Perceived impact of Ghana’s conditional cash transfer on child health

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SUMMARY

A plethora of studies from sub-Saharan Africa indicate that orphaned and vulnerable children are exposed to adverse health, education and other social outcomes. Across diverse settings, conditional cash transfer (CCT) programmes have been successful in improving health outcomes amongst vulnerable children. This study explored the pathways of CCTs’ impact on the health of orphans and vulnerable children in rural Ghana. Due to the multi-dimensional nature of CCTs, the programme impact theory was used to conceptualize CCTs’ pathways of impact on child health. A qualitative descriptive exploratory approach was used for this study. This study drew on the perspectives of 18 caregivers, 4 community leaders and 3 programme implementers from two rural districts in Ghana. Semi-structured individual interviews were conducted with the participants. Thematic content analysis was conducted on the interview transcripts to pull together core themes running through the entire data set. Five organizing themes emerged from the interview transcripts: improved child nutrition, health service utilization, poverty reduction and social transformation, improved education and improved emotional health and well-being demonstrating the pathways through which CCTs work to improve child health. The results indicated that CCTs offer a valuable social protection instrument for improving the health of orphans and vulnerable children by addressing the social determinants of child health such as nutrition, access to health care, child poverty and education.

Key words: conditional cash transfers; Ghana; orphaned and vulnerable children; programme impact theory

INTRODUCTION

Large-scale government conditional cash transfer (CCT) programmes have become a mainstay in poverty reduction strategies and child health interventions throughout Latin America and are increasingly being implemented in sub-Saharan Africa and the Middle East (World Bank, 2011; Baird et al., 2013). The Latin Americas (Mexico, Brazil, Nicaragua, and Honduras) are the pioneers of CCTs in the 1990s with the largest and iconic CCT programme being Bolsa Familia programme in Brazil reaching ~11 million families (Fiszbein et al., 2009). As a form of social protection, CCTs transfer cash to poor households on condition that such transfers are invested in the human capital development (health, nutrition and education) of children (World Bank, 2001). In sub-Saharan Africa (SSA), CCTs are increasingly used as a social protection strategy to address poverty and improve the health and well-being of orphan and vulnerable children (OVC) living in poor households (UNICEF, 2009; MacAuslan and Riemenschneider, 2011; Baird et al., 2013). Development partners particularly the World Bank, Department for International Development (DFID) and UNICEF continue to pay attention to CCT programmes in SSA (DFID, 2011). This is underpinned by the fact that social protection schemes of this nature play a significant role in the
fight against child health inequalities and vicious cycle of poverty which has engulfed developing countries as well as meeting the MDG 4 which focuses on reducing child mortality (Garcia and Moore, 2012; Wolf et al., 2013). Yet, the question of by what pathways CCTs work to improve child health remains largely unanswered since majority of impact evaluation studies have focused on quantifying the health outcomes of the programme (Lagarde et al., 2007). This article aims to explore the pathways of CCTs’ impact on the health of orphans and vulnerable children in rural Ghana.

Orphan prevalence is on the increase in many SSA countries due to increases in adult mortality resulting from HIV (UNICEF, UNAIDS and USAID, 2004). For instance, the 2011 Ghana Multiple Indicator Cluster Survey (MICS) indicates that the number of children becoming vulnerable due to poverty is on the increase (GSS, 2011). The MICS revealed that ~17% of children are not living with their biological parents and 8% of them have one or both parents dead. The Ghana National HIV and AIDS (2010) further estimates that there were 1.4 million OVC in 2009. A plethora of studies from sub-Saharan Africa indicate that OVC are exposed to adverse health, education and other social outcomes, such as increased risk of mortality (Watts et al., 2005), morbidity (Lindblade et al., 2003; Watts and Gregson, 2007), adverse sexual health outcomes and/or HIV infection (Gregson et al., 2005; Birdthistle et al., 2009), reduced school enrolment (Monasch and Boerma, 2004; Ardington and Leibbrandt, 2010) and poor emotional health (Cluver et al., 2009; Nyamukapa et al., 2010). The need to promote child health and especially that of orphans and vulnerable children is urgent in sub-Saharan Africa. Aside being a key indicator of development, child health has a close association with educational attainments, future health outcomes and employment opportunities (Case et al., 2005; Marmot Review Report, 2010).

Across diverse settings, CCTs have been successful in improving health outcomes amongst vulnerable children in Latin American countries by increasing the use of health services as well as reducing child mortality, anaemia and stunting (Gertler, 2004; Morris et al., 2004; Rivera et al., 2004; Rawlings and Rubio, 2005). In sub-Saharan Africa, even though evidence base remains more limited, CCTs have been found to improve health and education outcomes for children (Baird et al., 2013). Robertson et al. (Robertson et al., 2013) reported that CCTs in rural Zimbabwe increased school enrolment and improved orphans and vulnerable children’s access to health care. In Tanzania, CCTs have been found to have impacts across a broad array of areas, including health, use of health insurance and education (Evans et al., 2014).

It must be noted that nearly all the studies that have examined the impact of CCTs on health have mostly used experimental designs [randomized control trials (RCTs) or quasi-experiments] focusing on outcome evaluation with the aim of quantifying the impact of the programme on child health and have failed to provide a better understanding of the different pathways through which the programme works to improve health child health (Wolf et al., 2013). A key recommendation of Lagarde et al. (Lagarde et al., 2007) review was the need to look into the pathways of CCTs’ impact on health. It is against this background that this study investigated the pathways through which CCTs work to improve child health. Since the pathways of change that CCTs may affect child health have not been clearly identified, a programme impact theory was used as the theoretical framework for this study. Programme impact theory is a mechanism which helps to identify the processes through which programmes are anticipated to realize their set goals (Rossi et al., 2004; Rodgers et al., 2009). In this study, the programme impact theory was used to explore the implicit theory of change that connect Ghana’s CCT programme to its expected outcomes in terms of child health.

**METHODS**

**Study design**

Qualitative descriptive exploratory approach was used for this study. The study sought to examine the mechanisms through which CCTs work to improve child health, and as such, the phenomenon was explored with participants in a particular situation from a particular conceptual framework (Neergaard et al., 2009). Given the gap in the literature regarding the pathways of CCTs impact on child health, a qualitative descriptive exploratory design offered the best approach for the study since it helped to provide a rich and straight description of the pathways of CCTs’ impact on child health (Sandelowski, 2000). Qualitative descriptive design further aligns with the use of programme impact theory.
Study location and the cash transfer programme

In 2008, Ghana introduced a social cash transfer programme called the Livelihood Empowerment against Poverty Programme (LEAP) that aims in part to improve health outcomes for OVC through better nutrition and use of pre-natal care. LEAP provides cash and health insurance to extremely poor households across Ghana to alleviate short-term poverty and encourage long-term human capital development. LEAP started a trial phase in 2008 and currently reaches over 35,000 households across Ghana (Handa and Park, 2012). The programme provides a cash transfer to ultra-poor households with OVC, the elderly and the disabled. The cash is conditional upon school attendance and health check-ups for children, and enrolment in the National Health Insurance Scheme (Jones et al., 2009). In effect, the programme uses cash transfers as incentives for parents/caregivers to invest in their children’s health and education so that they obtain the capabilities necessary to escape poverty when they reach adulthood (Das et al., 2005; Crea et al., 2013; Robertson et al., 2013).

Monthly transfers to LEAP households ranged from 48 to 90 Ghana cedis per household per month (US$21–39) depending on the number of eligible individual beneficiary OVC per household. The present study was conducted in two contiguous districts in Ghana: Ahafo Ano North and Ahafo Ano South. Both districts were selected for the study because they were included in the LEAP pilot programme in 2009. The selection of these districts was further informed by the high prevalence of orphan and vulnerable children in both districts (National AIDS Control Programme, 2009). Also, most residents in these districts make a living through subsistence farming and experience a high incidence of child poverty when compared with other districts in the Ashanti region of Ghana (UN Children’s Fund Ghana, 2009).

Study participants

The study drew on the perspectives of 18 caregivers, 4 community leaders and 3 programme implementers. The participants were purposively selected (Neergaard et al., 2009) with support from the District Directors of Social Welfare who had oversight responsibility for the implementation of the LEAP at the District level. The study participants were 25 and they contributed to 25 semi-structured interviews. The sample size was determined by progress towards saturation (Ritchie et al., 2008). In our interviews with the caregivers, it can be recognized that some participants may have provided favourable responses to show their appreciation and did not want to say bad things about the programme out of fear for being withdrawn. This could result in response bias. However, data triangulation through the use of multiple sources of data (i.e. interviewing the programme implementers and some community leaders) and the use of trained research assistants who were able to establish rapport and openness helped to reduce the risk of survey-induced reporting bias.

Data collection and analysis

The programme impact theory framework guided the choice of data collection methods, tools and analysis. Semi-structured individual interviews were conducted with the participants (Tracy, 2010). Interviews (with the exception of one English language interview) were conducted in the local Twi language by the author with support from four trained research assistants. The individual interviews were tape recorded (Tracy, 2010) and lasted between 10 and 30 min. Most of the interviews with the caregivers took place in their homes (Wiles et al., 2008). The topic guide used was slightly structured in nature and covered areas such as cash spending, programme conditions, the impact of the programme on child health and programme’s benefits to caregivers. Ethical approval for the study was granted by the Committee on Human Research Publication and Ethics at the Kwame Nkrumah University of Science and Technology, Ghana (CHRPE/AP/020/14). Confidentiality was addressed in this research during data collection and data cleaning (Kaiser, 2009). During the data collection, informed consent was sought from all participants with the agreement that their identities would not be revealed. To avoid deductive disclosure, during the data transcription, codes were used and information that identified respondents such as names or addresses were removed to create a ‘clean data’ set. Pseudonyms have therefore been used throughout to protect anonymity (Wiles et al., 2008).

In line with qualitative description and the conceptual framework used for the study,
thematic content analysis (Attride-Stirling, 2001) was conducted on the interview transcripts to pull together core themes running through the entire data set. The analysis did not seek to draw attention to individuals’ accounts and their individualized personal perception of the programme, but to map out some of the prevalent perceptions as reported by the participants. Interviews were translated and transcribed into English and were manually coded for more in-depth examination. A total of 38 codes were generated from coding the transcripts. The author engaged a third person who independently examined the transcript and critically inspected the author’s coding scheme and comparisons to ensure content validity (Ritchie et al., 2008). The codes were subsequently subjected to a thematic network analysis (Attride-Stirling, 2001) involving the grouping together of codes into basic themes, grouping together basic themes into higher order and more interpretative organizing themes (see Table 1).

The use of thematic network analysis enabled the researcher to develop a framework conceptualizing the pathways of CCTs impact on child health. The themes were cross checked with the transcript to ensure that they were coherent and

Table 1: Global theme: pathways of CCTs impact on child health

<table>
<thead>
<tr>
<th>Codes</th>
<th>Basic themes (number of interviews discussing a theme)</th>
<th>Organizing themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeding</td>
<td>Increased dietary intake</td>
<td>Improved nutrition</td>
</tr>
<tr>
<td>Eat a lot of fish</td>
<td>Household food security</td>
<td></td>
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<tr>
<td>Money for food</td>
<td></td>
<td></td>
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<tr>
<td>Hunger problems</td>
<td></td>
<td></td>
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<tr>
<td>Food in the house</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health insurance registration</td>
<td>Reduced financial barriers to health care</td>
<td>Increased health service utilization</td>
</tr>
<tr>
<td>Purchase medicines</td>
<td>Access to health care</td>
<td></td>
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<tr>
<td>Access health care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Free health care</td>
<td></td>
<td></td>
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<tr>
<td>Health talk</td>
<td></td>
<td></td>
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<tr>
<td>Help other family members</td>
<td>Increased household income</td>
<td>Poverty reduction and social transformation</td>
</tr>
<tr>
<td>Supplement income</td>
<td>Child poverty</td>
<td></td>
</tr>
<tr>
<td>Get money</td>
<td>Improved saving</td>
<td></td>
</tr>
<tr>
<td>Able to save</td>
<td></td>
<td></td>
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<tr>
<td>Pay for items bought on credit</td>
<td>Reduced child labour</td>
<td>Improved education</td>
</tr>
<tr>
<td>Not engaged in menial jobs</td>
<td>School enrolment</td>
<td></td>
</tr>
<tr>
<td>Schooling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provide school items</td>
<td>Provision of children’s basic needs</td>
<td>Improved emotional health and well-being</td>
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<tr>
<td>Relief for children</td>
<td></td>
<td></td>
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<tr>
<td>Avoid ‘hung outs’</td>
<td></td>
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<tr>
<td>Provide clothing</td>
<td></td>
<td></td>
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<tr>
<td>Provide shelter</td>
<td></td>
<td></td>
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<tr>
<td>Buy shoes</td>
<td>Children feel comfortable</td>
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<tr>
<td>Children are happy</td>
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<td></td>
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<tr>
<td>Children no longer get worried</td>
<td>Psychosocial health</td>
<td></td>
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<tr>
<td>Equality</td>
<td></td>
<td></td>
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<tr>
<td>Children feel good about them</td>
<td></td>
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<tr>
<td>selves</td>
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<tr>
<td>Well taken care of</td>
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<tr>
<td>Source of hope</td>
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<tr>
<td>No more worried</td>
<td>Physiological health</td>
<td></td>
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<tr>
<td>Not feel like orphans</td>
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<td></td>
</tr>
<tr>
<td>Children fell included</td>
<td>Social inclusion</td>
<td></td>
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<tr>
<td>No longer remember dead</td>
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<td></td>
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<tr>
<td>parents</td>
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<tr>
<td>Relief</td>
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<td></td>
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<tr>
<td>No longer struggle</td>
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<tr>
<td>Caregivers’ control over</td>
<td></td>
<td></td>
</tr>
<tr>
<td>resources</td>
<td></td>
<td></td>
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<tr>
<td>Reduced caregiver’s stress</td>
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consistent with the data to maximize their reliabil-
ity (Fereday and Muir-Cochrane, 2006). As shown
in Table 1, a total of five organizing themes
emerged from the transcript, giving us an insight to
how participants in this context perceived the path-
ways of CCTs impact on child health. These five
themes are explored by systematically discussing
the 17 basic themes emerging from the analysis.

RESULTS

Five organizing themes emerged from the inter-
view transcripts: improved child nutrition, health
service utilization, poverty reduction and social
transformation, improved education and improved
emotional health and well-being demonstrating
the pathways through which CCTs work to
improve child health. These organizing themes
and their related basic themes have been dis-
cussed below.

Improved child nutrition

Interviewees often spoke about spending the
money received from the programme on food. A
female caregiver reported: ‘Oh it has helped me
a lot and I feel ok because I use that money to
buy nutritious food for my children. I no longer
use my own little money... And they won’t cry
or worry me of hunger anymore’. Even though
all the caregivers were peasant farmers, they
stressed that they still spend money on food
items such as fish, rice and meat. It was empha-
sized during the interviews that the cash grant
increased household income, which in turn
allowed households to purchase more nutritious
foods and attained food security at the household
level. It was frequently mentioned that children
were given money to buy food from school. One
female caregiver said: ‘The money helps them
[the children] in their feeding, in the morning
before they go to school and also helps them
when they get to school during break time’. The
Programme managers mentioned that they occa-
sionally organized health education workshops
for caregivers which might increase caregivers’
knowledge and preferences for nutritious foods
and improved feeding practices. Across all care-
givers, it was emphasized that the cash grant was
spent on the food needs of all children in the house-
hold (LEAP beneficiaries and non-beneficiaries)
because a household operates as a communal
entity.

Increased health service utilization

A recurrent theme that ran through all the inter-
views was the use of health services. The LEAP
programme conditions caregivers to register all
OVC under 18 under the National Health
Insurance Scheme (NHIS). One male caregiver
shared his experience after receiving the cash
grant: ‘When the money came, I went and made a
health insurance card for the children. Now I can
take them to the hospital when they are sick. With
the money too, I buy medicine for them and take
care of their health needs’.

The quote implies that the programme had
enabled caregivers access health care for OVC
and to purchase medicines for children when
they felt sick. Participants were particularly happy
about the NHIS registration condition of the pro-
gramme by indicating that it had reduced the
financial barrier to accessing health care as they
no longer had to pay for health-care services out
of their pockets. A lack of health insurance
required some to pay all expenses out-of-pocket
for medical care including registering, check-ups,
drugs and therapy. One programme manager
noted: ‘We sometimes hold health education
workshops for the caregivers in the communities.
We discuss with them the need to seek for care for
their children, eating habits and also how to
protect the children against malaria and other pre-
ventable diseases’. The occasional health talks
had promoted the need to seek for care for chil-
dren during illness. This was however contrary to
the practices of some caregivers who reported
self-medicating their children. One male care

giver observed: ‘Like last time she was vomiting
so I took her to the chemical shop and got her
medicine, after three days she got better’.

Poverty reduction and social transformation

One of the key goals of LEAP is to break the
intergenerational cycle of poverty. The commu-
nity leaders noted that at the start of the pro-
gramme, communities were educated on the
needs and plight of orphans and vulnerable chil-
dren and their caregivers. This was said to have
changed the mind set of citizens regarding strat-
egies to be adopted to help vulnerable children.
Across all participants, it was noted that through
the provision of cash grants, the programme has
contributed to poverty reduction at the household
level and among orphans. A community leader
said: ‘This is a small community so there is not
enough work in here. We educate them about how they can provide for the orphans and vulnerable children in the community. This has been helpful because they [caregivers] use the money wisely. Sometimes they use it to start a small business and this enables them to get additional income’.

Children benefiting from the LEAP were said to have improved in their outlook and were perceived to visually ‘leap’ the characterizations of childhood poverty. The community leaders noted that it was now difficult to tag OVC as being poor as they wore good clothes and shoes making them more equal to their peers. Most of the caregivers expressed the view that the grant has enabled them to gain control over their lives as they were able to diversify their household expenditure by prioritizing their needs. It was clear during the interviews that though the programme conditions caregivers to spend the grant on children’s education and health, caregivers still had a hand in effective utilization of the grant. Some caregivers mentioned that their saving culture has changed due to the cash grants as they could now save the money accrued from the sale of their farm produce. A female caregiver noted: ‘I spend the government’s money on the children. So the programme has helped me save the income that I earn from my farm to meet future needs’. Others were emphatic that they had been able to settle with debtors and were living a dignified life. The programme managers and community leaders indicated that the cash grant has brought social equity in the community as the orphans and vulnerable children were being sent to school with their educational needs (books, uniforms, shoes and money for food) being met on time. This was said to have avoided the situation where these children and their families are christened as poor and vulnerable, which could have a transformative impact on the health of children.

Improved education

The education component of the programme which conditioned households to send their children to school was well embraced by participants as central to breaking the intergenerational poverty cycle. The cash transfer programme has incentivized most caregivers to be committed to the education of their children. A female caregiver said: ‘The money helps me to take care of the children’s education. I pay for their school fees and other school stuffs. Once they are educated they can get better job to do when they grow’. All the caregivers indicated that child education was a priority. This was evident by the fact that when the cash grant is paid, educational needs of the children covered a greater portion of the household expenditure. In all the communities, it was said that even though children were not charged for school fees, there were other levies and school-related costs which made it difficult for the poor to send their children to school. The grant was thus spent on payment of class fees, school levies and provision of items such as school uniforms, books, footwear and pocket money for the children. In several instances, caregivers noted that the absence of basic school items kept children out of school especially when the payment of the grant was delayed. The caregivers noted that the motivation for attaching seriousness to the education condition of the programme was that education constituted the only ‘source of hope’ for children. The community leaders interviewed noted that the programme had contributed significantly to school enrolment. According to one community leader, ‘Now they [children] are happy to go to school unlike before’. Most of the participants noted that being in school was central to the health of the children. It came up strongly across all the interviews that with children going to school, child labour had reduced to the barest minimum in the communities. In the Ahafo Ano North District for example, most of the OVC were being used for illegal mining which was having a negative impact on their health. This situation was said to have been reduced now since these children no longer ‘hang around’ the community and were hardly used for small-scale mining during school hours.

Improved emotional health and well-being

An inherent theme across the interview transcripts was a sign of improvement in emotional health and well-being of children and caregivers. In all interviews with the caregivers, words/phrases such as ‘relief’, ‘source of hope’, ‘children are happy’, ‘children no longer worry’, ‘children feel good’, ‘pressure on me [caregiver] has reduced’, ‘no struggle’ ran through the interviews. These catch words clearly show an improvement in the physiological and psychosocial health of children. A female caregiver said: ‘It makes them happy when they go out and compare themselves with their friends in terms
of clothing. So they don't think that they are orphans when they have everything a father can offer to a child'. Most of the caregivers noted that by being able to provide the basic needs of children through the grant, children were generally happy and felt included among their peers in the community and in school. According to the community leaders, this can have a transformative impact on psychosocial and physiological well-being of children. Children were said to no longer have the feelings that they were orphans. The cash grant was also said to have resulted in increased sense of security as caregivers were able to meet future expenditures. One female caregiver said: 'This money has really helped me a lot. When I experience hardship and am emotionally disturbed and I hear that the money is in, I become very happy...the children too'. The caregivers noted that the cash grant constituted a great relief for them when it was paid. They linked this to a significant reduction in their stress level since the grant enabled them have full control over their lives and that of the orphans under their care.

DISCUSSION

The findings presented in this article point to the fact that CCTs offer a valuable social protection instrument for improving the health of orphans and vulnerable children in rural Ghana. LEAP like other CCT programmes can affect the health of orphans and vulnerable children through different mechanisms. As indicated in Figure 1, five pathways of CCTs’ impact on child health were identified: nutrition pathway, health services utilization pathway, poverty reduction and social transformation pathway, education pathway and emotional health and well-being pathway. Due to the complex nature of the CCT programmes and the context under which the programmes are implemented, it is worth mentioning that the impact pathways identified in this study is a simplification of reality. However, since evaluation of CCT programmes has primarily been based on neoclassical and behavioural economics to guide their design and understanding their effects (Wolf et al., 2013), the use of the programme impact theory in this study provides a conceptual understanding of the pathways through which CCTs affect child health outcomes.

Nutrition pathway

Improvement in child nutrition was a critical pathway of CCTs impact on child health that emerged from the study. The cash grant was found to increase household income, which allowed households to purchase more nutritious foods and attain food security at the household level. This finding is supported by a number of studies which have concluded that CCTs

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**Fig. 1**: Pathways of impact: a hypothesized model of the impact of CCTs on child health.
contribute to improved nutrition among children (Gertler, 2004; Hoddinott and Skoufias, 2004; Rivera et al., 2004; Behrman and Hoddinott, 2005). Improved nutrition is closely linked to improved child health outcomes (Leroy et al., 2009). The caregivers in this study noted that the cash grant was used for the benefit of both OVC and other children in the household as they were considered members of one household and ate from a common pot. This indicates that although, the cash transfers were to be utilized conditionally for the benefit of OVC, the household size influenced spending decisions of caregivers. This clearly reflects the family set up and culture in Ghana as the caregivers had cultural responsibility to share the food among all the children on their compound (Nukunya, 1992). The occasional health education workshops given to caregivers were said to have increased caregivers’ knowledge and preferences for nutritious foods and improved feeding practices. Health education has been found to be an effective and a valuable tool in community-based health promotion interventions (Cropley, 2004).

Health services utilization pathway

Access to health care remains a major determinant of child health (Commission on Social Determinants of Health, 2008). In this study, health services utilization was strongly voiced as a major impact of LEAP on child health. The health component of the LEAP which conditioned caregivers to register their children under the national health insurance was said to be yielding positive results on the health of orphans and vulnerable children. The caregivers noted that the programme has reduced the financial barrier to health care as most OVC were registered under the National Health Insurance Scheme. Thus, most children were sent for regular primary care visits, thus increasing health services utilization and reducing child morbidity and mortality. Several studies have confirmed that CCTs increase health services utilization (Morris et al., 2004; Handa and Davis, 2006) and reduce child morbidity mortality (Gertler, 2000, 2004). A recent World Bank study indicated that a community-based CCTs programme in Tanzania resulted in a surge in clinic visits for children aged 0–4 (Evans et al., 2014). It must be noted that for CCTs to increase access to primary health care for children, a well-functioning and free health care system must be in place to meet the increased demand for health services that would result from CCT initiatives (Lagarde et al., 2007).

Poverty reduction and social transformation pathway

The additional income to caregivers was a major pathway of the programmes’ impact on child health. In this study, it was found that the cash grant had contributed to increased disposable income of caregivers, thus giving them more control over resources. With the increase in income, the caregivers felt empowered with regard to decision-making relative to the care of orphans and other vulnerable children under their care. Caregivers also saw the cash grant as a relief for them and the children since it enabled them to pay off their debts. Most children were given money when going to school, thus contributing to child poverty reduction and increased dietary intake (Mistry et al., 2004). Caregivers could afford to provide the basic needs for children which brought about social transformation in the lives of the children. In rural Mexico, Gertler and Fernald (Gertler and Fernald, 2004) reported that the Mexican CCT resulted in ~9% improvement in the socio-emotional development of girls and a positive but non-significant improvement in boys. Fernald et al. (Fernald et al., 2008) also observed that CCTs increased household income, reduced child poverty and promoted social transformation in rural Mexico.

Education pathway

The education component of the programme which requires that school-going children enrol and remain in school can have a long-term effect on child health. The participants in this study noted that the programme has contributed to increased school enrolment and child education. This corroborates Akresh et al. (Akresh et al., 2013) study in Burkina Faso which reported that CCTs improve educational outcomes for children. Early childhood education is critical to addressing the social gradient in health particularly in tackling unemployment, poverty and social exclusion (Marmot Review Report, 2010). The caregivers in this study noted that since children are now in school, the incidence of worst forms of child labour has been reduced. Participants reported that previously, children used to engage in activities which were dangerous to their health especially artisanal mining. It is widely documented
that CCTs address the root causes of child labour namely poverty and vulnerability to shocks (Adato and Basset, 2009; Tabatabai, 2009). Considering the well-documented impact of maternal education on child health outcomes such as improved nutrition and high uptake of health services (Alva and Desai, 1998; Currie and Moretti, 2003), it is most likely that CCTs that significantly improve girl child education will confer long-term health benefits to their children.

**Emotional health and well-being pathway**

The study indicates that the emotional health and well-being of OVC was greatly improved due to the cash grants. At the household level, the programme was said to have improved living conditions. The increased disposable income of caregivers has the potential to improve the psychological well-being of caregivers and thereby improving the care, support and nurture provided to OVC in the household (Yeung et al., 2002). The participants acknowledged that the programme has brought a great relief to both caregivers and children, removing worries and reducing stress. The ability of caregivers to meet children’s basic needs such as clothing, food and education made the orphans felt more included in society, thus impacting positively on their emotional well-being.

**CONCLUSIONS**

This study has mapped out the pathways through which a CCT programme can improve child health. The results suggest that the cash grant increases household income, which in turn improves household living conditions, allows households purchase more nutritious foods and ultimately improve child nutrition. The health component of the LEAP (CCT) which conditions households to register children under the NHIS enhances children’s access to health care and has the potential to reduce child morbidity and mortality. This is however dependent on the availability, quality and capacity of the health system. The cash grant further enables poor households to have more control over resources, reduce poverty and enhance social transformation—creating more unified and socially cohesive community contexts for improved health outcomes amongst orphans and vulnerable children. The education component of the programme which requires that school-going children enrol and remain in school can have a long-term effect on child health as early childhood education is critical to addressing the social gradient in health particularly in tackling unemployment, poverty and social exclusion. In effect, this article has demonstrated the mechanisms by which CCTs impact on child health. Understanding this theory of change is important to understanding what programme adjustments are required to make CCTs more effective in improving child health and also the levers of change that can be targeted through future CCT initiatives. More research is however needed to better understand the contextual influences of the pathways of CCTs impact on child health.

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