection measures (Schubert, 2015). To promote health-seeking behaviour and improved child-care practices, and to increase the PSNP's nutritional impact, Public Works participants (both male and female) are required to participate in behavioural change communication (BCC) sessions on nutrition and related topics while working on public works projects (Schubert, 2015). Participation in such sessions replace participation in a public works session. They are complemented with wider community conversations, activities in school clubs, and integration of messaging in the school curriculum (UNICEF, 2016). BCC activities make use of existing tools for promoting good nutrition, health and sanitation practice as already used by Health Extension Workers (HEWs) where available; otherwise existing materials may be adapted or new materials are developed (UNICEF, 2016). BCC sessions are implemented under the guidelines of the MOH. Direct Support beneficiaries will be exposed to BCC through their direct contact with HEWs in line with co-responsibilities.

Case management and referrals

PSNP4 introduces 'co-responsibilities' for Temporary Direct Support (TDS) beneficiaries. Within the IN-SCT pilot, social workers are pivotal in administering and monitoring the co-responsibilities. Social workers in collaboration with officers from the relevant sector ministries and with the ground level committees (Health Development Army, Social Development Committee and the Community Care Coalition (CCC) or Community-Based Social Protection Committee (CBSPC)) at *woreda* and *kebele* (sub-district) levels, to determine what co-responsibilities are appropriate depending on the availability of easily accessible basic services (UNICEF, 2014).

Importantly, PSNP4 does not provide health and other social services directly, but the Government of Ethiopia has invested in the supply-side to facilitate increased uptake of these services on the demand-side. Local-level staff – Development Agents (DAs), Health Extension Workers (HEWs), and Social Workers (SWs) – interact directly with PSNP participants, advising them and linking them to services, for instance by referring individuals to relevant health services (see Table 1). Social Workers have specific responsibilities to ensure that PSNP participants move between Public Works and Direct Support as indicated, and to monitor co-responsibilities and engage with households that have difficulties with compliance. They are also tasked with strengthening community-based mechanisms and providing psychosocial support to programme participants (Schubert, 2015).

Table 1: Overview of tasks for DA, HEW and SW

| |
|--|
| Development Agent (DA) |
| <ul style="list-style-type: none"> ■ Select and design Public Works projects in line with prioritised community needs ■ Oversee the implementation of Public Works projects ■ Prepare PSNP attendance and payments lists ■ Support business plan development for participants pursuing the crop and livestock livelihood pathway ■ Provide technical assistance and mentoring to participants who receive livelihood transfers |
| Health Extension Worker (HEW) |
| <ul style="list-style-type: none"> ■ Participate with local Food Security Task Forces (FSTF) in PSNP targeting, and the graduation process ■ Identify households with malnourished children and refer them to PSNP for Temporary Direct Support ■ Plan implementation of behaviour change communication (BCC) in collaboration with local DA ■ Provide behaviour change communication (BCC) on nutrition, hygiene and sanitation to PSNP clients ■ Track attendance of PSNP Temporary Direct Support clients at health centres and participation in BCC |
| SCT Social Worker (SW) |
| <ul style="list-style-type: none"> ■ Strengthen the capacity of Community-Based Social Protection Committees (CBSPC) ■ Collect Permanent Direct Support (PDS) and Temporary Direct Support (TDS) beneficiaries of the PSNP ■ Enhance access of vulnerable community members to services (health, education, social, justice) ■ Provide psychosocial support to PDS and TDS households and other highly vulnerable people ■ Manage the cases of SCT clients who are not complying with their co-responsibilities |

Source: Schubert 2015: Annex 7b and Annex 8

4.3. Explaining success

As the implementation of this IN-SCT pilot only commenced early 2016 and is still underway at the time of writing, the assessment of success factors for implementation will be based on the baseline study of the overall evaluation. This study was undertaken a few months into programme implementation (Gilligan et al. 2016).

Baseline findings revealed that PSNP participants have good knowledge of appropriate child feeding practices and high self-reported rates of exclusive breastfeeding. The baseline fieldwork also found high levels of knowledge, attitudes and practises on hand-washing, and on use of latrines and toilets rather than open defecation (Gilligan et al. 2016). The most likely explanation for these positive findings is that Health Extension Workers (HEWs) and Development Agents (DAs) have already been posted in local communities for several years, spreading messages about good child care, nutrition and sanitation practices which have been widely adopted. Both quantitative and qualitative findings from the baseline survey indicate that HEWs provide strong support to PLW, with 78 per cent of women having received some form of antenatal care during their last pregnancy, and that HEWs have been instrumental in disseminating knowledge about good nutrition (Gilligan et al. 2016). One challenge identified in the baseline was access to clean drinking water – this was a drought year in the study communities, and drinking water was far away and/or expensive for many households. While the IN-SCT includes a small component of water source development in its package of nutrition-sensitive interventions implemented by Concern Worldwide, the remit of support is too limited to address this challenge.

Given the pivotal role of social workers in implementing co-responsibilities and establishing linkages to other social services, their performance is a key component for success of the pilot. Experiences with respect to social workers have been mixed since the start of the pilot. PDS and TDS beneficiaries in SNNP region appeared more aware of who the SWs were and received more support compared to beneficiaries in Oromia region (Gilligan et al. 2016). These mixed experiences across regions are also reflected in beneficiaries' perceptions of collaboration across SWs, DAs and HEWs, with beneficiaries from SNNP region pointing towards a truly integrated and collaborative approach. A potential explanation for the regional discrepancies is that Oromia also employs government para-social workers, who were already in post before the start of the IN-SCT pilot and have agreed to share responsibilities with the IN-SCT project social workers. No government social workers are in place in SNNP region, which may be reflected in lower levels of outreach and capacity on behalf of social workers. Social workers across both regions reported facing logistical constraints in performing their jobs, most notably lack of suitable means of transportation (Gilligan et al. 2016). Also, although it is part of their job description, few social workers had engaged in the provision of psychosocial support as a result of logistical and capacity constraints.

The fourth phase of PSNP includes a number of innovations, some of which require strong collaboration across sectors. Most notably, the transition of pregnant and lactating women (PLW) and of caregivers of malnourished children from Public Works to Temporary Direct Support requires DAs, HEWs and SWs to work together. Early findings from the qualitative baseline survey suggest that transitions of caregivers of malnourished children only occurred sporadically in the first year of implementation. Transitions of PLW have occurred but often with a high degree of confusion regarding roles and responsibilities as part of this process. Factors playing into these issues include lack of knowledge on behalf of HEWs and DAs as well as lack of commitment. While knowledge of procedures associated with new components of PNSP4 and modality of implementation as part of the IN-SCT pilot

was high among staff directly linked to the IN-SCT pilot – notably the social workers and programme coordinators – detailed knowledge was less widespread among DAs and HEWs. Particularly HEWs appeared to have limited awareness of PSNP innovations at large and those relevant to their work – including the transitions of PLW and caregivers of malnourished children from PW to TDS. Similarly, commitment to collaboration was identified as limited among sectors without direct involvement in PSNP and the IN-SCT (Gilligan et al. 2016).

4.4. Lessons learned

- i. Strong long-standing supply of services is crucial for achieving impact in areas of health, nutrition and positive behaviour change. The local-level presence of HEWs in communities across Ethiopia has greatly improved knowledge regarding positive health, nutrition and hygiene practices for children and has ensured the percolation of health care to the majority of the population. Building on and strengthening the supply of services is crucial for the achievement of positive impacts following referral to services.
- ii. Successful case management and referral hinge on a well-trained and well-resourced cadre of social workers. While collaboration across sectors requires the involvement of staff from different sectors, social workers represent the focal persons maintaining oversight and overall responsibility for linking beneficiaries to services and following up on their use. The availability of ample resources and practical means are crucial for social workers to perform their tasks successfully.
- iii. Cross-sectoral linkages to services requires strong knowledge and commitment of roles and responsibilities on behalf of all parties involved. The lack of knowledge and limited degree of commitment within the health sector appears to form an impediment to the successful establishment of linkages between programme components and across services.
- iv. For 'cash plus' programmes to achieve its intended impacts, its components need to provide or link to relevant services that assist beneficiaries in overcoming key obstacles towards improved outcomes. IN-SCT invests heavily in creating awareness to affect behaviour change while knowledge about feeding, health and hygiene practices is already high. At the same time, lack of access to water – a main barrier to improving nutrition, health and hygiene practices – is only addressed in limited manner.

5. CRITERIA FOR SUCCESS AND CHALLENGES AHEAD

This section summarizes the main lessons learned regarding successful implementation of 'cash plus' components from the three case studies above, and documentation from other programmes where available. We identify lessons learned for the implementation of 'cash plus' components integral and external to cash transfer programmes, as per the 'cash plus' menu presented in Figure 1. While many of these lessons refer to the design and implementation of social protection more generally, we focus specifically on issues regarding the provision of complementary support and cross-sectoral linkages.

5.1. Politics matter

Political commitment is crucial for forging relationships between implementing ministries and institutions, and for committing the necessary resources for operationalising linkages between programmes and services. The Ghana case study exemplifies the crucial role of political leadership in affecting change. It highlights how personal commitment by political champions such as the Minister and President can act as a catalyst for implementing programme linkages. A similar observation can be made for the Chile case study, where the instalment of the new President formed an important impetus in the fight against extreme poverty and the establishment of *Chile Solidario*. The importance of political advocates has also been noted elsewhere. In Kenya and Brazil, for example, champions within the respective ministries were considered crucial for driving capacity-building, scale-up and coordination of programmes across sectors (EC, 2015: 38).

The Ghana case study also highlighted how political dynamics in reference to elections and electoral incentives can provide impetus to a process of linking beneficiaries across sectors. Indeed, politics and the way in which social protection interacts with political processes is widely recognized as a key driver in determining the shape and scope of individual programmes and wider social protection systems (Hickey, 2007). Social protection can be instrumental to establishing political settlements in any given country (Lavers and Hickey, 2015).

While the need for political commitment and importance of political dynamics holds for the expansion and sustainability of social protection interventions in general, their role is compounded with respect to 'cash plus' programming. The integration of additional components and facilitation of access to services across sectors do not merely require a strong push from within the social welfare sector and negotiations with the Ministry of Finance; they also call for engagement with and creation of commitment across social sectors.

5.2. Formal agreements are a necessary foundation

Formal cross-institutional agreements provide a fundamental foundation for operationalising cross-sectoral linkages. The experience in Ghana demonstrates the importance of a Memorandum of Understanding (MoU) that clearly delineates the roles and responsibilities of each implementing agency, allowing the linkages between LEAP and NHIS to become actionable. In Chile, legislative frameworks vitally underpinned the coordination of services across sectors. While they do not present a sufficient condition for change in and of themselves, they form the necessary foundation for action when leadership and resources are available.

The role that legal frameworks and social protection strategies can play has also been recognized by Kaltenborn et al. (2017). Their review of legal and policy documents underpinning existing social protection schemes found that social protection strategies, and particularly the processes through which they are formulated, can galvanise action and serve as a frame of reference for building social protection systems. National legislation underpinning social protection policy is crucial for holding government to account for its statutory obligations for providing a basic level of income security and services to its citizens. As a case in point, South Africa has long been hailed for its rights-based approach to social protection policies, while Kenya provides an example of how the establishment of policy and legislative frameworks can support shifts towards a social protection system (ibid). Again, the existence of such frameworks is important for social protection as a whole but is particularly vital for establishing cross-sectoral collaboration and providing accountability frameworks across sectors.

5.3. Awareness and engagement of all stakeholders is imperative for coordination

Lessons from both Ghana and Ethiopia point towards the importance of staff at all levels having detailed knowledge of and commitment to programmes' 'plus' components for their success. Experiences in Ethiopia show that awareness of 'plus' components was comparatively low among service staff that are most removed or indirectly involved in the implementation of the social protection intervention. While the development agents and social workers were relatively well aware of programme guidelines and their roles within programme processes, the health extension workers had poor knowledge of the linkages between different components of the PSNP and their role in establishing such linkages, which hampered their implementation.

Coordination at programme and policy level is crucial for creating effective programme linkages (UNICEF and WB, 2013). *Chile Solidario's* umbrella function, overarching the *Puente* and other programmes, is deemed to be a key factor in its success to integrate cash transfers with other services (ibid). Sub-national and local level efforts underpin any such integration. In Ghana, regular engagements between staff from across sectors were found helpful in promoting knowledge on programme-specific criteria and fostering collaboration. Regular meetings and engagements on the ground between LEAP and NHIS programme staff at local and district level were considered vital to the recent success in expanding the registration of cash transfer beneficiaries into the health insurance system.

5.4. Personalized approaches require a skilled workforce and 'the right person in the right place'

An important part of the appeal and positive effect of 'plus' components such as psychosocial support and case management is their tailored response taking into account household-specific and individual issues of concern. A large part of *Chile Solidario's* success can be attributed to the support of skilled social workers that provided programme beneficiaries with a tailored response that helped them overcome personal barriers and navigate a complex system of social services. In Ethiopia, more personalized responses to beneficiaries' and their households' needs were the core of the IN-SCT pilot's theory of change, aimed at galvanizing the impact of cash transfers with respect to nutrition and health outcomes. The benefit of intense and personalized responses has also been recognized in parenting support programming (Engle et al. 2011) and 'graduation' programming (Roelen and Devereux, 2017).

The provision of more personalized approaches within cash transfers holds strong implications with respect to human resource requirements. Firstly, it demands a skilled and qualified cadre of social service workers. These can include professional or paraprofessional social workers, child and youth workers or community workers (see Global Social Service Workforce Alliance, 2015). The social service workforce in most low- and middle-income countries is highly strained suffering staff shortages and qualification gaps (ibid), making the development of a qualified social service workforce a top priority for advancing 'cash plus' interventions. Secondly, the provision of more tailored and personalised approaches also requires 'the right persons to be in the right places' and to offer appropriate support. While the provision of psychosocial support – such as within *Chile Solidario* and the IN-SCT in Ethiopia – requires well-trained social workers, the administrative processes of application and transfers payments could be implemented by a cadre of administrative staff. Yet many programmes that aim to provide more comprehensive support beyond cash alone tend to focus narrowly on social workers as implementers of a wide set of programme activities, ranging from social support to data entry (Roelen et al. 2016a).

At the other end of the spectrum there is also heavy reliance on community volunteers as a way of increasing community participation, filling capacity gaps and offering a cheaper alternative to the employment formal social service providers. The reliance on community volunteer structures has proven to be crucial for the effective implementation of programmes in Kenya and Zambia, for example, but are also feared to be unsustainable (Kardan et al. 2016). Effective implementation for 'cash plus' interventions therefore calls for creative and sustainable human resource solutions that build on a formal workforce, with appropriate division of tasks and responsibilities.

5.5. Establishment of linkages to services across sectors requires case management

Case management will be crucial for the effective implementation of 'cash plus' interventions in terms of their facilitation of access to and use of services. Experiences in Chile and Ethiopia clearly indicate that effective linkages to services requires mechanisms overseeing the referral to services, monitoring of the use of such services and follow-up in cases of non-take-up. Operationalizing such mechanisms requires a focal point with clear responsibility and oversight over individual cases with a mandate to ensure support from across sectoral services (Roelen et al. 2012). Such focal points – by communicating procedures, roles and responsibilities – ensure coherence and consistency on behalf of the service providers. They perform a similar function on behalf of the programme participants – by assessing household needs and identifying effective responses (ibid).

Chile Solidario is a case in point for highlighting the importance of case management. It has been widely applauded for its ability to act as an umbrella and refer families and their children to appropriate programmes and services (see EC, 2015). Experiences from other low-income countries also point towards the potential of case management approaches. The Community Case Management (CCM) approach in Mozambique intends to bridge social protection and child protection services, working with Child Protection Community Committees (CPCCs) for the identification of and response to vulnerable children and their needs (Roelen, 2011). Successful case management and integration of programmes across sectors at scale will also depend on implementation of MISs.

In Latin American countries, the provision of an integrated response with clear coordination mechanisms involved the decentralisation of services to ensure greater streamlining of the supply side. In Chile, the reorganisation of public services – including the devolution of mandates and responsibilities to subnational level – proved vital for strengthening collaboration between implementing agencies from different sectors. Similar models of decentralized delivery can be observed in Brazil and Mexico (EC, 2015).

5.6. Greater ambitions need to be matched with greater resources

While the implementation of 'plus' components with links to multiple services can increase their impact, there are important resource implications. 'Plus' components can be expensive, particularly when aiming to link social protection beneficiaries to a range of services and offer monitoring and follow-up support. The Ghana case study provides a pertinent example of how the commitment of financial resources proved the necessary catalyst for action in registering LEAP beneficiaries with the NHIS.

Financial implications of more comprehensive packages also feature heavily in debates about 'graduation' programming (Banerjee et al. 2015). Despite heavy resource requirements associated with the implementation of integrated approaches, the majority of programmes appear cost-effective (ibid). The importance of sufficient funds being allocated towards programme administration is illustrated by

the Pantawid Pamilya Pilipino Programme (PPPP) in the Philippines. This is an example of a strict spending cap on administrative costs, which causes frontline staff to be overloaded and severely limits their ability to successfully administer the programme or provide support beyond cash (Schelzig, 2017). Enthusiasm for 'cash plus' interventions thus needs to go hand-in-hand with a realistic understanding of resource requirements in order to adequately plan and implement resource mobilisation strategies.

5.6. Demand-side interventions needs to be matched with supply-side investments

All case studies clearly highlighted that 'cash plus' interventions can only be successful when services are widely available and of high quality. Low quality of health care was considered an impeding factor for achieving positive impacts from the LEAP-NHIS complementarity in Ghana. Supply-side constraints were also found to be a key factor in undermining *Chile Solidario's* impact. In Ethiopia, nutrition and hygiene practices for children were severely hampered by the lack of clean drinking water as a result of the drought.

The need for demand induced by 'cash plus' schemes to be matched with high-quality supply of services for achieving impact was also discussed by Ulrichs and Roelen (2012) in reference to the *Oportunidades* CCT scheme in Mexico. They argue that the programme fails to affect positive change for indigenous people in part due to the low quality of educational and other services. In terms of the PPPP in the Philippines, supply-side constraints and low quality of services in education and health were found to impede positive impacts of the programme, particularly with respect to immunization (Chaudhury et al. 2013). This need for supply-side investments to make 'cash plus' interventions effective compounds the need for the mobilisation of political will and formal agreements that were mentioned earlier, as they form the foundation of advocacy for such investments.

5.7. 'Cash plus' components need to be fit-for-purpose

Finally, 'cash plus' interventions need to respond to the need in an appropriate way. In Ethiopia, for example, the theory of change in the IN-SCT attributes high rates of stunting to lack of knowledge. However, the baseline survey found that knowledge about dietary and hygiene practice is generally high and that other factors – such as lack of clean water – play a significant role in preventing people from putting knowledge into practice. A heavy focus on BCC and knowledge creation may therefore have a much smaller effect than anticipated. 'Cash plus' can provide a powerful approach to maximising impacts of cash transfers, but only if accompanied with a sense of realism and pragmatism about an appropriate and feasible response to the pressing challenges at hand.

The Foster Child Grant (FCG) in South Africa presents a case in point. As receipt of the grant goes hand-in-hand with regular monitoring and supervision by social workers and placement reviews by the courts, the social work and judicial systems are under great pressure with delays and payment arrears as a result. While the programme was originally designed as a child protection mechanism, many children living without their biological parents have turned the FCG into a de facto poverty reduction scheme, calling in question the need for social worker assessments and follow-up for all cases (Roelen et al. 2016b). More generally, the notion of 'cash plus' presupposes a centrality of cash transfers that may not be appropriate in all contexts. While poverty and lack of income presents a key barrier to achieving second-order impacts, other obstacles might be more pertinent, calling for cash transfers to take a more supportive role. With respect to *Chile Solidario*, cash transfers were only secondary to its prime programme components of psychosocial support and facilitation of access to other services (Cecchini et al. 2012). In light of the multi-faceted nature of poverty, the provision of tailored guidance

and positive support was considered most important to assist extremely poor families. Cash transfers acted as support or incentive for facilitating behaviour change.

CONCLUSION

This paper aimed to identify key factors for success for the implementation of increasingly popular 'cash plus' programmes, based on (i) a review of the emerging evidence base of 'cash plus' interventions and (ii) an examination of three case studies, namely *Chile Solidario* in Chile, IN-SCT in Ethiopia and LEAP in Ghana. The analysis was guided by a conceptual framework proposing a menu of 'cash plus' components. The menu distinguishes between components that are integral to cash transfer programming – additional or in-kind benefits, information/ sensitization/ and behavioural change, and specialized case management – and others that are external to cash transfer programming – provision of access to services, and facilitating linkages to services.

Analysis of the case studies provides key lessons learned for effective implementation of 'cash plus' programmes. These include *policy level factors*; namely the importance of political champions in advocating in favour of social protection and 'cash plus' programmes in particular and the establishment of formal agreements, *programme level factors*; namely the need for awareness and engagement on behalf of all parties, the availability of a skilled and appropriate workforce, the use of case management, and the availability of greater resources, and *supply-side level factors*; namely the greater investments in availability and quality of services and potentially reorganization of services. Finally, 'cash plus' interventions should be 'fit-for-purpose' – in other words, their components should be appropriate for their intended purpose. This may mean that cash transfers take centre stage or that they exist in support of other more prominent components, such as in *Chile Solidario*.

The assessment of three case studies indicated that effective implementation of 'cash plus' components has indeed contributed to greater impacts of the respective programmes. It has thereby addressed some of the non-financial and structural barriers that poor people face and has reinforced the positive effects of cash transfer programmes. The analysis also highlights the ways in which 'cash plus' programming can make access to services more 'pro-poor'. This is done through explicit efforts to include the poor and most marginalized – going further than simply lifting their financial constraints.

Both integral and external 'cash plus' components enable services to be more pro-poor. In Ghana, the poorest segments of the population are automatically enrolled in the NHIS. In Chile, vulnerable groups gained knowledge of and received preferential access to a set of social programmes at local level. In Ethiopia, the poorest members of the community receive coordinated support from trained social workers.

We conclude by reflecting more broadly on the programmes' increasingly ambitious theories of change, and the need for more innovative monitoring and evaluation.

While there is no doubt that a more holistic approach to social protection programming can achieve greater impacts, there is a need for critical realism about the extent to which interventions targeting households and individuals can achieve positive change in contexts of addressing widespread poverty, inequality and power imbalance. While the rationale of 'cash plus' interventions explicitly recognizes

the need for supply-side investments, positive change remains predicated on the notion of individual action rather than structural change.

Furthermore, the exploration of success factors for the implementation of 'cash plus' components at large should not make us disregard the constraints faced by the most vulnerable and how such constraints can be overcome. All the programmes explored in this paper suffered from challenges in reaching marginalized groups, and ensuring full participation in cash transfer programmes and opportunities for making use of their 'plus' components should be a key concern when designing and implementing 'cash plus' programmes. The issue of conditionality is a case in point: while conditions are often introduced in explicit recognition of non-financial barriers, they may produce exclusion errors, impose greater costs on beneficiaries because compliance is compulsory, and undermine the idea of social protection as a right

Finally, while we presented an overview of evidence providing testimony to the importance of 'cash plus' programming, the evidence base remains relatively thin. The research on cash transfers plus complementary interventions is inadequate and more is needed to fill this gap (De Hoop and Rosati, 2014). The need for more innovative monitoring and evaluation is two-fold. Firstly, there is need for a greater understanding of the impact of the many variations of 'cash plus' programming. This includes evidence on the comparative roles of individual 'plus' components, requiring the disentanglement of income and behaviour effects as well as the knowledge, attitudes and behaviour pathways affording such effects. It also includes acknowledgement that such programmes are often implemented as a 'package' – with cash transfers either taking a central or secondary role – making it impossible or undesirable to examine the impacts of each component in isolation.

Future evaluations thus need to strike a balance between applying more complex evaluation protocols to investigate the contributions of individual components, while recognizing that the success of 'cash plus' programmes may well be about the total being greater than the sum of its parts. In addition, the need for more insight into how greater impacts can be achieved, calls for more in-depth and rigorous process evaluations that unravel programme processes and stakeholder engagement in programme implementation. This paper begins to fill this knowledge gap, though much more remains to be done.

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