

Spring 5-13-2016

# Investigating the Implementation of a Conditional Cash Transfer Program in DeKalb County, GA

Breana M. Jones

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INVESTIGATING THE IMPLEMENTATION OF A CONDITIONAL CASH TRANSFER  
PROGRAM IN DEKALB COUNTY, GA

by

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B.A., SOCIOLOGY/ANTHROPOLOGY AND RELIGIOUS STUDIES  
AGNES SCOTT COLLEGE

A Capstone Submitted to the Graduate Faculty  
of Georgia State University in Partial Fulfillment  
of the  
Requirements for the Degree

MASTER OF PUBLIC HEALTH

ATLANTA, GEORGIA  
30303

SPRING 2016

## Abstract

INVESTIGATING THE IMPLEMENTATION OF A CCT PROGRAM IN DEKALB  
COUNTY, GA

by

BREANA MICHELLE JONES

Spring 2016

Conditional cash transfer programs provide poor families with cash payments when they meet established behavioral requirements. These programs aim to reduce the effects of poverty in the short term by providing cash transfers. In the long-term, the conditions focused on health and education invest in human capital to address generational poverty.

This capstone outlines the successes and lessons learned from conditional cash transfer programs in the United States and abroad to inform the policy implications for the design and implementation of a CCT in DeKalb County, GA. Conditional cash transfers are an innovative approach used for decades in developing countries. DeKalb County would benefit from a CCT program that aims to improve high school graduation rates and poor health outcomes. The CCT conditions should dictate regular school attendance, proper wellness visits for women and children, and adherence to Georgia's vaccination schedule.

I propose the design and implementation of a conditional cash transfer program in South DeKalb County using private funds as modeled by Opportunity NYC. The pilot program should initially target the community assessment areas (CAAs) of Redan, SW DeKalb/MLK and McNair/Cedar Grove because they are disproportionately affected by chronic illnesses, violence and high infant mortality rates compared with other CAAs within DeKalb County. I suggest the following recommendations:

- 1) Complete a needs assessment to understand the social, political and economic needs of the targeted communities.
- 2) Discuss feasibility of a CCT by constructing an advocacy coalition with social local organizations with health and education focus.
- 3) Develop a task force featuring non-profits, schools in the targeted CAAs and government agencies to support the implementation of the program.
- 4) Construct a pilot CCT program that focuses on improving health outcomes and educational attainment in South DeKalb County using effective CCT models.
- 5) Design an evaluation protocol based on the toolkit provided by *Opportunity NYC* to determine the program's effectiveness.

Index Words: poverty, health outcomes, dekalb county, conditional cash transfers

APPROVAL PAGE

INVESTIGATING THE IMPLEMENTATION OF A CONDITIONAL CASH TRANSFER  
PROGRAM IN DEKALB COUNTY, GA

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## Acknowledgments

I would like to formally thank all of the faculty who inspired me throughout my time at Georgia State University. Their passion for public health motivates me to follow my dreams.

Thank you to my supportive family and friends who have encouraged me every step of the way in the pursuit of my degree. They have been the champions of my success and never let me second guess my abilities.

Dr. Stauber and Dr. Strasser are incredible women and scholars who are patient and believed in me. I am forever grateful for their guidance and support.

I am incredibly lucky to have an affirming and loving village.

## Author's Statement Page

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Breana Michelle Jones

Signature of Author

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### **Acronyms**

CDC: Centers for Disease Control and Prevention (USA)

ACA: The Affordable Care Act of 2010 (USA)

BFP: Bolsa Familia Programa (Brazil)

PRAT: Programa de Asignación Familiar (Honduras)

FII: Family Independence Initiative (USA)

TANF: Temporary Assistance for Needy Families (USA)

SNAP: Supplemental Nutrition Assistance Program (USA)

CAA: Community Assessment Areas (USA)

**Notice of Borrowers Page**

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## **Chapter 1: Introduction**

Poverty is an extensive and ongoing issue that has wide-ranging ramifications especially for health outcomes. As it stands, the poverty rate for the United States is 14.8% with individuals who are Black (27.2%) and those who identify as Hispanic (23.5%) experiencing the highest rates of poverty (Centers for Disease Control and Prevention, 2014). These rates increase to 45.8% when filtering for families with a female head of household and no husband present (CDC, 2014). The CDC research indicates the same percentage of individuals do not have a usual source of health insurance (2014). People who have limited funds are less likely to prioritize health and thus have decreased health outcomes. The uninsured rates have improved with the passage of ACA which has provided additional opportunities for healthcare access (Johnson & Fitzgerald, 2014). In particular, the expansion of Medicaid in select states has positively impacted impoverished communities across the United States (Higgins, Shugrue, Ruiz, & Robison, 2015).

Social class and poverty consistently have an independent effect on health (Starfield, 1992). There are a number of predisposing factors, such as environmental and social conditions, as well as genetic factors, that interact to increase the effects of poverty (Starfield, 1992). Poverty is a pervasive and all-consuming factor that is correlated with low maternal education, environmental overcrowding, poor access to fresh foods and places to play and decreased maternal health (Wight, Chau, Thampi, & Aratani, 2010). All of these factors interact to have a detrimental impact on an individual throughout his or her lifetime. It is evident that economic

insecurity has a clear effect on how people interact with the world from their physical health to their emotional stability.

When developing social programs, policy makers must fundamentally understand the effects of poverty and work towards alleviating poverty and its direct effect on families. In the developing world, conditional cash transfer programs have been implemented since the 1990s (Das, 2005). These programs are safety nets that alleviate social ills in the short-term and invest in human capital for the long-term. Over the years, conditional cash transfers programs have successfully reduced poverty and improved health outcomes for the involved families (Das, 2005; Glassman et al., 2013; Marlúcia Oliveira Assis, 2015; Marshall & Hill, 2015; Owusu-Addo & Cross, 2014; Rasella, Aquino, Santos, Paes-Sousa, & Barreto, 2013). The World Bank explains that conditional cash transfer programs address poverty and income equality in a sustainable way (2009). Typically, the United States implements cash transfer programs and other social nets (SNAP and TANF) to alleviate poverty. It is evident these programs do effectively assist families in the short-term but have not been shown to invest in human capital to stop the cycle of poverty (Eamon, Wu, & Zhang, 2009).

DeKalb County is one example of a diverse county in the United States that has diminished health outcomes due to poverty (“2015 DeKalb County Status of Health Report,” 2015). This county is located in Metro-Atlanta and showcases a population with urban and suburban characteristics. Residents of DeKalb County represent a wide-range of social and economic classes from an affluent northern part of the county to the economically depressed southern portion (“2015 DeKalb County Status of Health Report,” 2015). The county is politically diverse as well with a large liberal constituency within a conservative state. For these

reasons, DeKalb County is an effective microcosm to review the literature and consider the feasibility of implementing an effective conditional cash transfer program in the United States.

Development of a model conditional cash transfer program for DeKalb County, Georgia is the primary purpose of this project. In the subsequent chapters, a review of the scientific literature surrounding issues of poverty and health impacts, as well as a synthesis of effective conditional cash transfer programs implemented in distinct populations will be presented. Further, development of an enhanced program for DeKalb County, that takes into account significant ecological levels of influence as guided by Systems Ecological Model is articulated. The proposed program aims to shed insights on how DeKalb County may actively adopt a new model of alleviating poverty among the most vulnerable segment of its residents, rather than merely perpetuating it.

## **Chapter 2: Literature Review**

This chapter synthesizes scientific literature that showcases the historical development and basic structures of public programs aimed at improving one of the greatest threats to population health-poverty. The literature review will primarily focus on poverty in the United States, the rise of conditional cash transfer programs in the developing world and the adaptation of these programs to United States. Finally, the political, economic and social status of DeKalb County will be discussed to lay the foundation for understanding the needs for an innovative approach to addressing poverty and poor health outcomes.

### **2.1 Poverty in the United States**

Poverty affects millions of people in the United States and is "...a critical pathway to ill health and health inequities..." (Mercado, Havemann, Sami, & Ueda, 2007, p. i7). The primary populations that are affected by poverty are women, children and people of color who are consistently affected by social and economic shocks (Farrington & Slater, 2006). A major reason for the link between healthcare and poverty is the differences in the availability, affordability and accessibility to healthcare experienced by poor patients (Angier et al., 2014). Insurance coverage does not negate these social and economic disparities. Individuals who receive subsidized healthcare have expressed a push back in using their coverage (Angier et al., 2014). There are medical facilities that do not accept Medicaid and other public insurance due to the paperwork and lower medical reimbursement rates (Angier et al., 2014). Additionally Reading argues that healthcare providers are overwhelmed with the problems associated with poverty (1997). For these reasons, impoverished individuals are limited in where they can

receive care. This may manifest in traveling farther for medical providers, which increases the financial implications and the time required for access.

The procurement of health insurance does not indicate the ability to afford the necessary co-insurance or deductibles required. For impoverished people, they must prioritize limited funds and thus are more likely to forgo medical services until absolutely necessary (Angier et al., 2014). With the passing of the ACA, insurance companies are required to pay for preventive healthcare services without assessing a copayment. These changes have allowed more people to interact with the healthcare system and thus improve health outcomes, but it does not overcome all the challenges still associated with poverty. For 25% of poor families with children, they spend 10% of their yearly income on healthcare expenditures (Wherry, Kenney, & Sommers, 2016). These issues prevent individuals from fully utilizing healthcare services.

There are strong and extensive links between poverty and child health which has steadily increased over the last few decades. In the United States, the overall poverty rate has increased 2.3 percentage points since 2007 which is primarily attributable to the economic collapse in 2008 (United States Census Bureau, 2016). Individuals who are categorized as Non-Hispanic Whites have lower poverty rates than people of color, and children have a higher poverty rate than individuals over 18 (United States Census Bureau 2016). For women, 16.1% live in poverty compared to 13.4% of males, and the difference is most pronounced with women over the age of 65 (United States Census Bureau 2016).

Statistics show that impoverished children are worse off in all aspects of health compared with children from wealthy families (Reading, 1997). The earliest years are the most critical in cognition and emotional growth and thus future health outcomes (Smeeding & Thévenot, 2016). In particular, all causes of death except cancer are more prevalent for poor children, and they are

more likely to die before reaching adolescence (Reading, 1997). These differences are evident from lower birth rates and follow poor children for the rest of their lives (Racine, 2016). Additionally, poor children have more chronic illnesses than their wealthier counterparts (Smeeding & Thévenot, 2016). The most limiting chronic conditions experienced by poor children are the following: vision or hearing impairment, mental health issues and asthma (Currie & Lin, 2007). These conditions are primarily a result of the mother's health because they are more likely to live in substandard housing and have limited access to prenatal care (Wherry et al., 2016).

Parents and the community as a whole act as the primary protective factor against the effects of poverty. As explained by Smeeding and Thevnot, the United States underinvests in their impoverished population which results in poor health and educational outcomes (2016). It is imperative that communities are aware of the effects of poverty from crime to food insecurity. Successful social programs address the effects of poverty and understand how long-term sustainable positive changes require understanding the needs of communities.

## **2.2 Theoretical Framework for the Development of Social Programs**

The construction of social programs require an understanding of people's needs and how they interact with the world. Maslow's hierarchy of needs shows how the most basic needs should be met before secondary needs can be addressed (Taormina & Gao, 2013). Poverty affects every single aspect of the Hierarchy of Needs. Physiological needs are fundamental and related to human survival – food, shelter and water. Without physiological needs being met, an individual cannot focus on the other hierarchical needs – safety, love, esteem and self-actualization. Maslow's Hierarchy of Needs showcases how influential poverty is on a person's worldview. Moreover, basic human needs must be met to maximize the health and well-being of



any individual. The ecological systems theory is also effective in visualizing how poverty affects an individual's interactions. Successful, comprehensive social programs understand these two theories and speak to them in the design and implementation phases.

### **2.3 Conditional Cash Transfer Programs**

Conditional Cash Transfer Programs (CCTs) are designed to alleviate poverty in the short term through helping with the immediate need of additional monies for food, shelter and other necessities. In the long term, CCTs invest in human capital by encouraging education and proper health including vaccinations and annual physicals. The foundation of CCTs is transferring cash from the government to impoverished households. In return, the recipients of the money are required to comply with specific conditions to continue to receive cash transfers. These conditions are dependent on the program; however, they are typically focused on education and health initiatives. Conversely, cash transfer programs provide funding to families without any requirements or follow up. The benefit of giving cash (whether conditional or not) to families is that it empowers poor people to purchase what they need. In-kind donations of food or other supplies requires families to use those items, which may they not require. Consequently, a mother has the option to spend her cash transfer on clothing for her children or catching up on bills rather than food when she has a garden in her yard. Cash transfers provide poor families with purchasing power and support.

CCT programs were developed in Latin America in the 1990s and have since expanded to 750 million people in primarily developing countries (Jones & Presler-Marshall, 2015). These programs are innovative because they are social protection instruments that empower beneficiaries to prioritize their needs. By requiring conditions, CCTs have acquired acceptability by diverse political groups because receiving funds are contingent on families adhering to the

guidelines. There continues to be discussion about whether or not the conditions are necessary for effectiveness, but it is clear these programs are spreading across the globe and important lessons can be learned from their implementation.

Mexico's *Progresa*, the first country-wide CCT, was established in 1997 by government officials to reach impoverished rural families (Marshall & Hill, 2015). Over the years, the inaugural CCT program expanded and now covers 5 million Mexican families in a nation of 120 million citizens. *Progresa* provides a support system that acts as a safety net to prevent homelessness and hunger. While *Progresa* impacts thirty percent of Mexico's population, there are CCT programs in over forty countries that have built upon the CCT model constructed by the Mexican government (Marshall & Hill, 2015). The major conditional cash transfer programs are detailed in the chart on page 18. For the most part, each program has developed similar conditions around the needs of health and education while using a variety of funding sources.

Table 1 - Major Conditional Cash Transfers Around the World

<b>Country</b>	<b>Program</b>	<b>Funding Source</b>	<b>Recipient/Scope</b>	<b>Conditions</b>
<b>Brazil</b>	Bolsa Familia	federal government and developmental loans (World Bank and Inter-American Development Bank)	Female Head of Household/National	Attendance for school-aged children, vaccinations for children, parental education classes and prenatal and postnatal care for pregnant women
<b>United States, Oakland</b>	Family Independence Initiative	Private donors	Family Unit/Selected applicants	Program based on rewarding reported behaviors: maintaining bank account, attending group sessions, etc.
<b>United States, New York City</b>	Opportunity NYC	Private donors through NYC Mayor's Office and Center for Economic Opportunity	Family Unit/City-Wide (5 areas)	Rewards provided for adherence to set accomplishments. Enrollment and attendance for students, high achievement on standardized tests, parental involvement with school, maintaining health coverage, well visits for family and maintaining employment
<b>Nicaragua</b>	Red de Proteccion Social	Federal government	Female Head of Household/National	Enrollment for school-aged children, 85% attendance in school, children under 9 must be immunized, women and children must attend preventative visits, and attend educational courses bi-monthly
<b>Mexico</b>	Progresa (formerly Oportunidades)	Federal government	Female Head of Household/National	Enrollment in school for all children under 16, preventative well visits for children, prenatal and postnatal visits for mothers.
<b>Honduras</b>	Program de Asignación Familiar	World Bank and Inter-American Development Bank	Female Head of Household/National	Enrollment and attendance for all school-aged children, student cannot repeat a grade more than once, prenatal and postnatal visits and children must attend wellness visits
<b>Dominican Republic</b>	Solidaridad	Federal government	Head of Household/National (Small pilot)	Enrollment and attendance for all school-aged children, health check-ups for children under 5, and attend community groups every 3 months

(Das, 2005)

### 2.3.1 Women Benefiting CCTs

Conditional cash transfer programs are beneficial for the following reasons: “increased consumption among the poor, decreased poverty, protection from income shocks such as unemployment, and catastrophic illness and increased bargaining power of women” (Shei, Costa, Reis, & Ko, 2014). Most of the CCT programs across the world focus on women who are the primary providers of the ultimate targeted population, children. Researchers have determined women are the best holders of funds for the family (Barrientos & DeJong, 2006; Bobonis, 2009; Callister, 2013; Lindert, Linder, Hobbs, & de la Brière, 2007). There are a number of benefits by choosing mothers as the cash transfer recipient from improving the stance of women in communities to bolstering women’s empowerment movements (Bobonis, 2009). These programs allow women to make the choices for their families and an injection of cash into their households provides a needed safety net.

As families move their children into the school system due to the required educational conditions and women have more autonomy, the number of women in the workforce has increased (Marlúcia Oliveira Assis, 2015). Evaluation studies have been completed on CCTs throughout Latin American and indicate the beneficiary families have sustained poverty reduction even decades after their interaction with the programs ends. In particular, Mexico’s *Progresá* showed 11.7 percentage point reduction in poverty levels for the program group compared with the control group (Barrientos & DeJong, 2006). CCTs have strengthened the economic status of families by allowing additional streams of income and improved women’s rights.

Women are chosen because mothers are more likely to be concerned about the futures of all their children, and aware of the issues surrounding the needs of young girls (Fiszbein &

Schady, 2009). In some communities, investing in female children can be a deterrent to the family because boys are raised to support their families while girls join other households. The establishment of CCTs allow girls to be a benefit to the family in a clear, economic way. Thus CCTs establish an opportunity for all girls from impoverished families to be educated outside of the home. Along this line of thinking, CCTs have greatly improved the experiences of women and addressed gender based disparities (Bradshaw & Viquez, 2008; Callister, 2007; de Brauw, Gilligan, Hoddinott, & Roy, 2014; Glassman et al., 2013). By allowing the same amount of money for boys and girls to attend school, CCTs encourage families to support girls attending school (Fiszbein & Schady, 2009). Additional research around CCTs have shown these programs break the pattern of poverty in homes by guaranteeing that children are educated and thus are more marketable in the future (Fiszbein & Schady, 2009). In several CCTs, school attendance rates have steadily increased across the board (Marshall & Hill, 2015) and the number of children admitted to the hospital each year have decreased (Fernald, 2013).

### **2.3.2 Sustainability Considerations**

The conditions associated with CCTs are focused on investing in the next generation and providing more political acceptability for the programs (Fiszbein & Schady, 2009). For this reason, CCTs are easier to sustain through government funding because they are poverty reduction programs and not simply social assistance programs. These programs are more supported by politicians on both sides of the political sphere because they are focused on children. Additionally, political minds point to the conditions as placing an ear marker on the funds to ensure it is being used for the community good (Fiszbein & Schady, 2009). It should be noted there are additional concerns when establishing CCTs in the developed world considering the number of existing safety nets, social assistance programs. In these cases, conditional cash

transfers have been initially started with private funds because government funds are tied into other social programs. For CCTs to be sustained in the developed world, it would be imperative to start with adjusting the implementation of existing social programs or piloting a CCT initiative with private donors or open-ended government grants.

### **2.3.3 Program Regulations**

In the research community, there is discourse about whether or not cash transfer programs need conditions to be effective. When comparing CCTs to cash transfers without conditions, research has shown that families would not exhibit the same level of behavior changes if they were not required by the programs (Callister, 2013; de Janvry, Finan, & Saudolet, 2006; Lindert et al., 2007; Marlúcia Oliveira Assis, 2015; Paes-Sousa, Santos, & Miazaki, 2011). The World Bank reported that poor families are not more likely to “waste” cash transfers on alcohol or tobacco; they spend most of the cash transfers on health expenditures and general consumption (Evans & Popova, 2015). The concern is not if the transfers will be used in a constructive way but establishing programs to improve outcomes and future success for the targeted communities. In the case of BFP in Brazil, cash transfers dependent on children attending school and health requirements for family members was a critical component in the success of families who improved their economic standing (Shei et al., 2014). Similar results were noted in Burkina Faso where researchers determined conditional cash transfers increased preventative health care visits for children by more than 40 percent while there was no significant difference for unconditional cash transfers compared with the control group (Marcus, Akresh, Kazianga, Walque, & M, 2012). Through completing the required conditions, the participants of CCTs are encouraged to engage in positive behaviors in the social, economic and political spheres. A comparison study on BFP found families who were not required to have

their children attend school did not exhibit an increase in attendance (Das, 2005). The families who were a part of the program had higher educational attainment rates for students and girls were less likely to become pregnant (Callister, 2013). From the research, it is evident CCTs have real benefits when established and applied correctly into communities.

#### **2.3.4 Unintended Consequences**

There are countries where there is not sufficient health or education infrastructure to enforce conditional cash transfer programs. It is imperative that recipients have the ability to fulfill the program requirements without needless hardships. In the case of the Honduras' *Programa de Asignación Familiar (PRAT)*, research indicates fertility rates increased due to households believing more children would yield additional payments (Gaarder, Glassman, & Todd, 2010). Therefore, education needs to be provided to heads of households about the tenets of the program: maintaining self-sufficient homes and working towards financial independence. Recipients believing the demonstration of additional need is required has been found in non-conditional cash transfer programs as well (Marshall & Hill, 2015). Additionally, there is a concern that conditions have the ability to overburden the household with the number of requirements (Das, 2005).

Researchers who studied CCTs in Latin America found families use child labor as a way to cushion themselves from economic shocks in their homes (de Janvry et al., 2006). By requiring all children to attend school, government sponsored CCTs take income earners out of the family which, dependent on the number of children in the family, may not be fully replaced by the cash transfers (de Janvry et al., 2006). While this argument is valid, the longer-term results of ensuring young people adhere to the vaccination schedule and attend school cannot be

negated. The focus on education starting at youth provides an opportunity to ensure the next generation understands the benefits of investing in human capital.

Other researchers have highlighted that CCTs have the ability to alienate the targeted populations. Molyneux notes that requirements for receiving the cash transfers may be perceived as condescending by the women (2007). They argue the programs are telling recipients how they should conduct themselves and thus result in them believing that the government is looking down upon them. These issues can be alleviated by ensuring program participants understand the thought process behind the conditions and CCTs are voluntary initiatives. Another result that is rarely considered is that the emphasis CCTs have on women has increased divorce rates in some communities (Bobonis, 2009). While researchers should consider the effects CCTs have on the family unit, they need to address how increased divorces may reflect safer and happier homes. Through these initiatives, women have more choices in their lives.

While some researchers describe the concerns of stigma associated with conditions, they fail to mention how cash transfers provide recipients the opportunity to choose how their household is run (Freeland, 2007). In studies evaluating cash transfer programs, researchers have discussed the likelihood of corruption with cash transfers while in kind donations ensure funds are used in the intended way (Schubert, 2005). These arguments do not consider the empowerment that participants gain from supplemental income that allows them to decide which needs should be met. With cash transfers, the consumption effects are clearly evident with the injection of additional funds into the communities; however, there is less information regarding changes in production (Farrington & Slater, 2006). Studies about the *Eradication of Child Labor* (PETI) in Brazil show it was successful in raising productivity while decreasing the number of children working in hazardous conditions (Barrientos & DeJong, 2006). PETI provided a cash



subsidy to families in those communities with children aged 7-14 who had 85% of better attendance in school (Barrientos & DeJong, 2006). Consequently, it decreased the amount of stress on families to provide financially and allowed to work without concerns about the safety of the children. Also the children had the opportunity to learn rudimentary skills by attending school and thus improved future productivity in the communities.

### **2.3.5 CCTs: Moving Forward**

There are drawbacks that are evident in CCTs; however, these do not outweigh the benefits that the programs have exhibited in communities. Conditional cash transfer programs have shown marked improvements in the communities where they have been instituted. In the following section, *Bolsa Familia Programa* will be outlined as an example of a CCT in a developing, middle-income country. Then *Opportunity NYC* and the Family Independence Initiative will be highlighted to showcase the implementation of CCTs in the United States. All three of these programs have evidence based research indicating their successes and failures and provide a deeper understanding of CCTs.

### **2.4 Brazil's Bolsa Familia Programa**

*Bolsa Familia Programa* was established in 2003 after then President Luiz Inácio Lula da Silva federalized and combined four existing CCT programs throughout Brazil (Lindert et al., 2007). President Lula aimed to improve the availability of the program for the country's poor, and ensure the efficiency and consistency of the program. Currently BFP gives 13 million families a month cash benefits, which represents over 25% of the Brazilian population (Shei et al., 2014). The Ministry of Social Development and Fight Against Hunger manages the 28 billion Reias budget which is approximately 0.5% of Brazil's gross national product (Morais de Sa e Silva, 2015). The program has grown to fulfill the needs of impoverished Brazilians and has

become the largest CCT program in the world in regards to people served (Das, 2005).

Consequently, BFP provides a wealth of information about the construction of a large-scale CCT program and a useful framework for working with diverse populations. For these reasons, it is essential to study BFP when researching the establishment of new CCT programs and determining how to adapt them into more communities.

Historically, Brazil had one of the highest levels of income inequality with a Gini coefficient of .60 in 1970s (Lindert et al., 2007), and the implementation of BFP is a major factor in the Gini coefficient decreasing (Sánchez-Ancochea & Mattei, 2011). Brazilian leaders worked closely with the World Bank to create the BFP because of rampant income inequalities throughout the country. In particular, the poorest 60% of Brazilians received approximately 4% of the country's GDP prior to the BFP. Through the conditional cash transfers, 94% of the money provided by the government ends up the hands of 40% of the poorest segment of the population (Callister, 2013).

Eligibility for BFP is based on each household's income and funds are given to the female lead of the home to use as she sees fit. The benefit of the program is that individual families are able to determine where the money is best utilized to ensure the survival of their particular household. Depending on the needs of the family and its size, the transfers range from R\$15 to R\$95 per month. Cash transfers provided through the BFP are focused on extremely poor families, which is defined as less than R\$35 per person each month (Morais de Sa e Silva, 2015). Poor families (R\$35 to R\$70 per person per month) may apply for assistance if their household has any of the following 3 groups: children under 17, pregnant women or lactating mothers. In the case of the BFP's payments, each of these special groups receives R\$18 each

month then extremely poor families receive an additional R\$35 as a base benefit, regardless of family composition (Rasella et al., 2013).

World Bank has continually publicized BFP as a prime example of program that is focused on the needs of the people and provides opportunities for the poorest individuals in society to improve their standings (Fiszbein & Schady, 2009). In the international public health sphere, BFP is regarded as a program that provides benefits that enable individuals to improve their station in life and empower the next generation (Fiszbein & Schady, 2009). As with other CCTs, the BFP assists with two major areas: 1) the reduction of poverty and inequality by ensuring all families have a minimum level of monthly income and 2) the dissolution of the poverty cycle for the next generation by requiring human capital related conditions (adherence to vaccination schedule, prenatal visits for expectant mothers and regular school attendance) for recipient families (Lindert et al., 2007).

Table 2 - Conditional Cash Transfers for BFP

<b>Level of Poverty</b>	<b>Monthly per capita family income</b>	<b>Number of children 0- 15, pregnant or breastfeeding mothers</b>	<b>Quantity and type of benefit</b>	<b>Bolsa Família benefit received</b>
<b>Poor</b>	R\$ 60 – 120	1	(1) variable	R\$18
		2	(2) variables	R\$36
		3 or more	(3) variables	R\$54 -95
<b>Extreme Poor</b>	Up to R\$ 60	0	Base benefit	\$35
		1	Base + 1 variable	\$53
		2	Base + 2 variables	\$71
		3 or more	Base + 3 variables	\$95

(Lindert et al., 2007)

The conditions set forth for BFP are outlined in the Table 3 and were designed to address the major health and educational disparities affecting impoverished families. The BFP officials are strict when it comes to families adhering to these conditions, and the family can lose their benefits if they are out of compliance (Pires, 2014). Considering the poorest families are more likely to fail to meet conditions, there are questions around whether or not the program contradicts the aim to help families stay afloat (Fiszbein & Schady, 2009).

Table 3 - Conditions of BFP

	<b>Health Conditions</b>	<b>Education Conditions</b>
<b>Children</b>	For all children ages 0-7 years old: <ul style="list-style-type: none"> <li>➤ Adhere to vaccine schedules</li> <li>➤ Regular health check ups and growth monitoring of children</li> </ul>	<ul style="list-style-type: none"> <li>➤ Enroll all children ages 6-15 in school</li> <li>➤ Guarantee at least 85% minimum daily school attendance each month for all school-aged children</li> </ul>
<b>Women (lactating and pregnant)</b>	<ul style="list-style-type: none"> <li>➤ Pre-natal checkups</li> <li>➤ Post-natal checkups</li> <li>➤ Participate in educational health and nutrition seminars offered by local health teams</li> </ul>	[Parents] <ul style="list-style-type: none"> <li>➤ If child misses school, inform the school of the reason</li> <li>➤ Inform the local BFP coordinator if the child moves schools</li> </ul>

(Lindert et al., 2007)

There is substantial evidence that BFP has reduced poverty, increased educational rates and improved health outcomes for impoverished individuals in Brazil. Studies indicate the mean

monthly income per person has increased 46.5% and houses with inadequate sanitation have decreased 25.8% (Rasella et al., 2013). BFP has worked in conjunction with other Brazilian initiatives – raising the federal minimum wage, increasing pensions for the elderly and increasing the ability to acquire credit – to reduce the severity of poverty (Bither-Terry, 2014). Due to the extreme level of poverty in Brazil, BFP has resulted in an overall poverty reduction of 2% but the number of individuals in extreme poverty has decreased significantly (Lindert et al., 2007). BFP has primarily had an impact on inequality within Brazilian society and has been shown to be more effective in reducing inequality than increasing minimum wage (Pereira, 2015). In his assessment, Pereira explains that for every one comparable dollar of cash transfer funds that enter a community, the return on investment is estimated to be \$1.78 (2015).

The *Bolsa Familia Programa* has a racial and gender component where the program has positively impacted the lives of women and addressed the income equalities that affect Brazilians of color. The majority of BFP's participants are non-White and reside in the Northeastern part of the country, which is more economically and politically depressed than the South (Pereira, 2015). The injection of funds into these communities have resulted in stronger communities, and provided incentives for individuals to acquire identifying documentation for access to public services and voting.

Policy makers take the stance that women are more inclined to make decisions for the whole family so they are given the cash transfers for BFP (Pires, 2014). The program strengthens and invests in women especially when it is done in conjunction with effective primary health care wherein they are educated about themselves. Research shows that most women use the money for food – they are making the decisions of what they need to best help their family (Fiszbein & Schady, 2009). In that way, it is evident that the policy makers are correct about how

women handle the funds; however, the tenets of the program lead to a narrow focus of womanhood. BFP and similar CCT models showcase women as nurturers and primary caregivers which may not be the truth for all women. Moreover, the program puts pressure on the women to control the household and thus does not require any input from fathers (Bradshaw & Viquez, 2008)

Researchers have found BFP has decreased the number of children not enrolled in school, particularly those from extremely poor families - from 9.1% to 4.7% (Das, 2005). Evaluation studies show girls' school attendance has the greatest improvement with a 8.2% change (Reynolds, 2015). In comparison, the unconditional cash transfer program in Brazil had zero impact on school attendance (Fiszbein & Schady, 2009). Impoverished, rural families tend to underinvest in education because "they are unable to guarantee that their children will continue to reside in the village once educated" (Das, 2005, p. 66). Moreover, families benefit from additional incomes that comes when children work rather than attend school. Since CCTs like BFP provide cash transfers only when children attend school, the parents override their preferences to keep children at home and the household budget is supplemented. Pires argues the design of CCTs make children the family sponsors where their attendance of school ultimately leads to the family's survival (2014). For that reason, those attendance rates do not necessarily indicate children are being educated or will parlay the education into better career options (Pires, 2014). The success of educational conditions is dependent on efficient schools being available and students' interest in the learning process.

Several studies have found the BFP has improved the health outcomes of children in participant families. Bolsa Familia Programa has positive impacts on the under-5 child mortality rates; between 2005 and 2009 the rates decreased by 19.4% in the selected municipalities

(Rasella et al., 2013). In particular, BFP had the greatest effect on poverty related causes of death- malnutrition and diarrhea (Paes-Sousa et al., 2011). Furthering the point of BFP's impact, the municipalities with the highest BFP coverage had the lowest mortality rates (Fernald, 2013). The improved under-5 mortality rates are due to the health focus conditions required for BFP families: increased vaccination rates, increased women who receive prenatal care, and decreased rates of children under 5 hospitalized with nutritional issues (Fernald, 2013). With Brazil's public health care system, *Programa Saúde da Família* (Family Health Program), the participants have access to free, available health care to complete preventative health care conditions. Moreover, a study by Shei et al. indicates that participation in BFP is associated with better health outcomes than non-participation in terms of overall health for the entire family (Shei, 2013). There was an overlapping effect wherein older siblings who no longer had health related conditions still had an increased odds of going to the health centers (Shei et al., 2014).

With these conditional cash transfers, it is imperative to ensure families are receiving education about consumption. Fernald explained that a majority of Brazilian adults are obese and children have an obesity rate of 22% (2013). In previous studies around *Progresá*, researchers found receiving a greater cash transfer was associated with higher risk for obesity and hypertension in adults (Darney et al., 2013). Consequently, Fernald advises that BFP officials should design intentional policies and programs to prevent obesity considering participation in BFP is already associated with higher consumption of sugar (Fernald, 2013).

## **2.5 Opportunity NYC**

The first and only governmental entity based foray in cash transfer programs (*Opportunity NYC*) in the United States was established by New York City's (NYC) Center for Economic Opportunity (CEO), an organization led by Mayor Michael R. Bloomberg in 2007

(Ricchio, 2010). There has been widespread international interest in *Opportunity NYC* because the program is the first comprehensive CCT model in a high income country (Ricchio et al., 2013). *Opportunity NYC*'s program designers studied the implementation details and results of Mexico's *Progresá* then adapted it to "suit a vastly different social, economic and policy context than was present in Mexico and other middle and lower-income countries" (Ricchio et al., 2013, p. ES-2). The model designed by *Opportunity NYC* provides a clear blueprint for the construction of CCTs throughout the United States, as well as highlights the challenges of implementing these kinds of programs.

As evident in other CCT programs, the ultimate goal was to improve living standards in the short-term and empower participants to assist themselves in the long-term. *Opportunity NYC* was rolled out with three pilot programs- Family Rewards, Work Rewards and Spark. The initial program implementation involved a budget of \$53.4 million (Morais de Sa e Silva, 2015). Unlike other CCT models, *Opportunity NYC* was supported by private donors and all of the funding was provided directly to the Mayor's Fund to Advance New York City (Ricchio et al., 2013). Consequently, it was not necessary to lobby for policy and legislative changes to implement the program in New York City.

The most comprehensive of the three pilot programs was Family Rewards which had a budget of \$34.95 million and assisted approximately 2,550 people each year (NYC Center of Economic Opportunity, 2007). The NYC Center of Economic Opportunity (CEO) aimed to test how monetary incentives affected health, education and employment for the participants. The program was instituted in six districts in New York City with the most extreme poverty and provided supplemental income to the selected households. There were several criteria for eligibility including that families were required to have at least one child in 4<sup>th</sup>, 7<sup>th</sup> or 9<sup>th</sup> grade



within the NYC public school system. Program designers set the grade level standard based on research that shows those school ages are representative of important transitional phases in children's lives (Riccio et al., 2013). Therefore, positive behavior changes were most impactful at those junctions, and thus the best time to be involved with a CCT program. Once the families were selected, all of the school-age children in the household were able to earn incentives. Families were required to be at no higher than 130% of the federal poverty level to be eligible. The program was geared at alleviating poverty, and it was imperative that the involved families met a clear level of need.

Monetary incentives were provided to each family on a bi-monthly basis onto a debit card based on meeting established targets (Morais de Sa e Silva, 2015). The following targets were set by the program and exhibited through the reward system:

*Education: children's superior school attendance, sustained high achievement or improved performance on standardized tests and parental engagement in children's education.*

*Health: maintaining adequate health coverage for all children and adults, and age appropriate medical and dental visits for each family member.*

*Workforce: sustaining full-time work and/or combining part time work with approved education or job training.*

(NYC Center of Economic Opportunity, 2007)

Incentives were designed to target different activities and allow families to diversify their earning potential. More importantly, the incentives encouraged positive behavior change in a number of areas, so there would be a holistic approach to investing in human capital. The program included 22 incentives ranging from \$25 for parents that attend parent-teacher conferences to \$600 for high school students who pass at least two sections of the Regent's Exam. Each family had the opportunity to receive \$4000-\$6000 annually which was 25-35% of additional income. Almost all (98%) families earned at least one incentive in the initial two years of the program and 65% earned an incentive in every period during the program's implementation (NYC Center of Economic Opportunity, 2007).

Manpower Demonstration Research Corporation (MDRC), an education and social policy research organization, evaluated *Opportunity NYC* Family Rewards through a randomized control trial. The researchers found Family Rewards had several positive results in the targeted population; however, there were a number of areas where there were not improvements (Riccio et al., 2013). High school students, were more likely to earn the necessary credits to graduate (Riccio, 2010). Additionally, high school students who passed at least two sections of the Regent's exam increased by 6 points, and the likelihood of 95% or more attendance went up by 15 percentage points by the second year (Riccio, 2010). The results cannot be extrapolated at this point to discuss sustained behavior changes but increased interaction with the school system has been shown to be related to increased school achievement (Balfanz & Byrnes, 2012). The high school students who were already behind in school did not experience any educational gains (Riccio et al., 2013). Conversely, the students who were excelling in school prior to program participation did show educational improvement. Riccio et al. determined the successful students were more prepared to take advantage of the program's incentives, which was backed up in other research on achievement awards and incentives (2013).

In the design process of *Opportunity NYC*, the New York Department of Education was heavily involved but receded their role in the implementation phase. Morais de Sa e Silva theorizes there are several reasons for the Department of Education backing off from the program (2015). One of the primary reasons is the initiative was not spearheaded from the Department of Education, and thus they were not motivated to ensure the program was implemented properly (Morais de Sa e Silva, 2015). Additionally, a large-scale conditional cash transfer model has not been attempted in the United States, causing the Department of Education to be nervous about tying their name to the program (Morais de Sa e Silva, 2015). Due to these

issues, there was no one involved with the *Opportunity NYC* rollout had an educational background (NYC Center of Economic Opportunity, 2007). Considering these factors, it is not surprising there were not more educational gains evident among participants.

For the younger children –elementary and middle school–there were a few positive impacts due to the program; however, overall there were not clear improvements in school outcomes. The students were more likely to attend homework help sessions and community tutoring (Riccio et al., 2013). In the case of this population, the number of measures was limited compared with the high school students. One of the measurements that showed little improvement was attendance rates, but the elementary and middle school students had high levels of attendance prior to the program inception (Riccio et al., 2013). There are few standardized tests required for the elementary school students, so there was not sufficient data to make a determination on those educational outcomes. In this area, more research is necessary to provide a clear understanding of how the program affected this age group.

*Opportunity NYC* designers aimed to encourage increased use of preventive medicine and the research results show there were not significant effects on the health outcomes (Riccio et al., 2013). The program required participants to have health insurance with the purpose of families leading healthier and more productive lives. *Opportunity NYC* did not showcase a significant increase in the use of healthcare services nor a decreased use of emergency room services (Riccio et al., 2013). It should be noted that almost all of the families participating in the study already had health insurance and regular preventative check-ups (MRDC, 2012). The use of dental services increased in all three categories – younger children, high school students and parents or guardians (MRDC, 2012).. In particular, adults in the program group were 10 percentage points more likely to have visited a dentist in the last 12 months (Riccio et al., 2013).

While there were not improvements in every category, it is evident *Opportunity NYC* did make an impact in some areas.

Research by Berlin and Riccio determined the Family Rewards program was primarily successful in reducing poverty level and material hardship of families (Berlin & Riccio, 2010). The share of families living in poverty was reduced by 11 percent and those who live in extreme poverty went down by almost 50 percent (Berlin & Riccio, 2010). The research associated with the MDRC study on Family Rewards indicates that the program can make “an immediate difference in the lives of poor families in a developed country by increasing family income by 23 percent on average” (Berlin & Riccio, 2010, p. 32). In particular, parents in Family Rewards were almost 18 percent more likely to have a bank account after the program was completed. Also they were more likely to have at least \$500 in savings and not have to reach out to family or friends to borrow money (Riccio et al., 2013). Due to the recent introduction of the program, it is not clear whether the behavior changes will be sustained by participants. However, the improved outcomes showcase the conditions associated with the program did lead to positive behavior changes at least in the short-term (Berlin & Riccio, 2010). Overall the program was successful in improving the financial standing of the Family Reward households.

While there are clear improvements in the target population shown in the research study, *Opportunity NYC* had substantial criticism from conservatives and liberals. Many of the concerns were voiced prior to the program’s roll out especially because people thought CCTs would not work in developed, high-income countries. Democratic or liberal-minded criticisms of the program were about CCT’s fundamental notion that poor people were not already exhibiting positive behaviors, and they should be required to earn program money. Conservatives criticized the premise that participants should be paid to complete common-sense actions (Berlin & Riccio,

2010). Additionally, recruiting families was difficult because they were primarily suspicious and confused by the program (Bosman, 2010). The target communities do not necessarily have strong relationships with government agencies, and the incentives required family information to be provided. Consequently, the eligible families had to be thoroughly educated about the purpose of *Opportunity NYC* and the research behind CCTs.

At this time, the Family Rewards program is not currently operating in New York City or elsewhere in the United States. With the criticism of the program's premise and lukewarm results in some areas, it was not adopted by local governments. It is evident that for CCTs to be established in other parts of the United States that private donors will be necessary and the lessons learned from *Opportunity NYC* Family Rewards should be utilized in the program design.

## **2.6 Family Independence Initiative**

The *Family Independence Initiative* is a non-profit organization located in Oakland, California that empowers poor families through cash transfers and peer support. In actuality, the program is not a traditional conditional cash transfer program because participants are rewarded when they report behaviors. The initiative still provides lesson on handling alternative cash transfer programs in the United States. In FII each of the families has a substantial role in their experience because they organize themselves into support groups and set clear personal goals (Stuhldreher & O'Brien, 2011). Maurice Lim Miller founded the program because he was inspired by the history of American immigrant communities banding together to improve their standings through supporting each other's businesses to pooling money together for loans (The Family Independence Initiative, 2016). FII has three main pillars guiding the organization: social network reliance, cash transfers for engagement and monthly feedback. For the cash transfers, participants are provided \$25-\$30 for each reported behavior with a total earning of \$600 per

quarter (Stuhldreher & O'Brien, 2011). The program is a smaller initiative that has only a few hundred participants and does not have a large body of evaluation research. FII reported results show that incomes of participants went up 23% and savings increased 240% within two years (Bornstein, 2011). The framework used by Maurice Lim Miller shows cash transfers programs that are built around positive behavior changes encourage poor families to move in the direction of poverty reduction. In the case of FII, the program uses community building to sustain those changes as well. Overall the initiative is a low-cost framework that has improved the lives of poor participants and adds a dimension to reviewing conditional transfers programs in the United States.

## **2.7 Social Assistance Programs in the United States**

The United States has a complex system of social programs that are a mix of government spending, tax subsidies and private social spending. Compared with other democratic developed countries, the United States taxes its citizens less and spends less on social programs (OECD, 2016). While the country does not match the government spending efforts of other countries, there is still a significant safety net available in the United States. There are several federal programs that provide supplements and subsidies to poor families from the reduce cost cellphone Lifeline to Pell grants for college tuition. The primary programs that assist with the poverty gap and economic hardships are: TANF, SNAP, EITC and WIC. These programs have different eligibility requirements but effectively work together to create a safety net for the American poor.

During President Bill Clinton's administration, there was a full overhaul of the American welfare system with the creation of the Personal Responsibility and Work Opportunity Reconciliation Act. The most impactful change was the establishment of a 60-month lifetime

limit for receiving cash benefits and adults were required to work to be eligible (Gassman-Pines & Hill, 2013). At the time, these changes were necessary as major political opponents were concerned that the social safety net in the United States was encouraging people to be unproductive (Gassman-Pines & Hill, 2013). Over the years, these programs have successfully supplemented the households of poor Americans who are eligible. Throughout the United States they are useful tools for ensuring individuals' basic needs are met and are used in conjunction with private aid as well. The most important social program for this discussion is the Earned Income Tax Credit which is the primary cash transfer social protection in the United States.

### **2.7.1 Earned Income Tax Credit (EITC)**

The Earned Income Tax Credit is the largest cash transfer program for low income families at 200% of the federal poverty line (Eamon et al., 2009). Initially the program was established in 1975 to reduce the social security tax burden of low-income parents and later transitioned into an anti-poverty strategy. Americans are eligible to receive a credit even when their overall income does not meet the threshold for paying federal taxes. Consequently, poor families receive cash transfers during tax season that allow them to supplement their family's annual incomes. Research indicates the EITC has positive impacts on economic circumstances and raised 4 million people above the poverty line in 2003 (Gassman-Pines & Hill, 2013). Unfortunately, research does not exist indicating how these funds are used, and whether or not they sustain families for a significant period of time. The poverty reduction figures are based on adding the amount of money received to the family's annual income. This understanding of the evidence fails to consider how the EITC received during tax season may be utilized to pay debts rather than provide for new items or establish a savings account. Without sustainable

employment opportunities or education, it is not reasonable to assume the cash transfers made a long-term impact.

Overall the child poverty rates decreased from 19.2% to 16% since the EITC became an official portion of the welfare system in 1993 (Eamon et al., 2009). However, in more recent years, the poverty rate has steadily increased (Wight et al., 2010). From a 7% poverty rate in New Hampshire to 28% in Mississippi; it is evident that all Americans are not living the same experience (Wight et al., 2010). EITC has been associated with improved health outcomes, in particular pregnant women with EITC are less likely to have low birth weight babies (Gassman-Pines & Hill, 2013). Researchers have stated the financial status of children's households has long standing effects on their lives with financially secure children having better physical and mental health as adults (Morais de Sa e Silva, 2015). There have not been a significant number of studies regarding how the American social safety net programs have affected children's development. However, the available research shows cash transfers improve children's development, namely due to the funds helping families provide food and healthcare for their children (Gassman-Pines & Hill, 2013). At this time, it is unclear whether or not those changes are solely economic or if they are related to altered family dynamics from the cash transfer.

Due to the current safety net in the United States, low-income families have access to free or low cost healthcare along with food subsidies. Even with the availability of these social programs, the United States has a poverty problem which affects children more than any other segment of the population, and those have led to increasingly poor health outcomes (Racine, 2016). It is evident that EITC supplements family income in the short-term and has proven benefits to assist families in improving their economic station. However, there is not evidence that EITC has benefited families in the long-term and addressed generational poverty (Gassman-



Pines & Hill, 2013). There is no support to indicate that families receiving benefits have permanently changed or improved their socio-economic status.

## **2.8 DeKalb County**

DeKalb County, GA is divided into 13 CAAs—Dunwoody, Chamblee/Cross Keys, Tucker, Druid Hills/Lakeside, Clarkston, Stone Mountain/Stephenson, Atlanta, Decatur, Avondale/Towers/Columbia, Redan, McNair/Cedar Grove, SW DeKalb/MLK and Lithonia. The CAAs were established along old school districts, but still are an effective tool in dividing the county. These CAAs are incredibly diverse in terms of economics, ethnicities, and educational levels resulting in a county that does not have a silver bullet fit for its societal issues.

Approximately 700,000 people reside in DeKalb: 54.2% Black, 34.7% White, 5.2% Asian and 5.9% identify as other; 9.5% of the overall population is Hispanic (“2015 DeKalb County Status of Health Report,” 2015). The northern part of the county is more likely to have residents who are White, employed full time, middle or upper class and educated. The southern part is primarily Black residents and has higher rates of inadequate housing and poverty. DeKalb County has a significant poverty issue considering 1 in 5 residents are living in impoverished households (County Health Rankings, 2015). In particular, 14.7% of families are below the federal poverty level and the unemployment rate is well over the national average of % at 13.3% (County Health Rankings, 2015).

Table 4 Major Areas of Opportunity in DeKalb County, County Health Rankings Data

	<b>DeKalb County</b>	<b>Georgia</b>	<b>Top United States Performer</b>
Severe Housing Problems <sup>1</sup>	22%	18%	9%
Uninsured	22%	21%	11%
Children in Poverty	33%	26%	13%
	<b>DeKalb County</b>	<b>Georgia</b>	<b>Top United States Performer</b>
Violent Crime	605	59	385
Food Insecurity <sup>2</sup>	20%	19%	11%

Table 5 Areas of Strength in DeKalb County, County Health Rankings Data

	<b>DeKalb County</b>	<b>Georgia</b>	<b>Top United States Performer</b>
Physical Inactivity	21%	25%	20%
Access to Exercise	96%	75%	91%

Maternal and childhood health statistics show there is work to be completed around teen pregnancy and live births which are both below the Healthy 2020 targets (“2015 DeKalb County Status of Health Report,” 2015). Breast milk provides necessary nutrients including antibodies to protect infants, and women are recommended to breastfeed for the first 6 months (“2015 DeKalb

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<sup>1</sup> Severe Housing Problems– “Percentage of households where at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing facilities” (County Health Rankings, 2015).

<sup>2</sup> Food Insecurity – “Percentage of population who lack adequate access to food” (County Health Rankings, 2015)

County Status of Health Report,” 2015). When reviewing breastfeeding rates for clients of WIC in DeKalb County, a little over 50% initiated breast feeding but less than 20% continued breast feeding for the full 6 months (“2015 DeKalb County Status of Health Report,” 2015).

Information about the benefits of breastfeeding are imperative for women, and these lessons are shared during prenatal and postnatal visits. It is important to note that women who are poor are less likely to have jobs where they can continue breastfeeding or have paid maternity leave (Office of the Surgeon General, Centers for Disease Control and Prevention , & Office on Women’s Health, 2011). In the United States, the Family and Medical Leave Act of 1993 (FMLA) protects a mother’s position for 12 weeks; however, the leave is unpaid. Consequently, many women are unable to afford to take time off after the birth of their child.

The leading cause of death within DeKalb County is cardiovascular diseases followed by cancer - primarily lung, colon and breast (“2015 DeKalb County Status of Health Report,” 2015). Cardiovascular disease is attributable to poor diet, lack of exercise and smoking. The poor and less educated populations are more likely to smoke as well which enacts a vicious cycle of these individuals using resources to purchase tobacco products and becoming ill from their use (Dobson, 2004). These behaviors are often linked with poverty due to improper access to foods and safe places to exercise combined with less resources to purchase healthy foods. Survey data shows only 21% of residents in DeKalb County indicate they are physically inactive despite 96% having access to places for exercise (County Health Rankings, 2015). However, these numbers are percentages for the entire county and do not fully show the experience of all residents, especially those in South DeKalb.

A major concern in DeKalb County is the homicide rate which was 11.9 per 100,000 people, almost double the state of Georgia at 6.5 (“2015 DeKalb County Status of Health

Report,” 2015). Homicide is the number one cause of death for the following age groups within DeKalb County: 1-4; 15-24 and 25-34. Black males between the ages of 13 and 59 completely outpace other groups when looking at homicide rates; they are five times more likely to die from homicide. Poverty and violence have a clear interplay and improving the economic station of affected DeKalb County residents would be a positive step in decreasing the crime rate, especially the number of homicides.

The most common chronic illnesses in DeKalb County are asthma, diabetes and cardiovascular diseases -high blood pressure, hypertensive heart disease, obstructive heart disease and stroke (“2015 DeKalb County Status of Health Report,” 2015). In DeKalb County, chronic diseases are disproportionately affecting the southern portion of the county which is primarily populated by people of color and those who are low income (“2015 DeKalb County Status of Health Report,” 2015). For DeKalb County, Black residents were more likely than White residents to be overweight or obese (“2015 DeKalb County Status of Health Report,” 2015). Additionally, Black residents have higher rates of smoking and physical inactivity (“2015 DeKalb County Status of Health Report,” 2015). These increased percentages for risk factors correlates to the higher prevalence of chronic illness within the Black community in DeKalb County (“2015 DeKalb County Status of Health Report,” 2015).

In terms of educational outcomes, 71% of the public school students in the county are economically disadvantaged (“2015 DeKalb County Status of Health Report,” 2015). Of the ninth graders who entered high school in 2008, 53.4% of them graduated within 4 years (County Health Rankings, 2015). Education is a major concern in the county and informs many of the risk factors leading to poor health outcomes. All of the federal social assistance programs are available in DeKalb County, but these are not leading to sustainable changes regarding health,

education and poverty. DeKalb County would benefit from a program that would target alleviating the poverty levels, increasing educational attainment rates and improving health outcomes. Research indicates CCTs are helpful in addressing these issues.

## Chapter 3: Methodology

### 3.1 Ecological Systems Theory

The review of the literature was guided by the understanding that there are systems in society that interact to shape the experiences of individuals. As demonstrated in the literature review, evaluations of CCTs show these programs are effective tools to address poverty and the associated poor health outcomes and educational attainment rates. These programs show that conditions are imperative to changing behaviors that lead to poor health outcomes, and providing cash to families empowers them to improve their households. CCTs have chiefly been a tool of the developing world and must be adapted to work within the different social, economic and political context of the United States. More importantly, a CCT has to consider the unique needs of the local community and the areas of opportunity. The work completed by *Opportunity NYC* and FII are examples that CCTs can be implemented in the United States and are an innovative way to alleviate poverty. The reviewed programs were successful in addressing the overlapping levels of society and considering how they interact to inform an individual's behavior.

The findings in the literature review shaped the decision to recommend the construction of a CCT in DeKalb County. Existing social assistance programs in DeKalb are not addressing the widespread violence, high infant mortality rates, low educational attainment or the number of individuals with preventable chronic illnesses. While conditional cash transfer programs do not have a long history in the United States, the available evidence shows CCTs are a viable option to address poverty in this community. The experiences of *Opportunity NYC* show how important

it is to consider every level of society when some of their educational initiatives failed after not engaging the Department of Education.

In exploring the implementation of a conditional cash transfer program in DeKalb County, GA, the ecological systems theory by Urie Bronfenbrenner will guide the discussion. The selection of the Ecological Systems Theory was critical in ensuring that a systematic approach to planning a social program was adopted. The model states the behavior and development of an individual is influenced by the different environmental systems that affect him (Bronfenbrenner, 1992). There are five systems – microsystem, mesosystem, exosystem, macrosystem and chronosystem - detailed in the theory, and they overlap to clearly outline the interactions an individual faces in his life (Bronfenbrenner, 1992). The microsystem has the most impact because it refers to the direct environment where primary social interactions take place. When selecting the organizations to engage and the appropriate conditions to require, the ecological systems theory was a necessary tool to ensure the program has a holistic approach. Poverty is the state of being poor and a pervasive factor that affects all aspects of life and thus the ecological systems theory is an effective tool.

## **Chapter 4: Results**

### **4.1 Recommended CCT Program for DeKalb County**

The design and implementation of CCT programs must be adapted to the targeted community for the most successful results. Developers must understand the basic needs of the community and how those affect their ability to function within their environment. As apparent with the CCTs throughout Latin America and the ones established in the United States, the required conditions must be reasonable and address the health and educational concerns for those communities. In DeKalb County, there is fair access to the federal social programs – WIC, SNAP and TANF- and local non-profits to support vulnerable populations. The United States has several programs designed to address various needs; however, individuals must be aware of how to access these resources. Poor families have the opportunity to receive subsidies for necessary resources (housing, food and healthcare) and in-kind products. These recipients do not have autonomy to choose how those funds are utilized, meaning they are unable to prioritize their own needs.

In the case of TANF, there are requirements of education and immunization for minor children of recipients. Additionally, there are eligibility regulations that limit the ability to access the funds for most individuals and individuals may only receive a total of 48 months of benefits. For the most part, individuals are required to demonstrate need and fill out the appropriate paperwork to receive benefits from social programs in the United States. The social programs available do not have set conditions that must be met in exchange for funds, which may inform the reasons behind the inability to address long-term poverty. The EITC cash transfer is available



to eligible citizens; however, the funding is provided only during tax time, once a year.

Researching the effects of EITC indicates the injection of funds into families does alleviate the immediate effects of poverty, but there is no evidence of long term changes.

DeKalb County has poor health outcomes and negative socioeconomic factors attributable to the effects of poverty. While social programs exist and are utilized, the implementation of a social protection tool like a CCT has the promise of leading to sustainable change. From the demographics and geographic location of poor health outcomes in DeKalb, it is evident the largest area of need is south DeKalb County. The CAAs in this region have the highest prevalence of chronic illnesses, mortality rates and poverty rates (“2015 DeKalb County Status of Health Report,” 2015). These issues are combined with low educational attainment for adults and low rates of high school completion among young people. The overall unemployment rate is elevated compared with the greater United States as well (County Health Rankings, 2015), which may be related to lower educational status or due to diminished job availability because of poor infrastructure (“2015 DeKalb County Status of Health Report,” 2015).

Additionally, education and job availability have ties to the homicide rates within the county (“2015 DeKalb County Status of Health Report,” 2015). The primary age groups that are affected by homicide would gain the most from a push for school attendance and improving education. From the rates listed, it is evident that less than 55% of DeKalb County high school students are graduating in four years (“2015 DeKalb County Status of Health Report,” 2015). A conditional cash transfer program could encourage school attendance and combined with a partnership with the Department of Education has the promise of providing alternatives to poor behavior. As shown in the studies on conditional cash transfers, they inspire and invest in the next generation and illuminate opportunities to move past the cycle of poverty (Das, 2005;

Fiszbein & Schady, 2009; Morais de Sa e Silva, 2015; Owusu-Addo & Cross, 2014; Riccio et al., 2013).

#### **4.2 Program Design Considerations**

A CCT program in DeKalb County should target educational attainment. As demonstrated in *Opportunity NYC* and FII, the political atmosphere of the United States does not lend itself to utilizing governmental funds to establish a new social program. The federal government has set guidelines for social programs and there is not leeway to incorporate conditions. Georgia does have the flexibility with Medicaid expansion to design an innovative plan; however, this program is related to insurance. More importantly, Georgia is a conservative state that completely rejected Medicaid expansion even with the promise of federal funds. This decision proves the state would not fund an additional social program with public money. The program should be funded by private donors and grants as modeled by *Opportunity NYC*. It would be imperative to partner with community organizations (Georgia Healthy Family Initiative, Healthcare Georgia Foundation, Literacy Action, Our House, Georgia Campaign for Adolescent Power & Potential) that are aware of DeKalb County's needs and can facilitate program development. These organizations also have the resources to construct a coalition to collect and maintain funds for a CCT. The sustainability of the program would require the coalition to garner buy-in from government agencies as well. A systematic review of the literature on CCTs would inform the development as shown in this paper. Conditions that address the needs of DeKalb County have been developed and outlined in Table 6.

Table 6 Suggested Conditions for a Pilot Program

<b>Systems Level</b>	<b>Component Area</b>	<b>Conditions of Program</b>
Exosystem	Funding	Program should be funded by private donors and grants as modeled by <i>Opportunity NYC</i>
Exosystem	Design	Coalition of government agencies to ensure proper design and buy-in
Microsystem	Education	All children under 17 should be enrolled in school at the start of the academic year.
Microsystem	Education	All students under 17 are required to maintain an attendance rate of 85%.
Mesosystem	Health	Expectant mothers must attend prenatal visits and necessary wellness visits.
Mesosystem	Health	New mothers must attend postnatal visits including education courses.
Mesosystem	Health	All children under 18 must adhere to the vaccination schedule.
Mesosystem	Health	All children under 18 must attend preventative wellness visits.

## **Chapter 5: Discussion, Recommendations and Conclusions**

### **5.1 Discussion**

A proposed CCT program has been made based on review of exemplary programs and a theory guided development process for DeKalb County. While adoption of the program is an important first step, evaluation of its feasibility must be a priority. A two-year pilot program should be established to determine the feasibility and sustainability of a CCT initiative in South DeKalb. According to the Health and Human Services Department, a pilot program should be initially implemented to alleviate problems with the model and test the evaluation tools (The National Campaign to Prevent Teen and Unplanned Pregnancy, 2011). The pilot program will inform the next steps for a full-scale implementation in DeKalb County. Additionally, the pilot program will strengthen the community relationships that will be vital for the CCT's success. For BFP, the program was implemented for three years (Callister, 2013) before there was clear evidence of improvements and *Opportunity NYC* saw minor improvements within two years (Riccio et al., 2013). A two-year pilot may demonstrate short-term results; however, the reasoning behind the pilot is to ensure the program is properly adapted to DeKalb County and has the protocols in place to be successful. The guidelines of NIH's R21 grants are used for designing the length of the pilot study.

Initial participants should be selected from existing social programs. Eligible family units will be below the federal poverty line and have at least one minor child. The pilot will target participants in the most affected communities – Redan, SW DeKalb/MLK and McNair/Cedar Grove. The program should be evaluated at two-month intervals to determine effectiveness and

how to better serve the targeted communities. *Opportunity NYC* has designed an evaluation model which is provided on their online toolkit and can be adapted to fit DeKalb County's needs.

The successes and failures in the development of other CCTs informs the design of a CCT program in DeKalb County. The educational components – determined through required enrollment of all school-aged children and regular attendance – is a necessary condition. In Brazil, BFP noted increased graduated rates, more students pursuing secondary education and lower teenage pregnancy when evaluating their educational conditions (Rasella et al., 2013; Sánchez-Ancochea & Mattei, 2011; Shei, 2013; Shei, Costa, Reis, & Ko, 2014). By requiring school attendance, educational attainment rates increase which open the door for opportunities to overcome the effects of childhood poverty. For a CCT in DeKalb County to be successful, the program must engage and build connections with the Department of Education. This relationship will ensure the communication with participants and implementation of the conditions are reasonable and effective. With *Opportunity NYC*, there was not a significant change in the educational initiatives. The students involved in the program did not have higher test scores or show improved attendance rates. Researchers theorized the students selected were already achieving academic goals. However, they were more concerned with *Opportunity NYC*'s program developers' failure to communicate with the Department of Education about how to address educational needs in New York City. *Opportunity NYC* did not have anyone on their taskforce with a background in education.

Considering the number of chronic illnesses in DeKalb County, the health component is imperative to address. For the developing Latin American countries, the participants had access to free and accessible healthcare due to a strong, public healthcare system. Even with the passage of ACA, there remains an accessibility and affordability issue that affects poor families when

they engage with the healthcare system. Participants should be educated about how to access healthcare and the available resources. The success of CCTs requires that participants are educated and can efficiently and effectively address the conditions. The fact that the goal is to invest in communities through education and healthcare has to inform the development of every aspect of the program.

The logistics of disseminating funds for a cash transfer program can be challenging; however, the United States already has existing technology to address those issues. As shown in the *Opportunity NYC* program and BFP, the most effective means to provide a cash transfer is the use of debit cards. These are used to provide individuals with funds through SNAP. Determining the adherence to conditions may be problematic and difficult to ensure as a program grows. The completion of the health conditions would be proven by medical notifications from primary care physicians and the Georgia Registry of Immunization Transactions and Services (GRITS). For the educational initiatives, the design of a form to be filled out by homeroom teachers would be sufficient.

Cash transfers have been shown to be effective in the United States as evident by the EITC (Eamon et al., 2009). However, the transfer of a large amount of funds at the beginning of the year does not assist with a long-term plan to alleviate poverty. Conditional cash transfers in BFP are delivered on a monthly basis to a debit card. Consequently, families have a consistent injection of supplement income that allows them to make informed decisions to improve their economic standing. Participants have the opportunity to prioritize their needs and prevent the acquisition of additional debt. This process should be used in the development of CCT program in DeKalb County.

## 5. 2 Recommendations

1. Complete a needs assessment to ensure an understanding of the social, political and economic needs for the initial targeted communities. South DeKalb has the direst health and educational needs especially the following CAAs: Redan, SW DeKalb/MLK and McNair/Cedar Grove.
2. Discuss feasibility of the program with strong local organizations (governmental and non-profits) focused on health and education: Children’s Healthcare of Atlanta, DeKalb Regional Health, Emory Healthcare, Grady Hospital, CDC, city seats in DeKalb County, Agnes Scott College, Emory University, Mercer University, Mothers Offering Resources and Education (MORE), United Way, Adolescent Health and Youth Development Program, Special Supplemental Nutrition Program for Women, Infants and Children (SNAP) and Immunization Program
3. Develop an advocacy coalition of non-profits, schools in the targeted CAAs and governmental agencies to support the implementation of the program.
4. Construct a pilot CCT program that focuses on improving health outcomes and educational attainment in South DeKalb County using BFP, FII and *Opportunity NYC* as a guide. Determine an incentive guide to complement the CCT and is tiered for different family units. The program should utilize the conditions listed in Results. For the educational conditions, the program should partner with the Department of Education to ensure it addresses how to alleviate the poor educational attainment rates.
5. Design an evaluation protocol based on the toolkit provided by *Opportunity NYC* to determine effectiveness.

### **5.3 Conclusion**

In conclusion, cash transfers programs are a tool to address poverty and potentially alleviate the stigmas associated with the current social programs by requiring conditions. The stigma of utilizing public services is a reality and interplays with negative factors from living in poverty. A CCT program may empower poor families in DeKalb County and improve their health outcomes.



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