



Impacts of the Child-Sensitive Social Protection Programme in Burkina Faso: Endline Report

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Executive summary

Introduction

Burkina Faso is one of the world's poorest countries, despite a Gross Domestic Product (GDP) growth rate of 5.23 per cent per annum between 2000 and 2022, compared to a growth rate of 3.78 per cent per annum for sub-Saharan Africa within the same period (World Bank, 2024). It is ranked at 184th out of 191 countries in the 2021–22 Human Development Index (UNDP, 2022). The country is also vulnerable to recurrent climatic, economic, financial, and political shocks that continue to increase food prices and deficits, which make it difficult to build human capital and achieve sustainable poverty reduction.

Around 41 per cent of the population, or 8.4 million people, lives below the national poverty line (CFA 194,629 in 2018) (Institut national de la statistique et de la démographie (INSD), 2021). Children are generally more affected than adults (41.9 per cent of adults are poor compared to 45.3 per cent of children). Poverty rates are higher in rural areas (51.1 per cent) than in urban areas (13.1 per cent) (Institut national de la statistique et de la démographie (INSD), 2021). The highest rates of monetary poverty occur in the Northern region (70.9 per cent) and the Centre-North region (60.8 per cent) (INSD, 2021). Extreme poverty rates remain high, although they have declined from 52.6 per cent (2017 PPP at US\$ 2.15 per day) in 2009 to 25.6 per cent in 2023 (World Bank, 2024).¹

Burkina Faso faces humanitarian challenges, with around 2 million internally displaced persons, and an estimated 2.3 million people who were exposed to severe food insecurity in 2023 (World Bank, 2024). The country continues to experience insecurity, particularly terrorist attacks from extremist violent groups. The persistent insecurity, mainly in the northern parts of the country, has led to the closure of health facilities and schools and increased the risk of children and adolescents being recruited into armed groups. Therefore, there is need for large-scale interventions that can reduce poverty.

It is against this background that United Nations Children’s Fund (UNICEF) Burkina Faso initiated a programme aimed at reducing child poverty and vulnerabilities through child-sensitive social protection. The programme is called the Child Sensitive Social Protection Programme (CSSPP) and was implemented in 15 municipalities in four regions of the country from 2019 to 2023. The programme combines cash transfers with Water, Sanitation and Hygiene (WASH), and Nutrition related services. Beneficiaries received FCFA 16,000 (approximately US\$ 30) per month, per household, irrespective of the household size; this amount is paid every three months through electronic transfers. Beneficiaries of the cash transfer were selected using a national assessment tool that is used to construct a national database of the poor and vulnerable in Burkina Faso.

To generate evidence on the effectiveness of this cash plus programme in Burkina Faso, this study investigates the impacts of the programme on households, children, adolescents, and on gender dynamics.

The study aimed to answer the following research questions:

1. Has the programme been implemented as initially designed?
2. What are the impacts of the programme on households?
 - a) What are the impacts on poverty, food security, and household consumption?
 - b) What are the impacts on household members’ living standards, assets, savings, and economic activities?
3. What are the impacts of the programme on infants and young children?
4. What are the impacts of the programme on adolescent well-being?
5. What are the impacts of the programme on female caregivers and gender dynamics?
6. What are the impacts of the programme on the community?

To answer these research questions, the study investigates whether the programme improved various outcome domains at the household level (consumption, monetary poverty, food security, living standards, and economic activities); child level (health, nutrition, material well-being, childhood development, and multidimensional poverty); adolescent level (education, mental health, time use, and behaviours); and on gender dynamics (decision making, time use, norms, and spousal relationships).

Methodology

This study used a mixed-method approach to examine the impacts of the cash plus programme. Quantitative baseline data were collected between January and May 2020 prior to the start of the programme. The baseline survey collected data from 2,772 households (1,389 and 1,383 from treatment and comparison groups, respectively). The midline survey was conducted 12 months later, from June to July of 2021, and successfully re-interviewed 2,736 households (1,378 households in the treatment group and 1,358 in the comparison group). The endline survey was conducted from May to July 2023, about 36 months after the baseline, and approximately 24 months from the midline. A total of 2,266 households were successfully re-interviewed at the endline (907 households in the treatment group and 1,359 from the comparison group). Quantitative data were collected from four regions: Boucle de Mouhoun, Centre-Nord, East, and North region.

Qualitative data were also collected to gain a deeper understanding of the context, impacts, and the implementation process. This was achieved through 15 Key Informant Interviews (KII), 18 In-Depth Interviews (IDI), and 16 Focus Groups Discussions (FGD). Data collection activities were carried out by UNICEF Innocenti and the Institut Supérieur des Sciences de la Population (ISSP) Burkina Faso with logistical support from UNICEF Burkina Faso.

To assess the quantitative impacts of the programme intervention the study used the difference-in-differences (double difference) estimation strategy. This approach compares the changes in outcomes between the treatment and comparison groups over time. Thematic analysis is used on qualitative data.

Research findings

Programme implementation

Beneficiaries expressed their appreciation for the cash transfers and complementary interventions. Quantitative data shows that at endline (compared to midline) beneficiaries had substantially higher satisfaction rates (greater than 95 per cent) with the various design and implementation features of the programme, including the selection process, communication, transfer size, and frequency and payment modalities. However, several challenges were encountered:

- **Beneficiary selection:** Beneficiaries were identified and selected via community engagement, registration, and assessment against targeting criteria. Key informants highlighted the challenges faced, which included different eligibility criteria for the programme components and the possible exclusion of the most vulnerable, who had difficulties registering as they were unable to travel to designated points.
- **Cross sectoral co-ordination:** There was limited cross-sectoral co-ordination as the different components were implemented in silos.
- **Complaint and feedback mechanisms:** The complaint mechanisms were underutilized as communities were reluctant to report their problems, including their concerns on beneficiary selection.
- **Transfer size and regularity:** Beneficiaries reported that the transfer size was insufficient, and the value had been eroded by inflation. Additional challenges included payment irregularities and poor network connectivity for the mobile phone delivery of the cash transfers.
- **Nutrition and WASH sensitization:** Key informants cast doubt on the application of nutrition and WASH knowledge by beneficiaries who were mostly poor and had limited financial resources.

- **Sustainability:** Key informants raised concerns about the sustainability of positive impacts for the poorest in the long-term. They also acknowledged the potential of the programme to inform national social protection policy.

Programme impacts on households

The study assessed the impacts of the programme on several outcome domains at the household level. This included household consumption and poverty household living standards, assets, savings, and economic activities.

Consumption and poverty

- There were no impacts on the per capita expenditures (total, food, and non-food). There was an increase in real total household expenditure by FCFA 301,253.
- The programme resulted in significant improvements in various food security indicators (number of meals, reduction in food insecurity, and the consumption of adequate, high quality, and nutritious foods). These improvements were greater and more consistent at the endline rather than the midline.
- The programme marginally decreased the poverty headcount at endline, mainly among larger size households, by about 15 percentage points. However, there was no impact on poverty gap.

Living standards, assets, savings, and economic activities

- **Health:** The programme had minimal impacts on the health of household members. At endline, there was a reduction in the number of days caregivers stopped working due to illness/injury. However, in qualitative interviews beneficiaries reported improvements in health achieved through the reduction of financial barriers and greater health care utilization, in spite of the long distances to health care facilities.
- **Housing and WASH:** The programme improved the room occupancy rate, mainly due to the increase in the number of rooms constructed, improved roofing by 18.7 percentage points, and improved the use of lighting by 19.8 percentage points.

There was a positive impact on the use of treated water by 2.5 percentage points. These positive impacts were largely sustained from midline to endline. However, similar to the midline, there were no impacts on the use of an improved source of water, access to a toilet, and handwashing facilities.

- **Assets:** Positive impacts on the number of assets owned were largely observed at both the midline and endline.
- **Savings, debts, credits, and transfers:** There were no impacts at endline. However, at midline the programme decreased the amount of debt owed by households as well as savings. The negative impacts on savings were not observed at the endline. In qualitative interviews beneficiaries reported how they had used the transfers for investments and savings.
- **Agriculture and livestock:** The programme improved access to, and use of, land and the number of livestock owned and purchased. Beneficiaries reported an increase in agricultural production due to receiving cash transfers, although this impact was threatened by climate shocks. The programme had no impact on the probability of owning livestock, the values of livestock purchased and sold, and crop revenues and investments in agricultural inputs.
- **Non-farm enterprises:** The programme had no impacts on the revenues from non-farm enterprises. However, there were negative impacts on assets purchased for the businesses and monthly profits. Beneficiaries reported primarily engaging in farming and livestock breeding for income generation. Some beneficiaries cited insecurity and inflation as impediments to the running of businesses.

Programme impacts on children

The programme had significant impacts on a wide range of outcome domains. For most of the indicators (except for material well-being) the data is only available at baseline and endline.

- **Material well-being:** There were reductions in of the share of children (aged 5–17 years old) without blankets, pairs of shoes or sandals, and two sets of clothes, particularly at midline.
- **Breastfeeding:** There were positive impacts on the rates of exclusive breastfeeding (<5 months), introduction of solid foods (6–8 months), and the consumption of eggs/flesh foods.
- **Anthropometrics:** There were reductions in stunting by 5.7 percentage points and severe stunting by 6 percentage points. The results also suggest a marginal increase in the weight for age (WAZ).
- **Violent discipline:** There were reductions in the experience of severe physical punishment and any violent discipline.

The programme did not have any impacts on some outcomes and there were unintended impacts:

- **Child illness:** There was an increase in the prevalence of childhood diseases (fever, diarrhoea), and this impact may have been driven by baseline imbalances between the treatment and comparison groups. There was also a decrease in formal care-seeking for illness (e.g., coughs).
- **Vaccination:** The programme had no impact on vaccination coverage, birth registration, and early childhood indicators.
- **Diet:** Impacts on minimum dietary diversity and minimum acceptable diet that were observed at the midline were not sustained at the endline.

Programme impacts on adolescents

The study assessed the impacts of the programme on adolescent education, economic activities, time use, sexual behaviour, mental health, and experience of violence.

- **Education:** There was a reduction in current school enrolment of about 30.5 percentage points, with the strongest impacts observed among girls aged 15–19 years old. These impacts are driven by the security issues in two of the communes (Ye and Dargo), which resulted in school closures. However, in qualitative interviews beneficiaries reported that school attendance had increased due to the receipt of cash transfers.
- **Economic activities:** Among adolescent beneficiaries, there was a notable increase in their participation in economic activities of about 26.5 percentage points. They also spent more time on livestock activities, non-farm commerce, and non-household work.
- **Chores:** There was a reduction in hours spent caring, cleaning, and cooking (particularly among girls). Participation in other chores did not change.
- **Sexual behaviour and risks:** There were some unintended impacts. Adolescent knowledge of condoms as contraceptives (among both boys and girls) decreased. There was an increase in the proportion of adolescents who reported that they had ever had sex (girls) or had ever been pregnant.
- **Mental health, adverse events, and violence:** The programme had no strong and consistent impacts on mental well-being, adverse events, and violence.

Programme impacts on gender dynamics

Impacts on caregivers' nutrition knowledge and feeding practices, gendered impacts on time use, women empowerment, and gender norms were limited.

- **Nutrition knowledge and practices:** Unlike at midline, at endline there were positive impacts on knowledge about exclusive breastfeeding of children until 6 months old and the daily eating practices of children (6 and 8 months) who are breast-feeding. Qualitative findings also confirm that beneficiaries had better nutritional behaviours than the comparison group, which continued to encounter difficulties in procuring nutritious food for their families due to financial constraints.
- **Gendered impacts on time use:** There was an increase in the time spent by other women in the household on caregiving for the elderly and sick. Among all adults, there were no impacts on time spent collecting water, wood, and caring for children and the elderly.
- **Decision making and empowerment:** The programme increased the decision-making power of women on child healthcare and family or friend visits. These impacts are driven by the increased decision-making power by female heads of households and to some extent spouses. However, there was a negative impact on their decision-making power regarding girls' marriage. Qualitative findings confirmed that gender roles are still traditional, with men responsible for the financial decisions in the household and women responsible for managing the households and childcare.
- **Agency:** The programme is associated with reduced women's agency, particularly their control over their lives.
- **Gender norms:** The programme had no impacts on gender norms.
- **Impacts on spousal relationships:** Qualitative respondents reported improvements in spousal relationships after households received cash transfers and participated in the programme's awareness-raising sessions. This is attributed to the cash transfers which alleviated the financial pressures for purchasing food and for household expenses, and to the programme's awareness sessions, which advocated for the inclusion of women in household decision-making processes.

Moderating role of contextual factors

The programme is associated with improvements in aggregate community behaviours such as reductions in the practice of open defecation, reductions in the use of alcohol as well as improvement in access to drinking water. Qualitative findings showed that contextual factors such as the prevailing security and humanitarian crisis and inflation undermined the programme's effectiveness.

Conclusion and recommendations

Key findings

Overall, the programme had positive and mixed impacts on a number of domains. At household level, the programme increased food security, asset ownership, housing conditions, use of treated water, and agricultural production, while also reducing poverty. The positive impacts on assets, housing, and use of treated water were observed at both the midline and endline. However, there were no impacts on per capita household expenditures, savings and debt, livestock production, and non-farm enterprises. At child level, the programme improved children's material well-being and reduced stunting. There were no impacts on child illness and vaccinations. Healthcare seeking for child illness decreased. At adolescent level, quantitative results showed a reduction in school enrolment, which diverged from the qualitative results. Adolescents spent less time doing household chores and their participation in economic activities increased. However, there was a reduction in their contraceptive knowledge and the incidence of pregnancy and sexual activity increased. Unlike the results observed at the midline, there was a decrease in women's agency and decision-making power at the endline, as gender norms around decision-making remained entrenched. At the community level, the programme likely led to improved WASH behaviours as demonstrated by the reduction in the practice of open defecation, and improved access to drinking water.

The programme's effectiveness continued to be undermined by covariate shocks. The country continues to face multiple crises, including climate shocks, inflation, and the protracted humanitarian crisis due to insecurity. Insecurity in some regions resulted in school closures, which decreased school enrolment among adolescent

beneficiaries. The programme was implemented as initially planned. However, concerns were raised about the lack of inclusivity in the selection process, as people living with disabilities and the elderly were likely excluded from the programme as they were unable to travel to designated points and self-register. Concerns were also raised about the gender responsiveness of the design, particularly the gender of the cash recipient. The cash transfers were also not regular, while there was limited cross-sectoral co-ordination for the plus interventions.

Programmatic recommendations

The following programmatic recommendations are proposed for consideration:

- Strengthen the inclusivity of the programme by adopting disability and elderly inclusive protocols throughout the programme cycle to minimize the exclusion of the most vulnerable people.
- Strengthen the cross-sectoral integration and coordination of the plus interventions to enhance overall programme effectiveness.
- Build the resilience of households to climate, conflict, and economic shocks by incorporating adaptive interventions in the programme.
- Improve child health and feeding practices by improving linkages to child health services and strengthening the complementary nutrition interventions.
- Strengthen the gender responsiveness of the programme by designating women as the main recipient of the cash transfers.
- Provide alternative learning options when schools are not accessible due to security risks, such as radio lessons or remote teaching.
- Expand complementary services and access to reproductive health services, as findings show reductions in knowledge on contraceptives, and higher rates of sexual activity and pregnancies.

Research recommendations

- Further research can assess the moderating role of the insecurity on the programme's impacts.
- Conduct further research on the exact barriers to the uptake of child health services in order to inform appropriate complementary services.
- Future research could also examine the long-term and/or post-intervention impacts of the programme to determine whether positive impacts are sustained.

Introduction

1.1 Background

Burkina Faso, a landlocked West African nation, remains among the world's poorest countries despite an average GDP growth rate of 5.23 per cent per annum between 2000 and 2022, compared to a growth rate of 3.78 per cent per annum for sub-Saharan Africa within the same period (World Bank Development Indicators, 2024). In 2022, its GDP per capita – in 2015 constant prices – was US\$ 732.6, compared to sub-Saharan Africa average of US\$ 1,650 (World Bank Development Indicators, 2024). Income inequality – measured by the Gini Index – is estimated at 43, with the poorest 20 per cent of the population holding 6.3 per cent of the national income share whilst the richest 20 per cent of the population holds 50.3 per cent of the income share (World Bank Development Indicators, 2024).

Burkina Faso was ranked 184th of 191 countries in the 2021–22 Human Development Index (United Nations Development Programme 2022), below the sub-Saharan regional average. Policy reforms in the social sectors have resulted in marginal progress on the Sustainable Development Goals. Recurrent climatic, economic, financial, and political shocks continue to increase the vulnerability of the population. Sustainable poverty reduction and human capital development are becoming more challenging due to the exogenous shocks that increase food prices and deficits, and this is compounded by profound levels of extreme poverty. In 2018, the incidence of poverty at the national poverty line (FCFA 194,629) was 41.4 per cent, which corresponds to 8.4 million poor people (Institut national de la statistique et de la démographie, (INSD) 2021). Based on the national poverty line, children are generally more affected than adults (41.9 per cent of adults are poor compared to 45.3 per cent of children). There is also a wide disparity between poverty in rural and urban areas (51.1 per cent and 13.1 per cent, respectively) and across regions (Institut national de la statistique et de la démographie (INSD), 2021).

The Northern region (70.9 per cent) and the Centre-North region (60.8 per cent) represent the regions with the highest levels of monetary poverty, far above the national rate of 41.1 per cent, based on the national poverty line (INSD, 2021).

The persistent insecurity in the Sahelian belt is a concern in the north and negatively affects the rights of vulnerable children. Threats by extremist violent groups affect children and adolescents, mainly in the northern parts of the country, as they have led to the temporary closure of schools and health centres and the risk of being recruited into the armed groups. Therefore, there is need for an immediate large-scale intervention to build resilience to poverty shocks and strengthen local governance to promote sustained peace.

It is against this background that UNICEF Burkina Faso (UBF) initiated a programme aimed at reducing child poverty and vulnerabilities through child-sensitive social protection (Child Sensitive Social Protection Programme, CSSPP). A total of 15 municipalities in 4 regions have been targeted with the intervention with implementation running from 2019 through 2023. Funding for the intervention is provided by SIDA.

1.2 Programme description

The CSSPP is being implemented in 15 municipalities in the regions of Centre-North, East, Boucle du Mouhoun, and North. The programme entails a combination of cash, WASH, and nutrition-related interventions. Table 1.1 shows the list of the regions and municipalities and the planned interventions in each region, while Figure 1.1 shows the location of the regions in Burkina Faso. The main objective of the programme is to reduce household poverty. Though the programme doesn't explicitly include a gender component, the provision of plus services such as construction of water supply stations aims to reduce time spent by household members to collect water. Women and girls often disproportionately undertake these activities. The programme was implemented between 2018 and 2023.

The programme rollout used a two-step targeting mechanism. At the first stage, administrative data was used to identify the geographic

areas with the highest poverty rate and vulnerabilities in the levels of regions, communes, and villages/communities. An assessment of the availability of WASH services within the communities was also carried out. At the second stage, a Proxy Means Test based on living conditions and assets was used to identify the most vulnerable households that were eligible for the cash transfers. Beneficiaries of the cash transfers were selected using a national assessment tool that is being used to construct a national database of the poor and vulnerable in Burkina Faso. Validation of the pre-approved potential list of beneficiaries was carried out in all communities to confirm the accuracy of the beneficiary list.

A total of 3,700 households across fifteen municipalities in the four most deprived regions – in multidimensional poverty levels – received cash transfer amounts worth FCFA 16,000 (about US\$ 30) per month. The transfer amount is flat for all treatment households irrespective of the household size. The treatment households are paid every three months through electronic transfers, with households receiving a lumpsum of FCFA 48,000.

Complementary services are also provided to the treatment households. An estimated 101,000 pregnant women and 123,000 mothers with children under the age of two years participate in the multi-sectoral nutrition interventions.² In terms of WASH, the programme sought to build 65 water points and enrol 120,000 households in Community Led Total Sanitation (CLTS) programmes. The programme also aimed to provide 50 schools in 100 communities with menstrual hygiene management services (see Table 1.1). As part of the complementary services offered in the same intervention areas as the CSSPP, Save the Children implemented the Child and Youth Resilience Programme (*'Le programme de résilience des enfants et des jeunes'*). This programme included a series of 8 to 16 structured life skills workshops, led by facilitators once or twice a week, for the same group of children (aged 9–13 years) and young people (aged 14–20 years old). The objective of the programme is to build resilience, protection, and well-being among participants. The programme also included several sessions with parents and guardians of the children and youth to build parenting skills and improve understanding of child rights and protection.

Table 1.1: Intervention packages by region

Region	Municipalities	Intervention
Boucle du Mouhoun	5 (Boromo, Dédougou, Kona, Safané, Yé)	Cash + WASH + Nutrition (water supply interventions and nutrition-preventive interventions)
Centre-North	4 (Zimtenga, Dargo, Pensa, Korsimoro)	Cash only
East	3 (Madjoari, Manni, Namounou)	Cash + WASH + Nutrition (CLTS, menstrual hygiene management activities and nutrition-focused preventive interventions)
North	3 (Pilimpikou, Kossouka, Bassi)	Cash + Nutrition (nutrition-preventive interventions)

1.3 Conceptual framework and theory of change

The conceptual framework for the study is shown in Figures 1.1. The programme is comprised of several components, including the cash transfers, the complementary nutrition, and WASH services to the households.

At household level, the programme is expected to directly increase household consumption, improve households' food security, and reduce poverty, as well as increase investment in household economic activities such as crop and livestock production. The provision of WASH services – particularly water boreholes – is expected to reduce household time poverty, such as time spent/dedicated to collecting water for domestic use by adult caregivers and children.

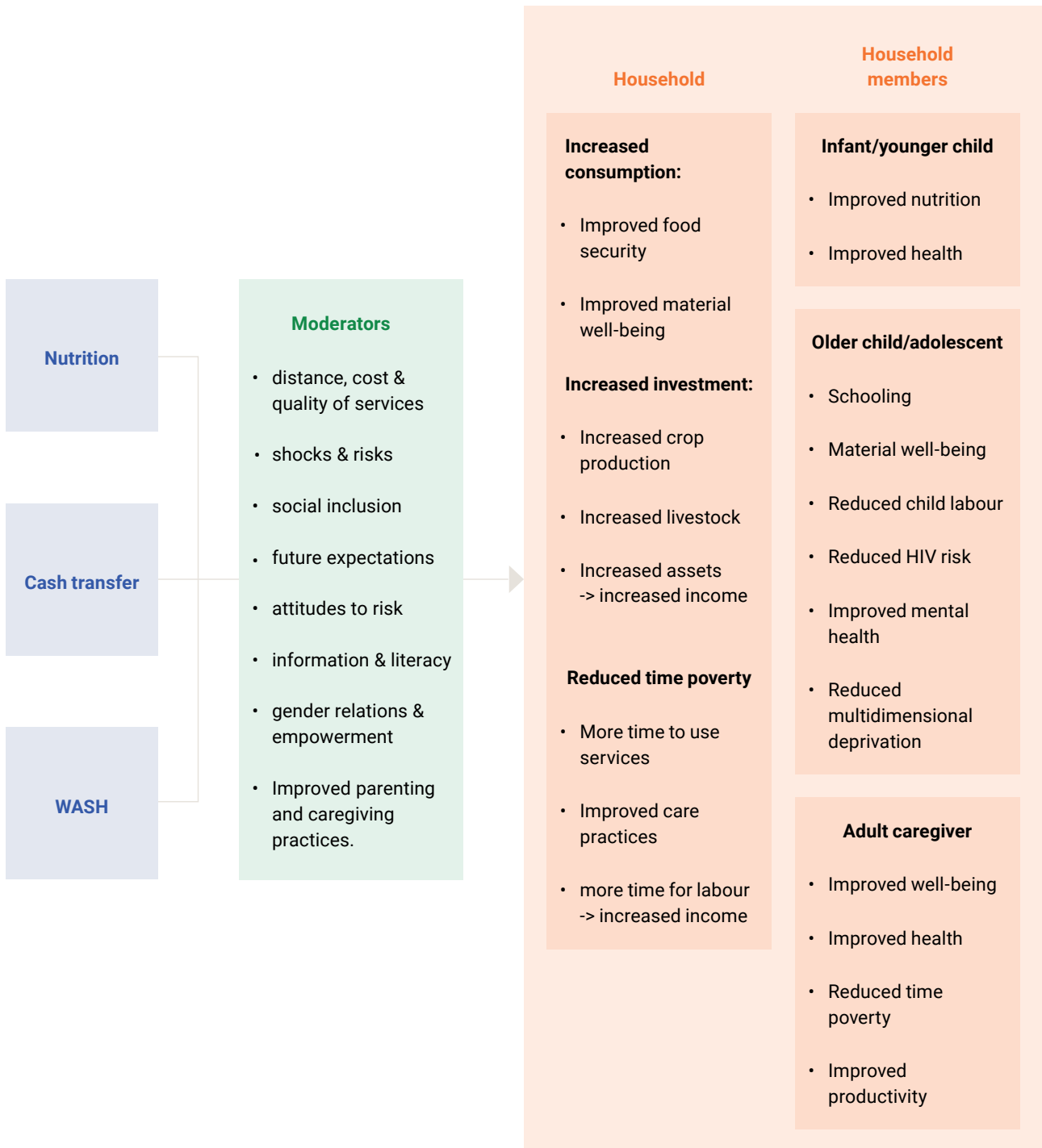
The injection of cash and complementary nutrition and WASH services is also expected to boost general health and well-being among adult caregivers and household members. As highlighted in the midline report, the programme is also expected to affect the gender dynamics in the household, including the gendered patterns of time use and women's participation in decision making.

In addition, at the child and adolescent level, the integration of WASH and nutrition services with cash transfers is expected to:

- **Improve nutrition and health among infants and young children. Improvements** in child health and nutrition outcomes would contribute to the reduction in multidimensional child poverty. The cash transfer, accompanied by complementary nutrition and WASH services, could provide much needed assistance to support households in the proper care of young children. Despite this promising potential, cash transfer programmes in general have had limited impacts on young child-specific outcomes related to health and nutrition.³ In an effort to address these limitations, cash transfers are increasingly accompanied by complementary services in similar fashion as the CSSPP. Results from previous impact evaluations on cash plus behaviour change communication programmes suggest that these programmes are not more effective than cash transfer alone in improving key outcomes, such as anthropometric measurements.⁴ This suggests that there is room for a better understanding of what works for cash plus programmes in affecting young child outcomes, especially related to health and nutrition.
- **Improve time use, schooling, material well-being, and mental health among adolescents.** Cash transfer programmes have received increased attention to contribute to the so-called 'second window of opportunity' for older children and adolescents to increase opportunities for economic inclusion and safe transitions to adulthood (Cirillo, Palermo, and Viola 2021). For example, cash transfer programmes have been shown to improve school enrolment, enhance school attendance, and reduce participation in labour outside the household among adolescents (Cirillo, Palermo, and Viola 2021). Despite these positive impacts, there is still limited understanding on how cash transfer programmes can contribute to the various specific needs of adolescents. In theory, cash transfers can contribute to adolescent development by providing resources to pay for schooling, by addressing the specific health needs of adolescents (especially for girls), and by reducing protection risks.

The potential realization of these impacts would be moderated by factors such as access to services, availability of information, household attitudes towards risk, and shocks.

Figure 1.1: Conceptual Framework for the intervention



1.4 Study objective and research questions

The main objective of the study is to examine the impact of the programme on main outcome domains at the household and individual level as elaborated in the conceptual framework. The main research questions are:

1. Has the programme been implemented as initially designed?
2. What are the impacts of the programme on households?
 - a) What are the impacts on poverty, food security, and household consumption?
 - b) What are the impacts on household living standards, assets, savings, and economic activities?
3. What are the impacts of the programme on infants and young children?
4. What are the impacts of the programme on adolescent well-being?
5. What are the impacts of the programme on female caregivers and gender dynamics?
6. What are the impacts of the programme on the community?

Study design, implementation, and fieldwork output

2.1 Study design

The study is a mixed-methods quasi-experimental design with treatment and comparison status defined at the commune level. The study is based on three waves of data collection, where the baseline data were collected from January through May 2020, prior to the start of programme, the midline data were collected between June and July 2021, whilst endline data were collected during the period May to July 2023, about 36 months from the baseline data collection or approximately 24 months from the midline data collection. Given the project lasted 36 months, the midline and endline waves help examine the effectiveness of the interventions with respective outcomes of interest at different levels of exposure.

The programme covered a total of 15 communes from four regions, namely Boucle Du Mouhoun, Centre-Nord, Est, and Nord. Of the 15 communes, 11 were assigned to treatment status while 4 communes were assigned to comparison status due to limited budget to cover eligible beneficiaries in all 15 communes. Furthermore, for this study, 4 treatment communes were randomly selected (1 from each region) to serve as treatment. This resulted in 4 treatment and 4 comparison communes for the study. However, the endline data collection did not cover Namounou due to inaccessibility because of security issues. Table 2.1 presents the lists of regions, programme communes, intervention status, and sample communes included in the study.

Table 2.1: Intervention and treatment statuses by commune

Region	Commune	Intervention Status	Study Status
Boucle Du Mouhoun	Safane	Control	Control
	Boromo	Treatment	
	Dedougou	Treatment	
	Kona	Treatment	
	Ye	Treatment	Treatment
Centre-Nord	Zimtenga	Control	Control
	Dargo	Treatment	Treatment
	Korsimoro	Treatment	
	Pensa	Treatment	
Est	Manni	Control	Control
	Madjoari	Treatment	Treatment
	Namounou	Treatment	
Nord	Bassi	Control	Control
	Kossouka	Treatment	Treatment
	Pilimpikou	Treatment	

2.2 Quantitative study

2.2.1 Sampling, statistical power, and sample frame

The required sample size was determined based on a power calculation to detect a predetermined minimum effect size in the key outcome of interest of the study. Poverty is the key outcome of interest and is determined based on household consumption. While poverty levels generally range from about 55 per cent to 80 per cent in the study regions, the minimum value of 55 per cent was assumed for the sample calculation. Accordingly, it was determined that a minimum of 2,810 households is required to detect a minimum of a 5 percentage point reduction in poverty with 85 per cent statistical power and a 95 per cent confidence level. Adjusting this sample size for non-response and attrition of 10 per cent, a total of 3,092 households should be sampled, equally split between the treatment and comparison

communes (1,546 households per treatment arm).⁵ The samples were distributed proportionally to communes based on the total number of eligible households in the sampling frame. This ensures that each household at the commune level has equal probability of being included in the sample.

The sampling frame for the study came from the list of eligible beneficiaries provided by the Permanent Secretariat of the National Council for Social Protection, created as part of a national exercise to build a comprehensive database of poor vulnerable people in the country. Building the list is based on the subsidiarity principle and uses a selective targeting methodology to identify poor and vulnerable households to be included in the communal single registry. The registry is then consolidated in the national database. The procedure has three steps: 1) self-registration by a representative of potentially vulnerable households at the municipal social service; 2) undertaking a census to capture information on households' main socioeconomic characteristics and classifying households as 'eligible' or 'non-eligible' beneficiaries for the project using a proxy household welfare indicator; and 3) undertaking community vetting of eligibility lists to capture those still excluded from this sequence.

2.2.2 Survey instruments and training

The quantitative data were collected using the following three instruments:

- Household questionnaire (administered to the main beneficiary/ household head) with an adolescent sub-module administered to one household member aged 10–19 years (if any).
- Young child modules (children under 5 years old). Several modules captured data on child health, vaccinations, feeding practices, anthropometry measurements, birth registration, early childhood development, and child discipline.
- Community questionnaire (administered to community opinion leaders).
- Price questionnaire.

The study collected data on a wide range of household level variables and women- and child-specific data including household demographics, education, members' health, economic activities, assets, agriculture, other safety nets including cash transfers, free food distribution or cash/food-for-work programmes, nutrition knowledge and feeding practices, child anthropometrics, maternal and child health, and child discipline. The adolescent survey module collected data on work, subjective well-being, mental health, social support, sexual behaviour, experience of adverse events, violence, and aspirations. Community-level data were also collected on infrastructure and access to services, shocks, and programme, as well as market prices of essential goods and services.

While the household questionnaire remained largely unchanged between the three survey rounds, the adolescent module, child anthropometric measurements, and other modules from the baseline were not part of the midline survey. Moreover, the midline and endline surveys included additional modules on gender and decision making to capture women empowerment, agency, and gender norms. A module on operational performance was also administered to assess the status of programme implementation. The latter module asks questions on receipts of cash transfer, adequacy of the transfer, and satisfaction with the transfer modality. While the household questionnaire was administered to the main beneficiary/household head, the gender module was administered to the main caregiver of children within the household.

The community survey collected data on community characteristics, access to services, schooling, shocks, cash plus interventions and other programmes, and agriculture. The instrument was administered to a minimum of three knowledgeable community members. The price survey, on the other hand, was administered to one major market in the community. The instruments were developed by the UNICEF Innocenti team, and they were informed by other previous questionnaires implemented by the research team in the region, as well as from other household surveys implemented in Burkina Faso. In addition, while some of the sections of the adolescent module were directly inputted from the Multiple Overlapping Deprivation Analysis survey instrument, the consumption and expenditure module

was obtained from the Burkina Faso National Institute of Statistics and Demography. All the survey instruments were shared with the UNICEF Burkina Faso Country Office for feedback both on the specific thematic areas and dimensions of analysis. The national research partner ISSP also critically reviewed the questionnaires and further adapted them to the local context. The instruments have been developed to cover multiple topics and they follow from the programme's theory of change. This impact evaluation has been implemented as part of the Transfer Project, a joint initiative between UNICEF, FAO, and the University of North Carolina at Chapel Hill, which aims to produce rigorous evidence on cash transfer programmes in sub-Saharan Africa and facilitate policy uptake of this evidence.

Prior to the start of data collection, all fieldwork personnel participated in compulsory training activities, where they were trained on the purpose and objectives of the study, ethics and principles of research, data integrity, and survey instruments. The training followed consistent processes in all three rounds. The first part of the training on the tools was conducted on the paper format, where every single question and skip pattern was explained. In the second part the electronic version was used, where enumerators did various simulation exercises. The enumerator training for each wave took place over a three-week period. These were followed by a pre-test of the instruments outside the study communes, which provided valuable feedback to enumerators and updated the instrument where necessary. Before a final selection of enumerators was done, enumerators were tested for their understanding of the survey instruments and all field protocols, and enumerators who failed were dropped from participating in the data collection exercise.

2.2.3 Data collection, outputs, and challenges

Data collection activities, including planning, recruitment, and training of field enumerators, developing the electronic data capture system and conducting the fieldwork, were led by the national research partner, ISSP. Data collections were undertaken in all four regions concurrently. The organization has several years of experience doing similar surveys. The UNICEF Innocenti staff supported the trainings to ensure the protocols were being followed thoroughly and to provide clarification to questions that arose.

To ensure the highest data quality, researchers at the UNICEF Innocenti undertook high-frequency data quality checks on the incoming quantitative data and communicated issues with enumerators for immediate action through revisiting the households to make necessary changes/clarifications before leaving the communities. In so doing, the quality of the data has been enhanced and inconsistencies, wrong entries, and outliers have been checked and addressed during the fieldwork.

The study faced multiple challenges throughout the three waves. The most common was related to the logistics, including outdated tablets, deteriorated storage capacity and power banks, and lack of internet connectivity in some localities. All these negatively impacted data collection activities. Additional challenges included difficulties in accessing several study areas due to poor road conditions during the rainy season.

2.2.4 Attrition analysis

Table 2.2 shows the distribution of response rates by commune across waves. The distribution shows that the response rate was higher at midline (98.7 per cent) but declined substantially at endline (81.75 per cent). The low response rate at endline was due mainly to the inaccessibility of Namounou commune due to security reasons at the time of data collection. This led to a relatively higher attrition in the treatment group. Taking this into consideration, we conducted attrition analyses for treatment households to check whether the panel (those included in the final analysis) and attrited households have significant differences with respect to selected demographic characteristics, housing, assets, food security, access to finance, and shocks at baseline. Results from the attrition analysis showed that the panel treatment and attrited households were similar in most of the characteristics at baseline, without any notable major statistical differences.⁶

Table 2.2: Field Output and Response Rates at Midline and Endline

Commune	Treatment Status	Baseline	Midline	Response Rate	Endline	Response Rate
Safane	C	201	200	99.50	199	99.00
Ye	T	351	350	99.72	280	79.77
Zimtanga	C	216	200	92.59	200	92.59
Dargo	T	302	298	98.68	285	94.37
Manni	C	509	503	98.82	505	99.21
Namounou	T	393	391	99.49	0	0.00
Bassi	C	457	455	99.56	455	99.56
Kossouka	T	343	339	98.83	342	99.71
Total		2,772	2,736	98.70	2,266	81.75

Note: C – Comparison, T – Treatment

Secondly, to ensure that internal validity conditions are not violated by the endline attrition, we re-performed a balance test between panel-treatment and panel-comparison households at baseline using the same set of indicators on demographic characteristics, housing, assets, food security, access to finance, and shocks used for the attrition test. Results show panel-treatment and panel-comparison households were very similar at baseline, thus conserving the study design.⁷

2.2.5 Sample characteristics

Table 2.3 presents some of most important characteristics of the panel households observed throughout the three waves by treatment status. The table also presents results on tests for statistical differences in means between treatment and comparison households for each wave. The general picture that emerges from Table 2.3 shows that sample characteristics have remained consistent across all three waves. Most importantly, at baseline none of the mean differences between panel-treatment and panel-comparison households were significant at 5 per cent significance level. Three indicators – household size, share of household members under 5 years of age, and share of members aged 60 years and above – were marginally significant (10 per cent significance level). At midline and endline, these differences were no longer significant.

Across all three waves, the average household is formed by 8 members with a mean age of 24 years. More than 50 per cent of the households' members are children from 0–17 years, with children aged 5–17 accounting for over 40 per cent of all household members. In addition, approximately 52 per cent of household members are female. With respect to the household head, 24 per cent of the household heads are female with an average age of 54 years. On marital status and literacy, 80 per cent of the household heads are married at the time of data collection whilst 15 per cent of household heads are literate.

Table 2.3: Sample characteristics of panel households, baseline, midline, and endline

	Baseline			Midline			Endline		
	Mean T	Mean C	T-C (p-value)	Mean T	Mean C	T-C (p-value)	Mean T	Mean C	T-C (p-value)
Household size	8.43	9.37	0.060*	8.26	9.00	0.240	7.63	8.42	0.299
Household mean age	24.48	22.72	0.106	24.66	23.17	0.167	26.34	24.72	0.165
Dependency ratio	1.54	1.52	0.876	1.47	1.52	0.746	1.40	1.40	0.976
Share of members aged 0–4 years	10.01	12.96	0.070*	10.04	12.43	0.129	9.14	9.60	0.686
Share of members aged 5–17 years	44.51	42.33	0.373	43.85	42.23	0.518	41.73	42.04	0.909
Share of members aged 18–59 years	35.73	36.75	0.626	36.71	37.27	0.800	38.68	39.52	0.726
Share of members 60 years or older	9.75	7.96	0.098*	9.40	8.07	0.254	10.45	8.84	0.311
Share of female members	50.62	52.29	0.257	51.25	52.19	0.505	52.00	52.06	0.970
Household head is female	19.88	24.12	0.529	21.26	24.65	0.617	24.26	26.67	0.753
Age of household head	55.01	52.75	0.255	55.47	53.42	0.299	56.56	54.79	0.369
Household head is married	82.51	80.28	0.604	81.67	78.02	0.373	79.26	77.95	0.804
Household head is literate	12.00	18.85	0.062	11.24	15.73	0.245	17.72	11.13	0.144
Observations	904	1,357		904	1,357		904	1,357	

Note: C – Comparison, T – Treatment. Means adjusted by sample weights. * 10% significance level; ** 5% significance level; *** 1% significance level

2.2.6 Estimation strategy

Following the attrition analysis and maintaining the principle of intent-to-treat for the impact estimates, the quantitative data have been analysed using the difference-in-difference (DiD) (double difference) estimation strategy on the panel of households. The DiD helps to identify the impacts of the interventions on the treatment households compared to comparison households. Recalling the interventions listed in Table 1.1, our main estimation model does not distinguish between intervention components. Although disaggregated analyses by the intervention components give intervention-specific insights, this will come at the expense of loss of statistical power to detect impacts.

Regarding the estimation strategy, the study used two different estimation frameworks to examine the impact of the programme. For indicators collected in all three waves, we estimate a multiple time period difference-in-difference which allows for a comparison between programme impacts at midline and endline and a statistical test as to whether any difference between the two impacts is significant. Formally, we estimate the following equation:

$$Y_{ijt} = \alpha + \beta_1 P_{ij} + \beta_2 T1_t + \beta_3 T2_t + \beta_4 (P_{ij} * T1_t) + \beta_5 (P_{ij} * T2_t) + \beta_6 X_{ij} + \mu_j + \varepsilon_{ijt} \quad (1)$$

where Y_{ijt} is the outcome of interest for individual or household i who lives in commune j at time t . P_{ij} is a binary variable set to 1 if household i in commune j is in the CSSPP programme, and to 0 otherwise. $T1_t$ is a dummy (binary) variable identifying the midline survey wave, set to 1 if the observation is from the midline survey, and to 0 otherwise. Similarly, $T2_t$ identifies observations from the endline survey round. $(P_{ij} * T1_t)$ and $(P_{ij} * T2_t)$ are the interaction terms of the programme and time dummies. X_{ij} is a set of individual/household characteristics, μ_j represents within-entity error term, and ε_{ijt} is the overall error term. Standard errors are clustered at the commune level. The coefficients of interest are β_4 and β_5 which represent the DiD programme impact at midline and endline respectively. The study included the region fixed effects in the analyses. Additionally, we test the null hypothesis that β_4 and β_5 are equal.

Secondly, as explained in sub-section 2.2.2, some indicator sets were collected at baseline and endline but not at midline. For these indicators, we estimate a reduced form of our main model using the following equation:

$$Y_{ijt} = \alpha + \beta_1 P_{ij} + \beta_2 T2_t + \beta_3 (P_{ij} * T2_t) + \beta_4 X_{ij} + \mu_j + \varepsilon_{ijt} \quad (2)$$

In equation (2), the coefficient of interest is β_3 , which estimates endline programme impact. Lastly, there were a small set of indicators, mostly on women empowerment and gender norms, that were administered at midline and endline but not at baseline. For these indicators, though equation (2) is still a valid estimate, interpretation is slightly different compared to comparing baseline and endline difference. For this case, β_1 represents midline cross-sectional difference between treatment and comparison households, whilst $\beta_1 + \beta_3$ represents the endline cross-sectional difference. Thus, the parameter β_3 represents the cross-sectional difference between midline and endline.

2.3 Qualitative study

The qualitative component sought to gain a deeper understanding of the socio-economic context, including household poverty, vulnerability, access to social services, gender norms, and intra-household decision making dynamics; as well as to capture the beneficiary perceptions around cash transfer adequacy and implementation, and the resulting changes in household and individual well-being. Focus Group Discussions (FGD) explored perceived improvements in community cohesion, health, and education as well as general well-being and wealth of those interviewed. In addition, In-Depth Interviews (IDI) also covered more sensitive topics including violence. Finally, Key Informant Interviews (KII) were conducted to gain a better understanding of the implementation processes, successes, and challenges.

2.3.1 Sample design

The initial sample was composed of 49 interviews: 12 FGDs and 12 IDIs among the programme treatment group and four FGDs and four IDIs among the comparison group in all four regions as well as 17 KIIs in the four regions and in Ouagadougou. The qualitative sample

was purposively selected to ensure the representation of individuals. Study participants were chosen in the same villages that were reached during the midline survey. They were selected based on criteria of treatment and comparison, and sex to allow for equal representation of men and women, and they were required to be parents. FGDs were conducted separately for women and men to allow respondents to express themselves freely. The FGDs and IDIs were conducted in local languages and recorded on devices after acquiring informed consent from each study participant.

However, due to the deteriorating security context, changes had to be made during the planning phase. With access to the East region compromised, it was decided not to send interviewers there and the Commune of Namounou was removed from the sample.

The following 49 interviews were conducted:

- 16 FGDs with treatment and comparison groups men and women;
- 18 IDIs with treatment and comparison groups men and women;
- 7 KIIs at the national level with UNICEF and partner organization representatives; and
- 8 KIIs at the community level with community leaders, social services representatives, and partner organizations.

Table 2.1 provides an overview of the distribution of FGDs and IDIs in the treatment and comparison communes.

Table 2.4: Overview of the qualitative FGD, IDI, and KII

	Treatment			Comparison		Total
	Ye (BdeM)	Dargo (CN)	Kassouka (Nord)	Safane (BdeM)	Bassi (Nord)	
FGD	2	5	5	2	2	16
IDI	4	5	3	2	4	18
KII (national)						7
KII (community)	3	3	2			8

Altogether, 79 respondents (42 women, 37 men) participated in the treatment group FGDs and 26 respondents (13 women, 13 men) participated in the comparison group FGDs. The overall average age of participants was 51.9 years and the average number of children per participant was 6.9.

Table 2.5: Characteristics of FGD participants

	Treatment	Comparison	Overall
Number of female participants	42	13	55
Number of male participants	37	13	40
Average age	54.3	43.7	51.9
Average number of children	7.2	6.1	6.9

2.3.2 Tools and data collection

To collect the qualitative data, four detailed guides were developed in French to cover the spectrum of various respondents:

- a guide for FGDs with treatment and comparison men and women;
- a guide for IDIs with treatment and comparison men and women;
- a guide for KIIs at national level; and
- a guide for KIIs at community level.

Training on qualitative methods was conducted from May 8–12, 2023. The teams were trained on the guides, on techniques of qualitative data collection, including interview techniques, as well as on ethical protocols. Before the teams were deployed to the field, a pilot session was organized with the aim of testing the instruments and ensuring enumerators' understanding of the questionnaires and ethical protocols.

Qualitative data collection took place between May and June 2023. However, as mentioned above, due to the deteriorating security context, changes had to be made. Firstly, with access to the East region compromised, it was decided not to send interviewers there and the Commune of Namounou was removed from the sample. Secondly, during data collection, some minor changes took place due to the security situation. The unstable security situation was particularly disruptive to FGDs. Group gatherings had to be carefully planned to avoid adding anxiety in a perilous security situation. This resulted in field plan adjustments and respondents being apprehensive about group gatherings.

Other challenges included the lack of motivation to participate in the interviews. This was observed in the treatment group with some participants that mentioned they were not at ease and feared attacks as well as in the comparison group where, despite clear explanations, expectations were high, and respondents asked several times if they would benefit from cash transfers in the future.

2.3.3 Data processing and analysis guidelines

All interview recordings were transcribed verbatim into French in July and August 2023. The transcripts were subsequently uploaded onto NVivo (2020, R1) software. The interview guides and research questions inspired the construction of a codebook that had been predesigned and uploaded into NVivo. This codebook was initially used to code the transcripts and was adapted accordingly as coding progressed. As such, coding was both deductive and inductive.

Thematic analysis was then carried out to provide answers to the study research questions. More specifically, the researcher closely examined the data to identify common themes, topics, ideas, and patterns of meaning that came up repeatedly. Finally, identified themes were thoroughly revised and organized, ensuring each had enough data to support it, before being formulated to communicate evaluation results to the readers.

To address the enhancement of credibility in the research results, an approach was adopted, encompassing both data saturation and triangulation methods. The state of data saturation was achieved,

ensuring that additional data collection would not yield further significant insights, as the gathered information was already comprehensive enough to formulate well-substantiated conclusions. Furthermore, the credibility of these findings was reinforced through triangulation. This involved a systematic comparison and corroboration of results across various data sources (including FGD, IDI and KII), thereby confirming the reliability and validity of the conclusions drawn from the study.

2.4 Ethical protocols

To ensure that the study design and the tools to be used met the ethical requirements to interact with human subjects in Burkina Faso, the study protocols and all necessary documentation were submitted to an ethical review board in Burkina Faso for approval. The study only proceeded after ethical clearance was received. The study was also pre-registered on the Registry for International Development Impact Evaluations (RIDIE).

Process evaluation and programme implementation

3.1 Beneficiary selection and transfer recipient

According to the CSSPP protocol, households benefitting from cash transfers were selected using the consensual method for identifying vulnerable people developed by the Burkina Faso government in collaboration with technical and financial partners and civil society organizations. The methodology involved three key steps: (i) Implementing an Integrated Communication Plan (ICP) using various communication tools to actively and broadly engage communities; (ii) After the communication phase, trained agents recorded households potentially vulnerable through social services and designated registration points, making efforts to include those unable to attend due to their vulnerability; (iii) Information was evaluated against 29 vulnerability criteria to establish a score. Households below the threshold were shortlisted and sent for municipal validation, culminating in a public listing of vulnerable households at the municipal level.

Generally, beneficiaries did not report any issues with the selection process, while key informants shared their views on challenges that were experienced and areas for improvement. Beneficiaries explained how they heard about the CSSPP, sometimes through an official medium and often by chance or via family members or friends, and voluntarily registered to become a beneficiary. Qualitative study respondents (FGD, IDI, KII) did not mention the active recruitment of the most vulnerable (second part of step ii above) and instead explained that selection was highly dependent on community members' own efforts to register. One respondent said:

At the hospital, we went to write our names, and I informed my brothers, who told me they wouldn't be going [to register] because it concerned the destitute. I replied that we were all destitute and

that if they didn't want to leave, it was their choice. As for me, I was lucky enough to be on the list when they made their selection since the choice isn't made here. Some people told me that they were in the village before me and that my name was on the list and not theirs. I told them that I'd warned them that there was no charge if you go and you're selected, so much the better, if you're not selected you come back and sit down, it doesn't cost anything. So, it was well done, it doesn't go any further than that.

[Male FGD participant, Ye, Boucle du Mouhoun – treatment group].

Key informants were more vocal about the beneficiary selection process. One issue they raised was that **beneficiary selection was done in a siloed approach** with different criteria for each activity pillar (cash transfers, WASH, and nutrition). Cash transfer beneficiaries were identified following the method described above. WASH activities (boreholes and latrine construction in schools, standardization of toilets to improve menstrual hygiene management, and awareness-raising sessions to put an end to open-air defecation) were conducted at village level, whereas nutrition activities targeted pregnant and lactating women as well as children from 0–59 months. In villages where WASH activities were implemented, WASH beneficiaries (the whole village) naturally overlapped with cash transfer and nutrition beneficiaries. However, a lack of overlap was reported between nutrition and cash transfer beneficiaries, who were selected on different criteria, with some community members benefitting from one pillar or the other, which, according to several key informants, may have contributed to decreasing the CSSPP's effectiveness. The siloed approach reflects the higher-level structures according to this key informant:

So, the targeting strategies, even for the sectors, are not the same. And it's a big challenge beyond this project, at the structures at country level, whether it's at the level of coordination of social protection and nutrition or even at the level of food security, they should find a common entry point.

[National level key informant (UNICEF), Ouagadougou].

Another issue raised was the difficulties faced by the vulnerable in registering for the CSSPP. Respondents (treatment group participants and key informants) reported the registration was done **by community members themselves, who had to make the effort to sign up and this was sometimes difficult or even impossible for the extremely vulnerable**, thus leading them to be excluded. In addition, as individuals needed to travel to designated points and get registered, they could say things that were not necessarily true. If selection had been done in the villages, the information could be verified and all those who were unable to make the trip for registration could have had a chance to be included. A national level key informant explained some of challenges and flaws in the selection methodology:

I don't agree with UNICEF regarding their targeting methodology. Their methodology is said to be consensual in the social service of my community, my commune. I say I'm [name] I'm vulnerable, I say ok, here we are, we submit a certain number of questionnaires to you, you have how many children, we register and then we do the sifting and at the level of the register and then that's it. It's true that they have criteria, but what's the problem? Our community members know a bit about these criteria, so they'll say what they want to hear, so we'll consider them vulnerable when they're not, they're not. [...] The so-called consensual methodology allowed guys to park motorcycles to come and take the cash while the truly vulnerable had no access. For example, if you go 30 km to register, you must be wealthy, you have to have a good bike, whereas in the community, people who don't, I'll walk 30 km to come, so it's the well-off who have gone to register. So, UNICEF would have had to go out into the field and develop other methodologies [...] That's how we get in touch with the beneficiary in his community, in his family, by observing him, you'll see certain things.

[National level key informant (implementing partner),
Ouagadougou].

There was a **complaint system** in place and some people were removed from the initial list, either because it was discovered that they were not truly vulnerable or because they had registered twice. This reportedly did not lead to any tensions:

Afterwards when we followed the reconciliations, at times when there were duplicates on the lists or there were households that had to be removed from the lists when we followed, we didn't really feel any tension between households, as there was a community validation.

[National level key informant (implementing partner), Ouagadougou].

However, some key informants reported that the complaint mechanism was not used by community members as it involved exposing neighbours, family, or friends and most did not want to do so to avoid issues and conflicts within the community. On the other hand, one key informant also highlighted that there was no way to please everyone. He explained how everyone could use additional income, yet there was a limit in the number of people who could benefit so a cut off had to be made at some point:

Right now, if you ask anyone, they'll tell you they need help. Even if you ask me, I'll say I need it (laughs). But if we involve other beneficiaries, we'll always identify those who are more vulnerable than others. But whatever we do, we're always going to make people unhappy because everyone wants to benefit ... that's it!

[Communal level key informant, Kossouka, Nord – treatment group].

Finally, there was a debate among key informants about whether **cash transfers should be given to the head of the household (usually the husband) or directly to women**. While some argued for giving it to the head of the household, others suggested women would make better use of the funds for family welfare. This key informant explains how transferring the cash directly to the women could also lead to further tensions as it may not be accepted:

We don't have any lessons to give the communities [...] it's very dangerous if you decide to give the cash to the woman, you can get into trouble. I'm talking about certain communities where

they told us: “the woman, her money, her children, that’s me”. Even if you want to give the money to the woman, as soon as you leave, she’ll take it and give it to her husband. Will we have solved the problem? No. So, we said, it’s the household that registers, so it’s to the head of household that we give. [...] But there are communities where the household has decided to give to the wife because it’s the wife who’s in contact with the children, she’s the one who knows what the children want, she’s the one who takes better care of the children than I [the husband] do because I’m really in charge of their safety, I’m in charge of certain things, I have my responsibilities but he’s not involved in the details, so give to the wife.

[National level key informant (implementing partner), Ouagadougou].

3.2 Adequacy of transfer amount and regularity

All CSSPP beneficiaries were very thankful for the transfers they received. These helped them purchase food, pay for school fees and health care needs, and be used as seed capital to start non-farm income-generating activity. **Although thankful, many suggested the amount was insufficient** and could be increased, especially in the light of the recent price inflation. Similarly, a few said the transfers did help them with their everyday needs, but these remained insufficient to invest in an activity or improved housing, as explained by this male interviewee:

In these times of crisis, it may even be necessary to increase even the value of cash.

[National level key informant (UNICEF), Ouagadougou].

Yes, the transfers have helped to improve the household. But we haven’t used it to buy anything yet. But we are not suffering, we are eating, and we are happy. So, we can’t say that there has been no improvement. It helps us in the home.

[Male IDI participant, Dargo, Centre-Nord – treatment group].

The **amount of cash transferred was also discussed in relation to household size**. Key informants pointed out that the transfer amount was the same for monogamous and polygamous households regardless of the number of children or number of family members, hence, the impact varied:

As the cash has not been modulated according to the size of the household, this means that in the distribution or redistribution within the household, there are disparities according to size. [...] Not only to adapt the amount to the size of the household, but also perhaps to see in polygamous households where each woman could be a recipient.

[National level key informant (implementing partner),
Ouagadougou].

Beneficiaries **appreciated receiving transfers every three months**, although several suggested that receiving them more often, for example every two months or even monthly, would be more helpful. Some beneficiaries however lamented that the transfers were not regular and reliable, which had a negative impact on their well-being as they were highly dependent on the cash transfer:

We were told that it was every 3 months, the problem which we come across is that when the 3 months arrive, we sit and wait, one says it is the hope which makes the beggar wait. [...] We received money transfers until the 4th month, but then it didn't come, that's twice now. Now we're sitting here again, wondering what we're going to do.

[Male FGD participant, Dargo, Centre-Nord – treatment group].

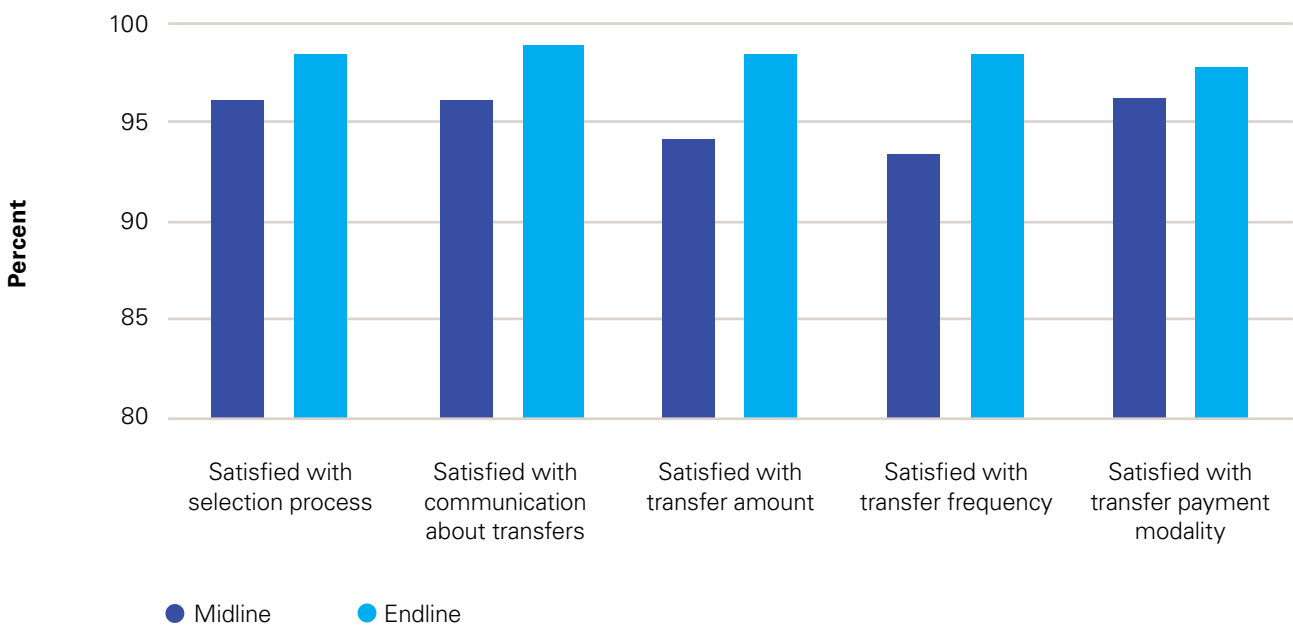
Another important challenge that was reported by many respondents was the poor **network connectivity due to the current ongoing security crisis**. They explained how towers were being sabotaged and how, due to the absence of networks, they often did not receive an SMS to inform them the transfer had arrived. Moreover, in some instances they had to go to great lengths to go collect their cash and several agencies had closed shop:

Even if we send you the transfer you won't know, we don't send you, you won't know. It's a pity the absence of the network is complicated. Even if you receive the transfer, there's no agency to collect it, let alone receive it. We're tired of it.

[Male FGD participant, Dargo, Centre-Nord – treatment group].

Quantitative data on beneficiary satisfaction with the CSSPP shows that compared to the midline, at endline beneficiaries had even higher satisfaction rates (greater than 95 per cent) with the various design and implementation features, including the selection process, communication, transfer size and frequency and payment modality.

Figure 3.1: Treatment group satisfaction with the CSSPP implementation



3.3 Cash “plus” components

3.3.1 WASH and nutrition components

The CSSPP was commended by several key informants for its holistic approach of integrating nutrition, WASH, and social protection. They saw this integrated approach as effective in addressing the well-being of vulnerable populations:

I really appreciated it because in terms of nutrition, when you look at the projects we usually do, without the social protection part, the mothers, the beneficiaries, they find it hard to put the advice we give them theoretically into practice. Wala. We tell a mother to diversify her diet, but if she doesn't have the means to buy the food, it's going to be difficult. So, this project fills a gap and ... makes a tandem, that is to say a package, cash transfer, social protection and then for nutrition in terms of advice to precisely allow to consolidate, to the mother to apply the theoretical knowledge that she learns in advisory groups on food and nutrition of young children.

[National-level key informant (UNICEF), Ouagadougou].

Each of the pillars was successfully implemented. However, **collaboration and coordination between implementing partners in charge of the different activity pillars (cash, WASH, nutrition)** was highlighted as an issue by most national-level key informants. Interviewee data showed that many involved in the CSSPP implementation did not know exactly what other activities were being implemented, where and who their beneficiaries were. The different activity pillars were being implemented by different partners in a siloed approach. Key informants from implementing partners reported that there was a lack of regular exchanges with other partners implementing the other pillars. It was therefore suggested that coordination mechanisms be set up as suggested by a national-level implementing partner:

All the questions related to nutrition and Wash [...], or if you notice I don't have too much information on that even though it's the same programme, I think that therefore at that level, it would

be interesting that we are perhaps a framework for dialogue, in any case set up something, a system that will allow us as actors of the same programme there to perhaps [...], have information on the other components of the programme and also share our information with others on the components of the project.

[National-level key informant (implementing partner), Ouagadougou].

Generally, the **awareness-raising activities that accompanied the cash transfers** were highly appreciated by all beneficiaries. On the one hand, these activities supported them in managing the cash received wisely, and especially investments in income-generating activities and savings. On the other hand, the cash transfers had a positive impact on relationships within the household:

The money has reached us, but the awareness campaigns we've benefited from are more satisfying. These awareness campaigns have brought us closer to our children and our husbands. Because of what we, our spouses and our children didn't know, this project has shown us. The children respect us, we respect our spouses. There's no more violence between us and our children. We didn't know all that. We'd like to see more awareness-raising.

[Female FGD participant, Kossouka, Nord – treatment group].

However, regarding the **nutrition pillar and to some extent the WASH pillar**, some respondents insisted that the lack of financial resources prevented the practical use of the knowledge gained from the awareness activities that accompanied the nutrition and WASH pillars. Indeed, beneficiaries did not always have the means to implement what they learned as this exchange shows: *"Yeah, it'll stay with the theoretical advice, since they don't have the means"*. [National-level key informant (UNICEF), Ouagadougou]. This issue is also linked to the beneficiary selection process as described earlier where each activity pillar selected its own beneficiaries so some may have been part of the WASH or nutrition pillars, but not the cash transfer pillar.

3.3.2 Youth involvement in the CSSPP implementation

The widespread feedback was that young people were not very involved in the project as initially planned. However, several respondents, key informants, and treatment group IDI participants reported that young people were involved as recipients, namely as participants in the awareness-raising activities. Although it was mostly mentioned that they were members of households receiving cash transfers, as illustrated by this female interviewee:

The young people are not too involved in the project. If you see a young person, it's because his dad is a beneficiary, or his mum is a beneficiary [...] it's because of his mum or dad that he comes to participate.

[Female IDI participant, Kossouka, Nord – treatment group].

A few respondents also mentioned how some youths were involved in the implementation of project activities, for example to help mobilize the community and support project staff as described below:

Yes, it's, I have to say that it's mainly a support role. For example, when we work in the villages, generally it's the young people who accompany us, the CVD [Village Development Councils] and others are the young people who accompany us in the implementation, who help us to reach our targets and who also often question us [...] otherwise I think that those are the young people who have really been involved in the process.

[Communal-level key informant, Ye, Boucle du Mouhoun – treatment group].

3.4 Suggestions for future programmes

Some interviewees suggested that the **CSSPP be extended or renewed**, with consideration for those who may not have initially benefited. This could involve increasing the number of beneficiaries or targeting those who remain vulnerable. Indeed, respondents and key informants highlighted that while the CSSPP had made a positive impact, more support was needed to help beneficiaries transition out of poverty and vulnerability:

Because you can't say in two years that you can get out of a fast-moving problematic situation, especially one linked to poverty and vulnerability. In any case, it helps them, it accompanies them, but in any case, to get out of this situation, I think we still need to accompany them.

[National-level key informant (implementing partner),
Ouagadougou].

A few key informants put forth the idea that **a village savings group could be created** to support beneficiaries, particularly the poorer households, with the creation of income-generating activities:

If we create emulation, we can create emulation around the programme by creating groups to go in the direction of village savings and credit associations, and this will bring them even households that we say were really at the bottom of the ladder, we could encourage them to really give of themselves, or even move towards income-generating activities, in the sense that in the philosophy of village savings and credit associations, it's what you pool together that really constitutes the capital from which you can build on this to develop something, especially as the same money that you pool together after a cycle can be redistributed among the members once all the loans have been returned.

[National-level key informant (implementing partner),
Ouagadougou].

A suggestion was also made to **diversify the CSSPP's activities**, for example to include additional social protection measures, especially considering the evolving needs of the beneficiaries. Moreover, a few respondents mentioned the distribution of goods: *"If they could often add food to the cash transfers, that would be good ... because we had started to receive food but that stopped. So, if they could help us with food as well, and even work."* [Male FGD participant, Kossouka, Nord – treatment group]. Another key informant suggested **interlinking the different activity pillars, thus introducing WASH-related income-generating activities**: *"One idea that is already being discussed*

with our WASH colleagues is to promote soap manufacturing and marketing. And this would be under the supervision of women.”

[National-level key informant (UNICEF), Ouagadougou].

Others also recommended **more inclusivity in the CSSPP**. A key informant reported that, although when awareness raising activities took place, they were not closed and anyone could come listen, youth should be intentionally invited. For example, in some cases only married men were targeted, but including young men who are soon to be married could have an important impact:

When we go to the village and set up the school [awareness raising session], it's the whole village, it's not specific [...] when they deal with a theme concerning pregnant women, they bring together the husbands of the pregnant women. If they deal with a theme in support of breastfeeding women, they bring them together to pass on the message, and so it's in this sense that we've also had young people, future husbands, as beneficiaries. It's true that in those schools, the emphasis was on husbands, but not on future husbands, so teenagers weren't really involved, but beneficiaries were. So now, except for the fact that a married man, for example, is raising awareness among a young person, a future husband, perhaps he too will implement good practices to support his wife.

[National-level key informant (implementing partner), Ouagadougou].

One key informant explained that one of the CSSPP's goals was to **transfer skills to the implementing partners** so that they could then be capable of independently running the CSSPP. The key informant felt that this had not been attained and therefore, in the current state, there would be a risk of loss of quality in the trainings if the CSSPP was scaled up:

It's true that we've had all the training we can, but we don't have this pool of trainers to ensure this scaling up. I mean, just as we trained the field teams, all the project staff were included in these

training sessions. In my humble opinion, during the skills transfer phase, we could train the trainers, and then the team in charge of managing the project would have the support of external experts who could also conduct the training sessions, or be supervised by these experts, so that all the elements relating to expertise in these areas could be well mastered by the national NGO teams, so that the next generation of experts that we had so much thought and insisted on could be available within the national non-government organizations.

[National-level key informant (implementing partner),
Ouagadougou].

In terms of the CSSPP design, other suggestions for improvements mainly focused on beneficiary selection, linking the transfer amount to household size, and improved collaboration between the different sectors.

3.5 Sustainability

Key informants agreed that the poorest of the poor were unlikely to benefit in the long term from the CSSPP. They often used the transfers for their daily needs and were the least likely to start an income-generating activity: *“It’s not always easy for the poorest people, but they try anyway.”* [National-level key informant (implementing partner), Ouagadougou]. The less vulnerable households were certainly more likely to start an income-generating activity. Among those, some failed but others managed to sustain their income-generating activities despite the prevailing instability and insecurity.

Yes, the beneficiaries, I know that, among all of us, our abilities to really develop an income-generating activity or something differs from one person to another. So, we can say that in the batch of beneficiaries, there are some with these two years of transfer, according to the level of vulnerability or the state of poverty in which they were initially ... since the state of households in terms of vulnerability differs from one household to another, so among those that were only relatively vulnerable, we observed changes.

[National-level key informant (implementing partner), Ouagadougou].

One participant highlighted that cash transfers were not a sustainable long-term approach and felt that as soon as the transfers stopped, the situation would revert to the previous state. The participant also expressed their view that cash transfers created a sense of dependency: *“It would be better to teach us a trade than we would take care of ourselves.”* [Female IDI participant, Kossouka, Nord – treatment group].

Finally, a national-level key informant also clarified how the CSSPP was getting attention from policy makers at the national level. The national social protection policy expired in December 2022 and there has been a political process to draw up a national social protection strategy. This means aspects of the CSSPP could potentially be scaled up at the national level through the new policy:

I think this programme is increasingly becoming a flagship initiative at the national level. Yes, on a national level, because it is of growing interest to a number of key players involved in the field of social protection, and all the more so. [...] Alongside this, there is a major social safety net project financed by the World Bank, which will also come to an end, and which will then be the subject of a second phase, a national social safety net programme, which is more than just a project. This national programme will aim to provide a unifying framework for all social safety net initiatives, including this project. The project’s experience and approach has been a major source of inspiration for the development of the national programme and strategy, particularly in terms of support measures, not the cash itself.

[National-level key informant (UNICEF), Ouagadougou].

3.6 Summary of findings and discussion

Beneficiary selection:

The programme followed a multi-step process for identifying vulnerable households, involving community engagement, registration, and evaluation against vulnerability criteria. While beneficiaries generally did not raise concerns about the selection process, key informants highlighted challenges such as disparate criteria across activity pillars and difficulties in including the most vulnerable due to the barriers to registration (e.g., unable to travel to designated point).

Cross sectoral co-ordination:

Effective co-ordination of the programme was hindered by siloed approaches and key informants highlighted the need for improved collaboration and information sharing. Key informants also highlighted the lack of overlap between activity pillars.

Complaint and feedback

mechanisms: Although the programme established a complaint mechanism, communities were reluctant to report their problems which included tensions over beneficiary selection.

Transfer size and regularity:

Beneficiaries expressed gratitude for the cash transfers, but they also mentioned that the amounts were insufficient, especially considering the recent inflation. Moreover, irregularity in transfers and connectivity issues were highlighted as challenges affecting their well-being.

Nutrition and WASH sensitization:

While beneficiaries appreciated the awareness-raising activities for the nutrition and WASH interventions, key informants reported that the practical use of nutrition and WASH knowledge by beneficiaries was hampered by limited financial resources.

Sustainability: Concerns were raised about the ability of the poorest to benefit in the long-run and the risk of dependency on cash transfers. However, positive impacts on income generation were observed among less vulnerable beneficiaries. Finally, the CSSPP potential to inform national social protection policy and scale up initiatives at the national-level was acknowledged, suggesting a positive outlook for broader impact beyond the immediate programme.

Programme impacts on household consumption, poverty, and food security

4.1 Household consumption

Table 4.1 presents the estimated impacts of the CSSPP on food and beverage, non-food, and total expenditures. Detailed consumption and expenditure modules were administered to households using modules obtained from the Burkina Faso National Institute of Statistics and Demography (INSD). Data were collected on food and beverage, alcohol, and tobacco expenditures and non-food expenditures such as firewood, charcoal, water, gasoil, newspapers, and magazines, as well as cereal milling costs, consumed from own produce or received in the past seven days. Other non-food expenditure data, including housing and utilities, communication, transport, hotel/restaurant expenses – or value of received as a gift, in return of work or in barter – were also collected for the past three months. In addition, the study also collected data on expenses and value of received on clothing and shoes, furnishings, household equipment, and leisure and cultural expenditure in the past six months and other miscellaneous expenditures in the past 12 months. Education and health-related expenditures were also collected in their respective modules, specifically annual expenses for education during the past 12 months and health expenditures from the past two weeks. Before analysis, all expenditures that were made during a reference period less than 12 months were extrapolated for 12 months and aggregated at the household level. Further computations were conducted to obtain per capita expenditures for food, non-food, and total expenditure and adult equivalent per capita, generated using the adult equivalent household sizes. In addition, all expenditures were adjusted to January 2020 (baseline) values, as well as for the general price increase (inflation) using a region-specific consumer price index (CPI).

The results presented in Table 4.1 show that although all values have increased from baseline to endline for treatment households, the CSSPP had significant impacts on total real expenditure at endline, increasing the real total household expenditure by FCFA 301,253, equivalent to a 26 per cent increase compared to the baseline average expenditure among the treatment group. The impacts on other indicators were statistically insignificant. This could be due to larger improvements in the respective values among comparison groups between baseline and midline, as well as endline.

**Table 4.1: Programme impact on annual household expenditure
(real, 2020=100) (FCFA)**

Dependent	Endline	Midline	Impact Diff	Treated Mean	Treated Mean	Comparison Mean
Variable	Impact (1)	Impact (2)	(Endline vs Midline) (3)=(1)-(2)	Baseline (4)	Endline (5)	Endline (6)
Food and Beverages	166,916.148 (97,433.54)	198,956.112 (163,580.50)	-32,039.964 (93,327.41)	827,370.96	882,887.67	923,436.76
Non-food expenditure	134,337.024 (85,279.79)	163,202.871 (90,393.74)	-28,865.847 (82,219.01)	335,834.63	380,957.70	437,295.94
Total Expenditure	301,253.175* (150,071.77)	362,158.987 (216,841.12)	-60,905.812 (147,338.31)	1,163,205.59	1,263,845.37	1,360,732.70
Food and Beverages per capita	25,697.976 (15,069.80)	27,098.509 (25,741.02)	-1,400.533 (13,355.03)	114,817.78	139,281.41	128,832.04
Non-food expenditure per capita	18,164.683 (12,402.75)	20,679.057 (11,951.56)	-2,514.374 (9,689.20)	42,582.66	56,100.91	57,076.38
Total Expenditure per capita	43,862.661 (22,975.65)	47,777.567 (32,851.09)	-3,914.906 (19,008.14)	157,400.442	195,382.324	185,908.416
N	6,783	6,783		904	904	1,357

Notes: standard errors in parentheses. * 10% significance level; ** 5% significance level; *** 1% significance level.

4.2 Poverty and severity of poverty

The study also evaluated the impacts of the programme on the poverty headcount and poverty gap (how far the poor are below the poverty line) for the full and disaggregated sample based on household size. We used the 2018 national monetary poverty line (FCFA 194,629) published by INSD and adjusted it for inflation to 2020.⁸ Results are presented in Table 4.2. The results show that the programme weakly ($P<0.1$) reduced the share of poor households by 15.282 percentage points. This reduction is more than the 5 percentage points anticipated in the programme theory of change and used for the sample determination. Disaggregated results based on household size further show the programme has significant impacts among large households (households with eight and more members), reducing poverty headcount by 14.194 percentage points. However, the programme did not have significant impacts on the poverty gap. It was also observed that none of the monetary poverty indicators were significantly impacted during midline (1 year after the intervention), showing that the programme has become more effective over time in addressing monetary poverty.

Table 4.2: Programme impact on monetary poverty

Dependent Variable	Endline	Midline	Impact Diff	Treated Mean	Treated Mean	Comparison Mean
	Impact	Impact	(Endline vs Midline)	Baseline	Endline	Endline
	(1)	(2)	(3)=(1)-(2)	(4)	(5)	(6)
Poverty head count	-15.282*	-14.557	-0.725	82.70	68.30	71.76
	(7.33)	(10.21)	(7.53)			
Poverty gap (distance from poverty line)	-9.513	-9.655	0.142	36.22	26.65	28.66
	(5.58)	(8.12)	(5.64)			
N	6,783	6,783		904	904	1,357
Poor in small household (size <8)	-16.603	-17.961	1.357	71.14	56.36	55.12
	(11.08)	(13.32)	(9.15)			
N	3,114	3,114		448	448	590

Poor in large household (size 8+)	-14.194** (4.64)	-12.154 (7.72)	-2.040 (6.33)	93.68	79.62	84.66
N	3,669	3,669		456	456	767

Notes: standard errors in parentheses. * 10% significance level; ** 5% significance level; *** 1% significance level

In qualitative interviews some respondents, namely those in the comparison group, found themselves in extremely destitute situations. They explained how they lacked money to pay for food and for needs such as schooling and healthcare. Children were therefore expelled, and sick family members were unable to recover. The extreme impoverishment led them to lose hope:

Interviewer: How or what do you do to adapt and live in this situation?

Respondent: What can we do? It's a river we're in, if you go forward you drown, if you turn around you drown. We're just in it. We only pray that God will make it easier.

[Female FGD participant, Safane, Boucle du Mouhoun – comparison group].

4.3 Food security

The CSSPP's impacts on key food security indicators at the household and child levels are presented in Table 4.3. The results show that the programme had strong impacts on the number of meals per day, the household and children food insecurity access scale, and the probabilities that children and households had insufficient and low-quality food intake. The estimates show that the CSSPP increased the number of meals per day by 0.278 (12.39 per cent relative to the baseline value for the treatment group) and reduced the food insecurity access scale by a score of 5.707 (by 54.5 percent compared to baseline value for the treatment group) at the household level in treatment households compared to comparison households. In addition, it also reduced the probabilities of households with insufficient food quality and intake by 32.507 and 42.009 percentage

points respectively. For children under 5 years old, the programme led to the reduction of the food insecurity access scale by 1.439 (by 66 percent compared to the baseline value for treatment group) and the share of the children who did not eat nutritious and sufficient food by 30.347 and 42.957 percentage points respectively. At common significance level (5 per cent), only the impact on share of households with insufficient food intake is significant for the midline, while (nearly) all dimensions show very significant effects in the expected direction at endline, suggesting the programme effectiveness improved overtime given relatively longer time to materialize effects. Lastly, the household dietary diversity score also increased by about 1 unit (by 18 per cent relative to baseline value at endline) at both midline and endline, showing that households have increased the number of food groups consumed with respect to baseline.

Table 4.3: Programme impact on food security

Dependent	Endline	Midline	Impact Diff	Treated Mean	Treated Mean	Comparison Mean
Variable	Impact	Impact	(Endline vs Midline)	Baseline	Endline	Endline
	(1)	(2)	(3)=(1)-(2)	(4)	(5)	(6)
Number of meals per day	0.278** (0.10)	0.119 (0.10)	0.159** (0.05)	2.26	2.59	2.36
Household Food Insecurity Access Scale Score	-5.707*** (1.35)	-2.960 (1.73)	-2.748 (2.47)	10.48	4.35	9.70
Child Under 5 years did not eat nutritious food	-30.347** (8.84)	-12.957 (8.11)	-17.390 (14.50)	69.96	45.62	70.22
Child Under 5 years did not eat enough food	-42.957*** (4.29)	-26.078* (11.14)	-16.879 (13.09)	67.88	34.83	66.70
Children Food Insecurity Access Scale Score	-1.439** (0.44)	-0.657 (0.51)	-0.782 (0.57)	2.18	0.98	2.24
Percent of households with insufficient food quality	-32.507** (12.61)	-9.733* (4.32)	-22.775 (14.77)	94.90	56.52	83.19

Percent of households with insufficient food intake	-42.009*** (6.06)	-20.980** (7.20)	-21.028* (10.28)	90.17	48.32	80.99
Household Dietary Diversity Score	1.076* (0.47)	1.109* (0.51)	-0.033 (0.26)	5.91	6.50	6.10
N	6,783	6,783		904	904	1,357

Qualitative results align with the quantitative results. Overall, the programme decreased hunger and increased food diversity, thereby enhancing the quality of life for the treatment group. They explained how before receiving the cash transfers, families struggled to afford essential food items like rice, but now they could buy a variety of foods, including rice, meat, and vegetables, which had positive impacts on their nutritional status, particularly of children. The cash has led to an increase in the number of meals per day, with households now being able to eat three times a day: *“Wallahi [I swear by God/Allah] we used to eat once a day, now we eat three times a day. And we eat what we want. Thanks to your help.”* [Female FGD participant, Dargo, Centre-Nord – treatment group]. Indeed, impacts that cash transfers have on food security are well documented in the literature. In their cross-country analysis in sub-Saharan Africa, Tiwari et al. (2016) found that transfers increased not only the quantity but also the quality of food consumed by families.

Households in the comparison groups discussed how they had more trouble ensuring food security in the FGDs. Mothers were generally more affected by the lack of food in the households as explained by this FGD participant:

Food security has not improved. On the contrary, it has deteriorated. There has been a reduction in the amount of food to be prepared in households. [...] We really don't have enough to eat anymore. In households, people haven't had enough to eat in the last two years. [...] I haven't eaten since the morning until this time in the afternoon. The food I've had I've given to the children. That's how it is, if I earn enough to eat, I give it to the kids and I manage to wait until the evening to eat.

[Female FGD participant, Safane, Boucle du Mouhoun – comparison group].

Respondents also said that lack of food security had an impact on children's education as they were unable to provide sufficient food for their children's lunches: *"Our children go to school. They are in other places where we must send them food. But it's often difficult for us to send them food because there's no food here. But to ask a child to study with hunger is impossible."* [Female FGD participant, Safane, Boucle du Mouhoun – comparison group].

4.4 Summary of findings

Household consumption:

The CSSPP had limited impacts on household consumption outcomes, in real values. The only significant impact at endline was observed on total expenditure.

Poverty headcount and poverty gap:

The study also finds that the CSSPP marginally reduced poverty headcount at endline, mainly among larger size households by about 14 percentage points, but there was no impact on the poverty gap. This shows that the programme seems to be less effective in lifting the poor households up to the monetary poverty line.

Food Security:

The programme had strong and consistent impacts on various food security indicators at the household and child level, particularly at endline. In qualitative interviews, respondents explained how they ate more regularly, as well as consumed food of better-quality. The evidence also suggests an improvement in the CSSPP's effectiveness between midline and endline.

Programme impacts on household members living standards, assets, and savings

5.1 Health and disability status of household members

Table 5.1 presents the results of the impact of the programme on the health outcomes and disability status for all household members. The results show that at endline, the programme marginally reduced the number of days caregivers stopped working due to illness or injury by 1.423 days ($P < 0.1$). There were no impacts on this indicator at the midline. On the other hand, there was an increase in the incidence of members aged 10 years and above with a disability by 0.008 percentage points at midline. This impact was not observed at the endline. The programme also did not have significant impacts on the incidence of illness or injury of household's members two weeks prior to the interview, treatment seeking at health facility for illness, the number of days usual activities have been stopped due to illness or injury, or the share of members with disability at endline.

Table 5.1: Programme impact on health status of members

Dependent	Endline	Midline	Impact Diff	Treated Mean	Treated Mean	Comparison Mean
Variable	Impact	Impact	(Endline vs Midline)	Baseline	Endline	Endline
	(1)	(2)	(3)=(1)-(2)	(4)	(5)	(6)
Any illness or injury in last 2 weeks	0.037 (0.05)	0.052 (0.04)	-0.015 (0.01)	0.10	0.05	0.06
N	57,555	57,555		7,488	6,756	11,207

Sought care for illness/ injury from a facility	0.093 (0.09)	0.060 (0.08)	0.033 (0.10)	0.53	0.61	0.56
N	4,918	4,918		679	372	702
Days stopped usual activities due to illness/ injury	-0.438 (0.57)	0.348 (0.38)	-0.786 (0.55)	3.25	2.93	2.78
N	4,918	4,918		679	372	702
Days caregivers stopped work due to illness/ injury	-1.423* (0.60)	-0.445 (0.25)	-0.977 (0.68)	2.22	1.26	2.10
N	4,918	4,918		679	372	702
Member 10yrs+ has a chronic condition	-0.012 (0.03)	0.011 (0.01)	-0.023 (0.02)	0.05	0.01	0.04
N	39,331	39,331		5,115	4,847	7,763
Member 10yrs+ has a disability	0.011 (0.01)	0.008** (0.00)	0.003 (0.01)	0.03	0.02	0.02
N	39,775	39,775		5,115	4,951	8,007

Notes: standard errors in parentheses. * 10% significance level; ** 5% significance level; *** 1% significance level.

Contrary to the quantitative findings, qualitative results showed that the programme contributed to improvements in the health status of household members, specifically children. These findings are in line with the systematic review by Van Daalen, et al. (2022). Beneficiaries and key informants agreed that the programme improved access to healthcare and the health status of communities. This key informant summarizes impacts the projects had on beneficiary communities:

In some households, there were often cases of illness, but the low purchasing power of the heads of households meant that they couldn't take them to the health centre for appropriate care. But with the cash transfers, purchasing power has improved, and now when a child is ill, we take him to the health centre and buy the prescribed medication to treat him. As a result, there are fewer and fewer cases of illness in families. Raising awareness of hygiene and sanitation promotion has also helped to better promote people's health. Cases of malaria have greatly diminished ... even dysentery and many other illnesses, and this is due to the improved hygiene and sanitation of the

beneficiaries' living environment. Children are also taken to the health centre very early on in the event of illness. Often the cost of treatment doesn't even exceed 1000f, but people didn't have the reflex to consult a health centre quickly. So, the project has done a lot to promote health in families.

[Communal level key informant, Kossouka, Nord]

The cash transfers have alleviated stress by covering the healthcare costs for beneficiaries, thus contributing to overall family well-being. Respondents reported how the financial relief had improved mental health, reducing worries related to health and financial stability. Treatment respondents explained how financial help in the form of cash transfers has significantly enhanced access to healthcare and how it had enabled families to move from reliance on traditional medicines to seeking hospital treatment, especially for children, thus improving health outcomes:

If a child falls ill, the aid allows you to take the child urgently to the hospital! That's right! Before the aid arrived, you can see if the child needs a consultation, but because of the lack of means, we stay with the traditional products for FCFA 100 or FCFA 200. Sometimes it works, sometimes the child dies! but with the arrival of funding, if the child is sick, we run quickly to the hospital!

[Male IDI participant, Kossouka, Nord – treatment group]

Respondents also recounted how the availability of funds has reduced instances where people had to leave identification cards at pharmacies due to lack of funds which used to be the case before:

If you bring FCFA 500 and you arrive, and they tell you that the medicines are worth FCFA 2500. and you tell them that you have FCFA 500, you leave them your CNIB [national identity card]. You take the medicine and leave. When you get home, you do everything you can to get the money and leave to collect your CNIB.

[Female FGD participant, Dargo, Centre-Nord – treatment group]

It was also reported how community health agents had been crucial in promoting hygiene and encouraging prompt medical consultation, significantly contributing to improved community health, as described by this key informant: *“The ASBC [community-based health workers] raise people’s awareness of the need to consult health centres quickly in the event of illness, without waiting two or three days before going. That’s another advantage of the project.”* [Communal-level key informant, Kossouka, Nord].

Comparison group respondents continued facing financial access issues. Many explained how they were unable to afford even basic treatments like 300 FCFA prescriptions, often resulting in the use of traditional remedies. Healthcare expenses, especially for families with multiple sick children, can be financially draining as this mother explains: *“Health-related expenses are too expensive for us. For example, if you have three children and two are sick, you’re going to spend all your money and even go into debt to treat them.”* [Female FGD participant, Safane, Boucle de Mouhoun – comparison group]. As a result, respondents told how healthcare decisions were often driven by financial constraints. Adults may endure illnesses without treatment, but sick children are usually taken to the hospital. Nonetheless, and similarly to the treatment group, comparison group respondents also reported that preventive measures, like early hospital visits and better hygiene, have reduced disease incidence: *“We can say that there has been a change, [...] over the past two years we can say that there has been a little improvement on cleanliness.”* [Male IDI participant, Safane, Boucle de Mouhoun – comparison group].

Despite notable improvements for beneficiaries, challenges remained for both groups as seen in Section 4. These included need for long-distance travel, as described in the section on access to services, as well as limitations in healthcare services and the lack of medical supplies, as illustrated by this male FGD participant: *“For more than five years now, you can send your patient to the hospital, when the nurse gives you a prescription and you go to the pharmacy, there’s nothing good there, no medicine. The staff are there, but the medicines are not available!”* [Male FGD participant, Bassi, Nord – comparison group].

5.2 Child material well-being (5–17 years old)

The questionnaire asked each child aged 5–17 years old whether they possessed a pair of shoes, at least two sets of clothes, and a blanket. The impact estimates shown in Table 5.2 show that the programme caused a significant decrease in children without clothes and blankets, more consistently at midline compared to endline. At midline, all impact estimates are significant, with two of the four impacts sustained by endline (having no blanket and having none of the three items). Households may have used the cash to buy these items until about one year into the programme (short-term) but more likely to become less responsive to cash transfers in the long term. The impact estimates range from a reduction of 36.28 percentage points for having no blanket, to a decrease of 11.56 percentage points in having none of the three items.

Table 5.2: Programme impact on child material well-being, children aged 5–17 years (Panel households)

Dependent Variable	Endline Impact	Midline Impact	Impact Diff (Endline vs Midline)	Treated Mean Baseline	Treated Mean Endline	Comparison Mean Endline
	(1)	(2)	(3)=(1)-(2)	(4)	(5)	(6)
Child has no pair of shoes or sandals	-13.544 (7.55)	-14.968* (7.47)	1.424 (4.86)	24.157	2.235	15.176
Does not have at least 2 sets of clothes	-19.321 (10.31)	-16.865** (5.43)	-2.456 (6.68)	27.734	2.554	14.909
Child has no blanket to use	-36.282** (12.80)	-36.273** (13.75)	-0.009 (9.24)	58.860	11.682	22.943
Child has none of all three basics	-11.563* (5.40)	-11.991** (4.80)	0.428 (2.07)	13.009	0.569	10.265
N	24,697	24,697		3,387	2,905	4,735

Notes: standard errors in parentheses. * 10% significance level; ** 5% significance level; *** 1% significance level.

5.3 Housing and WASH infrastructure

The programme impacts have been also examined with respect to several housing and WASH indicators, including room occupancy (number of people per room), quality of construction materials used for the exterior wall, roof and floor, main source of lighting for the dwelling, main source of drinking water during dry and rainy seasons, water treatment practices to make it safer for drinking, toilet facilities and sanitation and access to cooking energy. The results presented in Table 5.3 show that the programme led to mixed effects (positive, insignificant, and negative impacts). Accordingly, the endline estimates show that: the programme marginally reduced the number of persons per room by 0.738 people (by 22 per cent compared to the baseline value for treatment group) due to an increase in the number of rooms; improved the ownership of improved lighting by 19.825 percentage points; and improved roofing by 18.747 percentage points. The programme increased the probability of treating water before use by 2.474 percentage points at endline in treatment households compared to comparison households. Looking at the midline impacts, it is noted that while the significant programme impacts were sustained (the effect sizes) from midline to endline in access to improved lighting, having finished roofing and treating drinking water before use, the programme impact was marginally significant at endline related to the number of persons occupying a room. Impact differences suggest that the programme impacts (effect sizes) were also stronger at endline compared to midline related to access to improved sources of drinking water during rainy season. On the contrary, although the programme impact has been sustained over time, the impacts of the programme on treating water before use were stronger and have a larger effect size at midline compared to endline.

Table 5.3: Programme impact on housing and WASH

Dependent Variable	Endline	Midline	Impact Diff	Treated Mean	Treated Mean	Comparison Mean
	Impact	Impact	(Endline vs Midline)	Baseline	Endline	Endline
	(1)	(2)	(3)=(1)-(2)	(4)	(5)	(6)
Number of persons per room	-0.738* (0.31)	0.076 (0.48)	-0.814* (0.36)	3.31	2.04	2.92
Household size	0.153 (0.47)	0.206 (0.37)	-0.053 (0.30)	8.43	7.63	8.42
Number of rooms	1.031** (0.35)	-0.228 (0.30)	1.260* (0.62)	3.38	4.57	3.61
Improved lighting	19.825* (9.28)	16.165* (7.69)	3.660 (10.27)	20.22	49.18	36.18
Finished fence wall	-10.710 (8.53)	-5.061 (4.87)	-5.649 (11.64)	11.53	23.79	30.72
Finished roofing	18.747* (8.61)	11.619** (3.76)	7.129 (9.15)	67.38	82.12	76.35
Improved floor	-5.424 (12.90)	-12.857 (9.37)	7.433 (6.59)	28.38	42.40	48.92
Improved source of drinking water during dry season	-6.338 (4.75)	-0.223 (5.24)	-6.115 (3.74)	58.570	58.877	86.68
Improved source of drinking water during rainy season	-9.633 (5.48)	-0.423 (6.98)	-9.210* (4.37)	59.49	56.35	86.23
Treated water before use	2.474** (0.93)	5.551*** (1.09)	-3.078* (1.33)	1.78	2.45	1.05
Access to improved toilet	-6.698 (12.99)	5.039 (5.01)	-11.737 (10.07)	31.75	53.36	63.61
Access to improved cooking fuel	-0.226 (0.32)	-0.013 (0.20)	-0.212 (0.43)	0.00	0.23	0.52
Availability of hand washing facilities	-0.426 (0.60)	0.116 (0.43)	-0.542 (0.44)	0.31	0.16	0.46
N	6,783	6,783		904	904	1,357

Notes: standard errors in parentheses. * 10% significance level; ** 5% significance level; *** 1% significance level.

5.4 Household assets ownership

Table 5.4 presents the CSSPP impacts on household asset ownership. The programme has significantly and positively impacted the number of different asset types owned by the household, the asset index, the number of all assets owned by the household, and the value of home furniture. Estimates show that the number of different asset types owned increased among treatment households by 0.72 (25.8 per cent relative to baseline value) compared to comparison households at endline – the impact was significant during midline. Similarly, looking at the number of assets owned by the household, results showed that the programme resulted in an increase by 1.72 (32 per cent relative to baseline value) for treatment households more than comparison households. Again, the impact was also significant at midline, showing that the programme impact was sustained overtime. The household asset index, generated through factor analysis, was also increased by a score of 0.06 due to the programme. Looking at the real values of groups of assets, the sales value of home furniture increased by FCFA 30,673 (more than doubled from baseline value) in the endline. It is worth noting that the programme impacts on the values of port phone and home electronics are no longer significant at endline.

Table 5.4: Programme impact on assets ownership

Dependent	Endline	Midline	Impact Diff	Treated Mean	Treated Mean	Comparison Mean
Variable	Impact	Impact	(Endline vs Midline)	Baseline	Endline	Endline
	(1)	(2)	(3)=(1)-(2)	(4)	(5)	(6)
Number of different asset types owned	0.715*** (0.19)	0.457*** (0.12)	0.258 (0.20)	2.77	3.45	2.72
N	6,576	6,576		876	902	1,309
All asset owned index	0.060*** (0.01)	0.040*** (0.01)	0.020 (0.02)	0.21	0.28	0.22
N	6,783	6,783		904	904	1,357
Number of all assets owned by household	1.718*** (0.42)	1.171*** (0.28)	0.547 (0.29)	5.35	7.11	4.76
N	6,783	6,783		904	904	1,357

Value of Home Entertainment Appliance (FCFA)	2,834.205 (1,585.57)	5,467.423 (3,366.78)	-2,633.218 (1,990.95)	6,184.30	5,764.14	8,148.85
N	1,732	1,732		231	379	263
Value of Mobile and Port Phone (FCFA)	412.529 (2,073.62)	3,980.843** (1,352.96)	-3,568.314** (1,415.09)	11,645.59	19,407.32	22,245.26
N	6,157	6,157		807	878	1,157
Value of Home Electronics (FCFA)	4,959.424 (3,640.54)	8,080.446*** (1,933.27)	-3,121.022 (1,988.23)	12,116.77	13,883.92	20,849.11
N	2,484	2,484		266	480	513
Value of Home Furniture (FCFA)	30,673.940** (8,723.21)	18,199.349** (6,029.08)	12,474.592 (7,034.27)	13,909.76	30,068.17	22,856.26
N	699	699		73	79	210

Notes: standard errors in parentheses. * 10% significance level; ** 5% significance level; *** 1% significance level. All monetary values are real, using 2020 as a reference period and deflated using region-specific CPI.

5.5 Savings, debts, credits, and transfers

Households were also asked questions related to savings, debts, credits, and transfers, including monetary savings and amount in a bank or saving groups, outstanding debts, amount, sources, purposes, and transfers in the form of money, goods, and services or gifts. This included food, agricultural implements or inputs, labour or time, and values (received from other households and sent outside households) in the past 12 months. Again, all monetary values were re-based to the baseline values and adjusted using a general consumer price index.

The study did not find significant impacts of the programme on savings, debt, transfers and credits at endline (Table 5.5). However, in the short-term (midline), the programme reduced the total household savings by FCFA 35,956, total amount of debt owned by household by FCFA 14,782, and average amount of debt per debtor by FCFA 14,058 among treatment households more than the comparison households. Reduction in debt size along with reduced savings in the short-term (midline) may also imply that households may have

used the cash received to settle debts against savings. However, the impact differences (differences in effect sizes between midline and endline) suggest that none of the estimates were significantly different between midline and endline.

Table 5.5: Programme impact on savings, debts, and credits

Dependent Variable	Endline	Midline	Impact Diff	Treated Mean	Treated Mean	Comparison Mean
	Impact	Impact	(Endline vs Midline)	Baseline	Endline	Endline
	(1)	(2)	(3)=(1)-(2)	(4)	(5)	(6)
Households having monetary savings (%)	-3.544 (5.49)	0.928 (2.32)	-4.472 (3.92)	6.26	3.53	5.09
N	6,783	6,783		904	904	1,357
Total household savings amount (FCFA)	-11,138.906 (15,120.79)	-35,956.744** (11,180.71)	24,817.838 (18,099.56)	16,235.63	36,673.48	64,269.98
N	330	330		75	33	78
Households with an outstanding debt (%)	-4.089 (11.73)	-1.558 (3.99)	-2.531 (9.38)	35.12	12.33	31.58
N	6,783	6,783		904	904	1,357
Total amount of debt owned by household (FCFA)	-12,938.569 (9,430.32)	-14,782.881** (4,733.48)	1,844.313 (8,404.71)	42,402.60	31,953.28	52,470.03
N	2,206	2,206		336	127	390
Number of outstanding debts	-0.063 (0.26)	0.166 (0.23)	-0.229 (0.45)	1.46	1.45	1.78
N	2,200	2,200		336	125	388
Average amount of debt per debtor (FCFA)	-11,730.143 (11,128.37)	-14,058.483** (5,112.56)	2,328.339 (11,585.72)	32,637.97	24,933.14	38,039.76
N	2,200	2,200		336	125	388
Households making out transfers (%)	2.202 (17.66)	6.226 (14.18)	-4.024 (5.46)	25.84	16.79	11.92
N	6,783	6,783		904	904	1,357
Monetary value of out transfer (FCFA)	1,900.808 (11,211.63)	-3,863.798 (7,561.80)	5,764.606 (9,644.96)	10,836.06	15,370.23	15,783.78

N	1,394	1,394		307	177	181
Households receiving transfers (%)	18.404 (13.89)	12.908 (11.99)	5.496 (5.20)	29.08	19.81	22.15
N	6,783	6,783		904	904	1,357
Monetary value of transfers received (FCFA)	-8,630.557 (8,499.84)	1,989.323 (8,970.08)	-10,619.880 (16,376.68)	25,057.01	25,711.95	34,974.75
N	2,209	2,209		315	214	314

Notes: standard errors in parentheses. * 10% significance level; ** 5% significance level; *** 1% significance level.

Qualitative results were more positive and found that treatment group respondents explained how they had been taught through the programme activities to save and invest part of the cash received. They explained how they did so after they had taken care of their families' daily needs: *"When we receive the money, we first look at the problem of food, children and we also set [some money] aside in case a child falls ill. That's how we calculate, it's the same thing. It's like he [project staff] explained."* [Male FGD participant, Dargo, Centre-Nord – treatment group].

Investments were done to secure longer term earnings and savings to deal with unforeseen costs as explained by this focus group discussion participant:

You save money to deal with unforeseen events. Illness is something that doesn't come easily, so if you earn a little money, you should always set aside a portion to save, because unforeseen events don't come easily. That way, in an emergency, you can solve your problem. Often, too, if you're a trustworthy person, you can always get credit in the event of illness if you're short of money for medical care, even if you agree to pay it back afterwards.

[Female FGD participant, Kossouka, Nord – treatment group].

Having savings, however, did not prevent families from sometimes having to borrow money from friends or neighbours as the participant recounts above. The same was explained by comparison group respondents who had no incoming programme cash. They lived on a day-to-day basis and tried to get by with help from those who had more:

You have to manage ... if you know someone who's better off than you, you can ask them for 100 FCFA to buy bouillon cubes. Often someone can give you 500 FCFA that you can use to buy food so that the members of your household have something to eat. Apart from that, a neighbour might give you a little so that your children at least have something to eat so that they can sleep. That's how we live here.

[Female IDI participant, Bassi, Nord – comparison group].

5.6 Summary of findings

Health and disability status of household members:

The CSSPP has very limited impacts on the health of household members. The only significant and positive impact at endline was related to the reduction in the number of days caregivers stopped working due to illness/injury. Contrary to the results of the quantitative findings, qualitative study results showed that the programme contributed to improving the health status of household members by reducing financial barriers and thus increasing the use of health services, suggesting a positive relationship between cash transfers and health outcomes. However, geographical barriers did remain for all respondents.

Child material well-being:

The CSSPP had significant impacts on the possession of blankets, a pair of shoes, and two sets of clothes among children 5–17 years old, particularly at midline.

Housing and WASH infrastructure:

The programme impacts on housing and household-level WASH infrastructure at endline were mixed. Related to housing, the programme reduced the number of persons per room and improved ownerships of improved lighting and roofing. Positive and significant change was also observed related to a behavioural change indicator, i.e., water before use.

Household assets ownership:

The programme's impacts on asset ownership were positive and significant most of the time both at midline and endline, showing that the programme impacts were sustained overtime.

Savings, debts, credits, and transfers:

No significant impact was found on savings, debt, and credits at endline. However, at midline the findings were mixed and inconsistent, that is, the programme reduced the total amount of debt owned by households and average debt per debtor as well as

the total household savings amount. The negative impact on savings was insignificant at endline. However, as part of the qualitative survey, respondents told how they kept part of the transfers for investment and savings, as they had been taught during the CSSPP's awareness-raising activities. Investments were made to secure longer term earnings and savings to deal with unforeseen costs.

Programme impacts on household economic activities

6.1 Agricultural production

Table 6.1 presents results on the impacts of the programme on agricultural production, ownership agricultural inputs (tools, livestock, machinery, and structures), farm plots, and investments in agricultural inputs. At endline, the study finds significant impacts of the programme on the number of agricultural inputs such as hand hoe, axes, livestock, and machinery owned by the household, number of plots per household, and total land size cultivated by the household in the previous rainy seasons which could be own farmlands, rented-in or accessed through other arrangements. Accordingly, estimates show that the programme increased the number of agricultural inputs owned by 3.177 (by 58.3 per cent relative to the baseline value) and the number of plots per household by 0.49 (by 26 per cent relative to the baseline value) among the treatment group more than the comparison group. In addition, treated households also operated 14.0 (more than twice of the baseline value) more hectares of agricultural land at endline compared to households from the comparison group. Estimates on the ownership of any agricultural inputs were not statistically significant. The programme either sustained impacts or became more effective over time related to the number of agricultural inputs owned, plots operated by the household, and size of these plots. However, while expenditures on agricultural inputs by treatment households at endline were statistically insignificant, they were significant at midline.

Table 6.1: Programme impact on agricultural production

Dependent Variable	Endline	Midline	Impact Diff	Treated Mean	Treated Mean	Comparison Mean
	Impact	Impact	(Endline vs Midline)	Baseline	Endline	Endline
	(1)	(2)	(3)=(1)-(2)	(4)	(5)	(6)
Household owns any agricultural inputs	25.439 (18.81)	-1.688 (2.28)	27.127 (18.90)	97.40	97.74	72.61
N	6,710	6,710		904	904	1,357
Number of agricultural inputs owned	3.177*** (0.81)	0.598 (0.85)	2.579** (0.85)	5.45	7.12	3.56
N	6,710	6,710		904	904	1,357
Number of plots per household	0.493*** (0.13)	0.261** (0.07)	0.233* (0.11)	1.89	2.00	1.62
N	6,402	6,402		887	887	1,106
Total size of cultivated land (hectares)	14.005*** (3.28)	11.383* (4.74)	2.623 (3.17)	5.74	11.20	5.43
N	6,392	6,392		887	887	1,106
Total Crop sales (FCFA)	-8,516.409 (37,483.10)	-1,506.149 (13,590.95)	-7,010.260 (27,168.09)	7,480.41	38,004.58	66,794.39
N	6,289	6,289		862	867	1,061
Expenditure on agricultural inputs (FCFA)	3,203.349 (3,125.16)	3,230.924** (1,132.96)	-27575 (3,169.07)	7,343.68	13,689.31	13,259.37
N	4,094	4,094		615	609	454

Notes: standard errors in parentheses. * 10% significance level; ** 5% significance level; *** 1% significance level.

Likewise, in the qualitative study, the majority of the CSSPP beneficiaries explained how they experienced an increase in agricultural production in recent years thanks to the cash, leading to better food availability and variety in their diet. The importance of fertilizers in maintaining soil fertility and boosting crop yields was emphasized by respondents across both groups. However, the high cost of fertilizers remains a challenge for many, particularly in the comparison group. Several households in the treatment group explained how they used the cash particularly for fertilizers: *“It’s improved ... as we’ve had the chance to be beneficiaries of the project, it’s allowed us to have more access to*

fertilizer and that's allowed us to improve our agricultural yields." [Male FGD participant, Kossouka, Nord – treatment group].

Both groups reported how climatic conditions played an important moderating role for agricultural production. Indeed, inconsistent rainfall patterns and shocks such as drought and floods led to fluctuating crop yields, which negatively affected food security, causing significant losses as described by this participant: *"But last year, floods destroyed some people's fields. I think it's worth pointing this out too ... personally, the rainwater flooded my field, and I got nothing."* [Male FGD participant, Kossouka, Nord – treatment group]. In addition, crop diseases were equally mentioned as a significant problem, with one person mentioning how a disease destroyed all cotton and legumes, impacting their income source: *"Last year we experienced a shock in agricultural production. We cultivated but the disease destroyed all the crops. Cotton, vegetables, ... were all attacked by these diseases. Our income comes from agricultural production."* [Female FGD participant, Safane, Boucle de Mouhoun – comparison group].

Finally, both groups had concerns about the availability of land for farming. Respondents highlighted issues such as not owning land and having to farm on borrowed plots and the limitations in expanding family farming due to lack of available land: *"I don't have any land; I produce on the plot I'm given. As far as family production is concerned, we have not been able to increase the family farm on which we produce because there is no more land available."* [Female IDI participant, Safane, Boucle de Mouhoun – comparison group]. In addition, constraints such as the inability to access fields due to safety concerns or limited resources impacted respondents.

6.2 Livestock production

The programme has resulted in improvements in beneficiary household's economic activities compared to comparison households (see Table 6.2). Between baseline, midline, and endline, the number of livestock purchased (measured in Tropical Livestock Unit, TLU) as well as the livestock diversity (number of livestock types owned) have significantly improved among treatment households compared to comparison households. Estimates show that the programme

helped treated households to diversify their livestock portfolio by a score of 0.53 at midline and 0.60 (20.5 per cent relative to baseline value) at endline compared to comparison households. In addition, the programme increased the number of livestock owned by 0.17 TLU during midline and 0.08 at endline for treated households compared to comparison households.

Table 6.2: Programme impact on livestock production

Dependent Variable	Endline Impact	Midline Impact	Impact Diff (Endline vs Midline)	Treated Mean Baseline	Treated Mean Endline	Comparison Mean Endline
	(1)	(2)	(3)=(1)-(2)	(4)	(5)	(6)
Household owns any livestock	10.707 (8.36)	5.533 (3.59)	5.174 (10.15)	90.34	95.85	80.83
Number of livestock types owned	0.600** (0.20)	0.529** (0.19)	0.072 (0.16)	2.92	3.48	2.83
Number of Livestock Owned (TLU)	0.186 (0.51)	0.184 (0.10)	0.002 (0.53)	1.26	1.98	1.79
Livestock Purchased (TLU)	0.078** (0.03)	0.171*** (0.02)	-0.093*** (0.02)	0.05	0.12	0.05
Value of Livestock Purchased (FCFA)	10,932.306 (5,699.72)	27,380.366*** (5,972.27)	-16,448.060*** (2,269.92)	7,982.97	17,279.33	6,660.71
Value of Livestock Sold (FCFA)	4,178.315 (19,539.84)	5,265.770 (11,981.53)	-1,087.455 (14,767.46)	26,215.55	37,359.12	44,545.24
N	6,783	6,783		904	904	1,357

Notes: standard errors in parentheses. * 10% significance level; ** 5% significance level; *** 1% significance level.

These results were confirmed in the qualitative study where several treatment group respondents recounted how, thanks to the cash, they had been able to invest in cattle: *“Breeding has increased. With the money we received, we paid for animals to breed and it’s multiplying. And that’s it.”* [Female FGD participant, Kossouka, Nord – treatment group]. However, respondents from comparison and treatment households alike brought up the issue of maintaining cattle.

Indeed, several respondents explained how their cattle had died due to diseases and how feeding them could be a challenge, including because of reduced land for grazing: “We also raise livestock, but with the prevailing context and the practice of agriculture, it’s difficult to find enough space to better promote breeding. That’s why we avoid owning a lot of livestock. There’s no point in having a lot of head if you don’t have the means to look after them properly.” [Female FGD participant, Kossouka, Nord – treatment group].

Finally, many respondents felt that livestock breeding had altogether not increased in the past two years. This was linked to population displacement (described further in section 10.3), which meant that many had had to abandon their cattle, as explained by this female interviewee: *“Livestock farming hasn’t improved because with the displacement, we’ve had to abandon some animals, and some have died. With the ultimatum we were given to leave the village, many lost their animals and to this day don’t know where to find them.”* [Female IDI participant, Bassi, Nord – comparison group].

Contrary to the agricultural and livestock impacts, the programme did not result in positive changes on key indicators of household’s non-farm enterprise operation (Table 6.3). The estimates show that the value of non-farm enterprise assets purchased declined by approximately CFCA 119,442 more in treated households compared to control households. Treatment households also reported a decline of monthly profits by FCFA 10,288. Negative impacts on non-farm enterprises only materialised at endline.

Table 6.3: Programme impact on operation of non-farm enterprise

Dependent	Endline	Midline	Impact Diff	Treated Mean	Treated Mean	Comparison Mean
Variable	Impact	Impact	(Endline vs Midline)	Baseline	Endline	Endline
	(1)	(2)	(3)=(1)-(2)	(4)	(5)	(6)
Total non-farm enterprise sales last month (FCFA)	-29,386.582 (15,839.77)	10,302.995 (8,275.86)	-39,689.577* (16,477.30)	51,391.87	55,069.12	95,790.33
Assets Purchased for Business	6.146 (12.15)	11.420 (16.19)	-5.274 (9.73)	45.16	35.04	21.48
N	899	899		132	103	131
Amount of Assets Purchased (FCFA)	-119,442.597** (36,674.54)	-13,593.068 (30,078.31)	-105,849.529** (38,524.08)	27,380.43	33,515.76	157,268.89
N	179	179		34	23	11
Total Monthly Profit last month (FCFA)	-10,288.302** (3,785.20)	1,702.016 (8,431.77)	-11,990.318 (8,158.97)	19,845.82	17,546.75	34,958.05
N	855	855		128	99	126

Notes: standard errors in parentheses. * 10% significance level; ** 5% significance level; *** 1% significance level.

Similar to the quantitative survey, the qualitative research found that although the most common income-generating activities were farming and livestock breeding, some respondents developed non-farm enterprises. These could be buying goods in bulk and reselling them on markets or transforming raw materials into a product as this woman relates: *“With the transfers that we have, we take some money to buy the flour and make cakes and sell them to have money. So that’s what we’re working with at the moment”* [Female FGD participant, Kossouka, Nord – treatment group]. However, some respondents felt that, due to the precarious security context as well as inflation, trade and commerce could not be successful:

In the context we’re in now, small-scale trading doesn’t work anymore. If you go to the market, while you can’t get 500 you have expenses of more than 500f to bear. And at the market, you still have to go ... and if in this context, small-scale trade doesn’t work, it becomes very complicated... that’s it!

[Female FGD participant, Kossouka, Nord – treatment group]

In the comparison group, the same challenges were mentioned, namely the absence of markets for commerce due to insecurity. However, in addition, they reported often lacking time and money to even attempt a small income-generating activity.

6.3 Summary of findings

Agricultural production:

At endline, the programme significantly improved ownership of agricultural inputs such as farm tools and land, but there were no significant impacts on total crop sales and investments in agricultural inputs. In qualitative interviews, beneficiaries recounted how they experienced an increase in agricultural production in recent years due to the cash transfers. Finally, both groups reported the influential role of climatic conditions on agricultural productivity. Indeed, inconsistent rainfall patterns and shocks such as drought and floods led to fluctuating crop yields, which negatively affected food security.

Livestock production:

There were positive impacts on the number of different livestock types owned and number of livestock purchased. However, there were no significant impacts on the probability of owning a livestock, size of the

livestock owned, and values of livestock purchased and sold. The qualitative study corroborated these findings, with numerous participants from the treatment group highlighting their ability to invest in cattle. Nevertheless, both treatment and control group respondents raised concerns about livestock diseases, and the challenges associated with feeding cattle, which are exacerbated by limited grazing land.

Non-farm enterprise:

The programme had no impacts on total asset sales last month from non-farm enterprises. There were negative impacts on assets purchased for businesses and monthly profits. Qualitative results found that some participants ventured into non-agricultural businesses. However, they felt that, due to the precarious security context, closed markets as well as inflation, trade and commerce had less chance of succeeding.

Programme impacts on children under 5 years old

7.1 Child health and healthcare seeking (0–59 months)

Child health indicators among children under 5 years old were collected in all three study rounds and cover both preventive health indicators, prevalence of common childhood illnesses (diarrhoea, fever, and cough) and healthcare-seeking behaviours for such illnesses. Impact estimation results are presented in Table 7.1. Nearly all children under 5 years old had a health certificate at the time of the endline, with no significant programme impacts on this indicator. Similarly high indicator values were observed for children born in a health facility (over 98 per cent) and children born with the assistance of qualified health personnel (over 97 per cent).

At midline, the programme had a significant impact on participation in an under-5 clinic of 33 percentage points, yet this impact was not sustained at endline. However, while the endline impact on the probability that a child was taken to a health facility was insignificant, the impact difference between the midline and endline was positive and significant, suggesting a significantly higher impact at midline for this indicator. There were no impacts on other preventive care indicators such as participation in a nutrition programme.

In terms of childhood illnesses, there is a significant increase in the prevalence of diarrhoea at both midline and endline, and a similar increase in the prevalence of coughs at midline. These impacts seem to be driven by an imbalance at baseline for these indicators, with much higher values among the comparison group and a subsequent reduction over time, while the prevalence for children in the treatment group decreased marginally over time.

Table 7.1: Programme impact on Child Health indicators (Panel households)

Dependent Variable	Endline Impact	Midline Impact	Impact Diff (Endline vs Midline)	Treated Mean Baseline	Treated Mean Endline	Comparison Mean Endline
	(1)	(2)	(3)=(1)-(2)	(4)	(5)	(6)
Child has health certificate	2.083 (1.88)	-0.133 (3.27)	2.217 (3.62)	94.83	99.18	97.99
N	6,685	6,685		838	641	1,065
Child participated in nutrition programme	3.531 (5.90)	9.871 (8.04)	-6.340 (6.72)	18.09	22.18	20.62
N	6,698	6,698		842	642	1,065
Child participated in under-5 clinic	13.140 (8.91)	33.810*** (8.00)	-20.670* (9.73)	12.73	22.09	16.68
N	6,698	6,698		842	642	1,065
Child born in health facility	-0.471 (0.64)	-1.228 (0.64)	0.758 (0.82)	98.14	98.46	98.86
N	6,698	6,698		842	642	1,065
Childbirth assisted with qualified personnel	0.608 (1.48)	-0.078 (2.51)	0.686 (1.30)	95.32	97.59	97.83
N	6,698	6,698		842	642	1,065
Child taken to a health facility in last 12 months	16.419 (9.82)	2.919 (11.26)	13.501** (5.36)	21.54	38.18	25.42
N	6,698	6,698		842	642	1,065
Diarrhoea last 2 weeks	4.444** (1.50)	8.271** (2.46)	-3.826 (2.31)	5.95	4.51	7.13
N	6,698	6,698		842	642	1,065
Child had cough in the last 2 weeks	4.041 (3.45)	8.216** (3.07)	-4.175 (3.11)	6.45	4.44	6.34
N	6,698	6,698		842	642	1,065
Child had fever in the 2 weeks	0.302 (4.32)	4.725 (3.69)	-4.423 (3.35)	13.38	5.14	9.44
N	6,698	6,698		842	642	1,065
Child was sick (diarrhoea/cough/fever)	3.525 (6.30)	10.703* (5.11)	-7.178 (5.49)	19.75	10.83	15.29
N	6,698	6,698		842	642	1,065

Notes: standard errors in parentheses. * 10% significance level; ** 5% significance level; *** 1% significance level.

In case children reported one of these three childhood illnesses, follow-up questions were asked to determine with kind of curative care was sought. Indicators for care-seeking behaviours were constructed based on the source, including public facility, private facility, pharmacy, traditional doctor or no advice/treatment. It must be noted that the number of observations for these indicators are relatively small, so caution needs to be exercised in their interpretation. For diarrhoea, there is a weak negative impact on seeking care at a private facility in combination with a significant impact difference between midline and endline of 4.4 percentage points. In terms of coughs, it was more likely to seek no treatment or advice with a significant endline impact of 22 percentage points, in line with a decrease in care seeking at public facilities of 19 percentage points. At midline, there was a significant and positive impact on seeking care at public facilities for coughs of 12 percentage points. There were no similar findings for care-seeking in case of fever except two weak negative impacts on seeking care at a pharmacy or traditional doctor at midline.

7.2 Vaccination

The vaccination module for children under 5 years was included in the baseline and endline survey, collecting information on the types and number of vaccinations the child had received. The official immunization schedule in Burkina Faso includes the following vaccines:⁹

- BCG at birth
- 4 doses of OPV (Birth, W8, W12 and W16) or 2 doses of IPV (W16, M9) (IPV not included in questionnaire)
- 3 doses of Penta (W8, W12 and W16)
- 3 doses of PCV (W8, W16 and M9)
- 3 doses of Rotavirus (W8, W12 and W16)
- 2 doses of measles (M9, M15) - Only one dose included in questionnaire

- 1 dose of yellow fever (M9) - Not included in questionnaire
- 2 doses of Meningococcal ACYW (M9, M15) - Not included in questionnaire

For children aged 12–23 months, the coverage for each of these vaccines was calculated as well as an indicator for having received all basic vaccinations (BCG, 3 doses of OPV, 3 doses of a vaccine against DTP (in this case a Pentavalent vaccine), and 1 dose of a measles-containing vaccine (Table 7.2)). The same indicators are calculated for the cohort of children aged 24–35 months old. Two additional indicators about receipt of vitamin A droplets (among children 6–59 months old) and micronutrient powder (children 6–23 months old) are also included in Table 7.2.

The impact findings show that the programme had no significant impact on vaccination coverage. Vaccination coverage is high and nearly universal for many of the vaccines, especially the first two doses. At endline, 76 per cent of children 12–23 months in the treatment group had received all basic vaccinations. There were also no impacts on the probability of receiving a vitamin A droplet or micronutrient powder. Similar results hold for children aged 24–35 months, with no impacts observed on vaccination coverage, yet a small and weak impact of 5 percentage points on vaccination card ownership.

Table 7.2: Impact on vaccination indicators for children aged 12–23 months old

Dependent Variable	Impact Estimate (1)	Treated Mean Baseline (2)	Comparison Mean Baseline (3)	Treated Mean Endline (4)	Comparison Mean Endline (5)
Vaccination card ownership	0.986 (3.84)	93.24	93.92	98.06	97.84
BCG	-6.218 (8.59)	98.57	92.67	97.00	96.86
Hepatitis B- birth dose	7.921 (19.92)	80.51	88.09	95.11	94.65
Polio 0	-2.832 (9.89)	96.56	91.00	98.29	94.74

Polio 1	-1.231 (11.09)	96.51	91.23	99.41	94.63
Polio 2	-5.011 (11.95)	93.11	90.37	93.35	94.63
Polio 3	-5.450 (13.24)	86.83	83.10	88.23	88.87
Penta 1	-4.341 (9.88)	95.64	90.51	97.88	96.43
Penta 2	-2.969 (11.18)	94.06	89.19	96.76	94.18
Penta 3	-3.650 (11.21)	90.14	84.94	91.87	89.76
Measles	-1.107 (12.38)	86.51	82.26	89.05	84.82
Received all basic vaccinations	10.182 (24.21)	64.07	71.39	76.03	72.79
Child did not receive any vaccination	4.615 (5.61)	0.96	5.48	0.00	0.45
Received at least 2 doses of Rotavirus	-10.058 (14.30)	91.57	83.19	88.51	89.28
Received 3 doses of PCV	-10.966 (13.13)	90.81	79.17	87.34	85.76
N	846	152	387	118	189
Received Vitamin A in last 6 months (children aged 6-59 months)	5.146 (10.03)	60.32	62.06	78.03	74.63
N	3,896	764	1,592	579	961
Received MNP last 7 days (children aged 6-23 months)	1.703 (7.23)	17.21	13.26	21.20	13.45
N	1,189	227	528	175	259

Notes: standard errors in parentheses. * 10% significance level; ** 5% significance level; *** 1% significance level.

7.3 Infant and Young Child Feeding

As for infant and young child feeding (IYCF) practices, indicators were constructed following the latest guidelines from the World Health Organization (WHO) and UNICEF.¹⁰ The information on IYCF was collected in all three survey waves and allows for the construction of 13 IYCF indicators, presented in Table 7.3 below. The rate of ever being breastfed among children under 24 months is nearly universal, with rates close to 100 per cent. There is a small significant impact difference on this indicator, suggesting that the impact at endline was significantly larger than the impact at midline, even though the overall impact at midline and endline were both not significant. As for exclusive breastfeeding for infants under six months, the programme had a significant (at the 10 per cent level) impact at endline of 34.6 percentage points. At endline, 77 per cent of children under 6 months in the treatment group were exclusively breastfed, compared to 60 per cent of children in the comparison group. At midline, there was a significant decrease in the rate of continued breastfeeding for children aged 12–23 months old, but this impact was not found by the time of the endline. The programme had a significant impact on the share of children aged 6–8 months old who were introduced to solid or semi-solid foods of 19 percentage points.

Next, seven indicators on the quality and quantity of the diet were constructed for children aged 6–23 months old. The programme had significant impacts on minimum dietary diversity (at midline only), a minimum acceptable diet (at midline only) and the consumption of flesh foods or eggs (at midline and endline). In contrast, there was also a programme impact on the consumption of unhealthy foods at midline, suggesting an increase in the intake of unhealthy food items. It must be noted however that despite these positive impacts, the average values of these indicators remain very low, with only 4.5 per cent of children aged 6–23 months in the treatment group meeting the requirements for a minimum acceptable diet at endline. This is particularly driven by a lack of diet diversity as only 8 per cent of children meet the requirements for a sufficiently diverse diet. The final indicator in this section relates to bottle feeding, and the programme had no impact on this indicator.

Table 7.3: Programme impacts on infant and young child feeding practices.

Dependent Variable	Endline Impact	Midline Impact	Impact Diff (Endline vs Midline)	Treated Mean Baseline	Treated Mean Endline	Comparison Mean Endline
	(1)	(2)	(3)=(1)-(2)	(4)	(5)	(6)
Ever breastfed (children under 24 months)	1.323 (0.94)	-1.319 (0.94)	2.642* (1.27)	97.77	99.16	98.84
N	2,406	2,406		305	238	363
Exclusive breastfeeding under 6 months	34.633* (14.99)	24.508 (15.34)	10.125 (8.40)	62.71	77.33	60.00
N	637	637		78	63	104
Mixed milk feeding under 6 months	-1.229 (2.19)	-2.000 (1.59)	0.771 (1.51)	1.18	1.09	1.52
N	637	637		78	63	104
Continued breastfeeding at 1 year (children aged 12-23 months)	6.163 (5.74)	-3.784* (1.73)	9.947 (6.69)	88.88	86.34	78.79
N	1,254	1,254		152	118	189
Introduction of solid, semi-solid or soft foods (children aged 6-8 months)	19.288* (8.01)	7.651 (7.91)	11.637* (4.84)	28.07	50.92	47.99
N	273	273		41	30	37
Minimum dietary diversity (children aged 6-23 months)	12.844 (7.65)	5.883*** (1.43)	6.961 (6.67)	1.26	8.14	3.73
N	1,777	1,777		227	175	259
Minimum meal frequency (aged 6-23 months)	6.141 (13.43)	9.199 (6.35)	-3.058 (10.20)	34.22	34.62	37.26
N	1,777	1,777		227	175	259
Minimum acceptable diet (aged 6-23 months)	10.314 (5.86)	4.667** (1.75)	5.647 (4.88)	0.00	4.57	1.90
N	1,777	1,777		227	175	259
Consumption of eggs and/or flesh foods (children aged 6-23 months)	22.341* (9.99)	16.475*** (1.59)	5.866 (9.88)	8.01	15.48	12.36

N	1,777	1,777		227	175	259
Sweet beverage consumption (children aged 6-23 months)	0.860 (5.58)	-0.321 (5.31)	1.180 (2.60)	3.51	14.95	14.50
N	1,777	1,777		227	175	259
Unhealthy food consumption (children aged 6-23 months)	20.270 (13.86)	13.378* (5.50)	6.892 (11.68)	13.81	27.42	25.57
N	1,777	1,777		227	175	259
Zero vegetable or fruit consumption (children aged 6-23 months)	-25.389 (18.44)	-9.012 (6.38)	-16.377 (14.99)	82.30	52.21	59.04
N	1,777	1,777		227	175	259
Bottle feeding (children under 24 months)	0.953 (6.10)	9.972 (15.81)	-9.019 (16.27)	23.16	23.79	18.26
N	2,414	2,414		305	238	363

Notes: standard errors in parentheses. * 10% significance level; ** 5% significance; *** 1% significance level.

7.4 Anthropometry and nutritional status

The impact evaluation included weight and height measurements for children under 5 years at baseline and endline. These weight and height measurements were converted to z-scores according to the WHO 2006 growth standards (WHO Multicentre Growth Reference Study Group and de Onis, 2006). In line with international definitions, indicators were constructed for stunting, wasting, and underweight (children with z-scores < 2 standard deviations below the reference median), as well as severe stunting, severe wasting, and severe underweight (children with z-scores < 3 standard deviations below the reference median). The programme impacts are presented in Table 7.4 below.

The programme had a significant impact on stunting and severe stunting with a reduction of 5.7 percentage points and 6.0 percentage points respectively. The programme also caused a weakly significant increase in the average weight-for-age z-score (WAZ) of 0.12 SD. Other nutritional indicators were not affected by the programme.

Disaggregation by sex shows that the impact on stunting is driven by girls, and the impact on severe stunting is driven by boys. The impact on WAZ is found only among boys.

Table 7.4: Programme impacts on nutritional status

Dependent	Impact	Treated Mean	Comparison Mean	Treated Mean	Comparison Mean
Variable	Estimate (1)	Baseline (2)	Baseline (3)	Endline (4)	Endline (5)
Length/height-for-age Z-score	0.136 (0.11)	-1.23	-1.17	-1.02	-1.14
Stunted (HAZ <-2 SD)	-5.688*** (1.22)	28.90	27.27	19.72	24.83
Severely Stunted (HAZ <-3 SD)	-5.989** (2.03)	10.91	9.14	6.06	10.84
N	3,615	706	1,425	562	922
Weight-for-age Z-score	0.123* (0.05)	-1.17	-1.06	-1.13	-1.16
Underweight (WAZ <-2 SD)	-3.755 (3.39)	21.55	17.77	21.10	21.08
Severely Underweight (WAZ <-3 SD)	-1.399 (2.17)	4.56	4.24	4.68	5.78
N	3,642	696	1,448	568	930
Weight-for-length/height Z-score	0.081 (0.05)	-0.66	-0.57	-0.78	-0.73
Wasted (WHZ <-2 SD)	-0.261 (2.99)	9.66	9.85	11.10	10.93
Severely Wasted (WHZ <-3 SD)	-0.776 (1.63)	2.28	2.61	2.04	2.89
N	3,593	690	1,411	563	929

Notes: standard errors in parentheses. * 10% significance level; ** 5% significance; *** 1% significance level.

7.5 Birth registration and early childhood development

This section reports impacts of the CSSPP on birth registration and activities associated with child development. Both baseline and endline surveys asked whether children under 5 years were registered at birth or whether their birth had been declared to the local authorities. There was no impact of the programme on birth registration rates. Similar proportions of children (around 77 per cent) were registered at baseline between the comparison and treatment group and, while there is an increase in the proportion of registered children at endline with a larger increase among comparison-group children (84 per cent in the treatment group and 95 per cent in the comparison group), the impact estimate is not significant.

The next set of indicators relate to home support for childhood development, proxied by six different activities that were collected both at baseline and endline: reading books to the child or looking at picture books with the child; telling stories to the child; singing songs to or with the child, including lullabies; taking the child outside the home, compound, yard or enclosure; playing with the child; and naming, counting, or drawing things to or with the child. The questions asked whether any household member older than 15 years of age engaged with the child in any of the mentioned activities during the three days preceding the interview, and if so, the survey asked to specify whether the activity was conducted by the mother, the father or another household member. The impact estimates presented in Table 7.5 show that the CSSPP had no significant impact on any of these child development indicators, and likewise, no significant impacts were found by gender.

Table 7.5: Programme impacts on birth registration and early childhood development activities

Dependent	Impact	Treated Mean	Comparison Mean	Treated Mean	Comparison Mean
Variable	Estimate (1)	Baseline (2)	Baseline (3)	Endline (4)	Endline (5)
Birth registered	-12.436 (9.79)	77.55	76.93	83.86	94.62
N	4,319	842	1,770	642	1,065
# of activities with at least an adult member of the household	0.382 (0.53)	2.87	2.88	3.49	3.23
N	4,319	842	1,770	642	1,065
4+ activities with an adult member of the household	9.237 (10.93)	35.00	34.34	50.45	43.55
N	4,319	842	1,770	642	1,065
# of activities with the mother (for children living with biological mother)	0.149 (0.57)	2.33	2.22	2.99	2.83
N	4,060	760	1,663	606	1,031
1+ activities with the mother	4.563 (10.53)	80.16	78.03	85.73	80.10
N	4,060	760	1,663	606	1,031
# of activities with the father (for children living with biological father)	-0.035 (0.31)	0.87	0.68	1.15	1.02
N	3,663	677	1,501	544	941
1+ activities with the father	-3.325 (11.92)	43.06	33.42	47.42	40.82
N	3,663	677	1,501	544	941

Notes: standard errors in parentheses. * 10% significance level; ** 5% significance; *** 1% significance level.

7.6 Child disciplinary practices

The baseline and endline survey asked about disciplinary practices in the last month for each child between 1 and 4 years. The list includes 12 disciplinary practices ranging from psychological measures (shouting, yelling at, or screaming; calling the child dumb, lazy or another name like that; or isolating the child for several hours or days), to physical punishment (shaking the child; spanking, hitting, or slapping the child on the bottom with bare hands; hitting the child on the bottom or elsewhere on the body with something like a belt, hairbrush, stick or other hard object; hitting or slapping the child on the face, head, or ears; hitting or slapping the child on the hand, arm, or leg; beating the child up, that is hitting over and over as hard as one could). Severe physical punishment includes two of these actions, namely hitting or slapping the child on the face, head, or ears and/or beating the child up as hard as one could. There are also three non-violent practices, which include: taking away privileges, forbidding something or not allowing the child to leave the house; explaining why the child's behaviour was wrong; or, giving the child something else to do.

The impact estimates in Table 7.6 show that the CSSPP had a significant impact on severe physical punishment and any violent discipline, with reductions of 14.6 percentage points and 10.9 percentage points respectively. Disaggregating by sex, the impact on any violent discipline seems driven by boys, while for girls, reductions are observed in terms of psychological aggression and severe physical punishment. It must be noted though that average levels of exposure to violent disciplinary measures are still alarmingly high, with over 50 per cent of the children in the treatment group exposed to violent practices at endline.

Table 7.6: Programme impact on child disciplinary practices

Dependent Variable	Impact Estimate (1)	Treated Mean (2)	Comparison Mean (3)	Treated Mean (4)	Comparison Mean (5)
Psychological aggression	-16.074 (8.37)	45.53	46.84	32.64	51.41
Physical punishment	-7.553 (6.13)	52.11	54.71	44.22	55.56
Severe physical punishment	-14.634* (7.44)	11.15	11.43	3.02	19.07
Any violent discipline	-10.920** (3.81)	64.22	66.32	52.23	65.98
Only non-violent discipline	7.104 (8.16)	20.39	24.58	21.27	18.83
N	3,568	694	1,466	520	888

Notes: standard errors in parentheses. * 10% significance level; ** 5% significance; *** 1% significance level.

Likewise, qualitative study respondents explained how their relationships with their children had altogether improved. More specifically, they said that the fact that they now had funds to pay for children’s school and health fees as well as to provide them with more and better meals helped improve the situation and relationship. Moreover, parents explained how they had benefited from the awareness-raising sessions on parenting and implementing the advice given had helped improve their relationships with their children: *“We give them the advice you gave us. Because you advised us so that we can advise our children. When they come to the house, we accompany them.”* [Female FGD participant, Dargo, Centre-Nord – treatment group]. On the other hand, respondents also explained how the children changed after participating in programme activities: *“The programme has also helped our children. We had children who were bandits but when they developed a programme for them, with advice, it made the children who were bandits soften up wallahi [in the name of God]. It helped us.”* [Female FGD participant, Dargo, Centre-Nord – treatment group].

The change that took place and the appreciation from respondents is well summarized by this key informant:

The feedback from households in relation to the training that their children receive gives us further comfort in the sense that there really are parents who recognize that there have been changes within the household in relation to certain children who didn't accept to play such and such a role, or who didn't listen, who weren't really attentive to their, well, their advice. On the parents' side, there was also the parenting skills module, which taught parents to be more aware of the different stages of a child's development. And here again, the feedback from parents is very positive, in that they tell us that in terms of knowledge transfer and supervision, they are much more aware of what they should be taught, depending on their age group, since the parenting skills themes are developed in terms of the child's stage of development. They're taught how to behave towards the child so that he doesn't get frustrated, so that he knows what you want him to learn at a given moment, so that he can really focus on what you want him to learn.

[National level key informant (implementing partner),
Ouagadougou].

Comparison-group respondents did not have as much positive feedback and said they still struggled to provide for their children and were not at ease due to the security situation which had an impact on their relationship: *"We can't have fun with the kids because our minds aren't at ease. Whether you're at home or on the road, you're worried."* [Female FGD participant, Safane, Boucle de Mouhoun – comparison group].

7.7 Summary of findings

The survey for the impact evaluation included several modules related to young child outcomes, including child health, vaccinations, feeding practices, anthropometry measurements, birth registration, early childhood development, and child discipline. Some of these modules were collected at all three waves (child health and feeding practices), while others were only collected at baseline and endline.

KEY FINDINGS IN THIS SECTION

Child health:

Increase in the prevalence of childhood illness, but likely driven by imbalances at baseline.

Health care utilization:

The programme resulted in a decrease in care seeking at a public facility for cough and increase in not seeking care for cough (though number of observations are low).

Vaccinations:

No programme impacts were found on the rate of vaccinations.

IYCF:

The programme had positive impacts on the rate of exclusive breastfeeding (<5 months), introduction of solid foods (6–8 months), and the consumption of eggs/flesh foods. Some midline impacts were not sustained at endline. Despite these positive impacts, still very few children meet dietary recommendations.

Anthropometrics:

The programme had a significant impact on stunting (-5.7 percentage points) and severe stunting (-6.0 percentage points) and positive impact on WAZ (0.12 SD).

Birth registration and child development:

No programme impacts.

Violent discipline:

The programme caused significant reductions in severe physical punishment and any violent discipline. Indeed, parents participating in the qualitative study explained how they had benefited from the awareness-raising sessions on parenting and implementing the advice given had helped improve their relationships with their children. However, the majority of children are still exposed to violent discipline.

Programme impacts on adolescents

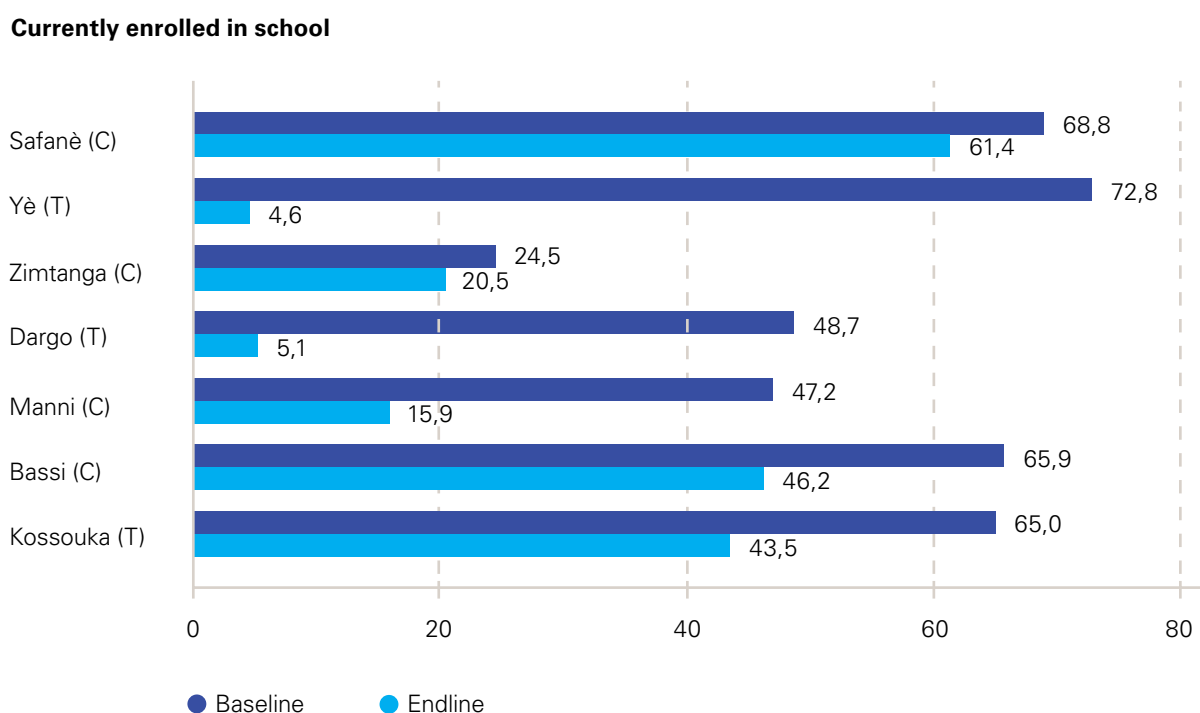
8.1 Education and schooling

The first sub-section presents findings on education and schooling outcomes. The key indicators include literacy, current school enrolment, and highest educational level attained. Table 8.1 provides the main impact estimates. There is no significant programme impact on levels of literacy. At endline about 56 per cent of adolescents in the treatment group were literate. There is a large and negative impact on current enrolment of more than 30 percentage points (significant at the 10 per cent level). At endline, only 15.5 per cent of adolescents in the treatment group were enrolled in school, compared to 32.4 per cent of adolescents in the comparison group. This finding merits some deeper explanation. It turns out that some study communes were more heavily affected by this drop in enrolment rates, as shown in Figure 8.1. Especially the treatment communes of Ye and Dargo noted some large decreases in school enrolment. These reductions in school enrolment are likely related to increasing security concerns around the time of the endline survey. In fact, UNICEF reported that at least 6,000 schools remained closed at the opening of the 2023–2024 academic year due to security concerns.¹¹ In order to check whether the impact was driven by the dropouts in both communes, we estimated the impacts excluding Ye and Dargo. The results show that the programme had no impact on current enrolment (see Table G.0), suggesting that the negative impact was more likely due to the reduced enrolment in Ye and Dargo.

This section reports the information as captured by the adolescent survey, yet some of these questions were also asked in the household survey, notably those on literacy and school enrolment. When considering the information from the household survey on the same age range of adolescents (10–19 years old), we observe positive

and significant impacts on literacy of about 10 percentage points at baseline. The negative impacts on school enrolment are of similar size (32 percentage points reduction among the full sample of adolescents 10–19 years), yet there are fewer significant impacts by gender and age subgroup compared to findings from the adolescent survey (Table G.1).

Figure 8.1: Adolescent school enrolment rates by study commune



Breaking down by age group and gender, the reduction in enrolment was most pronounced for older adolescent girls (-37.8 percentage points) although the average rate of enrolment for this group remains higher than boys of the same age. Younger girls were similarly affected with a reduction of 35 percentage points. The impact estimates are significant only at the 10 per cent level.

Table 8.1: Programme impacts on adolescent education indicators

Dependent Variable	Impact Estimate (1)	Treated Mean Baseline (2)	Comparison Mean Baseline (3)	Treated Mean Endline (4)	Comparison Mean Endline (5)
Able to read and write	-2.373 (4.61)	63.72	54.03	55.95	49.34
N	3,597	752	1,119	667	1,059
Currently enrolled in school	-30.476* (13.82)	63.91	50.32	15.51	32.37
N	3,597	752	1,119	667	1,059
If not enrolled, ever attended school	32.596*** (7.36)	31.89	29.29	71.09	34.46
N	2,046	281	525	537	703
Highest education: Attended some primary school	9.188 (13.06)	53.71	78.04	68.58	66.42
N	839	87	151	364	237
Highest education: Completed primary school	-9.964 (5.72)	24.77	7.48	15.54	13.49
N	839	87	151	364	237
Highest education: Secondary and above	0.420 (7.22)	20.70	12.83	15.87	19.74
N	839	87	151	364	237
Adolescent attends school full time	-6.977 (7.35)	90.48	91.21	77.00	84.98
N	1,547	471	593	129	354
Adolescent aged 10–14 enrolled in school	-32.152* (15.32)	69.92	56.47	17.37	34.65
N	2,178	488	704	392	594
Adolescent aged 15–19 enrolled in school	-26.811* (12.34)	52.67	40.13	12.78	29.33
N	1,419	264	415	275	465
Currently enrolled- Boys 10–14 years	-29.766* (13.79)	65.99	53.34	18.12	33.50
N	1,140	247	366	203	324
Currently enrolled- Girls 10–14 years	-35.121* (16.88)	74.04	59.81	16.59	36.03
N	1,038	241	338	189	270

Currently enrolled- Boys 15–19 years	-16.088 (12.06)	48.49	40.55	10.78	20.35
N	744	129	200	151	264
Currently enrolled- Girls 15–19 years	-37.835* (15.85)	56.65	39.76	15.25	41.25
N	675	135	215	124	201

Notes: standard errors in parentheses. * 10% significance level; ** 5% significance; *** 1% significance level.

Table G.0. Programme impacts on adolescent education indicators excluding Ye and Dargo communes

Dependent	Impact	Treated Mean	Comparison Mean	Treated Mean	Comparison Mean
Variable	Estimate (1)	Baseline (2)	Baseline (3)	Endline (4)	Endline (5)
Able to read and write	-7.934 (4.65)	61.68	53.03	63.14	49.30
N	3,022	570	1,137	255	1,060
Currently enrolled in school	-6.824 (6.20)	56.41	49.55	43.53	32.34
N	3,022	570	1,137	255	1,060
If not enrolled, ever attended school	8.462* (4.19)	31.84	28.74	50.00	34.42
N	1,624	237	539	144	704
Highest education: Attended some primary school	23.752* (10.87)	54.90	78.46	61.11	66.42
N	538	76	153	72	237
Highest education: Completed primary school	-9.472 (5.93)	21.75	7.33	22.22	13.49
N	538	76	153	72	237
Highest education: Secondary and above	-13.704 (7.12)	22.49	12.58	16.67	19.74
N	538	76	153	72	237
Adolescent attends school full time	-0.093 (3.90)	93.33	91.09	81.08	84.98
N	1,394	333	596	111	354

Adolescent aged 10–14 enrolled in school	-2.180 (5.65)	61.18	55.66	56.06	34.60
N	1,803	359	717	132	595
Adolescent aged 15–19 enrolled in school	-10.607 (7.70)	47.95	39.39	30.08	29.33
N	1,219	211	420	123	465
Currently enrolled- Boys 10–14 years	-1.562 (5.51)	63.75	52.74	58.82	33.41
N	933	168	372	68	325
Currently enrolled- Girls 10–14 years	-3.709 (7.32)	58.96	58.77	53.13	36.03
N	870	191	345	64	270
Currently enrolled- Boys 15–19 years	-6.836 (7.88)	43.61	39.61	20.00	20.35
N	651	109	203	75	264
Currently enrolled- Girls 15–19 years	-12.395 (11.31)	52.33	39.19	45.83	41.25
N	568	102	217	48	201

In the qualitative study, beneficiaries reported that the programme is positively associated with school attendance. In the treatment group, the positive impact of cash transfers on children’s education was frequently mentioned. According to this male respondent: *“Thanks to the transfers, the children go to school.”* [Male IDI participant, Dargo, Centre-Nord – treatment group] – thus underlining the extent to which cash transfers encourage school attendance. In addition, key informants from social services offered insights into the impact of cash transfers on the broader community. A communal-level informant noted how receiving support often used for children’s education was crucial for parents, *“It’s really at the level of education, at the level of children’s schooling. It’s a programme that has come to relieve [parents], it [schooling] is a real problem for parents.”* [Communal-level key informant, Ye, Boucle de Mouhoun].

Yet, among both groups, there was a consistent emphasis on the financial challenges associated with education. In the treatment group, cash transfers played a crucial role in covering essential expenses like

uniforms, soap, and school fees, alleviating some of these burdens. Despite the cash transfers, there were still significant challenges, as highlighted by this mother who explains that even with assistance, some families struggle to meet all their needs, especially in crisis situations. This quote also reflects on the closure of schools due to security threats:

At the start of the school year, classes had resumed, but with the terrorists' ultimatum to leave, there were no classes. In all honesty, it was those who could afford it who enrolled their children [...] sincerely, I have three children and I haven't been able to re-enrol any of my children. They stayed with me. And we pray to God that peace will return to [name of commune] and that school will resume. That's how it is.

[Female FGD participant, Dargo, Centre-Nord – treatment group]

Parents in both groups explained how financial difficulties in covering education expenses sometimes lead to children dropping out of school. Some parents explained how, if children were not supported, including with school material, uniforms and lunch money or food, they often dropped out and sometimes regretted it later. One respondent added how providing incentives for good academic performance helped keep them interested in schooling:

As far as the children's school is concerned, you can encourage a child to work hard, and if you succeed in passing his year, you'll give him something as a reward. If the child passes his exam, you must give him a reward. You can say you're going to buy him a suit or something if he does well at school, then you owe him something as a reward.

[Male FGD participant, Kossouka, Nord – treatment group]

Parents also discussed how discouragement due to poor academic performance led some students to seek alternative education paths or drop out. One distraction that led to school dropouts named by a few parents was gold mining:

There's more abandonment but it's the children who advise each other! The rest just follow in their footsteps. I have children who have had to tell me: "Dad, I don't want to go to school anymore!" I ask him, you're going to leave school and do what, he says he's going to look for gold. Gold mining is the main reason for school dropouts.

[Male FGD participant, Kossouka, Nord – treatment group]

The cumulative effect of cash transfers and awareness activities was shown to positively impact families' capacity to manage educational expenses and enhance children's well-being in crisis-affected areas. The benefit of awareness-raising activities was noted in the treatment group, particularly in how they influenced parental attitudes towards childcare and education. The importance of education and of enrolling children in school was mentioned by several respondents. More specifically, the importance of parental involvement in children's education was highlighted, explaining that without attention, the child's education may suffer. Parental monitoring and support of their children's education was underlined:

In my opinion, as far as school is concerned, if you enrol your child in school, you have to put the emphasis on follow-up. If you don't follow the child to see what he's doing, obviously he's going to drop out ... with follow-up you'll know whether the child is studying well or not ... because when you enrol a child in school it's for his future. ... because gold is an exhaustible resource whereas school is for the future. So, we really need to monitor this.

[Male FGD participant, Kossouka, Nord – treatment group]

Finally, the role of parents in making decisions about children's education was emphasized. A collaborative approach between mothers and fathers in educational decisions was suggested as stated by this male interviewee and father: *"That's what I said, it's the parents (mums and dads) who make this decision together"*. [Male IDI participant, Ye, Boucle de Mouhoun – treatment group]. Still, respondents also addressed the traditional roles of men and women in childcare, with women often taking primary responsibility: *"It's good but there's a bit missing because men don't look after the children. We look after our children"*. [Female IDI participant, Dargo, Centre-Nord – treatment group].

8.2 Economic activities, household chores, and child labour

In line with reductions in school enrolment, there is a subsequent increase in participation in certain economic activities. Adolescents were more likely to be engaged in livestock activities, helping in a non-farm household business and commerce activities in the week before the survey. Overall, the programme had a 26.5 percentage point impact on the likelihood of doing any economic activities in the past week (Table 8.2). Yet, there was no programme impact on the total number of hours engaged in economic activities, nor on the average earnings, except for a reduction in earnings among those who were engaged in any economic activities. The findings on livestock activities and any economic activities are similar for male and female adolescents. There are some differences in other types of economic activities, with impacts for females concentrated in commerce and non-farm businesses, while for males an increase is recorded in non-household work and begging (although this latter effect is driven by an imbalance at baseline rather than a true effect) (Table G.2 and G.3).

Table 8.2: Programme impacts on participation in economic activities during last 7 days

Dependent	Impact	Treated Mean	Comparison Mean	Treated Mean	Comparison Mean
Variable	Estimate (1)	Baseline (2)	Baseline (3)	Endline (4)	Endline (5)
Livestock activities	26.819* (12.74)	21.72	27.00	40.60	18.78
N	3,575	742	1,110	666	1,057
Household farm activities	5.822 (4.86)	2.05	7.75	5.32	5.19
N	3,586	750	1,116	662	1,058
HH non-farm business	2.767* (1.36)	2.02	3.91	3.99	3.06
N	3,577	741	1,110	667	1,059
Doing commerce	2.229* (1.13)	2.80	4.58	3.61	3.05
N	3,597	752	1,119	667	1,059
Domestic work outside household	0.722 (2.67)	7.90	8.38	4.50	4.02
N	3,597	752	1,119	667	1,059
Begging	0.907 (1.54)	2.11	3.14	0.25	0.34
N	3,597	752	1,119	667	1,059
Non-household work	1.839 (1.04)	6.82	6.72	5.52	3.62
N	3,597	752	1,119	667	1,059
Any economic activities	26.500** (10.73)	32.78	40.03	46.77	27.11
N	3,597	752	1,119	667	1,059
# hours doing economic activities	-4.665 (4.73)	8.81	12.18	12.02	20.59
N	1,304	246	441	310	307
# hours doing economic activities (all adolescents)	1.915 (3.07)	2.89	4.88	5.62	5.58
N	3,597	752	1,119	667	1,059
Tot. estimated earnings in the last 7 days (for those who worked)	-1,638.186* (670.32)	1,622.00	2,060.08	1,839.16	4,086.17
N	1,290	240	433	310	307

Tot. estimated earnings in the last 7 days (for all adolescents)	58.845 (489.17)	518.14	807.60	860.18	1,107.80
N	3,597	752	1,119	667	1,059

Notes: standard errors in parentheses. * 10% significance level; ** 5% significance; *** 1% significance level.

As for household chores, the CSSPP had no impact on the participation in chores (Table 8.3) but there was a significant impact on the hours spent caring, cleaning, and cooking, with adolescents in the treatment group spending less time on this activity. Disaggregating by gender and age, this seems to be driven by older adolescent girls, with a significant reduction of about 10 hours per week on household chores (Table G.4).

Table 8.3: Programme impacts on participation in chores in the last 7 days

Dependent Variable	Impact Estimate (1)	Treated Mean Baseline (2)	Comparison Mean Baseline (3)	Treated Mean Endline (4)	Comparison Mean Endline (5)
Collected water/firewood	1.624 (14.76)	62.95	64.04	46.79	45.02
N	3,597	752	1,119	667	1,059
Cared for other household members	-2.605 (5.86)	18.29	16.18	7.91	7.51
N	3,597	752	1,119	667	1,059
Spent time caring, cleaning, cooking	9.594 (9.99)	40.78	50.64	35.13	33.52
N	3,597	752	1,119	667	1,059
Spent time playing	-2.969 (10.51)	51.00	43.54	25.94	22.24
N	3,597	752	1,119	667	1,059
Spent time during homework	-13.363 (12.07)	45.00	39.50	8.63	16.46
N	3,449	735	1,056	644	1,014

Notes: standard errors in parentheses. * 10% significance level; ** 5% significance; *** 1% significance level.

Next, four child labour indicators are constructed using the adolescent data. Long hours in economic activities are determined by the age of the adolescent: adolescents 10–11 years old who did at least one hour of economic activity, adolescents 12–14 years old who did at least 14 hours of economic activity and for adolescents 15–17 years old, at least 43 hours of economic activity in the week prior to the survey. Long hours doing chores are also defined by age group: for those aged 14 years or less, at least 28 hours of chores, and for those aged 15–17 years, at least 43 hours of chores during the week before the survey. The third indicator combines these first two and measures whether adolescents were engaged in long hours in either economic activities or chores. Finally, an indicator was constructed on whether an adolescent was exposed to hazards while doing economic activities, based on a list of 12 different types of hazards that were including in the questionnaire. The results in Table 8.4 show that the programme had no impact on any of these four indicators, suggesting that the programme did not reduce, but also not increase the engagement of adolescents in these forms of child labour. There were also no programme impacts disaggregated by gender except a weak effect on reducing long hours in chores among male adolescents (-2.8 percentage points, significant at 10 per cent level) (Tables G.5 and G.6).

Table 8.4: Programme impacts on child labour indicators (adolescents 10–17 years)

Dependent Variable	Impact Estimate (1)	Treated Mean Baseline (2)	Comparison Mean Baseline (3)	Treated Mean Endline (4)	Comparison Mean Endline (5)
Long hours in economic activities past week	11.572 (8.64)	9.36	17.02	15.02	10.19
Long hours in chores past week	-4.572 (2.73)	4.13	4.01	2.11	6.21
Long hours in economic activities or chores past week	6.710 (9.26)	12.84	19.50	16.65	15.46
Exposed to hazards while doing economic activities past week	11.180 (8.24)	19.77	26.77	21.17	16.75
N	3,230	690	1,014	599	927

Notes: standard errors in parentheses. * 10% significance level; ** 5% significance; *** 1% significance level.

8.3 Subjective well-being and mental health

The next sub-section reports on subjective well-being indicators and mental health outcomes. The adolescent questionnaire included a direct question to ask if adolescents felt happy overall on a four-point scale (very happy, happy, not so happy, or not happy at all), which was dichotomized into being (very) happy or not. Table 8.5 reports the impact estimates for this indicator. Even though all estimates are positive, none of them reach statistical significance, suggesting that the CSSPP had no impact on adolescent self-reported happiness.

In addition to the general happiness question, two survey instruments were included to measure mental health: The Enhanced Life Distress Inventory (ELDI) and the 10-item short-form of the Center for Epidemiological Studies-Depression (CES-D) scale. The ELDI was developed to better measure outcomes related to stress in a context with low levels of education in sub-Saharan Africa (Palermo, Hall, and Cirillo, 2020). The scale includes 12 items and asks respondents to report whether they worried about any of the 12 items in the scale during the past 7 days, and if so, how distressed they felt (ranked from 1 to 3).¹² The answers to the individual items are summed up, resulting in a scale ranging from 0 to 36, with higher values indicating higher levels of distress. A binary indicator is constructed indicating whether an adolescent had no stress or worries on any of the items (i.e., the total score on the scale is zero).

The CES-D is a survey instrument collecting information on the depressive feelings and behaviours of respondents during the previous seven days, with answers recorded on a four-point scale, and internationally validated on similar groups of African adolescents (Kilburn et al., 2018). The scale yields a total score ranging from 0 to 30, with higher levels indicating more depressive symptoms, and a cut-off of 10 is generally used to construct a binary indicator to determine if a respondent presents depressive symptoms.

The estimates for these mental health outcomes are also presented in Table 8.5 below but show that the CSSPP had no significant impact on mental health outcomes.

Table 8.5: Programme impacts on adolescent subjective well-being and mental health

Dependent	Impact	Treated Mean	Comparison Mean	Treated Mean	Comparison Mean
Variable	Estimate (1)	Baseline (2)	Baseline (3)	Endline (4)	Endline (5)
Adolescents report being happy	18.129 (11.62)	86.95	82.20	96.52	73.79
N	3,587	749	1,115	664	1,059
Enhanced Life Distress Index (0-36)	1.276 (1.34)	4.29	6.36	3.13	3.80
N	2,249	451	670	421	707
Adolescents do not have any stress	-6.427 (7.52)	32.07	23.09	43.06	42.17
N	2,249	451	670	421	707
Depression index (CESD)	-1.000 (1.41)	7.12	7.88	5.76	7.46
N	2,004	390	579	357	678
Adolescent reports depressive symptoms (CESD>9)	-4.330 (7.11)	22.32	31.60	11.70	24.91
N	2,004	390	579	357	678

Notes: standard errors in parentheses. * 10% significance level; ** 5% significance; *** 1% significance level.

8.4 Sexual behaviour

Previous research on cash transfer programmes has shown potential to contribute to safe transitions to adulthood, by alleviating economic stress in the household, facilitating school attendance, and reducing risky behaviours among adolescents. The CSSPP included complementary services targeted to adolescents in the form of life skills sessions. As such, the programme has the potential to contribute to safe transitions during adolescence.¹³

For adolescents aged 15–19 years old, a questionnaire module was included about their sexual behaviours and sexual risks. The sample sizes for these outcomes are sometimes small, so caution is warranted for the interpretation of these findings.

About one quarter of adolescents in the treatment group at endline had ever had a spouse or cohabiting partner, and around 22 per cent currently had a romantic partner. The CSSPP had no significant impact on these indicators. In terms of sexual debut, about 20 per cent of adolescents in the treatment group had ever had sex by the time of the endline survey. The impact estimate was not significant for the full sample of male and female adolescents, but there is a positive impact estimate of 19 percentage points among female adolescents. When limiting the sample to those adolescents that never had sex by baseline, and so only considering sexual debut between the baseline and endline survey, there is significant reduction in sexual debut among the combined sample of boys and girls of 8.6 percentage points, which seems driven by the sub-sample of boys (-8.8 percentage points). However, the sample restrictions for this analysis results in a relatively low number of observations (N=109 for the combined sample of boys and girls).

As for condom use and contraception, there were also no impacts on the full sample of adolescents, but significant impacts indicating a reduction in the use of condoms for male adolescents of 33 percentage points (Table G.11). In addition, the CSSPP had a negative impact on knowledge about condoms as a contraceptive method of 22 percentage points. This effect seemed to be driven by female adolescents, with a negative effect of 29.7 percentage points, while

the impact estimate for male adolescents was not significant (Table G.11). This effect also seems to be driven by an increase in the comparison group, where the indicator value increased from 31.5 per cent at baseline to 54.1 per cent at endline, while the indicator value for the treatment group remained similar between the two survey waves (Table 8.6).

Table 8.6: Programme impacts on adolescent sexual behaviour (15–19 years old)

Dependent	Impact	Treated Mean	Comparison Mean	Treated Mean	Comparison Mean
Variable	Estimate (1)	Baseline (2)	Baseline (3)	Endline (4)	Endline (5)
Ever had spouse/cohabiting partner	15.210 (7.97)	19.99	30.82	26.77	21.43
N	1,273	257	399	232	385
Has a girlfriend or boyfriend	9.119 (6.99)	13.75	18.69	21.96	16.64
N	1,273	257	399	232	385
Ever had sex	11.341 (7.14)	13.71	22.15	19.76	16.14
N	1,285	258	405	234	388
Condom use during last sexual intercourse	-21.292 (13.25)	38.39	30.84	35.44	48.02
N	228	34	86	46	62
Use of contraception with current partner	-9.300 (14.67)	32.12	31.08	49.57	48.35
N	208	35	79	36	58
Knowledge of condom as contraceptive method	-22.156** (7.79)	40.42	31.57	38.92	54.13
N	1,327	264	415	243	405

Notes: standard errors in parentheses. * 10% significance level; ** 5% significance; *** 1% significance level.

As for risky sexual behaviours, the survey asked about whether the adolescent ever received money in exchange for sex, or gave money in exchange for sex, and whether this happened in the 12 months before the survey. The survey also asked if the adolescent ever received money from the current partner. The impact estimates, shown in Table 8.7, show that there were no programme impacts on these indicators of risky sexual behaviours.

The final set of indicators in this sub-section are pregnancy-related outcomes for female adolescents. There is a weakly significant impact on the share of female adolescents that were ever pregnant of 7.0 percentage points. On average, about 10.6 per cent of female adolescents had ever been pregnant by the time of the endline survey and three per cent were pregnant at the time of the endline. There is also a positive programme impact of 6.1 percentage points on ever having a life birth. When only considering those female adolescents that were never pregnant during baseline (N=35), there is no programme impact on ever being pregnant or currently being pregnant.

Table 8.7: Programme impacts on risky sexual behaviours and pregnancy outcomes

Dependent Variable	Impact Estimate (1)	Treated Mean Baseline (2)	Comparison Mean Baseline (3)	Treated Mean Endline (4)	Comparison Mean Endline (5)
Received money in exchange for sex in last 12 months	10.703 (6.15)	12.49	8.39	18.96	0.00
N	235	36	90	47	62
Gave money in exchange for sex in last 12 months	7.461 (12.94)	10.02	18.05	10.53	10.16
N	232	36	86	47	63
Ever received money in exchange for sex	7.774 (4.14)	5.43	8.36	12.65	0.00
N	233	35	88	47	63
Ever received money from current partner	17.534 (16.78)	34.85	40.70	55.13	28.62
N	233	35	90	47	61
Ever pregnant	7.049* (2.90)	12.80	14.02	10.57	4.77
N	614	132	210	104	168
Currently pregnant	2.171 (1.83)	2.79	4.36	3.28	2.06
N	614	132	210	104	168
Ever had a miscarriage/abortion/stillbirth	-1.902 (2.99)	4.16	1.57	0.00	0.00
N	614	132	210	104	168
Ever had a live birth	6.080** (2.25)	8.97	10.07	7.29	2.71
N	614	132	210	104	168

Notes: standard errors in parentheses. * 10% significance level; ** 5% significance; *** 1% significance level.

8.5 Adverse events and violence

This section presents the findings on indicators related to adverse life events and the experience of violence. Adverse life events include for example the death of a parent or the separation of parents, the presence of a household member with a drinking problem or mental health problem, and similar circumstances. Except for a positive impact on the share of adolescents with at least one deceased parent or guardian of 3.5 percentage points, there are no programme impacts on any of the adverse life events included in the survey.

The survey also asked whether the adolescent experienced any psychological violence from peers or household members, and whether the adolescent witnessed physical or psychological violence in the household. There is a substantial reduction in the share of adolescents that suffered from psychological violence from peers between the two survey waves, from between 13.5–16.5 per cent at baseline to about four per cent at endline. A lot more adolescents suffered from psychological violence in their household, between 28–35 per cent at endline. The CSSPP had no impact on these indicators of psychological abuse, as trends were similar in the treatment and comparison group (Table 8.8).

Just over 18 per cent of adolescents in the treatment group had witnessed physical violence in their household and a higher share (29 per cent) had witnessed psychological violence. There were also no programme impacts on these indicators of witnessing violence.

Table 8.8: Programme impacts on violence

Dependent Variable	Impact Estimate (1)	Treated Mean (2)	Comparison Mean (3)	Treated Mean (4)	Comparison Mean (5)
Adolescents suffering psychological violence from peers	3.162 (3.08)	13.52	16.57	4.48	4.33
N	3,553	744	1,101	665	1,043
Adolescents suffering psychological violence in household	0.625 (12.93)	44.49	38.30	34.83	27.75
N	3,565	743	1,102	666	1,054
Adolescents witnessing physical violence in HH	-0.079 (5.07)	21.68	28.33	18.25	24.23
N	3,581	747	1,112	666	1,056
Adolescents witnessing psychological violence in household	4.907 (9.96)	28.58	34.27	29.58	29.46
N	3,573	741	1,109	667	1,056

Notes: standard errors in parentheses. * 10% significance level; ** 5% significance; *** 1% significance level.

The survey continued to ask about whether the adolescent (or any of the household members) had been the victim of several forms of violence in the 12 months before the survey, as well as how they perceived the change in risk to become a victim of violence. These questions were motivated by the expectation that the CSSPP could contribute to feelings of safety, security, and social cohesion in the community. The impact results show that the CSSPP had no impact on the victimization on five different types of violence (physical violence, psychological violence, forced work, road accidents, and theft). However, there is a significant programme impact on the share of adolescents that are believed to be at a higher risk for road accidents and theft, each of about 11 percentage points.

Table 8.9: Programme impacts on adolescent victimization (last 12 months)

Dependent Variable	Impact Estimate (1)	Treated Mean Baseline (2)	Comparison Mean Baseline (3)	Treated Mean Endline (4)	Comparison Mean Endline (5)
Victim of physical violence	5.294 (3.53)	7.88	9.94	3.27	1.14
N	3,940	1,100	1,125	667	1,048
Victim of psychological violence	6.437 (5.33)	20.09	18.74	12.96	5.78
N	3,950	1,100	1,129	669	1,052
Victim of forced work	0.808 (2.80)	5.98	7.13	1.36	1.73
N	3,919	1,098	1,125	665	1,031
Victim of a road accident	-0.158 (0.72)	3.31	2.67	0.68	0.59
N	3,939	1,096	1,126	667	1,050
Victim of theft	3.056 (1.83)	4.03	7.15	1.19	1.42
N	3,938	1,099	1,125	667	1,047
Ever a victim of theft, robbery or destruction of property	3.733 (2.90)	7.81	14.41	3.89	6.99
N	3,829	1,067	1,101	658	1,003

Notes: standard errors in parentheses. * 10% significance level; ** 5% significance; *** 1% significance level.

8.6 Summary of findings

The impact evaluation included an adolescent survey, administered to one randomly selected adolescent aged 10–19 years old in each household at baseline and endline. This chapter presents the impact findings on several topics including education, work, mental health, sexual behaviour, and aspirations.

KEY FINDINGS IN THIS SECTION

Education:

negative impact on current enrolment (-30.5 percentage points), with strongest reductions among girls 15–19 years old. These impacts are mainly driven by treatment communes in Ye and Dargo and are likely due to security issues which cause schools to remain closed at the beginning of the latest school year. Treatment group qualitative study respondents explained that school attendance had increased thanks to the cash transfers. Among both groups, financial challenges were mentioned although cash transfers played a crucial role in covering essential expenses like uniforms, soap, and school fees, alleviating some of these burdens in the treatment group.

Economic activities:

CSSPP resulted in an increase in time spent on livestock activities, doing commerce and non-household work. There is an increase of 26.5 percentage points on doing any economic activities. However, this increase was not complemented by

any increases in exposure to work-related hazards, nor increases in indicators for child labour.

Chores:

A reduction in the hours spent caring, cleaning and cooking, yet participation in other chores was not affected by the programme. The reduction in hours was driven by impacts on adolescent girls.

Sexual behaviour and risks:

Findings show a decrease in knowledge of condoms as contraceptive (among both boys and girls), an increase in ever had sex (girls), and an increase in ever being pregnant.

Mental health, adverse events and violence:

No strong and consistent programme impacts were found on indicators related to mental well-being, adverse events, and violence.

Programme impacts on caregivers and gender dynamics

9.1 Nutrition knowledge and practices

Table 9.1 presents the results on the impacts of programme on the caregiver's knowledge on nutrition and child feeding practices. Very few indicators were positively affected by the programme both at midline and endline. At endline, the estimates show that the programme increases the proportion of caregivers in the treatment group who know that babies should exclusively be breastfed until 6 months of age by 10.99 percentage points more than those in the comparison group. Significant improvements have also been found regarding child feeding practices, where the share of caregivers who think that babies between 6–8 months that are still breastfed should eat 2–3 meals per day increased by 18.38 percentage points. Both indicators were not significant at midline, suggesting the programme improved its effectiveness at endline compared to midline in this respect. On the other hand, at midline, the programme increased the proportion of caregivers who thought that babies between 9–11 months of age that are still being breastfed should eat 3–4 meals per day by 22.01 percentage points and those that knew salt is often fortified with iodine by 20.98 percentage points. However, these positive programme impacts at midline were not sustained to endline. The study finds no statistically significant impacts of the programme on the other indicators.

Table 9.1: Programme impact on nutrition knowledge and practices

Dependent Variable	Endline Impact	Midline Impact	Impact Diff (Endline vs Midline)	Treated Mean Baseline	Treated Mean Endline	Comparison Mean Endline
	(1)	(2)	(3)=(1)-(2)	(4)	(5)	(6)
Baby should be breastfed immediately after birth	-1.531 (4.79)	-0.777 (3.03)	-0.754 (3.76)	93.02	96.61	96.97
N	6,513	6,513		850	894	1,342
Mother should give colostrum to baby soon after birth	2.531 (4.51)	6.907 (4.48)	-4.375 (3.78)	88.79	93.67	96.64
N	6,507	6,507		849	893	1,342
Baby should be exclusively breastfed until 6 months age	10.992* (4.62)	7.211 (5.28)	3.781 (7.45)	75.68	90.42	86.28
N	6,510	6,510		846	893	1,340
Baby should start receiving liquids (including water) at 6 months age	7.369 (4.47)	9.864 (9.35)	-2.495 (8.87)	72.56	73.10	76.55
N	6,504	6,504		839	894	1,341
Baby should start receiving food (such as porridge) at 6 months age	-6.482 (12.45)	3.588 (7.11)	-10.070 (14.94)	51.66	48.97	68.90
N	6,518	6,518		843	893	1,340
1-year old child should not eat alone without adult supervision	6.983 (13.09)	12.250 (11.14)	-5.267 (9.96)	78.31	81.72	78.47
N	6,517	6,517		838	895	1,345
Baby between 6–8 months that is still breastfeeding should eat 2–3 meals per day	18.377** (7.34)	15.005 (14.85)	3.372 (15.62)	58.76	68.32	55.87
N	6,547	6,547		854	895	1,345
Baby between 9–11 months that is still breastfeeding should eat 3–4 meals per da	15.417 (11.17)	22.010* (9.05)	-6.593 (14.40)	54.41	64.60	60.49
N	6,547	6,547		854	895	1,345

Infant between 12–24 months that is still breastfeeding should eat 3–6 meals per	-0.323 (5.52)	6.213 (5.30)	-6.535 (6.55)	85.55	88.57	92.61
N	6,547	6,547		854	895	1,345
Child should be fed more than usual when sick	4.558 (7.17)	-3.156 (9.90)	7.713 (4.78)	11.94	8.03	11.60
N	6,487	6,487		843	888	1,335
Child should be fed more frequently (more meals per day) than usual when sick	3.102 (6.03)	-9.328 (6.59)	12.430*** (3.01)	15.40	9.94	13.03
N	6,493	6,493		844	885	1,339
Salt is often fortified with iodine	15.597 (10.15)	20.983* (10.51)	-5.386 (5.08)	76.80	99.47	99.12
N	4,316	4,316		413	764	1,174
Can tell what could happen if children do not get enough iron	-5.019 (5.96)	-11.951 (10.58)	6.932 (7.32)	77.95	94.77	92.74
N	6,547	6,547		854	895	1,345
Can identify foods that are rich in iron	1.841 (7.53)	-8.716 (10.59)	10.556 (8.37)	74.57	96.89	93.99
N	6,547	6,547		854	895	1,345
Can tell what could happen if children do not get enough vitamin A rich foods	-4.535 (7.69)	-4.513 (7.10)	-0.022 (5.33)	73.08	95.85	94.50
N	6,547	6,547		854	895	1,345
Can identify foods that contain vitamin A	-4.681 (7.98)	-7.184 (9.22)	2.503 (10.46)	76.55	96.26	93.93
N	6,547	6,547		854	895	1,345
Can identify foods a mother could make to complement breastfeeding	-1.847 (3.64)	-2.209 (2.65)	0.362 (4.12)	97.60	99.15	94.00
N	6,547	6,547		854	895	1,345

Notes: standard errors in parentheses. * 10% significance level; ** 5% significance level; *** 1% significance level.

Qualitative endline results were positive for programme beneficiaries in terms of nutritional practices. The treatment group showed signs of improvement in their ability to provide better nutrition for their families and children, thanks to the cash transfers and/or the awareness-raising activities. Others said there was a general improvement in children's nutrition due to better food practices learned from the programme sessions: *"There's been an improvement in children's diets because we've managed to put into practice the training courses on children's diets. Since we have been following this advice, there has been an improvement."* [Female IDI participant, Ye, Boucle de Mouhoun – treatment group].

Treatment group respondents also pointed out improvements in children's health and reduced illness due to better nutrition as explained by this interviewee: *"Their health has improved, even if you look at their shiny skins now thanks to the improvement in their food. Before they didn't eat well and there wasn't enough food for them, but now there's a change and they don't fall ill frequently."* [Male IDI participant, Dargo, Centre-Nord – treatment group]. Some, however, said they still found it challenging to provide nutritious food, even though the cash received contributed to doing so.

In contrast, the comparison group did not report improved knowledge or practices and continued to face challenges in securing nutritious food for their families, largely due to financial constraints and limited resources: *"There has been no improvement. They don't even eat the rich food the body needs. If you can't afford it, you can't have vitamin-rich food for your child so that he'll be happy and grow up well."* [Female FGD participant, Safane, Boucle de Mouhoun – comparison group].

9.2 Gendered impacts on time use

Data were collected on who normally collects water, firewood, cares for children at home, cooks or cleans and cares for elderly or ill members of the household. Responses could be “myself”, “spouse”, “other woman(s)”, “other man(s)”, “boys”, “girls” or “responsibility of all members”, which were recoded as respondent herself, other women, other men, or shared for the analysis. Impact evaluation results show very limited effects of the programme on gendered division of labour (Table 9.2 to Table 9.5). The only significant effect related to caring of the elderly and sick where the programme weakly increased the probability of caring for the elderly and sick by other women by 7.56 percentage points in treatment households relative to comparison households.

Table 9.2: Programme impact on water collection practices

Dependent	Impact	Treated Mean	Comparison Mean	Treated Mean	Comparison Mean
Variable	Estimate (1)	Midline (2)	Midline (3)	Endline (4)	Endline (5)
Respondent herself usually collects water	-1.513 (15.68)	47.19	43.74	41.94	40.06
Other women usually collect water	-1.566 (6.14)	21.12	14.38	30.19	25.01
Other men usually collect water	-0.281 (0.82)	2.28	1.58	2.73	2.31
Water collection is a shared task	3.361 (16.61)	29.41	40.30	25.14	32.62
N	4,472	891	1,342	894	1,345

Notes: standard errors in parentheses. * 10% significance level; ** 5% significance level; *** 1% significance level.

Table 9.3: Impacts on wood collection practices

Dependent	Impact	Treated Mean	Comparison Mean	Treated Mean	Comparison Mean
Variable	Estimate (1)	Midline (2)	Midline (3)	Endline (4)	Endline (5)
Respondent herself usually collects wood	-4.923 (14.88)	53.54	45.55	45.30	42.40
Other women usually collect wood	-2.764 (7.37)	17.65	12.57	24.02	21.56
Other men usually collect wood	1.073 (2.64)	2.57	6.28	3.28	6.07
Wood collection is a shared task	6.614 (16.72)	26.23	35.59	27.40	29.98
N	4,308	885	1,217	886	1,320

Notes: standard errors in parentheses. * 10% significance level; ** 5% significance level; *** 1% significance level

Table 9.4: Impacts on childcare practices

Dependent	Impact	Treated Mean	Comparison Mean	Treated Mean	Comparison Mean
Variable	Estimate (1)	Midline (2)	Midline (3)	Endline (4)	Endline (5)
Respondent herself usually cares for children, cook, and cleans	-0.759 (15.68)	59.81	59.78	54.74	55.64
Other women usually care for children, cook, and clean	3.305 (4.22)	16.42	13.16	24.26	17.67
Other men usually care for children, cook, and clean	-1.392 (0.86)	1.30	0.88	1.12	2.10
Childcare, cooking, and cleaning is a shared task	-1.153 (15.30)	22.47	26.18	19.87	24.59
N	4,443	880	1,333	890	1,340

Notes: standard errors in parentheses. * 10% significance level; ** 5% significance level; *** 1% significance level

Table 9.5: Impacts on elder care practices

Dependent Variable	Impact Estimate (1)	Treated Mean (2)	Comparison Mean (3)	Treated Mean (4)	Comparison Mean (5)
Respondent herself usually cares for the elderly and sick	-7.246 (19.56)	55.72	49.79	52.90	52.05
Other women usually care for the elderly and sick	7.564* (3.68)	8.44	14.02	7.55	6.31
Other men usually care for the elderly and sick	-7.390 (11.29)	16.30	11.25	16.46	19.62
Sick and eldercare is a shared task	7.072 (20.77)	19.54	24.94	23.08	22.02
N	3,224	678	898	679	969

Notes: standard errors in parentheses. * 10% significance level; ** 5% significance level; *** 1% significance level

Based on the qualitative findings, the treatment group reported better time availability and increased involvement in community and family activities, whereas the comparison group faced challenges due to heavy workloads and insecurity, limiting their time for social and familial engagements. Many treatment group respondents emphasized having enough time to attend social events and participate in community activities, highlighting the importance of being present for others. They also explained how they had more time to look after their children as illustrated by this FGD participant:

We have time to look after our children. Children are with us in the home. When a child goes to school and it's time to come home and we don't see them, we're going to find out why they haven't come home yet. So, we have time to look after our children. Because of this, the children also do the right thing, they no longer sleep outside the house. We give them tasks and they do them. At this level we have the time to take care of our children.

[Male FGD participant, Dargo, Centre-Nord – treatment group]

One beneficiary respondent explained how they did have time available, but they lacked resources for income-generating activity as shown in this example from Kassouka: *“We have time, it’s the water we often miss. If we had more access to water, we could plant vegetables and sell them. We have time to do all that.”* [Female FGD participant, Kassouka, Nord – treatment group]. Similarly, some comparison group respondents also mentioned having a lot of time but lacking resources such as cash to invest, land, water or fertilizers.

Comparison group respondents were more likely to express challenges in finding time for children due to heavy workloads and agricultural commitments. A few said they weren’t accustomed to spending quality time with their children as it wasn’t part of their habits and culture: *“To think that you’re going to sit down with your children and talk to them and exchange ideas here, we’re not used to that, we’re not used to that.”* [Male IDI participant, Safane, Boucle de Mouhoun – comparison group].

Some also highlighted the negative impact of insecurity on their ability to manage time effectively, leading to reduced participation in social events and increased stress. They explained how insecurity meant they were too preoccupied to spend carefree quality time with their children.

Respondent 7: *We don’t have the peace of mind to take care of the children.*

Respondent 4: *We can’t have fun with the kids because we don’t have peace of mind. Whether you’re at home or on the road, you’re worried.*

[Female FGD participants, Safane, Boucle de Mouhoun – comparison group].

9.3 Decision-making and empowerment

The evaluation also included the impacts of the programme on a range of women's decision-making, empowerment, agency, and gender-related norms. However, these modules were introduced at midline, hence baseline data are not available to compare programme impacts between midline and endline.

Table 9.6 presents women's decision-making roles regarding key issues related to the household, children and herself. We generated binary indicators for each decision-making item based on the question "When decisions are made regarding the following aspects of household life, who normally makes the decision?" Before analysis, the responses were recoded, and binary indicators were generated based on the rescaled response to show full autonomy in decision making. Accordingly, those women who make decisions on the respective issue alone are coded as 1 and those who either make the decisions together with another member or other household members make the decision are coded as 0.

Results in Table 9.6 show that the programme is associated with reduced probability of women making autonomous decisions related to agricultural production, child healthcare, and child schooling. The estimates show that the programme reduced the probability of full autonomy in decision-making of women in treatment households on agricultural production, child healthcare, and child schooling by 15.21, 15.27, and 14.43 percentage points respectively compared to their peers in comparison households. Looking at the average changes in these indicators between midline and endline, contrary to the treatment households, women in comparison households experienced positive and larger changes in the three significant and most of other indicators compared to women in treatment households. This could be one of the explanations for negative impacts in treatment group.

Table 9.6: Impacts on full autonomy in decision-making

Dependent Variable	Impact Estimate (1)	Treated Mean (2)	Comparison Mean (3)	Treated Mean (4)	Comparison Mean (5)
Agricultural production	-15.214* (7.03)	27.37	25.65	26.91	40.30
Main expenses	-7.097 (6.79)	26.89	31.53	24.37	36.92
Child healthcare	-15.270** (6.15)	45.08	40.58	36.29	47.47
Child schooling	-14.427** (5.19)	32.94	32.68	23.29	39.21
Own earnings	-14.496 (9.04)	84.30	70.69	71.10	71.97
Own savings	-16.243 (12.33)	80.22	56.52	62.14	54.63
Contraception	-22.581 (19.07)	66.18	58.05	55.84	69.42
N	2,749	522	910	519	798

Notes: standard errors in parentheses. * 10% significance level; ** 5% significance level; *** 1% significance level.

Table 9.7 shows results on the impacts of the programme on women’s agency, regarding her control over her life and ability to make decisions within her household as head of the household and as a member. The study finds that women as member of treatment households have lower control over their lives (on a scale of 1–10) compared to similar women in the comparison households. However, no significant impacts of the programme were found regarding agency of women as heads and decision making as a household member.

Table 9.7: Impacts on women’s agency

Dependent Variable	Impact Estimate (1)	Treated Mean (2)	Comparison Mean (3)	Treated Mean (4)	Comparison Mean (5)
Has control over her life (at least 6 on a scale from 1–10)	-18.986** (7.52)	63.96	35.06	61.47	51.57
Can make decisions within her household (at least 6 on a scale from 1–10)	-18.524 (11.97)	70.73	40.13	64.67	52.60
Has control over her life (at least 6 on a scale from 1–10) - head	-7.717 (9.66)	93.76	64.38	80.61	59.56
Can make decisions within her household (at least 6 on a scale from 1–10)- head	-7.717 (9.66)	93.76	64.38	80.61	59.56
N	918	176	271	188	283

Notes: standard errors in parentheses. * 10% significance level; ** 5% significance level; *** 1% significance level.

In the qualitative study, the comparison and treatment groups both highlight the gender dynamics, economic struggles, and societal roles, with a focus on the impact of crises and projects aimed at empowerment and gender equality. In both groups, roles were defined as relatively traditional with men having the overall responsibility, namely financial, of the household and women being responsible for managing the household and caring for children. Women also play a more significant role in educating children compared to men.

Men express anxiety about potential displacement from their village, worrying about finding shelter, food, and the overall responsibility for their family's safety. In times of crisis, some, mostly men, believe that they are more affected, as they bear the responsibility of providing for the family and ensuring safety as explained by this male FGD participant: *"The most deprived are the men, because where you go to the wife and children follow you. [...] We all suffer, but the ones who suffer the most are the men."* [Male FGD participant, Kossouka, Nord – treatment group]. Moreover, men are considered to have more challenges related to traveling and providing for their families, especially in the context of insecurity.

However, many respondents, women and men from both groups, expressed how women were perceived as more vulnerable in crises, particularly in managing children's needs and household responsibilities. Men are the main breadwinners but even when they do not have any income, the women had to find solutions for their families. As women are in charge of children's caregiving, they were the ones children turned to for their needs: *"The children's expenses are more turned towards the woman than the man so when there is no income in the family the woman is much more concerned about some of the children's needs than the man."* [Male IDI participant, Safane, Boucle de Mouhoun – comparison group].

Although these concerns were expressed in both groups, they were more prevalent in the comparison group as the treatment group had fewer worries regarding income thanks to the cash transfers. Both necessity and programme activities created some changes in gender roles. Indeed, although men are primary breadwinners and decision-makers, women were reported to be increasingly involved in supporting their husbands in times of need. With their own economic activity, often livestock rearing or gardening, women support men when they did not earn enough to feed and support the family. One interviewee reported that in his village, women have adapted better to the current situation by engaging in gold mining activities, earning income to support their families, while men face limitations due to distance and other challenges:

In [name of the village], faced with the current situation, our women have found solution faced with the situation! They have gold mining areas which are not too far from here! If they go 3 to 4 times, they can earn FCFA 3000, sometimes FCFA 5000, it is they who deal with the loads of the family! The men can't do anything now! The gold-mining sites for men are miles away! It's impossible to get there! The women take all the burdens! The men fall back on poultry farming to have something! But there are poultry epidemics! We help each other like that! The women have found more solutions to adapt than the men!

[Male IDI participant, Kossouka, Nord – treatment group]

On the other hand, gender roles have also evolved thanks to project awareness-raising activities. Projects have started involving men to ensure effective change in family dynamics, recognizing that men are often the primary decision-makers. Some national- and communal-level key informants reported how men have started participating in traditionally female roles and vice versa, indicating a shift in gender roles due to sensitization efforts: *“When men fetch water for the women, it is the result of exchanges and awareness-raising, also when men who accompany the women to fetch firewood. All this is the result of awareness-raising.”* [Communal-level key informant, Dargo, Centre-Nord].

9.4 Gender norms

The main woman of the household (aged 15 or above) was asked whether she agrees on a range of statements on gender norms including girls' age to marry in the community, girls' excision, community perceptions about food consumption by gender, participation in household chores by boys and girls, and husbands' participation in household chores. Responses could be one of “not at all true”, “not true”, “true”, “absolutely right”, or “do not know”. Accordingly, the first two responses were grouped together and recoded as 1 to show the positive statements towards the interest of desired behavioural change, and the remaining responses were recoded as 0.

Results show that the programme does not have statistically significant impacts on the gender norms considered (Table 9.8). However, looking at the average values, results show that some of the indicators improved between midline and endline both among treatment and comparison households. The insignificant results could be either due to relatively larger improvements in comparison households in the respective indicators or due to the limited time period between midline and endline to observe the required behavioural changes due to the programme in the treatment households.

Table 9.8: Impacts on gender norms

Dependent Variable	Impact Estimate (1)	Treated Mean Midline (2)	Comparison Mean Midline (3)	Treated Mean Endline (4)	Comparison Mean Endline (5)
Girls are not expected to marry before 18	-5.190 (7.24)	46.43	27.01	55.04	40.94
Girls are not expected to get circumcised	1.001 (6.04)	89.53	85.24	83.16	77.90
Girls are not expected to stay at home during their period	2.240 (10.69)	58.60	68.94	65.49	73.69
Women and girls are not expected to eat less/lower quality when food is scarce	6.859 (3.96)	86.84	90.34	88.49	85.20
Girls are expected to go to school even if they are needed at home	10.075 (6.38)	79.63	82.37	90.05	82.72
Girls' behaviour is not expected to be more controlled than boys'	7.260 (17.32)	28.55	38.05	48.43	50.72
Women and men do not have the same opportunities in our country	19.843 (13.25)	49.08	54.83	63.42	49.36
People in this community approve of male participation in housework	-7.894 (7.26)	10.77	17.98	15.32	30.33

People in this community approve of male participation in childcare	-15.277 (15.49)	58.53	48.59	46.60	51.88
People in this community approve the use of modern contraception	-11.553 (13.83)	59.63	45.21	59.75	56.89
Progressive community norms index	0.622 (0.42)	-0.12	0.13	0.30	-0.07
Norms about child marriage, gender attitudes and roles (binary)	-0.129 (11.03)	56.36	56.41	55.31	55.61
N	4,476	891	1,343	894	1,348

Notes: standard errors in parentheses. * 10% significance level; ** 5% significance; *** 1% significance level.

Some changes mentioned by comparison group respondents, however, could not be linked to programme interventions but were simply a consequence of evolving customs and traditions. There is reportedly a shift in marriage practices, with young women now having more say in choosing their partners, a contrast to past practices where parents made these decisions.

Now, it become like, when a girl goes out to see the man of her choice, they come back to see their dads, and if their dad sees that there's no impediment, he gives his agreement before coming to see us women, once the girl and her are in agreement, you the woman can't oppose, you can only follow their wishes. Whereas in the old days, it wasn't you, the girl, who came to tell daddy that you'd had a man, it was the parents who decided, and you were obliged to go with him, but now it's not like that! If you come and tell daddy that you've got your man, we're not going to object, since you wanted it, we'll arrange for you to leave, even if there's a problem tomorrow, we can't say anything, because you wanted it.

[Female IDI participant, Bassi, Nord – comparison group]

9.5 Impacts on spousal relationships

Respondents in comparison and treatment areas both explained how generally men and women got along and lived together in harmony. Both groups, however, agreed that tensions were more common in polygamous families. One participant from the comparison group even went on to say that those tensions were usually caused by the man:

The reason why they don't have conflicts I can say that it comes from myself, you know that when you have two women there is rivalry between them if the man does something that puts the women in conflict it's difficult to put an end to this conflict. [...] Most women's conflicts are due to men, often if you prefer one of the women more you do something to make the other woman understand that you're not happy with her and that conflict never ends.

[Male IDI participant, Safane, Boucle de Mouhoun – comparison group]

Interviewees from the treatment group related how their relationships improved after receiving the cash and benefitting from the awareness-raising sessions. On the one hand, they were under less pressure with finding food to feed their families and money to pay for household costs. Respondents explained how increased food security improved relationships with neighbours and within the community more generally:

When I receive money, I pay for food. When I have visitors, I put out food for everyone. This money has strengthened our relationships with others. There's harmony now because when someone comes to your house and you give them food, they'll be happy. Also, the food we buy is for the whole family. If there's no hunger, there's joy.

[Female IDI participant, Ye, Boucle du Mouhoun – treatment group].

On the other hand, the awareness sessions focused on improving relationships by explaining how women should also be invited to participate in household decisions and tried to teach them to work as a team. This key informant summarizes this element:

At this level, I can say that because there has been sensitization, there have been several changes because the training and sensitization have made it known that in the couple it is not the man who is the boss and who does what he wants, because everyone is in the class, the woman is there, she has her say, the man also has his work and his place, it's so that the family lives in peace so the sensitizations were the cause that the man consults his wife and the woman also consults her man and together they exchange ideas to make the decision.

[Communal-level key informant, Dargo, Centre-Nord]

One key informant even told of some couples that had reunited thanks to the cash transfers: *"We've found that thanks to the cash, couples who were separated have reunited, because the cash has created a synergy of actions within the household, and it was really necessary to bring together all the members of the household to achieve the objectives."* [National-level key informant (implementing partner), Ouagadougou].

A female respondent from a polygamous household added how increased availability of cash and food improved relationship with her co-wives: *"With the help we've received, there are no more arguments: one wants to cook and the other wants to do the same, there's no more hunger so there are no more arguments."* [Female IDI participant, Kossouka, Nord – treatment group]. However, some issues usually persisted within polygamous households because of the use and distribution of cash:

At times we've found in certain households even when we're going to take and it's really quite isolated on both sides in the treatment communities that the cash in polygamous households, given that it's one member of the household who takes the cash

to redistribute for the benefit of the other households, there have at times been tensions especially between the parents, the husband, and the other wives. [...] Not necessarily in all polygamous households, it could be the man, it could be one of the women. So, one in the other, according to whoever is going to take the money, we've observed, it's not in all polygamous households. I mean, these are isolated cases.

[National-level key informant (implementing partner), Ouagadougou].

9.6 Summary of findings and discussion

The programme impacts on caregivers' nutrition knowledge and feeding practices, gendered impacts on time use, women empowerment, and gender norms were generally very limited.

Nutrition knowledge and practices:

At endline, the programme has positive impacts on the knowledge of caregivers about exclusive breastfeeding of children until 6 months old and the daily eating practices of children aged between 6 and 8 months who are breastfeeding. These indicators were not significant at midline. At midline, positive impacts were found related to the proportion of caregivers who believe that babies between 9–11 months of age that are still breastfed should eat 3–4 meals and those who know that salt is often fortified with iodine. Likewise, qualitative findings indicate favourable outcomes among programme beneficiaries

regarding nutritional behaviours. Notably, the treatment group which benefited from cash transfers or awareness-raising activities demonstrated significant enhancements in their capacity to ensure better nutrition for both their families and children. Conversely, the comparison group continued to encounter difficulties in accessing nutritious food for their families, primarily because of financial limitations and resource constraints.

Gendered impacts on time use:

There were no significant impacts on most of the gendered division of labour/time use indicators including water collection practices, wood collection practices, childcaring practices, and eldercare practices (by adults). One exception is regarding the role of other women in the household where the programme marginally increased their role in care for the elderly and

sick. Qualitative findings show that beneficiaries highlighted the improved availability of time and heightened participation in community and family affairs, while the comparison group encountered obstacles stemming from demanding workloads and insecurity, which restricted their opportunities for social and familial interactions.

Decision-making and empowerment:

The programme negatively affected women's full decision-making autonomy on agricultural production, child health, and child schooling. The programme has no impact on the full decision-making autonomy regarding her own earnings, savings, and contraception. In the qualitative study, both the comparison and treatment groups shed light on the evolving gender roles in this context, which were predominantly traditional, with men primarily assuming financial responsibilities for the household, while women undertook household management and childcare duties. However, both necessity and programme interventions prompted some shifts in gender roles. Notably, while men retained their roles as primary breadwinners and decision-makers, there were reports of increasing involvement of women in supporting their husbands during times of need.

Agency:

The programme negatively impacted women's control over their own lives in general but had insignificant impacts on all other indicators, including ability to make decisions within her household as a member and as a head, as well as having control over her life as a head.

Gender norms:

The programme has no significant impacts on gender norms.

Impacts on spousal relationships:

Qualitative findings highlight improvements in spousal relationships after households received cash transfers and participated in the programme's awareness-raising sessions. The cash transfers relieved the financial pressures for purchasing food and meeting household expenses. Furthermore, the programme's awareness sessions aimed to enhance relationships by advocating for the inclusion of women in household decision-making processes and promoting collaborative teamwork among family members.

Community level characteristics and dynamics

10.1 Community characteristics

The theory of change does not necessarily envision programme impact on community-level behaviours. However, as some of the interventions, such as supply of water interventions and community-led total sanitations, are implemented at the community level, some community dynamics and infrastructure may change overtime.

The study finds no statistically significant changes regarding average household size at endline. However, more treatment villages than comparisons reported that more people have moved into the communities in the last five years.

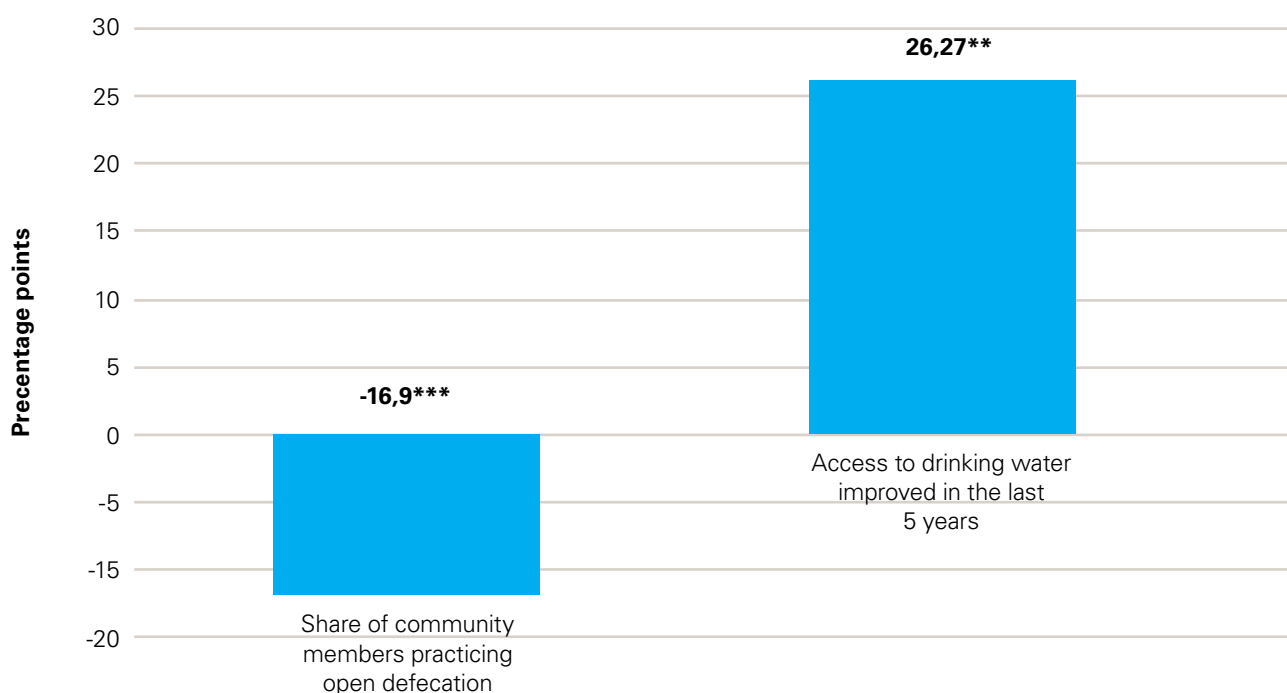
The programme is also linked with an increase in the proportion of women in the treatment communities who gave birth at the maternity home by 4 percentage points. Interestingly, it is also found that the share of communities with alcohol use among males categorized as negligible (smokers constitute less than 10 per cent of the population) increased by 20.4 percentage points (reduction in the share of communities with more than 10 per cent of smokers), providing further evidence for the argument that cash transfer did not nudge the use of temptation products such as alcohol. However, no statistically significant change in alcohol consumption has been observed among women.

10.2 Access to services, infrastructure, and other programme interventions

This sub-section discusses trends and potential impacts of the programme on availability and access to village-level services and amenities. Figure 10.1 focuses on WASH-related outcomes at the community level, which may have been impacted by the programme implementation. In this regard, the study finds that the programme is linked with a reduction in the proportion of community members practicing open defecation by 16.9 percentage points. The programme is also associated with improved access to drinking water in the last five years by 26.27 percentage points. These changes, which could be due to better community-level WASH and health-related campaigns, could jointly contribute towards better health outcomes at the household and individual levels.

Figure 10.1: Programme impacts on community WASH outcomes.

Programme impacts on community amenities



Notes: *** and ** indicate statistical significance at 1% and 5%, respectively.

Qualitative results were less positive and showed that despite the availability of infrastructure, access to basic services was often compromised. Respondents in both comparison and treatment communities shared some challenges in accessing basic services, mainly on three aspects: *“There are the three difficulties we see here: water, health centres, and schools.”* [Male IDI participant, Kossouka, Nord – treatment group].

The limited **water** sources in communities as well as at schools and healthcare facilities compounds was reported as a key issue by some respondents from both groups:

As far as water is concerned, there is no water here. Even if there is, it's not enough for the population. It's like the lady said, water isn't enough. In our neighbourhood we can get some, but the neighbouring doesn't have any. When you arrive where there's water, there happen to be a lot of people, so if you're in a hurry you have to go to the marigot to draw water. If the water from the dam runs dry, the marigots don't have any. If you want drinking water, you'll have to wait, and most of the time people fight over it. There isn't enough, the water problem is. What little there is, isn't enough for the population.

[Female FGD participant, Dargo, Centre-Nord – treatment group]

The communities from both comparison and treatment groups also faced challenges in terms of **healthcare**. Respondents explained how they faced difficulties accessing healthcare, particularly for urgent needs like childbirth or illness. High water levels often impede transportation to health centres, leading to dire situations, including women giving birth on the road:

Yes, yes, in [name of the village] there's a river on the road, and when it rains, most of our women give birth on the road. The river is impassable! Sometimes it's difficult to transport the sick, given the high-water levels, the sick sometimes succumb! Many of our women give birth before the crossing! They give birth, and the old women take care of the rest! Waiting for the

water to recede for two to three days before taking them to a health centre for the papers!

[Male IDI participant, Kossouka, Nord – treatment group]

In some locations, respondents reported a shortage of **school** facilities, with overcrowded classrooms and insufficient capacity to accommodate all students. Some parents have to send their children to distant locations for schooling, incurring additional expenses for rent and food. Due to insecurity some schools have been forced to close, leading communities to seek alternative methods and locations:

The closure or relocation of staff too. Education has identified alternatives that are already recognized approaches, including education in emergency situations, such as education by radio. There is also another alternative, especially in the North. In some areas, Koranic schools are not under threat, it's the formal schools that are under threat, and so we're introducing, education is introducing part of the curriculum in Koranic schools, so to some extent this ensures continuity of services. The health sector has also adopted community-based approaches, with what we call community-based health agents to get around the problem of closing the centre, but with constraints linked to health and nutrition inputs, since at the same time, there are security risks on the roads, with improvised mines, attacks on convoys, and so on.

[National-level key informant (UNICEF), Ouagadougou]

Despite the challenges, there are generally available health and educational services in most localities. However, the quality of these services is affected by the lack of medical supplies and the absence of healthcare professionals. In addition, respondents reported how the arrival of displaced people has put additional strain on healthcare services:

Yes, there are some, but it's complicated, everything has become expensive. As far as health is concerned, the size of the population has overwhelmed the doctors. There are foreigners [displaced people] who have joined us, which means that the doctors are overwhelmed. So, the health issue is a difficult one.

[Male IDI participant, Kossouka, Nord – treatment group]

10.3 Humanitarian crisis, shocks, conflicts, and displacement

Overall, the **humanitarian crisis and community displacements** have led to significant economic, educational, health, and social challenges for the affected population, necessitating a range of coping mechanisms and adaptations. The crisis has had a profound **psychological effect** on the population, instilling a constant state of fear and uncertainty about the future. The constant threat of being displaced from their village instils fear and uncertainty among men, who worry about providing shelter and food for their households in such a situation. The ongoing crises have impacted both mental and physical health, with stress and fear becoming commonplace. The unpredictable nature of the situation has led to widespread fear and anxiety, affecting the mental health of the community:

Nowadays, even if a bag bursts because someone trampled on it, you're scared to death. Because you don't know what's coming. That's why we say we're not in good health. We're in good health, but it's fear that makes us unhealthy.

[Female FGD participant, Dargo, Nord – treatment group].

Some treatment group respondents spoke about how they had become poorer. On the one hand this was due to challenges faced due to the security context. The insecurity has halted commerce, leading to financial hardships. The displacement of neighbouring populations, who were essential for the local market, has exacerbated the economic crisis as described below:

I don't have enough money to cover health-related expenses because we can't do business. With this situation of insecurity, there is no commercial activity as there used to be, which means we have no agents. Because of the terrorists, the surrounding localities have moved. There are no longer any villages nearby where people still live. The terrorists have chased them away, but it's the people from the surrounding villages who used to come and fill our market, and we used to make a lot of money. Nowadays in Yé, people don't even have money to buy anything.

[Female IDI participant, Ye, Boucle de Mouhoun – treatment group]

On the other hand, poverty increased with high inflation rates. One of the consequences of the fragile security situation is the increases in food items prices. The increase in prices was attributed to insecurity, closed markets, deteriorated roads, and increased transportation costs. The impact of **rising prices and inflation** was discussed by all respondents, in both the treatment and the comparison areas. Prices of essential products, especially food items, have increased significantly over the past two years, making life difficult for people in the villages in accessing necessities such as food, medicine, and household items, but also to pay for fertilizer. Treatment group respondents related the challenges inflation has brought:

For me it's really a huge suffering for us. Life has become expensive, and the problem of insecurity has also meant that people are cautious about where they go. You can want something but to get it is complicated, even if you could find it, to get the money to buy it, it's complicated, it becomes complicated. Prices have gone up. But we can't say anything, the goods come from far away and it's expensive. Nowadays, when someone is ill and you send them to a health centre, the doctor prescribes a prescription. When you get a prescription, you must go from here to find the medicines you need to buy. Even those who can afford it have a hard time, let alone us vulnerable people. Life has become sincerely expensive.

[Male FGD participant, Dargo, Centre-Nord – treatment group]

Rising prices have caused us a lot of trouble. These days, money is everything. If you don't have the money to buy food at the price it's sold for, the family won't be able to eat enough. During these two years, we haven't been able to buy the quantity of cereal needed for family consumption.

[Female IDI participant, Ye, Boucle du Mouhoun – treatment group].

Rising costs were also cited as a barrier to food security, especially for comparison group respondents. However, respondents in treatment communities mentioned that the cash transfer has provided them a safety net, which has eased the negative effect of inflation on their livelihoods, although these were sometimes perceived as insufficient to cover the totality of their needs. *“We get money to buy food. That's why we didn't feel the high prices too much.”* [Male IDI participant, Dargo, Centre-Nord – treatment group].

In addition, communities in both groups have developed **strategies to cope** with the deteriorating security situation, including adjusting their economic activities and finding new ways to access essential services. This adaptation was seen as a collective effort, involving both men and women. The crisis also affected gender dynamics, with women finding more adaptive solutions than men, and men feeling the burden of providing for and protecting their families in the face of increased risks. However, although the entire community is affected, women are considered more vulnerable as they often lack access to timely information and safe places to go in case of danger:

If I get up to go home and they tell us they're on the way, we don't go home anymore. There's no cell phone to call home, I can run to [name of the village] but the women and the children at home haven't heard the news, we men have information when we go out and that allows us to hide as quickly as possible but the women are here they don't go out they don't have information but they don't have a place to go, if there's a danger, it's going to reach them at home so I can say that the women are the most victims.

[Male IDI participant, Ye, Boucle de Mouhoun – treatment group].

As evidenced in the quantitative results in Table C.4, overall, respondents in the qualitative interviews reported a strong sense of community bonding and support among residents. They emphasized mutual aid, harmonious living, and collective participation in social events, which contribute to their cohesive community life. Respondents mentioned good intra-community relations, with people supporting and helping each other in times of need. They also noted how they support each other in events like baptisms and funerals:

There is no palaver between us. Palavers are what can damage good cohabitation. At home here, there's no palaver between us. When there's a baptism, for example, we get together and go to the baptism site to support the family baptizing their child. If there's also an unfortunate event such as a death, we get together to support the bereaved family.

[Female IDI participant, Ye, Boucle de Mouhoun – treatment group]

Respondents from the treatment group emphasized how the cash transfers and the programme more generally helped improve social cohesion. They pointed out that the aid received has not only helped financially but also improved relationships within the community and families, reducing conflicts and enhancing cooperation: *“Since the money arrived, it has strengthened relations between the inhabitants here in Kossouka. It really helps people's lives and strengthens ties, and we keep asking for it!”* [Female IDI participant, Kossouka, Nord – treatment group].

10.4 Summary of findings and discussion

In summary, the community/village level quantitative results show the significant moderating role played by community factors in the overall programme impacts. However, it should be noted that the cash plus interventions, targeted at the commune level, do not envision changes at the village level but are limited to their moderating role.

Community characteristics:

The availability of cash in the community did not lead to an increase in social vices such as alcohol consumption.

The findings show a reduction in the portion of men with alcohol use in line with previous findings reported by Handa, et al. (2018) that cash transfer does not encourage consumption of temptation products.

Availability and access to services and amenities:

The plus interventions of the CSSPP were in the reduction of the practice of open defecation as well as improving access to drinking water. Qualitative data also showed that despite the availability of infrastructure, access to basic services such as education, water, and healthcare was often compromised. Respondents in both comparison and treatment communities shared some challenges in accessing basic services. Cash transfers, however, did help

improve financial access to healthcare as evidenced in van Daalen, et al.'s mixed methods review (Van Daalen, et al., 2022). Access to education was equally impacted for those who had received cash transfers, similarly to Miller and Tsoka's (2012) research in Malawi.

Humanitarian crisis, shocks, conflicts, and displacement:

The qualitative narratives specifically showed how treatment group respondents could cope with inflation rates thanks to the cash received. Improved social cohesion, increased community support, and improved relationships thanks to reduced stress from lack of financial capacity in the community also played an important role in coping. Increased trust within communities and informal safety nets such as inter-household transfers was equally reported on in Tanzania by Evans and Kosec (2023). However, no positive impacts of the programme were found related to positive changes such as new infrastructure development; this was not the objective of the programme.

Conclusions and policy recommendation

11.1 Overview of programme and research design

The main objective of this report is to examine the impact of the child-sensitive social protection programme piloted in four regions of Burkina Faso. In a nutshell, the CSSPP provides an unconditional cash transfer to vulnerable households. In addition to the cash transfer, the CSSPP provides nutrition-preventive interventions targeted to pregnant women and mothers with children under 2 years old as well as WASH interventions in selected municipalities. The WASH interventions included the provision of water supply points, community-led total sanitation, and menstrual hygiene management for adolescent girls. The intent and objective of the CSSPP was to increase household consumption, through improvement in food security and material well-being, and ultimately reduce child poverty, including multidimensional poverty.

This study uses a mixed-methods approach combining both quantitative and qualitative data and analysis to examine the impact of the CSSPP according to its intended objectives and theory of change. The quantitative component uses a quasi-experimental impact evaluation design, which analyses data collected at baseline, midline, and endline. The qualitative component also uses longitudinal data collected at midline and endline from key informants' interviews, focus group discussions, and in-depth interviews. Specifically, the analysis presented in this report is aimed at answering the following research questions:

1. Has the programme been implemented as initially designed?
2. What are the impacts of the programme on households?
 - a) What are the impacts on poverty, food security, and household consumption?

- b) What are the impacts on household members living standards, assets, savings, and economic activities?
3. What are the impacts of the programme on infants and young children?
 4. What are the impacts of the programme on adolescent well-being?
 5. What are the impacts of the programme on female caregivers and gender dynamics?
 6. What are the impacts of the programme on the community?

11.2 Overall summary of main findings

CSSPPP implementation:

The process evaluation showed that the CSSPP was largely implemented as initially planned. Selection and targeting followed established programme protocols. However, the protocols were not **inclusive** as persons living with disabilities and other vulnerable populations (e.g., the elderly) were inadvertently disadvantaged by the protocols as they couldn't travel to designated registration points. Although the transfer size was highly appreciated by the beneficiaries, the transfers were also occasionally irregular. The plus interventions were implemented in a **siloed approach** thus preventing cross-sectoral integration, which would enable the various interventions to reinforce each other and enhance the overall objective of the programme.

CSSPP impacts at the household level:

The CSSPP had limited impacts on household expenditures. The programme marginally increased real total household expenditure by FCFA 301,253 at endline (equivalent to a 26 per cent increase from the baseline value). However, there were strong impacts on several indicators of food security, which were also confirmed by the qualitative narratives. While the programme reduced the poverty headcount, there were no impacts on the poverty gap. Qualitative results showed strong positive impacts on health outcomes, while

quantitative results showed limited impacts on health. The programme had strong and statistically significant impacts on child material well-being, such as possession of blankets. The programme also increased asset ownership, but no impacts were found on savings, debt, transfers, and credits. The programme also increased household agricultural production but impacts on livestock production and non-farm enterprises were limited.

CSSPP impacts on children under five years old:

The findings show the programme did not have impacts on health-related outcomes such as health status, preventive healthcare measures – vaccinations – or healthcare utilization. The programme, however, had significant impacts on the nutrition of both infant and young children feeding and it reduced stunting.

CSSPP impacts on adolescent well-being:

Qualitative findings showed an increase in school attendance attributed to the cash transfer that has enabled households to overcome financial barriers to schooling. However, the quantitative results showed a reduction in the school enrolment rate when compared to baseline. This was driven by school closures in two treatment communes – Ye and Dargo – due to insecurity. The study also found a reduction in the participation of adolescents in household chores, while their participation in economic activities increased. There was also a reduction in the knowledge of condoms as contraceptives and an increase in the incidence of pregnancy and sexual activity. The analysis found no strong and consistent impact on mental health, adverse events, and violence.

CSSPP impacts on female caregivers and gender dynamics:

The programme improved nutritional knowledge and feeding practices of caregivers, and this is attributed to both the cash transfer and the awareness-raising activities. The programme largely had no impact on gendered time use or gendered division of labour. A notable unexpected impact was the reduction in women's decision-making power regarding agricultural production, child healthcare, and child schooling and agency. Qualitative results highlight the entrenched traditional gender roles with men fortifying their role as the sole decision maker in the household as they were the recipient of the

cash transfer. The qualitative findings also indicated that there were improvements in spousal relations which are mainly attributed to the awareness sessions activities.

Moderating role of community factors on CSSPP impacts:

The programme is associated with improvements in aggregate community behaviours such as a reduction in the practice of open defecation, reduction in the use of alcohol, and improved access to drinking water. Qualitative findings highlight the moderating role of prevailing humanitarian crisis and inflation, which undermined the programme's effectiveness.

11.3 Recommendations

Programmatic recommendations

The following programmatic recommendations are proposed for consideration:

- **Strengthen the inclusivity of the programme by adopting disability and elderly inclusive protocols** throughout each phase of the programme cycle to minimize of the exclusion of the most vulnerable.
- **Strengthen the cross-sectoral integration and coordination** of the plus **interventions** to enhance overall programme effectiveness.
- **Build the resilience of households to climate, conflict, and economic shocks by incorporating adaptive interventions in the programme.** The main reasons for the lack of impact on household investments in economic activities were the precarious security situation and frequent exposure to livestock shocks.
- **Improve child health and feeding practices by improving linkages to child health services and strengthening the complementary nutrition interventions.** The programme had no impacts on child health indicators, and healthcare seeking even decreased. Also, despite positive impacts on infant and young child feeding practices, the share of children meeting

dietary recommendations remains low, with only 4.5 per cent of children aged 6–23 months meeting the conditions for a minimum acceptable diet.

- **Strengthen the gender responsiveness of the programme by designating women as the main recipient** of the cash transfers. Findings show a decline in women’s decision-making power over the duration of the programme. **Provide alternative learning options when schools are not accessible due to security risks**, such as radio lessons or remote teaching. Support schools and teachers to implement such alternatives and keep adolescents engaged in school activities to prevent permanent drop-out.
- **Expand complementary services and access to reproductive health services**, as findings show reductions in knowledge on contraceptives, and higher rates of sexual activity and pregnancies.

Research recommendations

- Further research can assess the moderating role of the insecurity on the programme’s impacts.
- Conduct further research on the exact barriers to the uptake of child health services in order to inform appropriate complementary services.
- Future research could also examine the long-term and/or post-intervention impacts of the programme to determine whether positive impacts are sustained.

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Acronyms

C Comparison

CES-D Center for Epidemiological Studies-Depression

CLTS Community-Led Total Sanitation

CPI Consumer Price Index

CSSPP Child Sensitive Social Protection Programme

DID Difference-in-Difference

ELDI Enhanced Life Distress Inventory

FAO Food and Agricultural Organization of the United Nations

FCFA Franc of the Franc of the Financial Community of Africa
(*franc de la Communauté financière africaine*)

FGD Focus Groups Discussions

GDP Gross Domestic Product

HAZ Height-for-age Z-score

IDI In-Depth Interviews

ISSP *Institut Supérieur de Santé Publique*

IYCF Infant and young child feeding

KII Key Informant Interviews

SIDA Swedish International Development Agency

T Treatment

TLU Tropical Livestock Unit

UNICEF United Nations Children's Fund

WASH Water, Sanitation and Hygiene

WAZ Weight- for age Z-score

WAZ Weight-for-age Z-score

WHO World Health Organization

WHZ Weight-for-length/height Z-score

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Endnotes

- 1 'The World Bank in Burkina Faso', World Bank Group, 27 March 2024, <<https://www.worldbank.org/en/country/burkinafaso/overview>>.
- 2 Pregnant and lactating women as well as mothers with children under 2 in the communities of intervention were eligible to benefit from these complimentary services, not just the cash transfer recipients.
- 3 Little, M. T., Roelen, K., Lange, B. C., Steinert, J. I., Yakubovich, A. R., Cluver, L., and Humphreys, D. K., 'Effectiveness of cash plus programmes on early childhood outcomes compared to cash transfers alone: A systematic review and meta-analysis in low-and middle-income countries', *PLoS Medicine*, vol. 18, no. 9, 2021.
- 4 Ibid.
- 5 Alternative sample sizes were also computed using other outcomes of interest but with a similar minimum detectable effect. However, while using children of school-going age (aged 6–17 years), school enrolment and regular attendance resulted in a lower sample size (ranging between 1,107 and 1,130) than that estimated using poverty rates; using stunting prevalence gives us a much higher sample size, beyond the budget ceiling for the study.
- 6 The full set of the attrition test results are included in the online annex Tables (see Tables A.1–A.6 in the supplementary online appendix for the attrition tables).
- 7 The full set of the balance test between panel-treatment and panel-comparison results are included in the online annex Tables (see Tables B.1–B.6 in the supplementary online appendix).
- 8 2020 corresponds to the year of baseline data collection.
- 9 As published by the WHO: https://immunizationdata.who.int/pages/schedule-by-country/bfa.html?DISEASECODE=&TARGETPOP_GENERAL=
- 10 World Health Organization and the United Nations Children's Fund, 'Indicators for assessing infant and young child feeding practices: definitions and measurement methods', WHO and UNICEF, 2021, <<https://www.who.int/publications/i/item/9789240018389>>.
- 11 United Nations Children's Fund, 'Burkina Faso: New academic year starts with one million children out of school due to ongoing violence and insecurity', UNICEF, 02 October 2023, <<https://www.unicef.org/press-releases/burkina-faso-new-academic-year-starts-one-million-children-out-school-due-ongoing>>.
- 12 Items include: 1. own/household's financial situation; 2. failure of own or household's farm or non-farm business; 3. employment or that of family members; 4. access to education or that of family member; 5. access to food and clean drinking water; 6. physical health or that of family members; 7. own/family member's substance use (drug/alcohol); 8. violence towards self/family members; 9. theft; 10. romantic relationship/marriage; 11. relationship with other family members; 12. relationship with friends/community members.
- 13 E.g., Lambon-Quayefio, M., Peterman, A., Handa, S., Molotsky, A., Otchere, F., Mvula, P., and Malawi Social Cash Transfer Evaluation Team, 'Unconditional cash transfers and safe transitions to adulthood in Malawi', *World Development*, vol. 175, 2024; Cirillo, C., Palermo, T. and Viola, F, *Non-contributory Social Protection and Adolescents in Lower- and Middle-Income Countries: A review of government programming and impacts*, Innocenti Working Paper 2021-07, UNICEF Office of Research – Innocenti, Florence, 2021.

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UNICEF works in the world's toughest places to reach the most disadvantaged children and adolescents — and to protect the rights of every child, everywhere. Across 190 countries and territories, we do whatever it takes to help children survive, thrive and fulfill their potential, from early childhood through adolescence. And we never give up.

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