

Social Cash Transfers and Children's Outcomes

A Review of Evidence from Africa



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Acronyms

AIDS	acquired immune deficiency syndrome
ART	antiretroviral therapy
CB-CCT	Community Based Conditional Cash Transfer
CCT	conditional cash transfer
CGP	Child Grant Programme
CSG	Child Support Grant
CT-OVC	Cash Transfer for Orphans and Vulnerable Children (Kenya)
DAC	Development Assistance Committee
DFID	Department for International Development (UK)
DSD	Department of Social Development (South Africa)
EC	European Commission
ECD	early child development
EPRI	Economic Policy Research Institute
FAO	Food and Agriculture Organization of the United Nations
GHS	Ghanaian cedi
GIZ	German Society for International Cooperation (Gesellschaft für Internationale Zusammenarbeit)
HIV	human immunodeficiency virus
HSCT	Harmonized Social Cash Transfer Programme (Zimbabwe)
HSNP	Hunger Safety Net Programme (Kenya)
IE	impact evaluation
IYCF	infant and young child feeding
LEAP	Livelihood Empowerment against Poverty (Ghana)
LEWIE	local economy-wide impact evaluation
MCP	Multiple Categorical Programme
NCTPP	Nahouri Cash Transfers Pilot Project (Burkina Faso)
NGO	non-governmental organization
NHIS	National Health Insurance Scheme (Ghana)
OECD	Organisation for Economic Co-operation and Development
PAS	Programme d'Allocations Scolaires (School Allowance Programme) (Tunisia)

PNAFN	Programme d'aide aux familles nécessiteuses (National Programme of Assistance to Needy Families) (Tunisia)
PSA	Programa Subsidio de Alimentos (Food Subsidy Programme) (Mozambique)
PSM	propensity score matching
PSNP	Productive Safety Net Programme (Ethiopia)
PSS	psycho-social status
PtoP	From Protection to Production
RCT	randomized control trial
SAGE	Social Assistance Grants Empowerment (Tanzania)
SASSA	South African Social Security Agency
SCT	Social Cash Transfer
SDG	Sustainable Development Goal
TASAF	Tanzania Social Action Fund
UNICEF	United Nations Children's Fund
UNICEF ESARO	United Nations Children's Fund Eastern and Southern Africa Regional Office
WASH	water, sanitation and hygiene
WFP	World Food Programme of the United Nations
ZECT	Zimbabwe Emergency Cash Transfer
ZMW	Zambian kwacha

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Executive Summary

The impact of social cash transfers on children in Africa

This document synthesizes the emerging evidence from various reports on the impact of social cash transfers in Africa. Social transfers are non-contributory, predictable transfers of cash or goods and services in kind, delivered to individuals or households in order to protect them from the impact of shocks, as well as to support the accumulation of human, productive and financial assets.¹ In Africa, alongside a few well-established programmes in southern and northern Africa, the rest of the continent has seen a progressive expansion in the use of social transfers, particularly unconditional cash transfers, since the 1990s. Social cash transfers have become a critical instrument of many national poverty-reduction and social-development strategies across the continent.

Due to the important investment of many governments in the region and the support of key partners, including the Transfer Project and others, the region has a critical mass of evidence to show the impact of social transfers on multiple areas and outcomes, including on: food consumption and security, nutrition, access to education and health, and mitigation of the impacts of HIV and AIDS. Social transfers likewise address social and economic drivers of HIV risk, adolescent wellbeing and prospects, and early childhood development. They have significant impacts in terms of household economic production and there are spill-over impacts on local markets. Emerging evidence

also shows the role of social cash transfers in revitalizing non-formal social protection structures and networks at the community and the village level.

The purpose of this document is to provide a synthesis of the available evidence that has so far come out of Africa, in order to strengthen the case for social cash transfers as a critical instrument of poverty alleviation at the national, regional and global level.

As social transfer programmes have expanded, so has the body of evidence demonstrating their impact. This desk review and mapping of the impact evaluations of social transfers in Africa includes two distinct types of assessment:

- **Evaluations of national programmes (pilot or national coverage²),** which are implemented through national governance structures. This evidence has been collected over a number of years; it is rigorous and robust, providing a strong basis on which to chart policy implications.
- **Evaluations of one-time experiments or programmes implemented in emergency contexts,** which are not part of government structures or development strategies, are more geographically localized and often implemented by non-governmental organization (NGOs) or other independent actors. These tend to be 'proof of concept' evaluations of small-scale pilots.

Social transfers have demonstrated an impact on a wide range of outcomes for children:

- **Multi-sectoral impact:** well-designed social transfer programmes have been

shown to have an impact on a broad range of outcomes in terms of human capital (improved education, health, HIV/AIDS outcomes, nutrition, etc.), as well as on economic development and on community and social dynamics.

- **Short-term and long-term impact:** social transfers can address both income deficits in the short term and structural vulnerabilities and power hierarchies in the longer term.
- **Building resilience:** social transfers can help build families' resilience to future crises, as well as to support the transition from a humanitarian to a development approach.

The nature and magnitude of the impacts vary across countries and sectors, due to differences in programme design, implementation and context. As the trend for rigorous impact evaluation continues, it is expected that the evidence base will also grow in coming years.

Operational lessons learnt

The success of social transfers is dependent on programmes being well designed and adapted to

the local context. Many operational lessons have been learnt from the experience of programmes in Africa and elsewhere: transfer values should be large enough to make a difference to families' incomes; it is essential that social transfers be delivered on time; targeting should be transparent and clearly communicated; transfers should be predictable, to allow households to plan, manage risk and invest in diverse activities; and the profile of beneficiaries will determine the type of impacts to be expected. When appropriate and good-quality social transfer programmes are designed and implemented, impressive results have followed.

The evidence to date shows that social cash transfers work in Africa. Home-grown models of social protection have contributed to an improvement in the standard of living of the poorest and most excluded populations in Sub-Saharan Africa. Although countries still face outstanding challenges in terms of capacity, scaling up and expanding programmes, and ensuring sustainable financing, social cash transfers are a critical intervention that addresses poverty and exclusion in the region in an effective way.

¹ Social transfers are one of the tools of social protection. UNICEF defines social protection as a "set of public and private policies and programmes aimed at preventing, reducing and eliminating economic and social vulnerabilities to poverty and deprivation".

² Evaluations of these programmes have been mainly supported by the Transfer Project.

Introduction: the strategic relevance of social protection for children in Africa

UNICEF defines social protection as a “set of public and private policies and programmes aimed at preventing, reducing and eliminating economic and social vulnerabilities to poverty and deprivation”. Social transfers (non-contributory, predictable transfers of cash or goods and services in kind) are one of the tools that can be used within a wider social protection programme. Globally, support for social protection has been gaining considerable momentum over recent years: the Social Protection Floor Initiative was established by the UN system's Chief Executives Board in 2009; the Social Protection Floors Recommendation (No. 202) was adopted at the International Labour Conference in 2012; international actors, including the European Union, World Bank,³ and UNICEF,⁴ have launched strategic frameworks and policies; and social protection is now one of the proposed targets under Goal 1 of the Sustainable Development Goals (SDGs).⁵

At the regional level, the African Union Social Policy Framework recognized social protection as one of its central components in 2009. Progressively, the political commitment to social protection, particularly cash transfers, has translated into a significant expansion of programmes. The wave of support for social protection has spread across Africa, adding to the already well-established programmes in the continent's northern (Morocco, Tunisia, Egypt) and southern (South Africa, Botswana, Namibia) parts. Between 2000 and 2005, many

other countries in Eastern and Southern Africa followed suit; they were then joined by a number of countries in West Africa that have also set up their own social protection programmes since 2006.⁶ This growing commitment to social protection has emerged in response to the impact of the HIV/AIDS epidemic in the region and growing concerns around predictable and recurrent food crises. Social protection is also integral to the region's approach to equity, promoting social inclusion and supporting the protection of children and the realization of their rights, as reflected in several continent-wide frameworks and policies.

Although there are some differences between social transfer programmes, reflecting each country's specific context, programmes generally share the following common elements:

- Eligibility criteria respond to economic vulnerability (poverty), and also focus on key social vulnerabilities, including exclusion due to HIV/AIDS, age, disability, etc.
- Average social transfer values range from US\$8 to US\$25 per household per month, depending on the country and payment structure (e.g. whether transfers are linked to family size or other factors of vulnerability).
- There are unconditional programmes, and also some conditional programmes. Many social transfer programmes in Africa are unconditional,⁷ and evidence shows that

this approach has proven results that are on a par with results from similar conditional programmes in other regions.

- There is strong community participation in the design and implementation of programmes, including in the selection of beneficiaries, the targeting and monitoring of programme implementation.

The positive outcomes of social transfer programmes are varied and depend on the particular context and issues that children face in each country, but include: strengthening human capital (improved health, education, nutrition, etc.), HIV/AIDS outcomes, resilience, economic development and state-building (reinforcing the social contract).

The evidence reviewed in this report is mainly from impact evaluations of national social transfer programmes.⁸ These evaluations have been designed as long-term endeavours, where data is collected in several follow-up rounds to monitor progress in critical indicators. The evaluations are methodologically rigorous and robust, providing a strong basis on which to draw policy conclusions. As social protection programmes expand and the children who benefit from them grow into adults – and have children of their own – the body of evidence is expected to reveal the longer-term positive impact. It is expected that the growing evidence will progressively make a strong case for social transfers as a tool that can address inter-generational poverty and contribute to transforming the very power relations that perpetuate inequality. To date, the impact of social transfers has already been rigorously measured; the assessments show impressive results in key outcomes, as will be presented in the forthcoming chapters.

However, despite the clear positive outcomes for

children, there are still some recurring concerns raised by national governments, international donors and the development community about the impact and rationale of social transfers, such as: Are the correct people being reached effectively by social transfers? Is the money being spent well by families? Are more children going to school even without this being a ‘condition’? Can social transfers actually reduce the likelihood of an adolescent engaging in risky behaviours that might lead to HIV exposure? Do families receiving the transfers become more economically resilient, rather than more dependent, as is commonly assumed?⁹ As will be discussed in this document, the large body of evidence available strongly suggests that the answer to all these questions is ‘yes’.

Drawing both on this evidence and on theory, this paper aims to synthesize the various impacts that social transfer programmes have had on child outcomes, making the case for social transfers as an effective policy and programme response to address social and economic vulnerability in Africa.

- **Part 1** examines the methodology and scope of the social transfer impact evaluations reviewed here.
- **Part 2** outlines the overall impact pathways, identifying the different ways in which social transfers can produce positive outcomes for children and their care-givers.
- **Part 3** covers the various impacts in each sector: consumption, food security and nutrition, education, health, HIV/AIDS and adolescent wellbeing, economic and productive impacts, social cohesion, child protection and early childhood development. The impact pathways for each sector are outlined and the evidence available from programmes in Africa is summarized.

³ World Bank (2012).

⁴ UNICEF (2012b).

⁵ Goal 1 of the SDGs is to “End poverty in all its forms everywhere” and target 1.3 is to “implement nationally appropriate social protection systems and measures for all, including floors, and by 2030 achieve substantial coverage of the poor and the vulnerable”. See <http://sustainabledevelopment.un.org/focussdgs.html>

⁶ According to World Bank (2014): “There are now 37 countries in Africa in which unconditional cash transfer programmes in place – 16 of these have been newly set up since 2010.”

⁷ The term ‘unconditional’ is used to mean that receipt of the transfer is not linked to the recipient doing certain tasks (such as taking children for health checks, school enrolment or participating in community works programmes). Conditionality should be distinguished from targeting/selection criteria (such as having a child under the age of five, disability, living in a certain area, etc.) which are used in all programmes to identify those individuals or families that are eligible for inclusion in the programme.

⁸ The Transfer Project was set up in 2008, designed to support rigorous impact evaluation and learning around cash transfer programmes in Africa. For more details see: <http://www.cpc.unc.edu/projects/transfer>

⁹ Outstanding questions are also present in terms of sustainability, graduation, affordability and cost, and operationalization of a systems approach to social protection. However, these require additional analysis and evidence which is beyond the scope of impact evaluations.

- **Part 4** identifies the operational lessons learnt and the keys to success, in terms of programme design and implementation (targeting, transfer amounts, etc.).
- **Part 5** presents key conclusions.

Box 1: Defining child-sensitive social protection

UNICEF defines social protection as a “set of public and private policies and programmes aimed at preventing, reducing and eliminating economic and social vulnerabilities to poverty and deprivation” (UNICEF 2012).

It identifies four key components of child-sensitive social protection systems:

- (1) Social transfers, which are non-contributory transfers of cash or goods in kind (such as food or school uniforms), delivered to individuals through a state-run, long-term programme;
- (2) Programmes to ensure economic and social access to services;
- (3) Social support and care services; and
- (4) Legislation and policies to ensure equity and non-discrimination in children's and families' access to services and employment/livelihoods.

Social protection programmes can address: (1) 'lifecycle' vulnerabilities, common to all people at certain stages in their lives, through instruments such as child grants, pensions, etc.; (2) 'idiosyncratic' vulnerabilities, affecting certain groups of individuals, such as chronic illness, loss of employment, etc.; and (3) 'covariate' risks, i.e. that affect a whole community, such as drought-related risks, through safety net programmes.

In its work with national governments, UNICEF promotes three core principles in social protection: (1) the progressive realization of universal coverage (so that all those eligible can be included); (2) national systems and leadership; and (3) inclusive social protection (i.e. developing systems that include and address vulnerabilities of all groups in society, including those that are marginalized or that experience discrimination).

Source: UNICEF (2012).

1. Methodology of impact evaluations

In our review and mapping of the impact evaluations (IEs) of social transfers in Africa, we identified two distinct types of assessment:

1. The first covers robust **assessments of national (government-owned) programmes**. These programmes tend to be wholly implemented through national governance structures. Some are in the pilot stage and others are in the process of scale-up and expansion to reach national coverage. The evaluations of these programmes have rigorous control or comparison groups, baselines and one or more follow-ups (see Box 2 below on evaluation methodology). They assess the impacts on programme objectives, such as food security and human capital, as well as 'secondary impacts', such as on HIV behavioural risk, adolescent transitions to adulthood, or economic and productive activities. In the course of writing this paper, we have reviewed and synthesized nineteen impact evaluations of this type, from programmes implemented in fourteen different African countries (see Table 1 below).
2. The second type consists of **assessments of pilot programmes or one-time experiments**. These are not always part of government structures or development strategies, are

more geographically localized and are often implemented by NGOs or other independent actors. They have been developed with rigorous methodologies, but they tend to be 'proof of concept' assessments of small-scale pilots, showing that, in a given context, a certain programme can indeed have a positive impact. See Table 1 below for list of the evaluations of this type reviewed here.

In addition, three evaluations of the use of **cash transfers in humanitarian action** have been reviewed. Due to the rapidly changing context in an emergency and the frequent lack of baseline data, evaluations of this type generally use the Organisation for Economic Co-operation and Development's Development Assistance Committee (OECD DAC) evaluation criteria for humanitarian action, and they adopt a more qualitative approach.¹⁰

Since pilots, one-time experiments and programmes implemented in an emergency context contain design features that may not always be applicable to national, large-scale interventions, arguably it is less easy to draw lessons that are applicable in other contexts. **This review therefore focuses mainly on evidence available from evaluations of government-led programmes.**

¹⁰ For more information on the OECD DAC criteria, see: <http://www.alnap.org/resource/5253>

Box 2: Evaluation methods used in the assessment of national social protection programmes

A simple technical overview of the evaluation methods employed in the assessment of national programmes is offered below.

Randomized designs: this entails randomly assigning eligible households (or individuals) to intervention or control status. In the public health sciences, these are often referred to as randomized control trials (RCTs), while in economics and social sciences they are referred to as social experiments, because they take place in the wider society (and not in a laboratory). Most large-scale social experiments collect baseline data, as well as one or more rounds of follow-up (post-intervention) data, in order to compare changes in outcomes over time from the baseline. Because they are equally large and because households or individuals are randomly assigned to treatment status, the treatment and control groups can be regarded as statistically similar in all respects, apart from the fact that one receives 'treatment'.¹¹

Matching methods: propensity score matching (PSM) is an approach that uses statistical analysis to identify households or individuals that are similar to those actually enrolled in a programme, and then uses these individuals as the comparison group to assess programme impact. Comparisons using PSM

may be done either at one point in time (after the programme has been in operation for a period) or longitudinally, comparing changes over time in the intervention and comparison groups. The success of this method relies on the ability to statistically model the likelihood that individuals or households are eligible for the programme; this in turn requires a good understanding of programme eligibility criteria. In general, matching methods entail some linkage of an intervention group or individual with a similar or 'matched' comparison. Matched case-control designs, for example, involve taking each treated unit and matching it to a control unit. For example, the Ghana LEAP evaluation uses longitudinal PSM, while the Zimbabwe HSCT uses a district matched case-control design, where each treatment district is matched with a control district.

Simulations: simulation methods entail statistically calculating key behavioural parameters, such as the marginal propensity to consume or the marginal productivity of an agricultural input (e.g. fertilizer) and then predicting the impact of the programme using these parameters. Simulation methods are used to calculate local economy impacts in Zambia, Ghana, Kenya, Lesotho, Zimbabwe and Malawi.

Table 1: Evaluations and research (by type) on the impact of social protection in Africa, reviewed for this report

Type of evidence	Country (in alphabetical order, by type)	Programme
1. Impact evaluations –national programmes	1) Ethiopia	Productive Safety Net Programme (PSNP) Tigray Social Cash Transfer (SCT) Programme*
	2) Ghana	Livelihood Empowerment against Poverty (LEAP) Programme
	3) Kenya	Cash Transfer for Orphans and Vulnerable Children (CT-OVC) Hunger Safety Net Programme (HSNP)
	4) Lesotho	Child Grant Programme (CGP)
	5) Liberia	Bomi Social Cash Transfer (SCT) Programme
	6) Malawi	Social Cash Transfer (SCT) Programme (Mchinji District Pilot) Social Cash Transfer Programme Expansion*
	7) Morocco	Tayssir programme
	8) Mozambique	Programa Subsidio de Alimentos (PSA) or Food Subsidy Programme
	9) South Africa	Child Support Grant (CSG)
	10) Tanzania	Productive Social Safety Net (PSSN)/Tanzania Social Action Fund (TASAF) Community Based Conditional Cash Transfer (CB-CCT) Programme
	11) Tunisia	Programme d'Allocations Scolaires (PAS), part of the Programme d'aide aux familles nécessiteuses (PNAFN) or National Programme of Assistance to Needy Families
	12) Uganda	Social Assistance Grants Empowerment (SAGE) Programme* Karamoja Food and Cash Transfers at Early Childhood Development Centres Programme
	13) Zambia	Social Cash Transfer (SCT) Programme
	14) Zimbabwe	Harmonized Social Cash Transfer (HSCT) Programme*
2. Pilots/Donor-led	1) Burkina Faso	Nahouri Cash Transfers Pilot Project (NCTPP)
	2) Malawi	Zomba District Cash Transfer Trial
	3) Tanzania	Cash Transfers for HIV and sexually transmitted infections prevention
	4) Uganda	Cash Transfer Effects on Transportation Costs for HIV-affected households
	5) Zambia	Cash Transfer Effects in HIV-affected Households
	6) Zimbabwe	Adolescent Orphan Girls in School (HIV Risk Prevention)
3. Humanitarian programme evaluations	1) Niger	Cash Transfer to Protect Blanket Feeding
	2) Somalia	Unconditional Cash and Voucher Programme in South Central Somalia
	3) Zimbabwe	Zimbabwe Emergency Cash Transfer (ZECT) Pilot Programme

* Evaluations, research or studies that are still ongoing in 2014.

NB: the above table lists the evidence that has been reviewed here – it is by no means exhaustive, but is intended to provide an indication of the breadth of evidence currently available.

¹¹ Studies using this approach include those undertaken in Zambia, Lesotho, Kenya and Malawi.

Key stakeholders

A number of key stakeholders must be acknowledged in the development of this body of evidence on the impact of social transfer programmes in Africa. First, many **African governments** have played a critical role in supporting the development of impact evaluations of their flagship programmes, being active stakeholders in the design and implementation of studies, as well as in discussing the results and implications for re-design and policy. This has included the commitment and leadership of ministries of social welfare/protection and others, but also of the national statistical agencies in many countries.

Secondly, since 2008 the **Transfer Project** has contributed to building innovative research into the impact of social cash transfers in Africa, supporting many of the large-scale, rigorous mixed-methods impact evaluations of national programmes.¹² The Transfer Project's approach to evaluation is based on an interdisciplinary conceptual framework, i.e. the notion that social transfers, particularly unconditional transfers, have wide and varied impacts on the family, community and local economy. A unique characteristic of these evaluations is the application of a mixed-methods approach, including quantitative and qualitative analysis, as well as simulations, specifically to explore the dynamics of local economies and the potential effects of cash transfers. The project is a collaborative effort on the part of UNICEF, the Food and Agriculture Organization (FAO), Save the Children UK (SCUK), the University of North Carolina at Chapel Hill and national

governments, particularly those of Ethiopia, Ghana, Kenya, Lesotho, Malawi, Mozambique, South Africa, Zambia and Zimbabwe. Others are expected to join soon. This exchange between different countries is a unique characteristic of the Transfer Project, and it takes the evaluation findings beyond the national policy discussions in which they are usually embedded. In addition, international research organizations involved in the Transfer Project have developed partnerships **with local researchers and institutions**; this has contributed to strengthening the local research capacity, enhancing context specificity, addressing local dynamics and developing national research protocols. As well as supporting impact evaluations of national cash transfer programmes, the Transfer Project aims to improve the technical methodology of impact evaluation and to share primary data sets.

As part of the Transfer Project, the **From Protection to Production (PtoP)** project has also contributed to building the evidence base reviewed here.¹³ PtoP is a multi-country impact evaluation that focuses on measuring the effect of cash transfers on productive and economic activities and is led by the FAO, in partnership with UNICEF. The seven countries and programmes that have participated in the project are: Ethiopia (Tigray Social Cash Transfer Programme), Ghana (Livelihood Empowerment against Poverty), Kenya (Cash Transfer for Orphans and Vulnerable Children), Lesotho (Child Grant Programme), Malawi (Social Cash Transfer), Zambia (Child Grant Programme) and Zimbabwe (Harmonized Social Cash Transfer).

UNICEF, as a partner in the Transfer Project and PtoP, has also been instrumental in building the evidence on the impact of social transfers.

Though social protection programmes are generally government owned and executed, many programmes in Africa also benefit from considerable technical and financial support from UNICEF country offices, helping to develop and maintain sustainable child-sensitive social protection systems. In 11 countries, the UNICEF office has also directly commissioned the impact evaluations reviewed here: Tunisia, Lesotho, Zambia, Liberia, Ghana, Malawi, Zimbabwe, Kenya, Mozambique, Uganda (Karamoja) and Ethiopia (Tigray). In addition, UNICEF country offices have commissioned evaluations of pilot or emergency programmes, such as in Somalia.

Finally, the implementation and rigorous evaluation of these social protection programmes would not have been possible without the strong and consistent support of numerous international **donors**, particularly the World Bank (i.e. Tanzania, Kenya, etc.), the UK's Department for International Development (DFID), the European Commission (EC), the Swedish Sida, Irish Aid, Finland's Ministry of Foreign Affairs, German Society for International Cooperation (GIZ) and others.

¹² Further information on the Transfer Project is available at: <http://www.cpc.unc.edu/projects/transfer>

¹³ Further information on PtoP is available at: <http://www.fao.org/economic/ptop/home/en/>

2. Impact pathways: why social protection makes sense

Conceptual framework to understand the impact of social cash transfers on multiple outcomes

This section will discuss a proposed framework to help explain the different factors that contribute to understanding the impact of social cash transfers on different outcomes.

A social protection system should include numerous components, and UNICEF generally identifies four categories of social protection interventions:

- Social transfers, whether cash, vouchers or in-kind transfers (such as food or school uniforms);
- Programmes to ensure access to services;
- Social support and care services; and
- Legislation and policy reform to remove inequalities in access to services and livelihoods.

The way in which these social protection interventions complement one another, improving the fulfilment of human rights, is depicted in Figure 1.

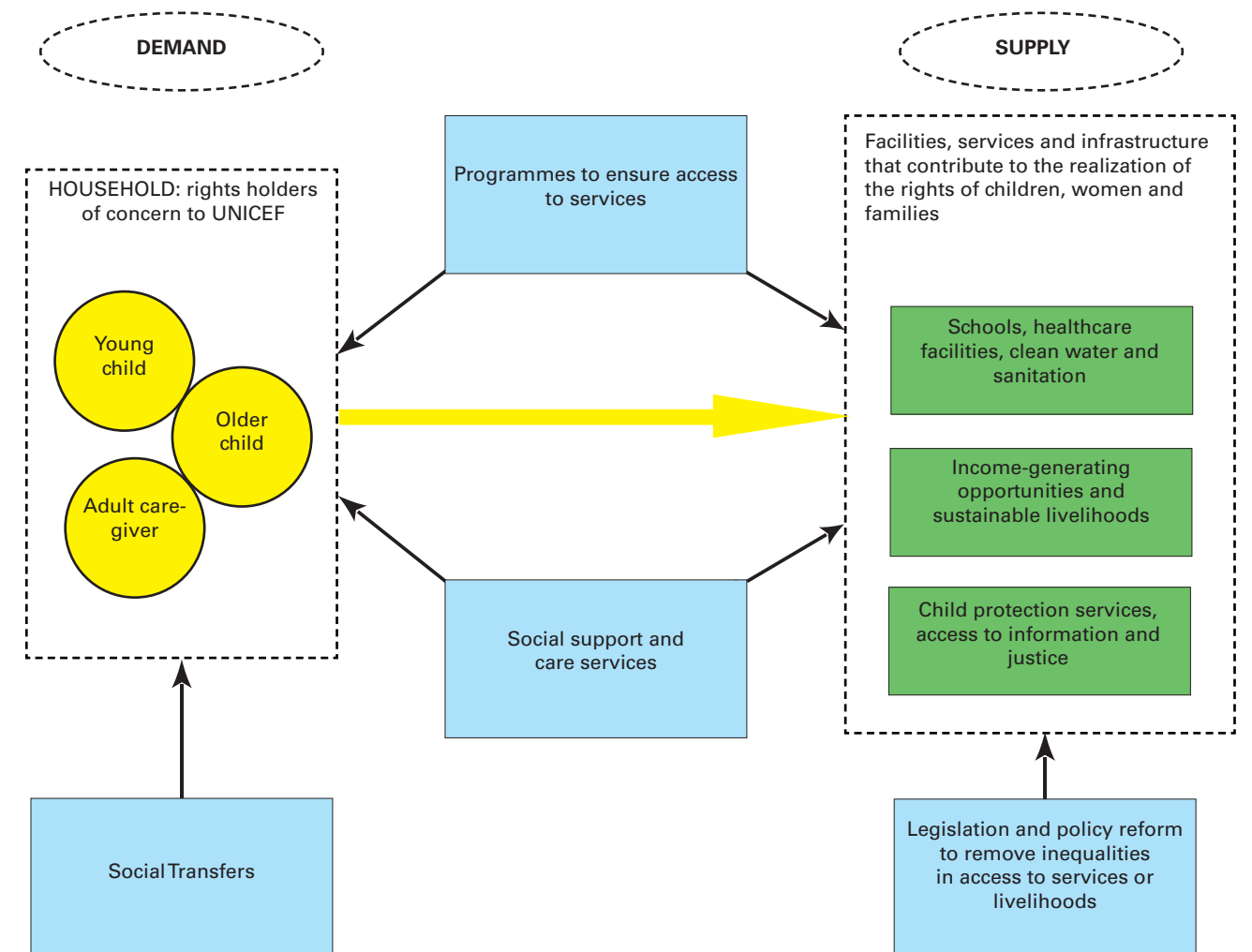
The bulk of the evidence in this paper relates to the impact of **social transfers (mostly cash,**

rather than in-kind transfers), supported by the enabling environment in which other social protection interventions are implemented. This focus on social transfers in the existing evidence is for two reasons: first, because the use of formal social transfers in Africa is relatively new, and therefore there is a demand to know what works well and what does not; and secondly, because of the sheer volume of resources invested in social transfer programmes, a high degree of accountability is evidently necessary and has resulted in the rigorous impact evaluations reviewed here.

Social cash transfer programmes are designed to address, reduce and eliminate economic vulnerabilities to poverty and exclusion, enabling all members of society to realize their rights. The impacts can be wide and varied, for example:

- **Multi-sectoral impact:** well-designed social transfer programmes can have a positive impact on human capital (improved health, education, nutrition, etc.), as well as on HIV/AIDS outcomes, economic development and state-building (reinforcing the social contract).
- **Short-term and long-term impact:** social transfers can address both income deficits in the short term and structural vulnerabilities and power hierarchies in the longer term.

Figure 1: UNICEF's rights-based approach to social protection

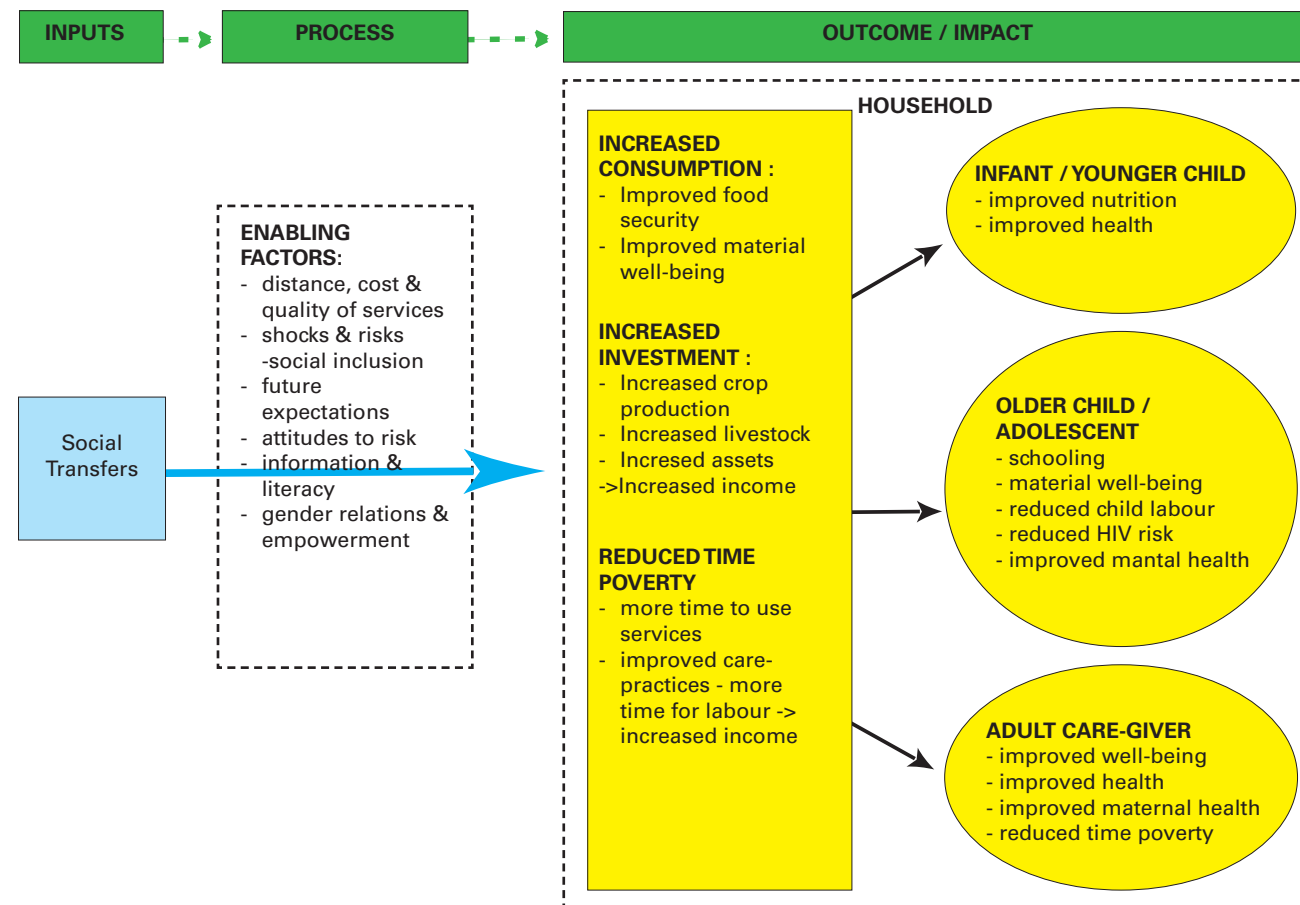


- **Building resilience:** social transfers can help build families' resilience to future crises, as well as support the transition from a humanitarian to a development approach (see Figure 2).

Given the complexity of identifying impact pathways, and the fact that most of the existing

evidence relates to social transfers, Figure 2 below provides a conceptual framework that focuses on the impact that social transfers can potentially have. This impact should nevertheless be considered within the context of a social protection system, in which other interventions may also be implemented.

Figure 2: Conceptual framework for the impact of social transfers at the household and individual level



Source: inspired by the conceptual frameworks for the evaluations of the Zambia Child Grant Programme (CGP) and the Malawi SCT.

It should be noted that the conceptual framework presented here is a generic one and needs fine-tuning, according to the specificities of any given context; more sophisticated and complex models have been used for each impact evaluation. However, despite being generic, the framework sets out the logic of social transfers and breaks down the way in which impacts can be measured at both the household and the individual level. Reading the diagram from left to right, a social transfer (cash, vouchers or food) is the input that is received by a given household. In this process, the impact of that social transfer is moderated and mediated by a number of variables, which we have called 'enabling factors' here. These

include factors such as: the distance, quality and cost of services; the shocks and risks that the household is exposed to; its attitude to risk; social inclusion; literacy rates and parents' level of education; access to information, and gender relations. All of these enabling factors affect the degree to which a social transfer can have a positive impact on children and their families. Moving to the right of the diagram, indicators are listed that describe expected changes at the household level (such as increased consumption, increased investment, reduced time poverty, etc.) and expected changes for some of the individuals within the household: infant, older child and adult care-giver.

A similar conceptual framework is included for each sector below, showing the impact pathways in specific areas: food security, consumption and nutrition, education, health, HIV/AIDS and adolescent wellbeing, economic and productive impacts, social cohesion, child protection and early child development.

Multi-sector impacts and multiplier effects

Multi-sector impacts: social transfers are intrinsically multi-sectoral, as each family will use the transfer to meet its own specific needs: spending it on food, water, healthcare, education, improvements to housing, investing in livelihood activities or saving for the future. Given the fungible nature of cash transfers, an effect on a variety of different outcomes is to be expected, depending on each family's priorities.¹⁴ Furthermore, when transfers are provided unconditionally, full responsibility is given to each family, enabling it to prioritize, according to its specific needs and the context in which it lives. Evidence shows that recipients of social transfers have their families' and children's best interests at heart and use the transfers to meet both short-term and long-term needs. In contrast, conditional cash transfers (CCTs) constrain households to use the cash to meet the stated conditions, which may or may not coincide with the household's own assessment of its priorities.

Supplementary impacts: improved child outcomes in one sector can also have knock-on impacts in other sectors. For example, there is evidence that, by reducing economic insecurity, social transfers (particularly cash transfers) increase the likelihood of a child or

adolescent being enrolled in secondary school, and that this in turn has an effect in terms of reducing exposure to HIV risk.¹⁵ This is because children in school are less likely to engage in risky behaviours that may increase their exposure to HIV; they are more likely to benefit from HIV education, more likely to partner with someone of their own age, and less likely to marry early (as there is a strong perception in many countries that marriage and child-bearing come after education is completed).¹⁶ In other words, the educational impact of social transfers 'moderates' the impact of the social transfers on HIV outcomes. For all these reasons, education has been called the 'social vaccine' for HIV vulnerability, and social transfers can contribute to this chain of positive impacts (more details are provided below, in the section on HIV/AIDS and adolescent wellbeing).

Multiplier effects: social transfers have been shown to have a 'multiplier effect', i.e. stimulating local economies and supporting others in the wider community who are not necessarily beneficiaries of the programme themselves. This is because social transfers increase purchasing power, and the beneficiaries of social transfers generally spend their money at local businesses (which are likely to be owned by non-beneficiaries). In this way, the positive effects for beneficiaries are also multiplied for some non-beneficiaries within the same market system. The PtoP project has developed a specific approach to estimating the economic multiplier effects of social transfers, known as the 'local economy-wide impact evaluation' (LEWIE)¹⁷ and has collected a large amount of data; for further details of the evidence, see the section below on economic and productive impacts.

¹⁴ Arguably this is also the case for in-kind transfers: for example, a food transfer increases the household's total incoming resources, thereby freeing up other cash which can be spent on healthcare, education, etc.
¹⁵ Evidence from Ethiopia, Ghana, Kenya, Lesotho, Malawi, South Africa and Zambia.
¹⁶ A three-year RCT of a school-based conditional cash transfer in rural Zimbabwe found that comprehensive school support was effective in reducing early marriage among orphan girls (one or both parents deceased) who were in grade 6 at study entry (Handa et al. 2014: 2).
¹⁷ For more information see the Production to Protection methodological guidelines, available at: <http://www.fao.org/docrep/018/aq661e/aq661e.pdf>

Box 3: Social transfers contribute to building resilience

UNICEF defines resilience as: "The ability of children, communities and systems to withstand, adapt and recover from stresses and shocks, advancing the rights of every child, with special attention to the most vulnerable and disadvantaged children" (UNICEF 2013: 3). Within UNICEF's global and regional approach to resilience, social protection has been recognized as a key programmatic area. This box looks at how social transfers, as a tool of social protection, can contribute to building resilience.

At the **individual level**, there is considerable evidence that social transfers contribute to building human capital (health, education, etc.), which in turn contributes to building an individual's longer-term resilience. Much of this evidence comes from the impact evaluations reviewed here and is summarized in the sector chapters of this report below.

At **household level and community level**, there is evidence that social transfers reduce negative coping strategies that can weaken future resilience (such as reducing food intake, selling assets, pulling children out of school, sending them to work, early marriage of children, begging, share-cropping and other forms of casual labour, migrating for work, etc.). For example, in the Lesotho CGP, the evidence shows that beneficiaries of the cash transfers were less likely to engage in disruptive coping strategies in response to shocks (Transfer Project 2014). In the Uganda SAGE programme, it was found that families that did not receive cash transfers were more likely to migrate to Kampala or other cities in search of work than were families that did receive regular transfers (OPM 2013). In Zambia, the Multiple Categorical Programme (MCP) has strengthened household resilience by increasing assets, diversifying livelihoods and reducing the need for casual labour during shocks (AIR 2014).

Social transfers can also build community resilience and social cohesion; for example, there is evidence from the Somalia Cash and Voucher Programme that beneficiary households

shared the cash with neighbours and extended family, thereby maintaining dignity and inclusion in reciprocal support networks (Hedlund et al. 2013). This contributes to building the resilience of households and the wider community as a whole.

Health, education, productive assets and social cohesion are all aspects of resilience; measuring resilience per se (as a composite indicator) is also an emerging area of work. For example, UNICEF Somalia has been working with the FAO and the World Food Programme (WFP) on a resilience index that aims to measure the impact of a joint programme (including social safety nets, productive assets and access to basic services) on levels of household and community resilience. However, the full results of this impact evaluation are not yet available.¹⁸

At the **systems level**, there is growing interest in integrating the capacity to scale up existing social transfer systems in the event of an emergency, particularly in the Sahel region, which is affected by recurrent slow-onset crises to which an early response can build resilience prior to the peak of the emergency. For example, in Southern Africa, initial results from the Zambia Child Grant Programme show that cash received prior to a shock has a much greater ability to mitigate negative coping strategies than does cash received after a shock, supporting the call for building comprehensive social protection systems and responding early to potential crisis situations (Lawlor et al. 2014). In the Horn of Africa, the impacts of the 2011 drought and food security crisis in Ethiopia were significantly reduced by the existence of the Productive Safety Net Programme (PSNP), which was scaled up so as not only to reach its regular beneficiaries with increased payments, but also to provide three months of support to an additional 3.1 million people. Following the 2011 crisis, both the Ethiopia PSNP and the Kenya HSNP are testing out an integrated social transfer and emergency response system.¹⁹

Of critical importance is the need to identify **operational elements** that enable existing social protection systems to be more flexible in emergencies. These include:

- Multi-sector and comprehensive vulnerability analysis to inform the design of targeting methodologies that go beyond poverty and social vulnerabilities to include political and environmental risk;
- Pre-identification of triggers, thresholds and accountabilities for emergency response;
- Information management systems that are regularly updated and can also integrate additional beneficiaries in the event of a crisis (horizontal scale-up);
- Payment systems that can expand to increase the size of transfers to existing

beneficiaries (vertical scale-up), as well as to include additional beneficiaries;

- Design features and implementation mechanisms that are flexible enough to adapt and respond quickly to a crisis or shock, e.g. potential beneficiary lists that capture populations that are likely to be at risk, or cash delivery mechanisms that will continue to function;
- Flexible financing structures that can rapidly respond to short/medium-term scale-up due to recurrent and predictable crises (e.g. seasonal hunger gap); and
- Coordination of the different timeframes of humanitarian and development donors, focusing on immediate response, but also on recovery and long-term development.

¹⁸ Baseline report published in 2014 and available at: <http://resilienceinsomalia.org/>

¹⁹ For further details, see Cherrier (2014); Slater and Bhuvanendra (2014).

3. Existing evidence of the impact of social protection by sector

While social transfers are inherently multi-sectoral, adapting to the priorities of each family, the impact on specific sector outcomes is also routinely measured. The following section presents the ways in which social cash transfers can contribute directly to sector outcomes: consumption, food security and nutrition; education; health; HIV/AIDS and adolescent wellbeing; economic and productive impacts; social cohesion and community dynamics; child protection; and early childhood development. Each section begins with key messages and best practice; there then follows a table showing the impact pathways for sector outcomes and a summary of the evidence available to date. It should be noted that the examples presented here provide an overview of the range of impacts that social cash transfers have demonstrated, but are not intended to be an exhaustive list of outcomes.

Consumption, food security and nutrition

The main objective of many social transfer programmes is to improve food security, increase purchasing power and smooth consumption. Assessments show that households primarily use social transfers to buy food and are thus able to progressively increase the quantity, quality and diversity of the food they consume. There is strong and established evidence from across Africa that social transfers are an effective and efficient way of achieving results in terms of consumption and food security.

The purchasing of food can, however, be affected by inflation and price hikes; for example, beneficiaries in Ethiopia stated a preference for food transfers rather than cash when food prices were high.²⁰ To address this issue, social cash transfer programmes have considered specific solutions in their design, including: increasing the transfer amount in line with inflation, delivering a top-up at times of food shortage (successfully implemented in Malawi) and supporting market interventions to improve the supply of food available.

Social cash transfer programmes also have the potential to improve nutrition outcomes among children. As laid out in the UNICEF conceptual framework on nutrition, the underlying causes of malnutrition reflect a variety of interconnected socio-economic risks and vulnerabilities, including: access to adequate food (dietary intake), health (services and status) and care (adequate maternal and childcare practices). Social transfers can help to address some of these causes of malnutrition, both directly and indirectly, through diverse mechanisms:²¹

- **Increasing households' food consumption and dietary diversity:** social transfers can increase households' spending on food, allowing families to have greater choice and placing nutritious foods within economic reach. It provides families with the opportunity to improve complementary feeding among young children, as well as the diets of older household members.
- **Minimizing negative coping mechanisms affecting nutrition and health:** in the event of shocks, predictable social transfers

can minimize negative coping mechanisms, such as a decrease in food intake within the household or the purchase of cheaper, less nutritious food.

- **Enhancing households' productive capacity:** social transfers can also strengthen production capacities and/or generate additional income, which can be leveraged to increase investments in production, promote dietary diversification and, ultimately, achieve improved nutrition outcomes.
- **Addressing economic and social barriers to accessing services (direct and indirect):** social transfers can remove financial and social barriers to access and use of essential nutrition, health, education, water and sanitation services, thus contributing to improvements in children's nutritional status.
- **Social protection interventions as entry points to access health and nutrition services:** social protection systems require a functioning comprehensive national information database (i.e. a single beneficiary registry, management information systems, etc.), that is able to capture and identify multiple vulnerabilities faced by the population. These systems become an institutionalized source of socio-economic information, which can be used for targeting and programme delivery, as well as to monitor families and facilitate their referral to relevant services, including health and nutrition.
- **Complementary interventions – social transfers as an entry point:** linking the delivery of social transfers to other interventions, such as in-kind transfers

(nutritional supplements), or to training and information sessions, can also contribute to an enhancement of child outcomes. Social protection interventions become important entry points for increased access to information on the causes of illness/preventive measures, effective nutrition and hygiene practices, as well as for the delivery of nutrition-specific programmes. In addition, community-based services can complement other interventions, providing counselling and support to vulnerable families.

- **Addressing gender issues around intra-household dynamics:** in many countries, women's low education levels, unequal social status and limited decision-making power can negatively influence the nutritional status of women and children. The UNICEF progress report (UNICEF 2013) documented the fact that improving access to education and creating opportunities for both girls and boys (and their families) will confer many benefits in terms of nutritional status and child development.²² When there is differentiated treatment in terms of feeding practices and care between girls and boys, policy reform and changes in key legislation can contribute to ensuring equal access to services for women and men.

As can be seen from the points above, social protection (including social transfers) is only one of many interventions that can contribute to sustainable change in the nutritional status of children. Social transfers alone may or may not have a positive impact on nutritional status, but transfers could be part of a broader nutrition programme that might include, for example, raising awareness of hygiene and care practices, sanitation, and early child development intervention and quality nutrition services.

²⁰ See From Protection to Production for further details: <http://www.fao.org/3/a-i3979e.pdf>
²¹ UNICEF (2012).

²² For further details, see UNICEF's Social Protection Framework, Chapter VI on Inclusive Social Protection: http://www.unicef.org/socialprotection/framework/index_61911.html

Table 2: Conceptual framework for the impact of social transfers on consumption, food security and nutrition outcomes

INPUT	ENABLING FACTORS	HOUSEHOLD IMPACT	INDIVIDUAL IMPACT through the LIFECYCLE
Social transfer	Food (availability, cost and quality) Healthcare services, including nutrition centres (availability, cost and quality) Water and sanitation (availability, cost and quality) Health and hygiene practices	Increased spending on food Increased quality and quantity of food Increased access to clean water and sanitation Increased access to health services	Infant/younger child Higher rates of exclusive breastfeeding (mother has more time for childcare) Increased food consumption Increased dietary diversity Reduced prevalence of stunting and wasting Improved nutrition leads to improved cognitive and motor development
			Older child/adolescent Increased food consumption Increased dietary diversity Improved nutrition leads to improved cognitive and motor development
			Adult care-giver Improvement in maternal health and nutrition More time for childcare (including breastfeeding) Increased food consumption Increased dietary diversity

When measuring the impact of social cash transfers on nutrition, it is critical to note the following:

- **Monitoring:** social cash transfers can have an impact on the economic drivers of nutrition, and thus there is a need to look at a wide range of indicators, including anthropometric measures; dietary diversity or meal frequency; food consumption; and participation in health and nutrition activities, including public awareness, national health and nutrition campaigns.
- **Timeframe:** outcomes in anthropometric measures of nutritional status may not be recorded in a short time frame, but require a

long-term evaluation period.

- **Social protection plus:** sustainable nutrition outcomes, such as reduced stunting, will only be achievable with a combination of social protection (including transfers) and complementary interventions in other sectors, such as health, education, water, sanitation and hygiene (WASH), etc.
- **Target age group:** the main beneficiaries of a social protection programme should be clearly identified (i.e. children under five, adolescents, etc.), as this is important in understanding which nutrition indicators should be monitored and what impacts can be expected.

Table 3: Evidence of the impact of social protection on consumption, food security and nutrition outcomes

Impact area	Evidence (in alphabetical order, by country)
Food security and consumption	<ul style="list-style-type: none"> • Ghana LEAP: the programme has had no durable impact on overall food or non-food consumption (impact appears limited to the days just after each payment). This unexpected finding is most likely due to the irregular, unpredictable payments, coupled with the low transfer value. • Kenya CT-OVC: led to an increase in spending on food (17 per cent over two years, but less impact thereafter), as well as to a greater share of household food consumption acquired from own farm production. The increase in own production was substantial – up to 20 percentage points in the case of dairy/eggs for smaller households (see also the section below on economic and productive impacts). • Lesotho CGP: improved ability of households to access food throughout the year, reducing by 1.5 the number of months in which beneficiary households faced extreme food shortages. The proportion of children who had to eat less or have fewer meals fell by 11 percentage points, and the proportion of adults who went to bed hungry because there was not enough food dropped by 7 percentage points. • Malawi SCT: led to an increase in spending on food, and to a greater share of household food consumption acquired from own farm production. • Zambia SCT: led to an increase in spending on food, and to an increase in the percentage of households eating two or more meals per day (of 8 percentage points, from 89 per cent to 97 per cent)
Dietary diversity	<ul style="list-style-type: none"> • Ghana LEAP: though qualitative research showed beneficiaries eating more diverse and nutritious foods, the impact was limited to the days immediately after the payment (see above). • Kenya CT-OVC: led to increased dietary diversity for families after two years of cash transfers. Positive and statistically significant results are observed in consumption of meat and fish (39 percentage point increase); dairy (22 percentage point increase) and cereals (45 percentage point increase), while spending on tubers decreased by approximately 16 percentage points. • Malawi SCT: increased variety of food purchased and produced on farm, including eggs, meat and beans (though impact limited by delays in payment). • Zambia CGP: Increased dietary diversity was observed, including an increase in the consumption of meat, dairy, cereals, fruit and vegetables, sugars, fats and oils (see Table 4 below). • <i>No significant impact on dietary diversity was evident in the Lesotho CGP and Tanzania TASAF programmes, possibly linked to the unpredictable timing of delivery of the transfers.</i>
Infant and young child feeding (IYCF)	<ul style="list-style-type: none"> • Zambia CGP: large impact of the programme on IYCF (i.e. the proportion of children aged 6–24 months meeting minimum feeding requirements) with an increase of 28 percentage points (from 32 per cent to 60 per cent; the control group improved to only 43 per cent), equivalent to an 88 per cent increase in IYCF over the baseline mean
Stunting and wasting	<ul style="list-style-type: none"> • South Africa CSG: receiving the cash transfer in the first two years of life increased the likelihood that a child's growth is monitored and improves height-for-age scores for children whose mothers have more than eight grades of schooling. • Zambia CGP: the programme significantly increased weight-for-height (0.196 z-scores) among children aged 3–5, though it had no statistically significant effect on weight-for-weight, weight-for-age or height among children aged 0–5. There was some evidence that children who were stunted at baseline were more likely to catch up as a result of receiving the transfers (see also the early childhood development section below).

Source: AIR (2013), Romeo et al. (2014), Transfer Project (2014), From Protection to Production.

Table 4: Evidence of the impact of social transfers on consumption

	Zambia	Kenya (2007–2009)	Malawi	Ghana	Lesotho	Tanzania
Total consumption	+++	+++	+++	Not significant	Not significant	Not significant
Food	+++	+++	+++	Not significant	Not significant	Not significant
Education	Not significant	Not significant	Not significant	Not significant	+++	++ (2)
Health	+++	+++	+++	Not significant	Not significant	Not significant
Clothing	+++	+++	+++ (1)	Not significant	+++	++ (3)
Alcohol/tobacco	Not significant	Not significant	Not significant	Not significant	---	Not significant

Source: Transfer Project.

(1) Changes of clothing, not consumption per se.

(2) Children's clothing.

(3) Female-headed households, children in boarding schools.

Note: in both Table 4 (above) and Table 5 (below), green represents an increase in this activity, yellow represents an increase that was not considered statistically significant (or an impact that varied), and red represents a reduction in this activity.

Table 5, below, shows that in Zambia, Kenya and Malawi, social transfers had a big impact on dietary diversity (often through increased agricultural production), whereas the impact in Ghana and Lesotho was not considered statistically significant.

Table 5: Evidence of the impact of social transfers on dietary diversity

	Zambia	Kenya (2007–2009)	Malawi	Ghana	Lesotho
Meat	+++	+++	+++	---	Not significant
Dairy	+++	+++	+++	Not significant	Not significant
Cereals	+++	Not significant	+++	Not significant	Not significant
Fruit/vegetables	Not significant	Not significant	+++	Not significant	Not significant
Sugars	+++	+++	+++	Not significant	Not significant
Fats, oil, other	+++	+++	+++	+++	Not significant
Dietary diversity	+++	+++	+++	Not significant	Not significant

Source: Transfer Project.

Education

There is solid evidence that social transfers can contribute to removing the direct and indirect financial barriers to accessing education services. As is shown in Table 6, social cash transfers have increased enrolment and attendance rates in both primary and secondary schools. Moreover, even in contexts where education is free, families can still face direct out-of-pocket expenses, for instance on travel, books, food, uniforms and shoes, and this may constitute a serious barrier for poorer families.²³ Sometimes sending a

child to school means that the family loses the income from child labour or has less help with housework. In such cases, social cash transfers can considerably help to ease these opportunity costs.

However, long-term educational outcomes depend not only on economic drivers (cost of education and cost of accessing education services), but also on the availability and quality of the education services, as well as on the social norms that determine attitudes to schooling. Maximizing education outcomes should therefore involve a combination of demand-

side interventions (such as social transfers) and improvements in the provision of education services (i.e. the quality and accessibility). For example, social transfers will not have a positive impact on school enrolment if the school is too far away to be accessible, if children are at risk of abuse at school or if the quality of education is not good enough to get parents' support.

Results in other sectors can also have knock-on effects on educational outcomes. For example, social transfers can improve food security, nutrition, health and wellbeing, and there is evidence that children whose families receive social transfers perform better in terms of literacy and numeracy. In short, a healthy, happy child performs better at school.

Unconditional social transfer programmes have produced results in terms of education outcomes that are comparable with conditional programmes (Fiszbein and Schady 2009).²⁴

For example, in the Kenya CT-OVC, clear results in secondary school enrolment were achieved without any conditionality, and the increase observed compares favourably to the increase in similar conditional cash transfer programmes (Kenya CT-OVC Evaluation Team 2012). The evidence shows that in Kenya, it was not necessary to impose conditions in order to increase school enrolment: the financial support of the cash itself was enough. Similarly, in the Morocco Tayssir pilot programme, which compared conditional and unconditional cash transfers, the impact evaluation concluded that the conditionality itself did not appear to have any additional impact on school participation, abandonment, learning or absenteeism, and that the unconditional transfers were "as effective at increasing education as traditional CCTs have been in other contexts, and cost much less" (Benhassine et al. 2013: 6).²⁵

Table 6: Conceptual framework for the impact of social transfers on education outcomes

INPUT	ENABLING FACTORS	HOUSEHOLD IMPACT	INDIVIDUAL IMPACT through the LIFECYCLE
Social transfer	Education services (availability, cost and quality)	Increased household income	Infant/younger child Increased primary school enrolment, attendance, grade attainment, reduced grade repetition and absenteeism Improved gender equity: improves access for both girls and boys Better performance at school (literacy, numeracy)
	Levels of education of care-givers and teachers	Increased expenditure on education and associated costs (fees, materials, transportation, uniforms, shoes)	Older child/adolescent Children not being pulled out of school as negative coping mechanism to economic shocks Increased primary and secondary school enrolment, attendance, grade attainment, reduced grade repetition and absenteeism Improved gender equity: improves access for both girls and boys Better performance at school (literacy, numeracy)
	Level of trust in education services	Improved access to quality food and healthcare	Delayed early marriage and childbirth reduces dropout rates of girls and adolescents
	Social norms	Reduced stress (parents and children)	Adult care-giver More time for educational support of children at home Better able to absorb the financial loss of child labour and reduced support from children helping with housework

²⁴ A World Bank review (Fiszbein and Schady 2009) reports secondary school impacts for CCTs in Bangladesh (12 percentage points), Turkey (5.2 percentage points) and Colombia (5.6 percentage points). The impact of the unconditional Kenya CT-OVC is similar to these impacts at 7.8 percentage points.

²⁵ The unconditional transfers were referred to as 'light conditional transfers' or LCTs, as the registration for the programme took place in schools, though there was no condition to attend (Benhassine et al. 2013: 4).

Table 7: Evidence of the impact of social protection on education outcomes

Impact area	Evidence
Primary school enrolment and attendance	<ul style="list-style-type: none"> Ghana LEAP: the programme reduced absenteeism from primary school by 8 percentage points: 80% attendance at school was a condition of the programme, but beneficiaries also reported that reduced absenteeism came from being able to afford add-on costs (uniforms, pencils, exercise books, breakfast and snacks).
	<ul style="list-style-type: none"> Kenya CT-OVC: unconditional cash transfers had a strong positive impact on primary school children who faced relatively higher prices (extra fees, long distances, obligation to wear shoes and uniforms). For children in this group, there was a 19 percentage point increase in enrolment.
	<ul style="list-style-type: none"> Lesotho CGP: the cash transfers contributed to retaining children in primary school, particularly boys over the age of 13 (i.e. late learners who would otherwise have dropped out). For boys in this group, there was a 6 percentage point increase in primary school enrolment. However, the programme did not have any other noticeable impact on school outcomes; this was likely due to problems with the supply of education services.
	<ul style="list-style-type: none"> Malawi SCT (Pilot): many families only reported enrolling their children in school after they joined the programme. This may be due to the unconditional cash transfer (\$2.30–\$5.50 per month) or to the additional bonus that was conditional on school enrolment (\$0.70 for primary school, \$1.40 for secondary school). However, a delay in payment reportedly left families unable to pay for schooling and led them to rely on their children for income (child labour).
	<ul style="list-style-type: none"> Zambia CGP: children aged 6–8 are 9 percentage points more likely to start school at the beginning of the year than if they are assigned to the control group. For children with less well-educated mothers, the programme had an impact on enrolment and attendance – this is because better-educated mothers had already enrolled their child and so there was less room for growth.
Secondary school enrolment and attendance	<ul style="list-style-type: none"> Ghana LEAP: enrolment in secondary school of children aged 13–17 increased by 7 percentage points. The effect on enrolment was particularly marked among boys. Among girls, absenteeism fell significantly – by 11 percentage points.
	<ul style="list-style-type: none"> Kenya CT-OVC: led to a positive effect on secondary school children, with an 8 percentage point increase in enrolment (see Table 8).
	<ul style="list-style-type: none"> Morocco Tayssir: enrolment, re-enrolment (of those who had dropped out) and attendance all improved on receipt of the social transfer. The programme led to a significant reduction in school dropout, particularly at higher levels of schooling; after two years of transfers, the dropout rate for beneficiaries was 57 per cent lower than in the control group (6.6 per cent dropout for children receiving transfers compared to 14.8 per cent in the control group). The impact was relatively strong for girls in general and for all children in satellite schools. Making the transfer conditional on school attendance (rather than unconditional) made no difference in terms of outcomes (possibly because the conditions were not clearly understood), but transferring the cash to the mother (rather than the father) improved outcomes.
	<ul style="list-style-type: none"> South Africa CSG: receipt of the cash transfer by the household reduces adolescent absences from school, particularly among males, even when the household does not receive the grant specifically for the adolescent.
	<ul style="list-style-type: none"> Tanzania TASAF: led to a higher likelihood of children (aged 0–18) having attended school at some time, with a 4 percentage point increase from 69 per cent at baseline. However, the programme had no impact on self-reported literacy rates.
<ul style="list-style-type: none"> Zambia MCP: increased school enrolment of children aged 14–17 by 12 percentage points, with significantly larger (19 percentage point) impacts among girls. 	

Grade progression and learning	<ul style="list-style-type: none"> Ghana LEAP: the programme reduced grade repetition among both primary-aged children (11 percentage points) and secondary-aged children (10 percentage points).
	<ul style="list-style-type: none"> Kenya CT-OVC: Secondary school children in households that received the transfer are fewer grades behind (0.096, or 7 per cent at mean) and are 5 per cent more likely to progress to the next grade.
	<ul style="list-style-type: none"> Morocco Tayssir: the cash transfers improved student learning in arithmetic, particularly among boys, and especially in satellite schools.
	<ul style="list-style-type: none"> Tanzania TASAF: led to a significant increase in the likelihood of children completing primary school (i.e. in the Tanzanian context, attaining Standard VII or higher), with a 15 percentage point increase, after 31–34 months of CCTs, in the proportion of children aged 15–18 completing this level of schooling. The primary school completion effect was particularly striking among girls, who were 23 percentage points more likely to complete primary school than were their comparison group counterparts; 80 per cent attendance at school was a condition of the programme.
	<ul style="list-style-type: none"> Tunisia PAS: for children receiving the cash transfers there was a temporary improvement in the rates of grade progression, reduced rates of grade repetition and reduced rates of dropout, but only in the first year in which the household received the transfer. A third of households reported that the transfer had influenced their decision to keep their child in school. In terms of learning, children from beneficiary households generally performed worse than those from non-beneficiary households, probably due to the fact that beneficiary families are poorer and face many other difficulties that affect school performance.
	<ul style="list-style-type: none"> South Africa CSG: children who were enrolled in the CSG at birth completed significantly more grades of schooling than children who were enrolled at age six, and achieved higher scores in a maths test. The impact among girls was particularly significant, with early receipt of the CSG increasing girls' grade attainment by a quarter of a grade, compared to those receiving the grant only at age six. The impact was largely because early receipt of the CSG reduced delays in girls entering school by 27 per cent, and girls who enrolled early obtained higher scores in maths and reading tests. For children whose mothers had less than eight grades of schooling, the impacts were even greater; the CSG appears to narrow the schooling gap between children whose mothers have less education and those whose mothers have more (also see early childhood development section below).

Source: AIR (2013), Benhassine et al. (2013), Ministère des Affaires Sociales (Tunisie) (2014), Ministry of Gender, Children and Social Protection (Ghana) (2014b), Transfer Project (2012a, 2014).

Impact evaluations usually report a range of schooling outcomes, including current enrolment, grade progression, attendance during the reference period and grade attainment. The most comparable indicator across all studies is current school enrolment, and so this is the indicator that is compared in Table 8, below. In

addition, since the largest financial barriers to schooling occur at the secondary level, impacts for secondary-age children (usually 12–17) are reported here (as this is where social transfer programmes have been shown to have the most effect).

Table 8: Impacts of cash transfer programmes on school enrolment of secondary school age children

Country (in alphabetical order)	Percentage point impact
Ghana Livelihood Empowerment against Poverty	7
Kenya Cash Transfer for Orphans and Vulnerable Children	8
Lesotho Child Grant Programme	6
Malawi Social Cash Transfer ¹	5
South Africa Child Support Grant ²	8
Zambia Multiple Categorical Grant	12
Zambia Social Cash Transfer	8

1) Includes primary and secondary age children. 2) Primary age children only.

Source: Transfer Project (2014). See: Impacts on Schooling: http://www.cpc.unc.edu/projects/transfer/publications/briefs/TransferProjectBrief_201501_SCTImpactSchooling.pdf

Box 4: Evidence from the South Africa Child Support Grant

The South Africa Child Support Grant (CSG) began to deliver cash transfers to children and their families in 1998, leading the way for social protection in Sub-Saharan Africa. The programme is managed by the Department of Social Development (DSD) and the South African Social Security Agency (SASSA). In the wake of policy reforms, the CSG has expanded to include all children in low-income households under the age of 18 (initially the programme targeted only children under seven) and the transfer amount has been adjusted for inflation. The programme now reaches over 10 million children across the country every month, and is an integral part of one of the most comprehensive social protection systems in the developing world.

In 2009, an impact evaluation was commissioned by DSD, SASSA and UNICEF and carried out by a consortium led by the Economic Policy Research Institute (EPRI). The evaluation found that the CSG had a significant positive effect on the nutrition, education and health outcomes of children. The grant was used for the needs of the whole household (not just the eligible child), with 95 per cent of the cash being spent on five main types of commodities: food, education, clothing and household durables, health and transport. Generally the mother (or main female care-giver) received the grant and had control over the way in which it was spent; with very few exceptions, men had limited access to, or control over, the CSG.

The child grant had a strong impact on **early child development (ECD) outcomes**, as the cash was used to pay for ECD services such as crèches, pre-schools and day-care centres. These services were highly appreciated not only for their role in young children's development, but also for supporting mothers by providing childcare while they were at work. Many families reported that without the CSG they would not have been able to access these facilities. Quantitative data also showed that when children received the grant in the first two years of life, it improved their nutrition and reduced the incidence of stunting (particularly when their mothers had more than eight grades of schooling). The strong positive effect on early

child development is particularly important to note, as this impact has not been routinely measured in many other social cash transfer programmes (apart from in Zambia: see details in the early childhood development section below).

The child grant also had a **strong impact on schooling**, enabling children to stay in school for longer, miss fewer days and score better in maths, reading and vocabulary tests. The impact was particularly marked for those children who were enrolled in the CSG at birth (compared to children who were enrolled at age six). Impacts for girls were particularly significant, and those who received the CSG at birth attained one quarter grade more at school than did those girls who were enrolled at six. For adolescents, particularly boys, receipt of the child grant reduced the number of days when they were absent from school. The grant also reduced the likelihood of child labour, particularly for girls, who were less likely to work outside the home as adolescents if they received the child grant early in life.

Adolescents who received the grant, particularly from early childhood, were **also less likely to engage in risky behaviour** that could expose them to HIV. For example, the child grant had a significant impact on: reducing sexual activity and the number of partners; reducing pregnancy; and reducing alcohol and drug use (particularly among adolescent girls) (see the section on HIV/AIDS and adolescent wellbeing for further details).

The evidence gathered by the evaluation led to a number of important **operational conclusions** for the programme in South Africa and for similar programmes elsewhere. Impacts were maximized when: children began receiving the grant from birth; there was predictable and continuous provision of the grant; and complementary services were also provided (financial services, promoting savings behaviour, involving social workers and psychologists in schools, more parent-teacher interaction, etc.). Regular provision of transfers also enabled some families to borrow against the grant in order to meet unexpected health costs; the grant therefore provided a kind of informal health insurance.

Source: DSD, SASSA and UNICEF (2011, 2012).

Health

Social protection interventions – such as social transfers, social health insurance and removal of user fees – have proven results on health outcomes. Social transfers have been shown to have a positive impact on the likelihood and frequency of illness, seeking healthcare, improved immunization and mental health among adolescents.²⁶

However, as with education outcomes, the direct impact of social transfers on final health

outcomes is highly dependent on the availability, cost and quality of health services, as well as on social norms that determine attitudes to healthcare. Social transfers are a demand-side intervention and should be coupled with improvements in supply – i.e. quality and provision of health services. Though social transfers can, in some instances, encourage increased availability and quality of services (as social transfers can create greater demand for services, which in turn can create incentives to supply them), there is as yet no clear evidence from Africa to support this causal link.

Table 9: Conceptual framework for the impact of social transfers on health outcomes

INPUT	ENABLING FACTORS	HOUSEHOLD IMPACT	INDIVIDUAL IMPACT through the LIFECYCLE
Social transfer	Healthcare services (availability, cost and quality) Health and hygiene practices Access to health information Level of trust in health services Social norms Gender equality	Increase in health-seeking behaviour Increased health expenditure (out-of-pocket costs, user fees, cost of medicine) Covering associated health costs (transportation, reduced labour capacity) Increased quality and quantity of food	Infant/younger child Higher rates of exclusive breastfeeding (mother has more time for childcare) Higher rates of immunization Improved nutrition leads to improved cognitive and motor development Reduced incidence of preventable disease
			Older child/adolescent Higher rates of immunization Reduced incidence of preventable disease Improved psycho-social status and mental health
			Adult care-giver Improved peri-natal and maternal welfare More time for childcare Reduced incidence of preventable disease Improved psycho-social status and mental health Covering cost of reduced labour capacity due to illness

²⁶ The evidence from Latin America and Sub-Saharan Africa on the impact of social transfers (whether conditional or unconditional) on vaccination coverage remains mixed (Romeo et al. 2014: 7).

Table 10: Evidence of the impact of social protection on health outcomes

Impact area	Evidence
Recent illness	<ul style="list-style-type: none"> Ghana LEAP: beneficiary children aged 6–17 were 5 per cent less likely to be ill than were those who had not received the social transfer.
	<ul style="list-style-type: none"> Kenya CT-OVC: older children (31–59 months) experienced a 13.2 percentage point reduction in diarrhoea incidence in the last week as a result of the programme. This was after four years of cash transfers, as compared to baseline.
	<ul style="list-style-type: none"> Lesotho CGP: the proportion of young children suffering any illness in the previous 30 days fell by 15 percentage points (from a baseline of 39 per cent) as compared to the control group.
	<ul style="list-style-type: none"> Malawi SCT: the pilot SCT in Malawi had a positive impact on beneficiary adults and child health: 73 per cent of beneficiary adults and 81 per cent of beneficiary children experienced improved health, compared to 7 per cent of adults and 15 per cent of children in comparison households. In addition, sickness among beneficiary adults fell from 80 per cent to 59 per cent, compared to a decrease from 80 per cent to 73 per cent in control households.²⁷
	<ul style="list-style-type: none"> South Africa CSG: early enrolment in the Child Support Grant programme (i.e. in the first two years of life) reduced the likelihood of illness (as measured by a 15-day period prior to the survey), with the effect particularly strong among boys: boys enrolled at birth had a 21 per cent likelihood of being ill, compared to a 30 per cent likelihood for boys enrolled later. The effect was particularly marked for children whose mothers had eight or more grades of schooling (see also early childhood development section below).
	<ul style="list-style-type: none"> Tanzania TASAF: beneficiary households were healthier than those in the control group. Their members were 5 percentage points less likely to be sick (averaging across all ages), and children aged 0–4 were 11 percentage points less likely to be sick. The impact on the health of the poorest children aged 0–4 was particularly significant, as they were on average sick for one day less per month as a result of the cash transfers.
	<ul style="list-style-type: none"> Zambia CGP: the programme had a slight impact on reducing the incidence of diarrhoea in children under five (4 percentage points) after 24 months of transfers; but at 36 months this change no longer persisted. But there was no measurable impact on other young child health outcomes. There was no increased use of health facilities, probably because of the poor capacity of the services available.
Access to healthcare	<ul style="list-style-type: none"> Ghana LEAP: led to an increased number of beneficiaries seeking preventive care, especially for young girls aged 0–5.
	<ul style="list-style-type: none"> Kenya CT-OVC: led to a 13 per cent increase in the share of children under the age of five accessing preventive care. It also led to an increase in the proportion of children with a health card, and it enabled households to maintain health spending during price increases, whereas there was a reduction in spending in the control communities.
	<ul style="list-style-type: none"> Lesotho CGP: there was no significant increase in the proportion of children seeking a healthcare provider.
	<ul style="list-style-type: none"> Malawi SCT: healthcare access for SCT beneficiaries was 84 per cent among adults, compared to 10 per cent in the control group. For beneficiary children, 80 per cent had healthcare access, compared to only 8 per cent among comparison children.
	<ul style="list-style-type: none"> Zambia CGP: though spending on health increased, there was no increased use of health facilities, probably due to the poor capacity of the services available.
Health insurance	<ul style="list-style-type: none"> Ghana LEAP: beneficiaries are automatically included in the National Health Insurance Scheme (NHIS) and 90 per cent of LEAP households therefore have at least one member enrolled in NHIS (see Box 5 below).
	<ul style="list-style-type: none"> Tanzania TASAF: households receiving cash transfers were more likely to purchase health insurance and much more likely to finance medical care from this insurance (25 per cent) than was the control group (6 per cent), even without this being a condition of the programme.

²⁷ This evidence comes from the impact evaluation of the pilot programme (Miller et al. 2008: 22). The SCT programme has since been expanded and results from the impact evaluation of the national-level programme are forthcoming in 2016.

Immunization	<ul style="list-style-type: none"> Kenya CT-OVC: the programme significantly improved vaccination coverage for those receiving cash transfers. In particular, BCG vaccination coverage against tuberculosis increased by 10.8 percentage points in 2009 and 14.2 percentage points in 2011, with respect to baseline. MCV vaccination against measles also increased by 9.7 per cent in 2009 and 11.7 per cent in 2011 compared to baseline values. As a consequence, full immunization coverage increased by 13.8 per cent (BCG) and 14.8 per cent (measles) with respect to baseline levels. This impact was observed without any of these results being requirements or conditions of the programme. South Africa CSG: it was reported that the CSG in South Africa enabled adults to take their children to clinics for immunization and that the grant was used in part to pay for medicines.
Mental health	<ul style="list-style-type: none"> Kenya: a study led by the Transfer Project demonstrated that social transfers improve mental health outcomes among young people aged 15–24, with the relative risk of displaying depressive symptoms decreasing by 22 per cent. These effects, however, were concentrated among men, particularly younger males aged 15–19.

Source: AIR (2014), DSD, SASSA and UNICEF (2012), Evans et al. (2014), Handa (2014), Kilburn et al. (2014), Miller et al. (2008), Ministry of Gender, Children and Social Protection (Ghana) (2014a), Romeo et al. (2014), Transfer Project (2014).

Box 5: Evidence from the Ghana Livelihood Empowerment against Poverty (LEAP) programme

The LEAP programme in Ghana provides cash transfers to extremely poor households, with the twin objectives of alleviating immediate poverty and contributing to longer-term sustainable livelihoods. Targeting is based on poverty criteria combined with three categorical criteria – having in the family an orphan or vulnerable child, an elderly poor person, or a person with a disability who is unable to work. Households receive approximately US\$7.50–US\$14 (24–45 Ghanaian cedi (GHS)) per month, depending on the number of eligible people in the family.

LEAP is currently the only programme in Africa where beneficiaries are also automatically included in the National Health Insurance Scheme (NHIS) and coverage among beneficiaries is impressive: in 2012, 90 per cent of LEAP households had at least one member enrolled in NHIS, compared with 65 per cent in 2010. LEAP led to a 16 percentage point increase in the number of children aged 6–17 enrolled in the NHIS, and a 34 percentage point increase in the same figure for children aged 0–5.

The LEAP programme had a range of positive impacts: families reported eating a greater quantity and variety of nutritious foods and spending more on education for their children.

The programme increased the number of families seeking preventive healthcare (particularly for girls aged 0–5) and enabled beneficiaries to maintain health by paying for on-going prescription medicines and operations. Importantly there was also a reduced incidence of sickness: beneficiary children aged 6–17 were 5 percentage points less likely to be ill – an important result, as this also had a knock-on impact on improving school attendance. Households receiving the transfer similarly reported a significant increase (16 percentage points) in their happiness as a result of the programme.

The transfers also provided a small amount of capital, which helped beneficiaries increase their income-generating potential. Households used this money for small-scale trading, hiring labour to increase production on their own land, buying farm inputs and, in just a few cases, trying out new business opportunities. However, the willingness of families to take risks and invest in income-generating activities was also hindered by the fact that the transfers were not distributed in a regular and predictable fashion.

Source: Ministry of Gender, Children and Social Protection (Ghana) (2014a), Handa et al. (2013), OPM (2013), Transfer Project (2014), From Protection to Production.

HIV/AIDS and adolescent wellbeing

HIV is now the leading cause of death among adolescents in Sub-Saharan Africa: the figure has doubled since 2003 (WHO 2014, UNAIDS 2012 HIV and AIDS estimates). There are an estimated 160,000 new HIV infections annually in Eastern and Southern Africa among adolescents, with girls accounting for over 62 per cent of new infections.

The UNAIDS HIV Investment Framework, UNAIDS Business Case on Social Protection²⁸ and the UNICEF/EPRI review, *HIV-Sensitive Social Protection: State of the evidence 2012 in Sub-Saharan Africa*,²⁹ show how HIV-sensitive social protection contributes to mitigating the negative effects of HIV and AIDS on children and their families – economic impacts, exclusion, stigma and discrimination. They also demonstrate the critical role that social protection plays in addressing the social and economic drivers of the epidemic: inequality, education levels, food insecurity, poverty and exclusion.³⁰

HIV/AIDS should be understood as a disease of inequality, both economic and gendered.³¹ The relationship between HIV/AIDS, poverty and inequality is complex and multi-directional: HIV/AIDS worsens poverty and inequality, while poverty and inequality can increase people's vulnerability to HIV in the first place. Because of the importance of these socio-economic factors, social protection can play an important role in the care and support of HIV-affected people, as well as in the prevention and treatment of the disease:

- **Social and economic care and support:** HIV/AIDS has a huge negative socio-economic impact, due to chronic illness and loss of labour capacity, as well as frequent loss of the prime-age breadwinner and

consequent high dependency ratios. Social transfers help households smooth their consumption and enable investment in strategies that strengthen livelihoods and household economies; they also contribute to education and health access for children affected by HIV and AIDS.

- **Prevention:** Social transfers contribute to HIV prevention by alleviating the underlying causes of HIV infection risk. These are the structural social and economic drivers of the epidemic, which increase the likelihood that people will engage in risky behaviour. They include: school dropout, early sexual debut, unprotected sex, early marriage, early pregnancies, gender inequality, dependence on men for economic security, migration for economic reasons and transactional sex. In addition, new evidence shows that 'cash plus care' (i.e. transfers combined with social support, such as positive parenting or teacher support) can considerably augment the impact that cash can have on HIV prevention (Cluver, Orkin et al. 2014).
- **Treatment:** Social transfers can support HIV treatment; for example, cash can be used to buy food, contributing to improved nutritional status. This in turn improves resilience to other diseases and adherence to antiretroviral therapy (ART). Cash can also be used towards the costs associated with accessing treatment (direct and indirect).

In conclusion, the impact pathways are multiple and emerging evidence has shown that social protection, through cash transfers, has a role in mitigating the negative impacts of HIV and AIDS. There is also emerging evidence to show that social transfers can address the social and economic drivers of the epidemic, and also reduce economic barriers to access to treatment and care for someone who is affected by HIV.

Table 11: Conceptual framework for the impact of social transfers on HIV/AIDS and adolescent wellbeing outcomes

INPUT	ENABLING FACTORS	HOUSEHOLD IMPACT	INDIVIDUAL IMPACT through the LIFECYCLE
Social transfer	Healthcare services (availability, cost and quality) Health practices Social norms Access to information Gender equality	Mitigation: of negative economic impacts of HIV and AIDS (loss of family member/productivity due to AIDS; chronic illness)	Infant/younger child Treatment: improved nutritional status increases resilience to other diseases (for children affected by HIV) Treatment: improved nutritional status increases adherence to ART and reduces likelihood of transition from HIV to AIDS (disease progression) Treatment: increased access to treatment services (removing economic barriers)
		Prevention, treatment and care: increased income and economic independence Prevention: reduced likelihood of inter-generational cycle of poverty Prevention: increased knowledge and empowerment Treatment: increased economic access to medical treatment	Older child/adolescent Prevention: lower school dropout can reduce likelihood of engaging in risky behaviours Prevention: improved psycho-social and economic status can reduce likelihood of engaging in risky behaviours Prevention: reduced risky behaviours can prevent likelihood of exposure to HIV, i.e. delayed sexual debut; reduction in unprotected sex, early marriage, early pregnancies; reduction in dependence on men for economic security, migration for economic reasons, transactional sex Treatment: improved nutritional status increases resilience to other diseases Treatment: improved nutritional status increases adherence to ART and reduces likelihood of transition from HIV to AIDS
		Care: reduction in HIV-related stigma Treatment and care: increased quality and quantity of food, improved nutrition	Adult care-giver Prevention: improved psycho-social and economic status can reduce likelihood of engaging in risky behaviours Prevention: increased power over sexual choices and reduced risky behaviours can prevent likelihood of exposure to HIV, i.e. reduction in unprotected sex, dependence on men for economic security, migration for economic reasons, transactional sex. Treatment: improved nutritional status increases resilience to other diseases Treatment: improved nutritional status increases adherence to ART and reduces likelihood of transition from HIV to AIDS

An innovative contribution of the Transfer Project is the generation of evidence on the impact of national social transfer programmes on adolescent wellbeing and HIV prevention. Some of the impact evaluations conducted under the Transfer Project include a specific module on adolescent wellbeing and behaviour. The emerging evidence from the South Africa Child Support Grant and the Kenya Cash Transfer for Orphans and Vulnerable Children is a significant contribution to strengthening our understanding

of the impact that social protection has on HIV outcomes, particularly HIV prevention among adolescents. Impacts are evident in terms of reducing risky behaviour, including engaging in inter-generational sex, sexual exploitation and delayed sexual debut. The evidence from these national, large-scale programmes, in contrast to 'proof of concept evaluations', provides strong grounds for regarding unconditional cash transfer programmes as a critical strategy for HIV prevention.

²⁸ http://data.unaids.org/pub/BaseDocument/2010/jc1879_social_protection_business_case_en.pdf

²⁹ <http://epri.org.za/wp-content/uploads/2012/06/HIV-Sensitive-Social-Protection1.pdf>

³⁰ http://www.cpc.unc.edu/projects/transfer/publications/briefs/SocialProtectionHIVBrief_Jan2015.pdf

³¹ This argument is put forward by Lutz and Small, as cited in Miller and Samson (2012: 4).

The table below presents an overview of the type of data that was collected in four evaluations: Zimbabwe HSCT, Malawi SCT, Kenya CT-OVC and Zambia MCP.

Table 12: Summary of Transfer Project impact evaluation data with adolescent modules (all longitudinal except Kenya)

	Zimbabwe 13–20 N=1170	Malawi 13–19 N=2109	Kenya 15–25 N=2255	Zambia 13–17 N=2098
Name of programme evaluated	HSCT	SCT	CT-OVC	MCP
Study design	District matched case-control	RCT	RCT	RCT
Years of panel (first year is baseline)	2013, 2014, 2015	2013, 2014, 2015	2007, 2009, 2011	2011, 2013, 2014
Examples of indicators				
HOPE Scale (Snyder)	X		X	X
CES-D Short Form (depression)	X	X	X	X
Aspirations		X		X
Raven's test of logical reasoning		X		X
Alcohol/tobacco use	X	X		
Patience		X	X	X
Material deprivation (blanket, shoes, change of clothes)	X	X		X
Schooling (enrolment, attainment, progression)	X	X	X	X
Subjective health status				X
Health (morbidity, physical limitations)	X	X	X	X
Sexual debut	X	X	X	X
Transactional sex	X	X	X	X
Marriage*	X	X	X	X
Condom use first sex	X	X	X	X
Condom use last sex	X	X	X	X
Concurrency	X	X		
Partner age/schooling – first sex	X	X	X	X
Partner age – last sex	X	X	X	X
Knowledge of HIV	X	X	X	X
Pregnancy*	X	X	X	X
Ante-natal care*	X	X	X	X
Child mortality	X	X	X	X

* Collected for all women aged 12–49 on roster; N refers to number of adolescents in the young person's module. All studies include a multi-topic household survey administered to main respondent. Overall study sample sizes are typically larger than size of adolescent sample.

Table 13: Evidence of the impact of social protection on HIV/AIDS and adolescent wellbeing outcomes

Impact area	Evidence
Prevention and risky behaviour	<ul style="list-style-type: none"> South Africa CSG: there is evidence that unconditional cash transfers can reduce risky behaviour among girls, thereby decreasing the risk of HIV transmission. For example, living in a beneficiary household reduced by two-thirds a girl's likelihood of having sex with a much older man, with only 1.7 per cent of girls reporting such relations, compared to 4.8 per cent of those in non-beneficiary households.
	<ul style="list-style-type: none"> Kenya CT-OVC: after four years of cash transfers, young people aged 15–25 enrolled on the programme were 30 per cent more likely to delay their sexual debut than those who were not enrolled. See Box 6, below, for further details.
Pregnancy	<ul style="list-style-type: none"> South Africa CSG: reduction in pregnancy found in analysis using eligibility and enrolment criteria and propensity score matching.
	<ul style="list-style-type: none"> Malawi Zomba Pilot: evidence from an 18-month proof-of-concept RCT showed reduced pregnancy in the last year and reduced early marriage among girls who received social transfers, aged 13–22 at baseline over a 14-month period. This result is primarily due to strong impacts among girls who were either out of school at baseline or were recent dropouts.
Link between school attendance and HIV	<ul style="list-style-type: none"> Zimbabwe Adolescent Orphan Girls in School: evidence from an RCT of a schooling conditional cash transfer targeting orphaned adolescent girls in rural Zimbabwe found that the transfer directly reduced school dropout rates by 82 per cent and pregnancy by 63 per cent two years later. Participants reported more equitable gender attitudes and were better informed about sexual risks than were control group members.
	<ul style="list-style-type: none"> South Africa CSG: adolescents from beneficiary households were absent from school on average 2.3 days fewer in the past eight weeks, and at the time of the survey were 16 per cent more likely to be abstaining from sex, compared to those from non-beneficiary households.
HIV prevalence	<ul style="list-style-type: none"> Malawi, Zomba Pilot: evidence found that women aged 13–22 years who received the transfer had a 64 per cent lower prevalence of HIV than those who received no transfer, though this figure is driven by a difference of just 22 positive cases between the two groups. Evidence was supported by changes in self-reported sexual behaviour. Furthermore there was no significant difference in impact between unconditional and conditional transfers, suggesting that conditionality was not necessary to reduce HIV prevalence.

Source: Baird et al. (2012), Cluver (2013), Hallfors et al. (2011), Heinrich et al. (2012), Miller and Samson (2012), Transfer Project (2014).³²

Box 6: Evidence from the Kenya Cash Transfer for Orphans and Vulnerable Children programme

The Kenya CT -OVC, implemented by the Children's Department of the Ministry of Gender, Children and Social Development, is Kenya's flagship social protection programme, currently reaching nearly 150,000 households across the country with cash transfers. The objective is to support families living with orphans and vulnerable children and to promote the human capital development of these vulnerable children.

Eligibility is based on poverty and having at least one orphan or vulnerable child below the age of 18 in the household. Families are provided with a flat monthly allowance of 2,000 Kenyan Shillings (approximately US\$22), which is paid directly to the care-giver, 80 per cent of whom are women.³³ There are no punitive conditions attached to the transfer, though there is some 'messaging': care-givers are informed that the money should be used for the care and support of children.

The impact evaluation showed that after four years of cash transfers (2007–2011) the programme had

had a wide range of significant impacts on child outcomes: reduction of child labour, decreased symptoms of depression among young people, reduced likelihood of early sexual debut, delayed early pregnancy and increase in birth registration (despite this not being a condition of the programme).

Even though the CT-OVC programme is primarily poverty focused, and reducing HIV risk is not an explicit objective, the transfers have nevertheless had an important knock-on effect on HIV-related outcomes. For example, evidence shows that the programme has reduced the odds of sexual debut among young people aged 15–25 by 30 per cent (or 8 percentage points), compared with the baseline. Furthermore, the cash was received by the care-giver and not by the child, yet there was still an impact on the child's likelihood of contracting HIV. This is an important finding and is likely to be applicable to other similar programmes in Africa.

Source: Transfer Project (2013).

Economic and productive impacts

Social transfer programmes have an impact on the productive activities of both beneficiary and non-beneficiary households in the communities where they are implemented. While the principal objective of most social transfer programmes in Africa is to reduce immediate vulnerability and smooth consumption, there is also strong evidence that social transfers can facilitate households' investment in productive activities, improve access to markets, shift from agricultural wage labour to on-farm activities, and generate multiplier effects for the local economy. Evidence shows that well-designed social transfer

programmes do not create disincentives for families to work and save money; rather they create opportunities for beneficiaries to become progressively more self-sufficient (through investment in productive assets) – even among those who are labour constrained and extremely poor. The nature and magnitude of these impacts vary from country to country, however, because of differences in programme design, implementation and context.

The livelihoods of most beneficiaries in Sub-Saharan Africa are predominantly based on subsistence agriculture and rural labour markets: more than 80 per cent of beneficiaries produce crops and more than 50 per cent own livestock (Davis 2014). Most beneficiaries live in places

where markets of all kinds are lacking or do not function well: markets for financial services (such as credit and insurance), labour markets and markets for goods and farming inputs. In this context, cash transfers that are provided in a regular and predictable fashion have been shown to help households to overcome liquidity and credit constraints and to manage risk, though many households remain risk averse (see section below on social cohesion and community dynamics). However, as is the case with other sectors, although cash transfers address key market failures and can help to catalyse economic and productive outcomes, for there to be any long-term and sustainable impacts on productivity and productive inclusion, there would also need to be important complementary interventions, such as information and skills training, alongside agricultural programmes.

Social transfers have also been shown to have a 'multiplier effect' – i.e. to stimulate local economies and benefit the community, including non-beneficiaries. Beneficiaries generally spend

their cash in local businesses (most of which will likely not be beneficiaries of the social transfer programme themselves). Some local businesses respond to the additional demand by expanding production, and thus the social transfer also has a multiplier effect on non-beneficiaries and the wider economy. The multiplier effect is often directly related to the proportion of beneficiaries versus non-beneficiaries in a given market area. As a key conclusion, non-beneficiaries and the local economy can also benefit from cash transfer programmes via trade and production linkages; maximizing the income multiplier may require complementary interventions that target both beneficiary and non-beneficiary families.

Most of the evidence reviewed here has been produced within the **From Protection to Production (PtoP)** project, a part of the Transfer Project and a multi-country impact evaluation that focuses on measuring the effect of cash transfers on productive and economic activities (see above for further details).

Table 14: Conceptual framework for the impact of social transfers on economic and productive outcomes

INPUT	ENABLING FACTORS	HOUSEHOLD IMPACT	INDIVIDUAL IMPACT through the LIFECYCLE
Social transfer	Cost of living Labour market and livelihood opportunities Frequency and severity of covariate risks and shocks (droughts, floods, conflict, etc.)	Economic means to deal with costs of services, clothes, etc.	Infant/younger child
			Increased access to services leads to improved human capital
		Economic means to deal with lifecycle shocks (illness, loss of breadwinner, un- or underemployment)	Older child/adolescent
			Increased access to services leads to improved human capital
		Smoothing consumption Reduces asset depletion in response to shocks	Adult care-giver
			Increased access to services leads to improved human capital
			Regular and predictable transfers can increase livelihood investment and risk taking
			Shift from decreased casual wage labour to increased own business activities
	Increased access to credit		
	Increased participation in informal social assistance networks		

³³ In July 2012, the monthly transfer value per household for the Kenya CT-OVC was increased from 1,500 to 2,000 Kenyan shillings.

Table 15: Evidence of the impact of social transfers on economic and productive outcomes

Impact area	Evidence
Investment in farm and non-farm business	<ul style="list-style-type: none"> Ghana LEAP: led to an increase in spending on seeds and beneficiaries hired more casual labourers. However, there was no observable growth in agricultural production. In just a few cases some beneficiaries started new businesses, but there was no increase in livestock ownership.
	<ul style="list-style-type: none"> Kenya CT-OVC: there was an increase in female-headed households conducting non-agricultural business enterprises, but a decline in male-headed households doing the same. Ownership of small livestock increased.
	<ul style="list-style-type: none"> Lesotho CGP: led to an 8 percentage point increase in the proportion of households using pesticides, which in turn contributed to a large increase in maize output per household (overall an increase of 38 kg from a base of 37 kg) and an increase in sorghum production; garden plots were also harvested more frequently. However, no evidence was found that households diversified their income-generating activities by starting new, off-farm businesses.
	<ul style="list-style-type: none"> Malawi SCT: significant increases in the ownership of farm tools (hoes, sickles, axes) and all types of livestock (large and small) – up by about 50 percentage points.
	<ul style="list-style-type: none"> Zambia CGP: led to a 34 per cent increase in the area of worked land and an increase in the use of agricultural inputs (seeds, fertilizers, hired labour). The growth in input use led to a 50 per cent increase in the overall value of the harvest from baseline. The number of beneficiaries selling some of their production also increased by 12 percentage points, or 50 per cent from baseline. Ownership of all types of livestock went up.
Reallocation of family labour	<ul style="list-style-type: none"> Ghana LEAP, Kenya CT-OVC, Lesotho CGP, Malawi SCT, Zimbabwe HSCT: consistent reports from all these countries that households receiving cash transfers were able to shift from agricultural wage labour of last resort to activities on their own farms (on-farm activities).
	<ul style="list-style-type: none"> Zambia CGP: significant shift from agricultural wage labour to on-farm activities, particularly for women (17 percentage point reduction and 12 days fewer per year).
Local economy	<ul style="list-style-type: none"> Ethiopia SCT, Tigray province: potential multiplier effect of US\$2.52 in local economy in Hintalo-Wajirat, i.e. it is estimated that for each \$1 transferred to beneficiaries, the local economy as a whole benefits from a \$2.52 increase (using the LEWIE model). This was the highest multiplier effect observed for the seven countries in the PtoP project.
	<ul style="list-style-type: none"> Kenya CT-OVC: potential multiplier effect of US\$1.81 in Western Kenya, but multiplier effect of only \$1.34 in Eastern Kenya (Nyanza). This was the lowest multiplier effect observed in the PtoP project. The difference in multiplier effects between different regions in Kenya is due to the varying size and integration of the markets.
	<ul style="list-style-type: none"> Malawi SCT: beneficiaries reported that local vendors started selling goods (such as dried fish and tomatoes) door-to-door on transfer paydays. The multiplier effect on the local market was minimal, probably because beneficiaries make up a small proportion of total local population.
	<ul style="list-style-type: none"> Zimbabwe HSCT: local shops near to transfer pay points benefited from increased trade on paydays. However the multiplier effect on the local economy was marginal.
	<ul style="list-style-type: none"> Zambia: potential multiplier effect of US\$1.79 in the local economy. This was the highest multiplier effect for a national programme observed for the seven countries in the PtoP project.

Source: AIR (2013), Boone et al. (2013), Covarrubias et al. (2012), Davis (2014), Evans et al. (2014), Samson (2009), Taylor et al. (2012), Transfer Project (2014), From Protection to Production.

As is shown in the tables below, the evidence demonstrates that households do indeed use the cash to invest in their livelihood, but the type of livelihood activities (and the extent to which there is an impact) varies from country to

country (see Table 16). In Zambia and Malawi, overall the cash transfers had a strong impact on investment in livelihood activities, whereas in Kenya and Lesotho the results were more mixed, and in Ghana the cash transfers had less impact.

Table 16: Households' investment in livelihood activities, by country

	Zambia	Malawi	Kenya	Lesotho	Ghana
Agricultural inputs	+++		-	++	+++ (1)
Agricultural tools	+++	+++	Not significant	Not significant	Not significant
Agricultural production	+++ (2)		Not significant	++ (3)	Not significant
Sales	+++	Not significant	Not significant	Not significant	--
Home consumption of agricultural production	Not significant	+++	+++ (4)		Not significant
Livestock ownership	All types	All types	Small livestock	Pigs	Not significant
Non-farm enterprise	+++	Not significant	+FHH		
-MHH (5)	-	Not significant			

(1) Reduction in hired labour.

(2) Overall value of production; reduction in cassava.

(3) Maize, sorghum and garden plot vegetables.

(4) Animal products.

(5) Positive impact for female-headed households, negative impact for male-headed households.

Note: in the table above, green represents an increase in this activity, yellow represents an increase that was not considered statistically significant (or an impact that varied), and red represents a reduction in this activity.

Source: From Protection to Production.

Table 17, below, shows that social transfers can support households in shifting from casual labour activities (on other people's land) to working on their own farms and in family businesses. This shift was consistently reported

in Zambia, Kenya, Malawi and Lesotho. The evidence from these countries, however, shows no clear picture in terms of the impact of social transfers on child labour.

Table 17: Shift from casual wage labour to on-farm and family productive activities

Adults	Zambia	Kenya	Malawi	Lesotho	Ghana
Agricultural/casual wage labour	---	--- (1,2)	---	-- (2)	Not significant
Family farm	+ (2)	++	+++	++ (2)	+++
Non-farm business	+++	Not significant		+	Not significant
Non-agricultural wage labour	+++	Not significant	Not significant	Not significant	Not significant
Children					
Wage labour	Not significant	Not significant	---	Not significant	Not significant
Family farm	Not significant	--- (3)	+++ (4)	--	Not significant

(1) Positive farther away.

(2) Varies by age, gender.

(3) Particularly older boys.

(4) Increase in chores, reduction in leisure.

Note: in the table above, green represents an increase in this activity, yellow represents an increase that was not considered statistically significant (or an impact that varied), and red represents a reduction in this activity.

Box 7: Evidence from the Zambia Child Grant Social Cash Transfer programme

In 2010, the Government of the Republic of Zambia, through the Ministry of Community Development, Mother and Child Health, began implementing the Child Grant Programme (CGP) in three districts: Kaputa, Kalabo and Shongombo. The CGP targets all households with children under the age of five living in those districts, providing each family with 60 kwacha (ZMW), or roughly US\$12 per month, regardless of the size of the household.

Evaluation findings after two years of programme implementation showed exciting evidence not only of the short-term effects, but also of a significant increase in the long-term productive capacity of households. The cash transfer supported existing income-generating activities, enabling households to use and purchase more agricultural inputs, more livestock and other business assets, thereby increasing their agricultural production and the money earned from selling their produce. There was a significant shift from agricultural wage labour to family agricultural, or non-agricultural

businesses, i.e. recipients of the transfer were able to dedicate more time to their families' own farms, or to other family-run business opportunities, rather than working on other people's farms. The social transfer also enabled some households to diversify their livelihoods and start earning an income in new ways, causing a 16 percentage point increase in the share of households running non-agricultural business enterprises.

In addition to the impact on the productive capacity of households, the CGP has demonstrated a whole range of positive impacts on families' consumption and wellbeing, such as: increased spending on food, a reduction in the poverty gap between households, an increase in the number of meals eaten per day, reduced frequency of diarrhoea for children under five, improved nutrition among young children (improved feeding and reduced wastage).

Source: AIR (2013).

Social cohesion and community dynamics

The African continent has a long and strong tradition of community, kin-based support systems and social networks. However, as a result of migration, poverty, recurrent risk, impacts of the HIV epidemic and other factors/trends, these structures have suffered severe constraints and challenges. As we witness an increase in the number and scope of social protection programmes, including social cash transfers, countries are exploring the best mechanisms for linking formal and non-formal social protection systems, so that they are mutually reinforcing, exist in parallel and complement one another.

Evidence reviewed in this document shows that social transfers can help to enable people to 're-enter' social networks, pay off their debts, reduce

their borrowing and increase their savings (see Table 18 below). For instance, in Lesotho and Ghana, receipt of social transfers strengthened social networks of reciprocity and enabled households to participate in informal safety nets, as beneficiaries in both countries considerably increased their sharing of resources with others in the local community. In Malawi and Lesotho, households receiving cash transfers reported receiving fewer remittances from abroad (see Table 18 below). Similarly, in Somalia qualitative data suggests that the emergency transfer programme (delivered by NGOs) also promoted resource sharing and thus contributed to maintaining the reciprocal support networks or 'informal' social protection systems that are such an important coping mechanism for Somalis in time of crisis (Hedlund et al. 2013).

However, the evidence suggests that the impacts on social cohesion are closely

linked to the eligibility criteria and targeting mechanisms (for selecting those entitled to the programme), and to the role and capacity of community committees and front-line workers. The communication and case management strategy in place is also important for effectively transmitting the objectives and selection criteria of a programme to beneficiary communities/the public, and for providing feedback from communities to implementers (e.g. acting as grievance mechanisms). Good case management improves perceptions of fairness and enables people to complain when they have grievances or when an abuse of the system occurs.³⁴ In some communities there is pressure to re-distribute resources in order to 'correct' what is perceived as an unfair system, or to control targeting, so that families that are included in one programme are not included in others, even when this is contrary to government policy.³⁵ Community participation and clear information on the programme objectives and

plans for expansion can contribute to addressing misconceptions linked to social transfers and their delivery. The impact of transfers on social cohesion will ultimately vary from context to context, and is dependent on the level of social cohesion prior to the programme, as well as on the way in which communities share resources and apportion risk.

It is important to acknowledge that – given the long tradition of community and solidarity networks in the form of, for instance, intra- and inter-family transfers, gift giving, labour-sharing arrangements, burial and funeral societies, and informal credit and savings schemes – the transfer potentially has an impact on the wider community, and not just on the beneficiary households (ACPF 2014). Social transfers also contribute to the family's social capital, providing them with a sort of 'social insurance' and contributing to improved dignity, social inclusion and the possibility of future support from others, if and when needed.

Table 18: Conceptual framework for the impact of social protection on social cohesion outcomes

INPUT	ENABLING FACTORS	HOUSEHOLD IMPACT	INDIVIDUAL IMPACT through the LIFECYCLE
Social transfer	Social norms and gender relations Levels of social cohesion (within and between communities) Social contract between state and citizens Quality of programme targeting (risk of poverty targeting undermining social cohesion)	Rebuilding social contract (state and citizens)	Infant/younger child
			Improved material wellbeing
		Empowering the recipient (woman or man) of the cash transfer in decision making	Older child/adolescent
			Increased social capital (participation in community activities and networks)
			Improved psycho-social status and reduced stress
		Reduction in stigma and isolation	Increased dignity derived from improved material wellbeing
			Adult care-giver
		Increased participation in social networks	Increased social capital (participation in community activities, networks, religious institutions)
			Increased economic and social independence for those who were previously dependent on others (elderly, disabled, widows, etc.)
			Improved psycho-social status and reduced stress
Increased participation in informal social assistance networks			
			Increased dignity derived from improved material wellbeing

³⁴ In Ghana, it was reported that the LEAP programme had generated mistrust between non-beneficiaries and beneficiaries, as targeting criteria were not clearly understood and there were allegations of bias. The feedback mechanism was not adequate to enable people to express and resolve their grievances. See <http://www.fao.org/docrep/018/i2968e/i2968e06.pdf>

³⁵ In the Malawi SCT, it was reported that some communities had tried to control targeting processes in this way, see: <http://www.fao.org/3/a-i3997e.pdf>

Table 19: Improved ability to manage risk

	Zambia	Kenya	Malawi	Ghana	Lesotho	Tanzania
Negative risk coping			---		---	
Paying off debt	+++			+++	Not significant	
Borrowing	---	Not significant		---	Not significant	Not significant
Purchasing on credit	Not significant			Not significant	Not significant	
Savings	+++	+++		+++	Not significant	++
Giving informal transfers			Not significant		+++	
Receiving informal transfers				Not significant	+++	Not significant
Remittances			---	Not significant	---	Not significant
Trust (towards leaders)						++

Note: in the table above green represents an increase in this activity, yellow represents an increase that was not considered statistically significant (or an impact that varied), and red represents a reduction in this activity.

Table 20: Evidence of the impact of social protection on social cohesion outcomes

Impact area	Evidence
Sharing resources	<ul style="list-style-type: none"> Ghana LEAP: enabled some beneficiaries to provide assistance to other family members in need. Beneficiary families increased the amount they spent on providing support to others (by GHS 1.60) and this was particularly notable for female-headed households (increase of GHS 1.80 shared).
	<ul style="list-style-type: none"> Lesotho CGP: had a significant impact on strengthening the informal sharing or social safety net arrangements in the community, as beneficiary households were more likely to provide support to others in the community (cash and in kind).
	<ul style="list-style-type: none"> Zimbabwe HSCT: beneficiaries reported being able to share resources with friends and neighbours, thereby consolidating existing social networks.
Inclusion in networks and risk management	<ul style="list-style-type: none"> Ethiopia SCT, Tigray province: some beneficiaries reported joining informal rotating savings groups; however, they were unable to join burial societies (due to high joining fees).
	<ul style="list-style-type: none"> Ghana LEAP: led to a 10.8 percentage point increase in the likelihood of holding savings, increased debt repayments and reduced loan holdings among smaller households. The transfer also reduced borrowing and financial risk and asset disinvestment, while increasing capacity to cope on a day-to-day basis. LEAP households reported that they were less likely to get into debt when they needed money to survive, and were also more creditworthy, since they were viewed as more financially reliable.
	<ul style="list-style-type: none"> Ethiopia Tigray: beneficiaries were able to access increased credit from local shop keepers, thereby enabling them to maintain consumption of food and household goods (such as cleaning products) throughout the month.
	<ul style="list-style-type: none"> Malawi SCT: beneficiaries have become better integrated into networks where participation is dependent on financial contributions, such as church contributions.
	<ul style="list-style-type: none"> Tanzania TASAF: the poorest half of households receiving the cash transfers saw a five-fold increase in non-bank (informal) savings as a result of the programme.
	<ul style="list-style-type: none"> Zimbabwe HSCT: church offerings and funeral contributions provided an opportunity for recipients of the transfer to be included in social networks.

Dignity, self-esteem and wellbeing	<ul style="list-style-type: none"> Ethiopia SCT, Tigray province: beneficiaries reported that being able to purchase coffee and sugar, as well as soap and new clothes (improving personal hygiene and helping to get rid of fleas), had a positive effect on their social ties and involvement in community life. Cash transfers also enabled some of the poorest families to move out of caves and into rented accommodation. The transfer also contributed to a reduction in begging and having to ask for support from relatives.
	<ul style="list-style-type: none"> Ghana LEAP: the programme increased self-reported happiness by 16 percentage points. Beneficiaries also reported that the transfers enabled them to contribute to ceremonies and other social events, thereby improving their self-esteem and social status in their communities.
	<ul style="list-style-type: none"> Kenya CT-OVC: recipients of the cash transfer showed a 6 percentage point increase in the quality of life index.
	<ul style="list-style-type: none"> Lesotho CGP: qualitative research reported increased self-esteem and sense of self-worth, due to beneficiaries being able to support others in the community. There was also a reduction in begging among programme participants.
	<ul style="list-style-type: none"> Malawi SCT: despite little change in formal social standing in the community, beneficiaries nevertheless reported feeling greater dignity, due to improved material wellbeing. There was also a reduction in begging, and the share of households reporting that they were satisfied with their life increased by 20 percentage points.
	<ul style="list-style-type: none"> Somalia Cash and Voucher Programme: women cited improvements in their self-reported social status and sense of dignity, as they were able to pay back debts and lend (cash and in kind) to neighbours and extended family.
	<ul style="list-style-type: none"> Zambia CGP: the share of households that felt they were better off increased by 45 percentage points.

Source: FAO (2014), Hedlund et al. (2013), Ministry of Gender, Children and Social Protection (Ghana) (2014c), Transfer Project (2014), From Protection to Production.

Child protection

Child protection aims to reduce the violence, exploitation and abuse that children from any background can suffer, whether it occurs in the home, at school, within the community, through the care and justice system, or as a result of conflict and natural disaster. This section focuses on three outcomes that are particularly important in the region from a child protection perspective: increasing birth registration, reducing child labour and reducing violence against children.

Social cash transfer programmes can address some of the underlying economic causes of violence, exploitation and abuse, as well as reducing the unnecessary separation of children from their families. In this way, social cash transfers can have an indirect effect on child protection outcomes. For example, there is some evidence to show that social transfers can increase birth registration and reduce child labour, as well as increase access to treatment

for mental health problems and cut rates of early marriage (see section above on HIV/AIDS and adolescent wellbeing). Child labour is an important area of work for both social protection and child protection, since large numbers of children work on the family farm in Sub-Saharan Africa – 50 per cent in Zambia, 30 per cent in Lesotho and 42 per cent in Kenya, according to Davis (2014).

In terms of violence against children, to date there is very little evidence concerning the impact of social protection, including cash transfers. It is an area that may require further research. Even though poverty and exclusion can be drivers of violence, the studies reviewed here did not explicitly include questions that assessed the impact of social transfers in this sphere. Though the evaluation of the Zimbabwe HSCT does include a specific module on violence, to date only the baseline report has been completed and data collection for follow-up is expected to take place in 2016.

Table 21: Conceptual framework for the impact of social transfers on child protection outcomes

INPUT	ENABLING FACTORS	HOUSEHOLD IMPACT	INDIVIDUAL IMPACT through the LIFECYCLE
Social transfer	Social norms Gender equality Community attitudes Access to justice	Increased household income More time for childcare Reduction in family separation and institutional care (when driven by poverty) Reduction in stigma and isolation Increased participation in social networks	Infant/younger child
			Increased birth registration (as some social transfer programmes increase payment amounts for larger families, and birth registration details may be necessary to prove the number of dependent children)
			Older child/adolescent
			Reduced child labour
			Increased aspirations, improved psycho-social status (PSS), mental health and reduced stress
			Increased access to treatment for mental health issues
			Increased control over sexual choices, i.e. delayed sexual debut, reduction in unprotected sex, early marriage, early pregnancies, reduction in dependence on men for economic security, migration for economic reasons, transactional sex
			Adult care-giver
			Greater economic and social independence for those who were previously dependent on others (elderly, disabled, widows, etc.)
			Improved PSS, mental health and reduced stress
Increased access to treatment for mental health issues			

Table 22: Evidence of the impact of social protection on child protection outcomes

Impact area	Evidence
Birth registration	<p>Kenya CT-OVC: the unconditional programme had a substantial effect on the proportion of recipient children (aged up to 17 years) with a birth certificate or a birth registration form, with a 12 percentage point increase over the controls. This was significant for both younger and older children.</p> <p>Lesotho CGP: there was a loose requirement that beneficiary children should have a birth certificate within six months of their enrolment in the CGP (as cash transfer amounts increased with family size). There was an increase in birth registration of 37 percentage points.</p>
Child labour	<p>Ghana LEAP: qualitative evidence suggests that there has been some reduction in child labour, as children from beneficiary families who used to work all day now work on farms and stalls only after school and at the weekends. However, there is no clear quantitative evidence of the reduction in child labour.</p> <p>Kenya CT-OVC and Lesotho CGP: large reduction in child on-farm labour.</p> <p>Malawi SCT: switch from off-farm wage labour to on-farm activities for children, as a result of the cash transfer.</p> <p>Zambia CGP: Switch from paid to unpaid domestic labour in treatment group relative to control group.</p>
Violence	<p>The evidence on the wellbeing of adolescents and their increased control over sexual choices as a result of social transfers is included in the HIV/AIDS and adolescent wellbeing section above, as it contributes to HIV prevention.</p> <p>As yet there is no clear evidence of social transfers reducing violence against children.</p>

Source: Baird (2010), Handa et al. (2015 forthcoming), Heinrich et al. (2012), Ministry of Gender, Children and Social Protection (Ghana) (2014b), Pellerano et al. (2014), Peterman et al. (2014), Transfer Project (2014), From Protection to Production.

Early childhood development

Early childhood development (ECD) programmes involve work by a number of sectors (particularly health, nutrition, education and child protection), since the first years of a child's life are crucial for his or her immediate survival and later success. The scope of ECD programmes is generally from the pre-natal period until primary schooling (sometimes up until the age of eight), as cognitive and biological development is particularly fragile at this time and is highly dependent on the care and nutrition that an infant receives. Social cash transfers can play a role in investment in these important few years of a child's life. The impact of social transfers on ECD outcomes can be direct – tackling financial barriers to accessing specific ECD services – or

indirect, in the sense that the cash transfer may trigger a series of behavioural responses by the household (AIR 2014: 28). For these behavioural reasons, children whose mothers have more education (eight or more grades of schooling) are also more likely to benefit from the positive second-round effects of social transfers, and there is significant evidence of this from the South Africa CSG (DSD, SASSA and UNICEF 2012: iii).

However, despite the potential links, there are still significant gaps in knowledge of how social protection contributes to ECD (UNICEF 2012: 65). As is the case with child protection outcomes, only a few assessments have deliberately included ECD indicators in their questionnaires. Examples from two programmes are presented below: the Zambia Child Grant Programme (CGP) and the South Africa Child Support Grant (CSG).³⁶

Table 23: Conceptual framework for the impact of social transfers on ECD outcomes

INPUT	ENABLING FACTORS	HOUSEHOLD IMPACT	INDIVIDUAL IMPACT through the LIFECYCLE
Social transfer	Legislative environment (incl. parental leave, childcare in the workplace, etc.) Availability of family care services Social norms – attitudes to breastfeeding Levels of education of care-givers and teachers	Increased income Increased quality and quantity of food Increased access to healthcare Provision of childcare	Infant/younger child (0–5)
			Higher rates of exclusive breastfeeding for first six months (mother has more time for childcare)
			Increased parental and/or paid time for childcare and interaction
			Improved infant and young child feeding (IYCF) ³⁷
			Higher rates of immunization
			Improved nutrition leads to improved cognitive and motor development
			Participation in early education (kindergarten, pre-primary)
			Older child (5–8)
		Higher rates of immunization	
		Improved nutrition leads to improved cognitive and motor development	
		Participation in early education (kindergarten, pre-primary)	
		Increased enrolment in primary school	
		Adult care-giver	
		Improved pre-natal and maternal welfare	
		Improved PSS and reduced stress	
		More time for childcare (through income support and parental leave)	
Provision of childcare gives mothers the choice of whether or not to work			

³⁶ The data collection on ECD outcomes in these two evaluations is based on the Multi-Indicator Cluster Survey (MICS) 4 module on ECD. MICS is a standardized data collection methodology developed by UNICEF. Further details can be found at: <http://www.childinfo.org/mics.html>

³⁷ Infant and young child feeding (IYCF) is a term that refers to the nutritional practices for feeding children under five. UNICEF and the World Health Organization promote early initiation of breastfeeding (within one hour of birth), exclusive breastfeeding for the first six months, followed by the introduction of nutritionally adequate and safe complementary (solid) foods at six months, together with continued breastfeeding up to two years of age or beyond. See: <http://www.who.int/mediacentre/factsheets/fs342/en/>

Table 24: Evidence of the impact of social transfer programmes on ECD outcomes

Impact area	Evidence
Infant and young child feeding (IYCF)	Zambia CGP: as stated in the consumption, food security and nutrition section above, the Zambia CGP had a large impact on IYCF (i.e. the proportion of children aged 6–24 months meeting minimum feeding requirements), with an increase of 28 percentage points (from 32 per cent to 60 per cent, the control group improved to only 43 per cent), equivalent to an 88 per cent increase in IYCF over the baseline mean.
Stunting and wasting	South Africa CSG: receiving the cash transfer in the first two years of life increased the likelihood that a child's growth is monitored and improves height-for-age scores for children whose mothers have more than eight grades of schooling.
	Zambia CGP: the Zambia CGP also significantly increased weight-for-height (0.196 z-scores) among children aged 3–5, though it showed no statistically significant effect on weight-for-weight, weight-for-age or height among children aged 0–5. There was some evidence that children who were stunted at baseline were more likely to catch up as a result of receiving the transfers (also noted in the consumption, food security and nutrition section above).
Illness in under-fives	South Africa CSG: early enrolment in the CSG reduced the likelihood of illness (as measured by a 15-day period prior to the survey), with the effect particularly strong among boys. Boys enrolled at birth had a 21 per cent likelihood of being ill, compared to a 30 per cent likelihood for boys enrolled later. The effect was particularly marked for children whose mothers had eight or more grades of schooling.
	Zambia CGP: the programme had a slight impact in terms of reducing the incidence of diarrhoea in children under five (4 percentage points) after 24 months of transfers, but at 36 months this change no longer persisted. But there was no measurable impact on other young child health outcomes. There was no increased use of health facilities, probably because of poor capacity of the services available (also noted in the health section above).
Use of health services	Zambia CGP: though health spending increased, there was no increased use of health facilities, probably because of poor capacity of the services available (also noted in the health section above).
Support for learning	South Africa CSG: children who were enrolled in the CSG at birth completed significantly more grades of schooling than did children who were enrolled at age six; they also achieved higher scores in a maths test. The impact among girls was particularly significant, with early receipt of the CSG increasing girls' grade attainment by a quarter of a grade, compared to those receiving the grant only at age six. This was largely because early receipt of the CSG reduced the delay in girls entering school by 27 per cent, and girls who enrolled early obtained higher scores in maths and reading tests. For children whose mothers had less than eight grades of schooling, the impacts were even greater: the CSG appears to narrow the schooling gap between children whose mothers have less education and those whose mothers have more (also noted in the education section above).
	Zambia CGP: there was some positive impact on support for learning and ownership of books after 24 months of cash transfers, but these impacts had disappeared at 36 months. It was noted that only 1.5 per cent of children had a book.
Impact in later life	South Africa CSG: early receipt of the Child Support Grant (in the first seven years of life) reduces the likelihood that children will grow up into adolescents who work outside the home (as reported in the adolescent survey). This is particularly true of girls who receive the grant in early childhood.

Source: AIR (2013, 2014), Miller and Samson (2012).

4. Operational Lessons Learnt and Keys to Success

As has been shown in previous sections, the size and scope of the results differ across countries. This section discusses some of the elements that can help to explain these differences, including: (i) size of transfer; (ii) predictability of payments; (iii) profile of beneficiaries; (iv) conditionality; and (v) national ownership. This section specifically focuses on key design and implementation elements that have been shown to influence impacts. Other operational elements – such as coverage, cost, enabling environment, etc. – which are critical in terms of efficiency, are not discussed here.

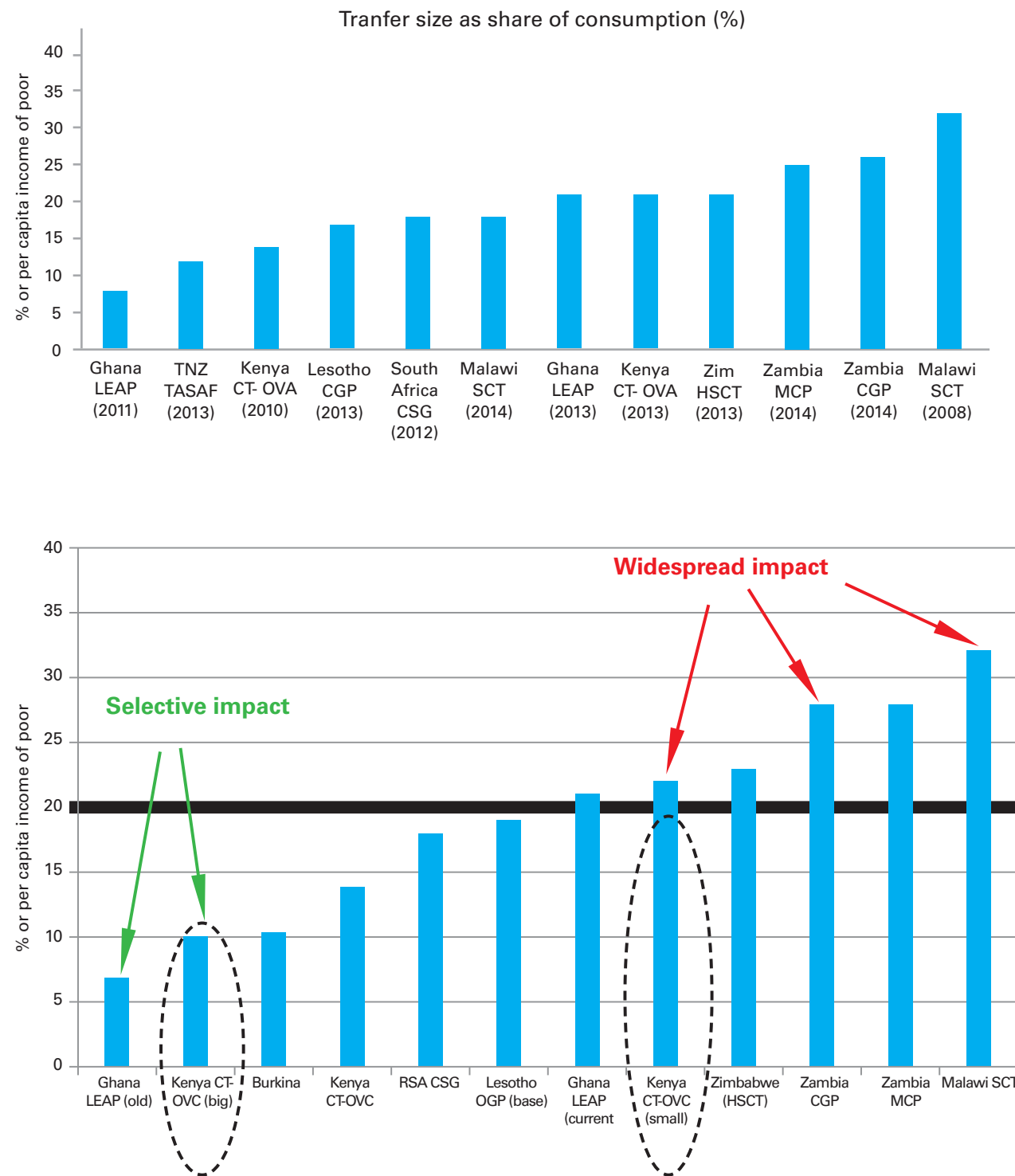
Size of transfer

A review of Transfer Project-led evaluations shows that impact increases with the size of the transfer. The average value of the social transfer ranges from US\$8 to \$25 per household per month – or, as a share of per capita consumption

of beneficiary households, from 7 per cent in the case of Ghana to almost 30 per cent in the case of Zambia, depending on the country and each programme's payment structure. It should also be noted that transfer values are likely to vary over time, depending on inflation. This has been the case for the Kenya CT-OVC programme, for which the value of the transfer decreased by 38.6 per cent in real terms between 2007 and 2011, before the transfer amount was raised by 33 per cent in July 2011 (Romeo et al. 2014: 3).

As Figure 3 below shows, changes in food consumption, as well as economic/productive impacts, are seen when transfer size is at least 15–20 per cent of household food consumption. The exact definition of these parameters would require detailed analysis of labour market dynamics (e.g. minimum wage level), local markets and price structures, and spending patterns at the household level.

Figure 3: Size of transfer matters



Source: Transfer Project (2015).

However, questions remain: Is this threshold applicable to all programmes, despite differences in coverage and systems development? What are the benefits and trade-offs (socio-economic and political impact) of prioritizing increased size of transfer vis-à-vis expansion of programme coverage?

Key message: Impacts on food consumption can be expected if the value of the transfers is between 15 and 20 per cent of household food consumption of beneficiary households.

Predictability and timeliness of payments

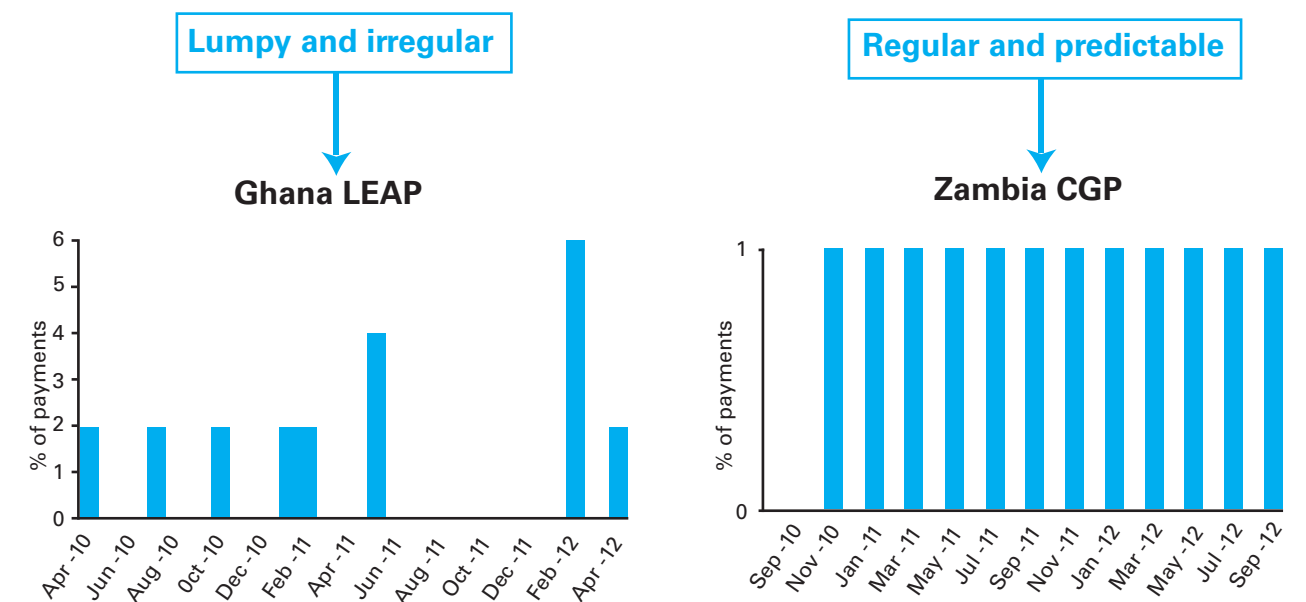
The frequency of payments will affect how resources are invested, and it thus has an impact on specific outcomes. As well as having an impact on overall results, irregular payments can have an effect on the perception and support of the programme at the local level.

For example, in Ghana payments were provided in a lump sum because of internal administrative

delays. The irregularity of the payments did not allow beneficiary households to smooth their permanent consumption, and thus led to families using the resources for bulk purchases, such as food grains and rice, which could be stored and used. There was also a significant impact on savings and gift giving (Handa et al. 2013). Irregular, lump-sum payments, combined with the smallness of the transfer (at the time of the evaluation), meant there was no effect on consumption. Careful review and discussion of these results at country level resulted in an increase in the size of the transfer and adjustments to the implementation of the programme.

By contrast, in Zambia the 24-month evaluation of the Child Grant showed that payments were distributed in a timely manner (every other month) in all districts. As a result, the CGP increased total per capita consumption spending by ZMW 15.18. In other words, the programme had a significant impact on increasing the average consumption of beneficiary households (AIR 2014).

Figure 4: Payments timeliness: comparison between Ghana and Zambia

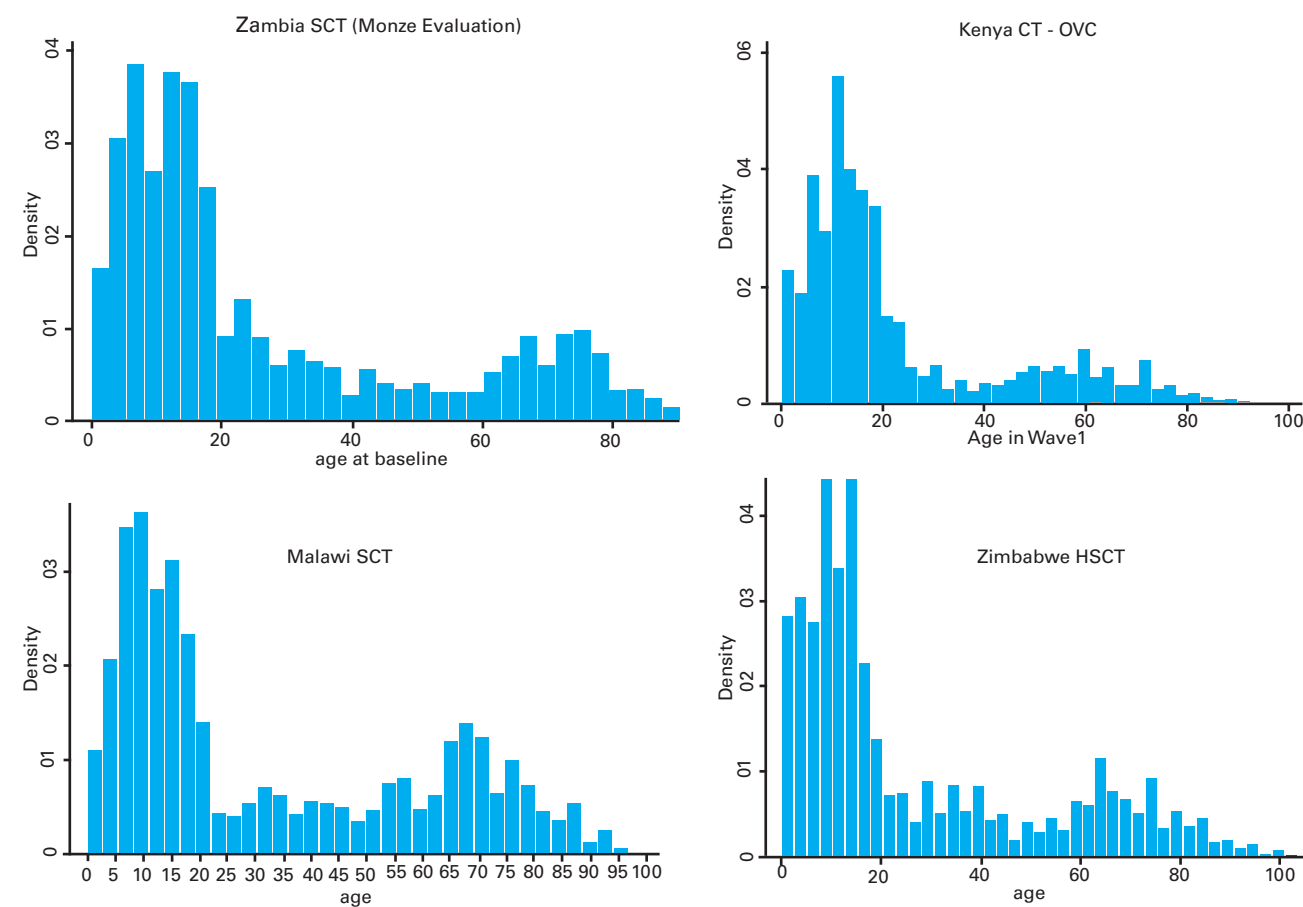


Key message: Regular and predictable payments facilitate planning, consumption smoothing and investment. The protection and risk management function of social protection, including of cash transfers, is maximized when beneficiaries are able to meet immediate food and other basic needs, as well as to plan how to invest incoming resources and to manage risk better (including engaging in credit and/or investment activities). The ability to plan (as well as to manage predictable and recurring shocks) also minimizes the likelihood of people engaging in negative coping strategies, such as selling assets, pulling children out of school, reducing food consumption and/or quality.

Profile of beneficiaries

Review of the evidence has also shown that the profile of beneficiary households will influence the type of impact expected. For instance, as a result of the *eligibility criteria* of many of the social cash transfer programmes reviewed in this document, beneficiary families are labour-constrained households, with high dependency ratios, and with missing generations (due to AIDS), where grandparents or older family members are taking care of children and adolescents. Some programmes, such as the Zambia Child Grant or the South Africa Child Support Grant, included a bigger proportion of families with younger children.

Figure 5: Profile of beneficiaries, selected programmes: Zambia, Kenya, Malawi and Zimbabwe



Source: Transfer Project analysis.

Given this scenario, in the case of programmes where the eligibility criteria include households with children under five (i.e. child grants), such as Zambia or South Africa, we should expect impacts on nutrition, ECD, young child survival, etc. In programmes that target families which are composed of grandparents taking care of grandchildren (older children), we should expect impacts on adolescent wellbeing. In addition, many of these households are subsistence producers that face constraints in terms of labour capacity, credit and liquidity. It is expected that these households will witness limited economic and productive impacts because of these additional constraints. However, the evidence shows that even among the poorest and most labour-constrained households, cash transfers do have a considerable economic and productive impact. As discussed in the section on economic and productive impacts, older farmers are able to hire labour to work on their farms, as well as to increase their ownership of livestock.

Given that the profile of beneficiaries will determine the scope and the type of impacts, should programmes define their eligibility criteria and coverage parameters based on desired results? In other words, should cash transfer programmes be designed and adjusted based on the objective of achieving specific sector outcomes, such as HIV prevention, economic productivity or nutrition?

The fungible nature of cash, together with the fact that many cash transfer programmes in Sub-Saharan Africa are unconditional, has led to a broad range of impacts across programmes and countries, generating interest not only from the social welfare and development sector, but also from multiple key sectors, in the potential of cash transfers to maximize specific sector outcomes. Moreover, from a child-sensitive perspective, recognizing that children face multiple and multi-sector vulnerabilities – age specific, but also shared by their families and communities – cash transfers can be both more effective in terms of achieving multiple impacts and a cost-effective

intervention contributing to multiple results.

On the one hand, from a sector perspective, if cash transfers demonstrate that they can become important contributors to a specific outcome, it would also be desirable to adjust the design of the transfer to maximize such an outcome. For instance, if evidence from Kenya CT-OVC and South Africa Child Grant shows that social transfers contribute to addressing the structural drivers of HIV risk (such as inter-generational sex, early sexual debut and other), and if most new infections occur among young females aged 15–24, then should we consider redefining those programmes' eligibility criteria to tackle these issues?

On the other hand, if every sector defines its specific cash transfer (or other social protection) programme to meet its sectoral objectives, are we moving away from the core objective and overall aim of social protection: to eliminate vulnerability to poverty and exclusion? Without doubt this is an important area of debate and discussion.

As we further develop and strengthen the evidence base, it is important to realize that – as discussed and presented in section 2 (conceptual framework) – cash transfers will not by themselves address and achieve developmental outcomes across the board. Given the current proven impacts of social cash transfers in terms of consumption, use of services (removing financial barriers to access) and production (direct investment), the question for discussion may be: what are the complementary sector-specific interventions that are needed to reach and sustain outcomes across sectors?

Key message: Countries define the eligibility criteria for programmes on the basis of their definition of poverty and social vulnerabilities. These criteria will then influence the scope and type of impact expected. Social cash transfers contribute to specific sector outcomes through their direct impact on consumption, on access to and use of services (removing financial barriers to access) and on production (direct investment).

Conditionality

Even though research has compiled evidence on the impacts of cash transfers, there are still pending questions as to the level of correlation between the transfers and the different factors that contribute to the impact. For example, we know that cash transfers generate impacts in terms of school attendance; however, we cannot emphatically conclude that these impacts are due to an income effect, a demonstration effect, or both. In terms of economic impact, we have seen that crop production increases as a result of social cash transfers; however, is the cash transfer addressing a failure in credit or a failure to access food markets? Although we can identify some of the potential pathways that would help to explain such impacts (as shown in the conceptual framework presented in section 2), at this point the evidence is only indicative.

The qualitative analysis conducted as part of many of the Transfer Project-led impact evaluations has started to provide some indications as to the pathways and explanatory factors for the recorded impacts. However, more detail and more focused analysis are needed.

Linked to this discussion is the role of **conditionality and messaging**. Are the impacts on health and education due to a pure income effect – a direct result of the conditions (in the case of CCTs) – or are they due to the messaging and information linked to the social cash transfer programmes?

In this context, a couple of conclusions can be drawn:

- On the subject of conditionality, the evidence from unconditional cash transfer programmes (particularly in Sub-Saharan Africa) shows a strong and consistent impact across countries on different outcomes. For instance, in terms of secondary school enrolment, where financial barriers to

access are larger (compared to elementary or primary education), the effect sizes – ranging from 5 to 10 percentage points – compare favourably to the effect sizes found for conditional cash transfer programmes in other regions, including Latin America. Moreover, the flexibility linked to unconditional programmes allows households to invest in different activities and sectors, and thus it is possible to record a broad range of impacts. In this context, there are key policy questions to explore, such as: is the additional cost (in terms of financial, human, technical capacity) of applying conditionalities justified by the relative benefit?

- Qualitative assessments have shown that even though programmes are not conditional, when programmes are implemented and explained to potential beneficiary communities, they are not always message free. For instance, in Lesotho beneficiaries are explicitly instructed when they receive the cash that it should be spent on their children (or on agricultural inputs), and as a result there are large impacts on education spending and purchases of children's uniforms and shoes. The impact is particularly large for boys and girls aged 6–12, with increases of 35 and 27 percentage points, respectively, in the share of pupils who have uniforms and shoes (Transfer Project 2014). Without imposing strict conditions, there are opportunities to use positive messaging if a certain behaviour change is one of the programme's objectives.

Key message: Emerging evidence from Sub-Saharan Africa shows that the impacts generated by unconditional transfers compare favourably to the impacts of conditional transfers in other regions, including Latin America.

National ownership, sustainability and evidence-based policy

This document includes impact assessments from national social cash transfer programmes, as well as from some small-scale, pilot programmes. There are at least four types of programmes considered and reviewed in this document:

- **Pilot programmes**, to evaluate specific aspects of design, to inform a potential scale-up/roll-out at the national level. For instance, the pilot of the Malawi Social Cash Transfer scheme in the district of Mchinji, evaluated in 2008, is now undergoing significant expansion to become the national flagship programme, Social Cash Transfer, under the Government of Malawi National Support Policy, 2013.
- **Proof of concept pilots**, designed as short-term experiments to explore the potential contribution of a cash transfer scheme to particular outcomes. For instance, the Zomba Cash Transfer Pilot, also in Malawi, was a randomized intervention to assess the potential impact of social transfers on HIV outcomes, such as HIV prevention among young girls (and also the impacts on education).
- **Cash in emergencies**, designed as short-term interventions to provide emergency support for households living in areas affected by crises (natural disasters, conflict, etc.). Given the context, these interventions are generally led and funded by donors and fall under humanitarian response strategies. For instance, in response to

the 2011 famine in Somalia, development partners designed and implemented a cash and voucher system in Southern and Central Somalia. In some instances, these programmes are implemented for short timeframes, and tend to be closed when humanitarian resources are withdrawn. In other cases, as communities progressively transition from emergency response to flexible programming, the structures and mechanisms in place to implement and deliver the schemes are used as a basis for establishing a national social protection system. This is currently being explored and developed in Niger and Somalia.

- **National social cash transfer programmes**, which are embedded in a national social protection strategy or policy or other relevant national framework, are led (and in some instances financed) by governments. These are long-term programmes that are generally intended to progressively reach a significant proportion of the national poor population. All of the Transfer Project-led evaluations have focused on assessing the impact of national cash transfer programmes.

It is important to recognize the different kinds of evidence that are generated by these four types of intervention. In addition, consideration needs to be given to how to use the evidence from these different types of intervention when determining specific policy recommendations. In other words, whether the methodology applied is robust enough to permit definite conclusions and the applicability of the results. In terms of internal validity, this document has included impact evaluation studies with varied (but robust) methodologies that indicate the strength of the results. See Table 25 for some examples.

Table 25: Examples of quantitative assessments/design-transfer project-led evaluations

	Core Design
Ethiopia/Tigray Pilot	RDD
Ghana/LEAP	Longitudinal PSM
Kenya/CT -OVC	Location RCT
Lesotho/CGP	EA RCT
Malawi/ SCT, expansion	VC RCT
South Africa/ Child Grant	PSM
Zambia/ CGP	CWAC RCT
Zimbabwe	District matched case- control

Note: RDD – regression discontinuity design; PSM – propensity score matching; RCT – randomized control trial.

Source: Transfer Project.

As the focus of this document is on assessing the extent to which policy recommendations can be drawn from the results presented, the following paragraphs will discuss some issues surrounding external validity.

Evidence generated from pilot programmes implemented as a first step towards large-scale investment and implementation provides some critical elements in terms of design and implementation – for instance, in terms of the feasibility of the proposed targeting methodology; the capacity for delivery and monitoring at the national and sub-national levels; the operational costs; and, to some extent (depending on how long the pilot has been implemented), the potential impact. However, as the programme is being implemented in one particular district or geographical area, there may be some outstanding questions about how representative that particular area is, compared to the rest of the country; what the context-specific elements are that contribute to the programme's success (or its problems); and the feasibility of utilizing specific mechanisms and components of the programme on a national scale. For instance, to what extent can community-based structures continue on a

permanent basis to fulfil certain responsibilities, such as identification of beneficiaries, case management, monitoring and follow-up? Is the situation – the human, infrastructure and financial capacity – at a district level the same across the country? Are there specific communities and areas in the country that would require a different assessment in terms of consumption and livelihood patterns, and that may require different (or complementary) instruments (e.g. pastoralist communities)? These and other questions should be considered when using the evidence from pilot programmes to scale up to the national level.

Evidence from proof-of-concept experiments is useful in shedding light on the potential contribution of social transfers in specific areas. We have seen an increasing number of such experiments – for instance, in the health and HIV sectors – exploring the extent to which conditional transfers can generate significant impacts on risky behaviour and HIV prevalence among youth. The limitation of these experiments is that such programmes are often not based on 'real life' situations and dynamics, and have been designed outside the national dynamics.

5. Areas for further research

Despite the evidence summarized in this paper, there remain many gaps in the existing knowledge base on the impact of social protection in Africa. The starting point of most of these evaluations was to assess whether the objectives of the programme, in terms of poverty and (in some cases) human capital accumulation, were achieved. Furthermore, in some cases, additional modules were integrated in order to explore other 'secondary' impacts – such as the impact on adolescent wellbeing and HIV risk, or the PtoP-led economic and productive impacts. As the evidence grows, so additional questions emerge regarding potential impacts on other sectors, complementary interventions and intra-household dynamics. The following (non-exhaustive) lists highlight some of the gaps identified so far.

In terms of sector outcomes:

- **Water, sanitation and hygiene (WASH) outcomes:** can social cash transfers have an impact on improved access to WASH, for example increasing expenditure on clean water or investing in the construction and maintenance of household latrines?
- **Violence and child protection:** to what extent can social cash transfers address the economic factors that trigger violence against children and women?
- **Early childhood development:** the evidence from Zambia and South Africa regarding the impact of social transfers on ECD outcomes is promising, but can these types of impacts be found systematically across programmes?
- **HIV antiretroviral adherence and treatment:** can social cash transfers improve access and adherence to HIV

antiretroviral therapy? What are the necessary preconditions and enabling factors?

In terms of instruments:

- **Combined impact of 'Cash plus':** there is a critical mass of evidence regarding the impact of social cash transfers on multiple outcomes. However, what about other social protection components and instruments? And closely linked to this, emerging evidence shows that other non-cash social protection interventions (such as access to social insurance or care programmes) can considerably enhance the positive impact of the cash itself. More research is now needed to assess the combined impact of other 'cash plus' interventions, such as the evidence of 'cash plus care' to maximize HIV prevention; or cash combined with financial inclusion, agricultural inputs, etc. to enhance productive and rural development impacts.
- **Linking social protection systems to emergency response:** within the framework of building resilience and disaster risk reduction there is growing interest in how social protection systems can potentially be used to rapidly scale up in the event of an emergency. Some programmes (such as in Ethiopia, Kenya, Niger and Somalia) are already integrating this scale-up capacity into their design. However, more research and evaluation will be necessary in order to identify the effectiveness of such a response mechanism and to understand better the design features necessary, such as comprehensive targeting, single beneficiary registers, early warning systems, flexible funding, etc.

Looking within the household:

- **Intra-household impacts**, including gender dynamics.
- In terms of design:
- **Targeting modalities** to minimize exclusion errors, as well as to enhance the impact on specific sectors, e.g. HIV or nutrition. How to balance specific narrow outcomes against a broad range of outcomes across sectors?
- **Impacts over time**: are there differences in impact when households are enrolled for a longer period of time? Can we make a strong investment case in terms of inter-generational cycles of poverty, labour productivity, etc.?
- **Pathways**: what are the specific pathways that have enabled specific outcomes? Will these outcomes be maximized with a strong supply (and a good quality) of services?

6. Conclusion

The evidence presented in this document shows that there is a critical mass of evidence regarding the impact of social transfers in Africa on multiple outcomes: consumption, food security, nutrition, education, health, HIV/AIDS, adolescent wellbeing, productive impacts, social cohesion, and early child development. Social transfers have enabled families to reduce the financial barriers to accessing services, to smooth their consumption patterns, and to increase their productive capacity; they have also contributed to families gradually becoming more self-sufficient. It is hoped that the evidence summarized in this paper will add momentum to the already growing support for social protection from national governments in Africa, international donor and development practitioners, and will thereby enable existing programmes to improve and expand, and new programmes to be set up.

Clearly, social protection cannot address all risk factors or redress all structural inequalities; but it can certainly contribute to a more equitable society. In order to achieve this vision, social

protection systems must go hand in hand with improvements in the supply of quality services (health, education, child protection, etc.). In order to maximize the results for socially or economically excluded groups, national policies (such as labour laws, agricultural policy, etc.) should be consistent with the rights-based approach that underpins the logic of social protection.

The success of social transfers is, of course, dependent on programmes being well designed and adapted to the local context. Many operational lessons have been learnt from the experience of programmes in Africa and elsewhere: social protection systems should be nationally owned; transfer values should be large enough to make a difference to families' incomes; social transfers must be delivered on time; and targeting should be transparent and clearly communicated. When appropriate and good-quality social transfer programmes are designed and implemented, impressive results have followed.

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