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Are Cash Transfers the answer for children in Sub-Saharan Africa? A Literature Review

by James Manley and Vanya Slavchevska

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Abstract

Early evidence has been ambiguous on the effects of cash transfer programmes on children, but little has focused on Africa. We review the literature on twenty cash transfer schemes, including twelve from Sub-Saharan Africa. Such interventions have shown improvements in household diet and in some cases to agriculture, but have not always improved child health. However, a larger perspective focusing on the first 1000 days of life reveals more opportunities for impact. In particular the opportunity to empower young women to get secondary education and cut adolescent pregnancy rates can improve the health of African children. Cash transfer programmes seem cost effective, though they are not without flaws.

JEL codes: O15, I18, I15, J13

Key Terms: social protection, cash transfers, Sub-Saharan Africa, child health, adolescent health

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[2] Contact Author. Department of Economics, Towson University, Towson, MD 21252, USA. Email jmanley@towson.edu

[3] Consultant, gender analysis, FAO, Rome, Italy. Email vs4030a@student.american.edu

1 Introduction

Health during childhood can affect a person for the rest of her life, making protecting children particularly important. The World Bank, in a study of the effectiveness of its renewed commitment to early childhood development, concludes, "Investing in ECD [early child development] has high potential to help achieve the Bank's twin goals of eliminating poverty and increasing shared prosperity" (Sayre et al. 2015). In particular, scientists have identified the first thousand days after conception (i.e. roughly until a child's second birthday) as a particularly crucial time for ECD (Ruel 2010; Black et al. 2013).

The last few years have seen a resurgence of the idea that cash transfers might be an efficient means for improving early childhood development. Opinion articles in the New York Times (Blattman 2014) and major outlets such as Newsweek (Werth 2010) as well as whole books (Hanlon, Barrientos, et al. 2010) have been written advocating the use of cash transfers.

The success of these programmes is often measured by their ability to alleviate the incidence of chronic malnutrition (low height-for-age or stunting) and acute malnutrition (low weight-for-height or wasting). Anthropometrics, comparing the height and weight of children against international norms such as those established by the World Health Organization, give quick insights into the health of children regardless of ethnicity and socioeconomic status (WHO 2006).

However, evidence that cash transfers improve child nutritional status is limited (Manley, Gitter, and Slavchevska 2013). This may be because nutrition depends not only on children's diets but also on their being healthy enough to take in the food, which in turn relies upon a number of factors. In addition to the household's access to food, caregivers' awareness of nutrition, and their ability to provide it to children, the child's health status is in part a function of environmental determinants of health such as access to clean water, developed means of sanitation, and health care. As Smith and Haddad put it, "safe water and sanitation, women's education and empowerment, and the quantity and quality of food available in countries have been key drivers of past reductions in stunting. Income growth and governance played essential facilitating roles. Complementary to nutrition-specific and nutrition-sensitive programmes and policies, accelerating reductions in undernutrition in the future will require increased investment in these priority areas" (2014).

Are cash transfer programmes a promising approach for improving child health in Africa, and if so, how can their effectiveness be maximised? To answer this question, we will review studies of many cash transfer programmes already undertaken in sub-Saharan Africa. After reviewing the programmes to be considered, we look at the context in which early childhood development happens. Then we will look not only at programmes' demonstrated effect on nutritional status,

but also look at how they might affect the pathways to child health, including a variety of factors likely to be important through the first 1000 days of life. These range from household food security to child illness and finally the ability of the mother to provide care to their children.

Cash transfers are promising partly because they enable parents/care givers to flexibly respond to the various needs of their children. This includes providing them with food, but also with shelter, water, or medical care. Advocates contend that household members are best able to improve the household in whichever area most needs attention, so providing them with cash should enable them to optimize. However, parents' ability to improve child welfare requires a relatively clean and disease-free home. Further, it assumes that they know how to take care of a child.

We will see that cash transfers can help keeping young women in school, thereby helping to prevent early marriage and teenage pregnancy which in turn should reduce the incidence of intra-uterine growth retardation and low-birth weight. Further, education itself is valuable, partly because they might learn better how to create a healthy environment and partly because they are more able to be economically independent. "Pregnancies in adolescents have a higher risk of complications and mortality in mothers and children and poorer birth outcomes than pregnancies in older women. Furthermore, pregnancy in adolescence will slow and stunt a girl's growth" (Black et al., 2013). Thus, cash transfers for young women can help produce healthier babies.

These are some of the reasons that cash transfer programmes particularly in Africa are likely to lay important groundwork for improved early child development, even though they may not achieve improvements in anthropometrics. Next, we list the programmes to be examined, and then we review the framework laid out by health experts for child development. Finally we apply the framework to the cases of the various programmes and see the successes and shortcomings of programmes. We conclude with some suggestions on how to maximise programme impacts.

2 Programmes

Cash transfer programmes began in Brazil around 1995, when several communities began independently running programmes such as the "Bolsa Escola" and the "Guaranteed Minimum Family Income Program" (Lindert et al. 2007). Each programme was targeted to the poor, usually through means-testing, and participants were required to meet other obligations including school attendance. Shortly thereafter Mexico began what was then known as PROGRESA, providing cash to poor rural families conditional on accessing health care as well as ensuring children were in school. Today there are dozens of such programmes operating around the world (Barrientos, Niño-Zarazúa, & Maitrot, 2010).

We identified a set of twenty cash transfer (CT) programmes that are relevant, well-documented, and useful. These include six from Latin America, including Brazil's Bolsa Familia and Mexico's PROGRESA (since renamed to *Oportunidades* and thence to *Prospera* by successive governments) as well as two in Asia providing important lessons. Twelve programmes of note

were identified in Sub-Saharan Africa. Programmes were selected by Save the Children UK in anticipation of helping to improve social protection in the country of Zambia; selection was based on the following five criteria. Programmes needed a food security or nutrition-related objective; evaluations must be available; they should be comparable to Zambia's social cash transfer, i.e. employing a cash transfer modality; they need to have been active for at least a year in total, and active in the past decade; and priority was given to countries near Zambia. Table 1 lists the programmes and countries where they occurred.

Table 1: Programmes Reviewed

	Program	Country
1	Bolsa Alimentação/ Bolsa Familia	Brazil
2	Familias en Acción/CCT	Colombia
3	Bono de Desarrollo Humano	Ecuador
4	Productive Safety Net Programme (PSNP)	Ethiopia
5	Livelihood Empowerment against Poverty	Ghana
6	Hunger Safety Net Program	Kenya
7	Lesotho Child Grants Program	Lesotho
8	Social Cash Transfer	Malawi
9	Zomba Cash Transfer Program	Malawi
10	PROGRESA / Oportunidades / Prospera	Mexico
11	Programa Subsídio de Alimentos (PSA)	Mozambique
12	Child Grant	Nepal
13	Red de Protección Social and Atención a Crisis	Nicaragua
14	Juntos	Peru
15	Pantawid Pamilyang Pilipino Program	Philippines
16	Child Support Grant	South Africa
17	Child Grant Program	Zambia
18	Social Cash Transfer/ Multiple Category Targeting Grant	Zambia
19	Monze Social Cash Transfer	Zambia
20	National Harmonized Social Cash Transfer (HSCT)	Zimbabwe

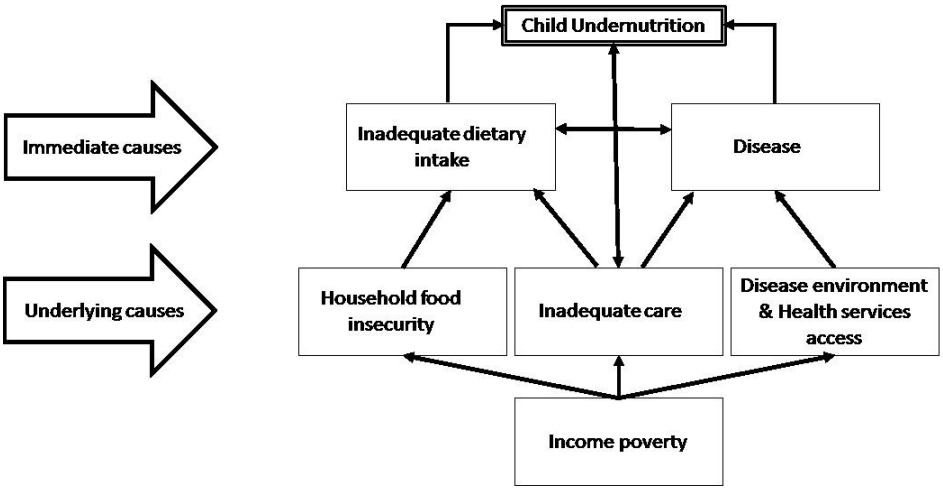
This report considers six Latin American programmes: Brazil's Bolsa Familia, Colombia's Familias en Acción, Ecuador's Bono de Desarrollo Humano, Nicaragua's Red de Protección Social, Peru's Juntos, and the Mexican programme formerly known as PROGRESA. Like the earliest programmes, five of these six are "conditional" cash transfer programmes, meaning that in order for households to claim the cash, they had co-responsibilities such as getting health check-ups or making sure that children attend school. Ecuador's programme is the only exception, and even there many recipients believed that they needed to meet similar conditions (Fernald and Hidrobo 2011).

We chose to include programmes in middle income countries partly because the programmes have a longer history, but the majority of the schemes we consider are in Africa, where conditions are quite different. According to the World Bank, the 2010-2014 average GDP per capita in Brazil was $11,612.50 and in Mexico $10,361.30, but in Zambia the average was just $1,801.90. Some of Zambia's neighbors look even worse, as in Zimbabwe, the average was just $935.90, while Malawi produced just $253.00 (World Bank 2015).

3 Framework

While it would make analysis much easier if the link between income and child nutritional status were a simple, direct one, things are somewhat more complicated. The following diagram illustrates the relationship between poverty and child nutritional status.

Figure 1: Factors Affecting Child Nutrition



Based on Black et al. 2008

The importance of these diverse factors is illustrated in this discussion of Kenya's Hunger Safety Net Programme. Merttens et al. (2013) note, "Child nutrition is an area heavily influenced by a number of exogenous factors, beyond simple access to food. These include hygiene and feeding practices, cultural beliefs, and knowledge about what constitutes an appropriate diet, which a cash transfer by itself is unlikely to influence. Malnutrition is highly seasonal in nature, and severe cases of malnutrition are generally treated under programmes run by the government and NGOs. Supplementary feeding in health centres and schools, as well as medical treatment of children with acute malnutrition, were recorded in all research areas."

This provides some explanation why the link between cash transfers and child health is not as clear as we might like. In their systematic review of the evidence Manley, Gitter, and Slavchevska (2013) conclude that cash transfers do not reliably improve child nutritional status. In the next sections we review the evidence in the context of the programmes we have chosen to

examine, and consider some parts of Figure 1 not often considered when analysts evaluate this relationship.

4 Cash Transfers and Nutritional Status

As shown in Figure 1 above, child nutrition is the outcome of a complicated process. Nonetheless, many analysts have looked at the overall relationship, attempting to identify effects from increased income (i.e. cash transfers) on child nutritional status. Here are the impacts of our chosen programmes on anthropometrics. Blank spaces in the table indicate that we could find no evidence either way.

Table 2: Programme Impacts on Nutritional Status

	Programme	Stunting (under 5)	Wasting
1	Brazil	*No impact*[1]	*No impact*[1]
2	Colombia	**10% drop**[2]	*No impact*[2]
3	Ecuador	*No impact*[3]	
4	Ethiopia		
5	Ghana		
6	Kenya	*No impact*[12]	*No impact*[12]
7	Lesotho		
8	Malawi-SCT	**4% drop**[4]	**2% drop**[4]
9	Malawi-ZCT		
10	Mexico	**10% drop**[5]	
11	Mozambique	*No impact*[6]	**30% drop**[6]
12	Nepal		
13	Nicaragua	**5% drop**[7]	*No impact*[7]
14	Peru	**Extreme stunting ↓8%**[8]	**BMI improves**[13]
15	Philippines	**Extreme stunting ↓ 10%**[9]	*No impact*[14]
16	South Africa	**HAZ ↑ 20%**[10]	
17	Zambia-CGP	*No impact*[11]	**0.2 WHZ**[10]
18	Zambia-MCTG		
19	Zambia_MSC		
20	Zimbabwe		

[1]de Brauw et al. 2012; [2]Soares & Silva 2010; [3]Paxson & Schady 2010; [4]Miller 2008; [5]Fernald, Gertler & Neufeld 2008; [6]Soares & Teixeira 2010 [7]Maluccio & Flores 2005; [8]Sanchez & Jaramillo 2012; [9]Reyes et al. 2014; [10]Agüero Carter & Woolard 2006; [11]AIR 2013; [12]Merttens et al. 2013; [13]Andersen et al. 2015; [14]Chaudhury & Okamura 2012

Among the six Latin American programmes, four were linked to improvements in height for age or stunting: only Brazil and Ecuador failed to show an impact. The largest and most celebrated programmes saw limited improvements in nutritional status: Brazil never saw improvements in nutritional status (Soares & Silva 2010) while in Mexico the initially observed improvements in

child nutritional status slipped away over time (Behrman et al. 2008, Fernald Gertler & Neufeld 2009), perhaps as the controls caught up to the treated households.

Out of the 12 African programmes we examined, just two report positive impacts on anthropometric outcomes (in South Africa, Agüero, Carter, and Woolard report 20% improvements in HAZ for children covered by the programme for at least 24 months; for Malawi Miller (2008) reports a 4% drop in stunting and 2% drop in wasting among children under 5 years), two report no significant impacts (the Zambian Child Grant Programme and Mozambique's Programa Subsídio de Alimentos (PSA) Program) and the rest do not examine anthropometric outcomes at all.

Why are such impacts not even measured? Measuring children is expensive, and impacts may be deemed unlikely due to the difficulty of connecting cash transfers, at the bottom of Figure 1, with child nutritional status, at the top. Being lower on the development index (i.e. the per capita GDP discrepancy described in section 2) means that there are many needs in these places, and many means by which improving household welfare might not translate to improved child nutrition. In other words, the depth of the need limits the effectiveness of any one intervention. While the promise of cash transfers lies in their ability to address a variety of needs, they are still not a "silver bullet" (Handa et al. 2014) to end poverty and the context must be carefully considered. Since the majority of the population in Sub-Saharan Africa are poor or extremely poor, hunger and poverty reduction become major objectives of social protection schemes. As shown in Figure 1, improving child malnutrition may require improving household food insecurity, care practices, and/ or the household disease environment.

In addition, use of international standards for height and weight require knowledge of children's precise ages. In many parts of Africa, a lack of formal birth records or other problems with the quality of gathered data make it difficult to get sufficient precision (Merttens et al. 2013).

5 Cash Transfers and Food Security

Since Table 2 shows that cash transfers do not always simply improve child health, we now turn to look at the whether cash transfer programmes might at least be associated with improving the underlying causes from Figure 1. The first underlying cause is "Household Food Insecurity." We expect that households receiving transfers are more able to improve the quality and/ or quantity of the food they consume, and in general we see that programmes do manage to increase household consumption and dietary diversity.

Table 3: Programme Effects on Household Food Security

	Program	Consumption	Dietary Diversity
1	Brazil	+[1]	+[1]
2	Colombia	+[2]	+[2]
3	Ecuador	No Impact[3]	No Impact[3]

4	Ethiopia	No Impact[4]	
5	Ghana	No Impact[5]	
6	Kenya	+[6]	+[6]
7	Lesotho	No Impact[7]	No Impact[7]
8	Malawi-SCT	+[8]	+[8]
9	Malawi-ZCT	+[9]	+[9]
10	Mexico	+[10]	+[10]
11	Mozambique	+for boys, women[11]	
12	Nepal		+[12]
13	Nicaragua	+[13]	+[13]
14	Peru	+[14]	+[14]
15	Philippines	No Impact[15]	+[15]
16	South Africa	+[16]	
17	Zambia-CGP	+[17]	+[17]
18	Zambia-MCTG	+[18]	+[18]
19	Zambia_MSC	No Impact[19]	No Impact[19]
20	Zimbabwe	No Impact[20]	+[20]

[1]Olinto et al. 2003; [2]de Bem Lignani et al. 2011; [3]Paxson & Schady 2010; [4]Gilligan et al. 2009; [5]Handa, Park et al. 2014; [6]Merttens et al. 2013; [7]Pellerano et al. 2014; [8]Miller et al. 2011; [9]Baird, Chirwa, et al. 2014; [10]Hoddinott, Skoufias, & Washburn 2000; [11]Soares & Teixeira 2010; [12]Adhikari et al. 2014; [13]Maluccio & Flores 2005; [14]Perova & Vakis 2009; [15]Chaudhury, Friedman, & Onishi 2013; [16]Williams 2007; [17]Handa, Seidenfeld et al. 2014; [18]American Institutes for Research 2014; [19]Seidenfeld & Handa 2011; [20]FAO 2015.

Five of the six Latin American programmes have clearly shown improvements in the dietary habits of programme participants, including increases in consumption expenditures, total consumption, and dietary diversity. In the sixth programme, in Ecuador, an increase in consumption and/ or dietary diversity was not seen directly but was inferred by an observed increase in haemoglobin.

Other programmes, such as those in Nepal and the Philippines, provide cautionary tales. In Nepal, supply bottlenecks meant that while the goal was to deliver transfers monthly, in fact most households received a year's worth of transfers at once. Further, the set transfer amount was too small (and it was smaller still after corrupt bureaucrats took a cut). While households appreciated the gesture and often used a year's worth of benefits to buy a meal or two, overall there was no significant impact (Adhikari et al. 2014). In the Philippines, the conditional nature of the transfer was wielded harshly, and on average households received about half of the amount that they were entitled to. Because of this, participating households did not on average have higher levels of consumption than control households. Still, some effects were observed, such as a reduction in severe stunting and greater participation in primary (though not secondary) education (Chaudhury, Friedman & Onishi 2013).

Due in part to the reduced logistical requirements, most programmes in Africa so far have been unconditional, providing cash to the needy without investigating whether each household is getting children to school or getting health care. Still, many programmes have been successful in improving households' access to food. In Kenya, all recipients increased their level of consumption, and the poorest recipient households improved their dietary diversity (Merttens et al. 2013). The Child Grant Programme (CGP) and the Social Cash Transfer – Multiple Category Targeting Grant (MCTG) in Zambia and the SCT in Malawi led to improved diets as measured both by the higher number of food groups consumed relative to the control (AIR 2013; Miller Tsoka & Reichart 2011) and the increased expenditures on poultry and fish (American Institutes for Research, 2014).

A few programmes have not managed to improve consumption as much as they would like. The Monze SCT, similar in design and targeting to the other pilot SCT in Zambia, failed to achieve significant improvement in food consumption and expenditure, though the findings are not conclusive because the expenditure data were not detailed enough. Still, some studies of programmes in other countries also fail to find strong evidence of higher diet quality. Ethiopia's Productive Safety Net Programme (PSNP), which transferred cash to households affected by shocks conditional on the households' providing labor to public works projects (with certain exemptions), also did not have any impacts on food security unless households received at least half of the designated amount or received support from Other Food Security Programme (OFSP) to enhance the productivity of their farms (Gilligan, Hoddinott, & Taffesse, 2009). In fact, the largest impacts were found for participants in the PSNP who also received access to any component of OFSP, raising the question about the need for a more comprehensive package of interventions rather than any one single intervention.

As a side note, in addition to immediate food security CT programmes have enabled many households in Africa to invest in agriculture thus potentially reducing long-term economic vulnerability (American Institutes for Research, 2014; Covarrubias, Davis, & Winters, 2012; Gilligan et al., 2009; Handa, Park et al., 2014; Handa, Seidenfeld, Tembo, Prencipe, & Peterman, 2013; Hoddinott, Berhane, Gilligan, Kumar, & Taffesse, 2012; Oxford Policy Management, 2013; Seidenfeld & Handa, 2011). In some countries, investments in agriculture were unintended consequences of infrequent and unpredictable transfer deliveries resulting in lump sum payments. The untimely and unpredictable delivery of the payments did not allow households to smooth consumption, but the resulting lump sum amounts enabled them to make larger purchases for the farm.

6 Cash Transfers and Child Illness

The first link in Figure 1 appears to be relatively robust: with a few exceptions, cash transfers do seem to promote household food security. However, support for the relationships on the right side of our figure is not as robust. In this section we consider the effects of cash transfers on

household access to care, an underlying cause of child undernutrition, and effects of transfers on illness, an immediate cause.

Table 4: Programme Effects on Child Illness & Household Health Care Access

	Program	Illness	Health Care Access
1	Brazil	– [1]	+ [1]
2	Colombia	– [2]	+ [2]
3	Ecuador		+ [3]
4	Ethiopia		
5	Ghana	+ [4]	+ [4]
6	Kenya	No Impact [5]	
7	Lesotho	– [6]	No Impact[6]
8	Malawi-SCT	– [7]	+ [8]
9	Malawi-ZCT		
10	Mexico	– [9]	No Impact[10]
11	Mozambique		
12	Nepal		No Impact[11]
13	Nicaragua		+ [12]
14	Peru	– [13]	+ [14]
15	Philippines		+ [15]
16	South Africa	–for some groups[16]	+ [16]
17	Zambia-CGP	– [17]	No Impact [17]
18	Zambia-MCTG	No Impact [18]	+ [18]
19	Zambia_MSC	No Impact [19]	
20	Zimbabwe		

[1]Campello & Côrtes Neri 2014; [2]Attanasio et al. 2005; [3]Paxson & Schady 2010; [4]Handa, Park et al. 2014; [5]Merttens et al. 2013; [6]Pellerano et al. 2014; [7]Miller et al. 2010; [8]Miller et al. 2008; [9]Gertler 2004; [10]Barber & Gertler 2010; [11]Adhikari et al. 2014; [12]Moore 2009; [13]Perova & Vakis 2009; [14]Perova & Vakis 2012; [15]Chaudhury, Friedman, & Onishi 2013; [16]DSD, SASSA and UNICEF, 2012; [17]Handa, Seidenfeld et al. 2014; [18]American Institutes for Research 2014- note that the increase in "health care" is an increase in health-related expenditures only; [19]Seidenfeld & Handa 2011.

While most programmes with noted impacts do show the correct signs one fact that stands out on the table is the number of blank spaces, particularly on the left. Many studies simply did not consider the incidence of illness among children in recipient households. While gathering data on anthropometrics is costly, difficult, and time-consuming, it is less complicated to ask mothers about whether their children have been well or ill. Of course rigorous questioning on this subject requires care, as for example in the case of diarrheal illness for which investigators may want to know whether a child has repeatedly shown symptoms; still, it may be more of an oversight than a question of cost why these questions are not asked. It is unfortunate that many surveys asking about whether families used health care did not also ask about whether children have been sick,

as this would help us know the degree to which disease is limiting the potential impact of cash transfers on nutritional status.

Ultimately we can only conclude that seven or eight of our twenty programmes are also having an effect on child illness. This is concerning, but since there is simply no evidence in many cases (rather than negative evidence) we can conclude only that more evidence would be useful here. If children are ill and cash transfers are not helping them get better, then transfers are unlikely to achieve the lasting gains manifest in anthropometrics.

7 Cash Transfers and "Care"

Perhaps the most nebulous portion of Figure 1 is the box in the centre. "Inadequate care" can affect child health directly and it can limit the effect of household food security on a child's diet. However, what does it refer to, exactly? First, if a mother is not healthy, not educated, or not economically self-sufficient, she may not be well prepared to "care" for a child, i.e. to make sure a child gets what he or she needs. This is particularly true during pregnancy, which constitutes the first portion of a child's first 1000 days of life. If a woman is not able to take care of herself, that is likely to have a profound impact on her children as well.

The mother's health and status during the child's conception and gestation are areas of considerable concern in low income countries, where adolescents account for more than half of all births (WHO 2016). Around 11% of births worldwide, or about 16 million each year, are to girls aged 15-19 (Laski et al. 2015). In Africa in particular, adolescent fertility rates are high: from 2010-2014, the average rate in Zambia is 122 per 1000, in Zimbabwe 58, and in Malawi there are 143 pregnancies per 1000 people, while the UK has just 26 (World Bank 2015). 41% of women ages 20-24 in sub-Saharan Africa were married before age 18. Marriage is an economic strategy to alleviate the household consumption burden (Handa et al. 2015a).

Young women are at higher risk for difficult pregnancies, complications, and death and injury as a result of pregnancy (Laski et al. 2015). Much adolescent pregnancy in Africa is due to non-consensual and transactional sex: surveys show that a large share of young women in Malawi, for instance, are "forced, pressured, or tricked" into sex (Handa et al. 2014). Thus, in an African context, it makes sense to focus on addressing adolescent fertility.

In this context, Handa et al. (2015a) identify four pathways by which cash transfers can link to healthy babies and healthy households in which to raise babies. First is increased investment in girls' education: Patton et al. (2016) conclude, "Guaranteeing and supporting access to free, quality secondary education for all adolescents presents the single best investment for health and wellbeing." The second pathway of Handa et al. (2015a) is an increase in economic stability. The third means by which transfers can make a difference is by improved mental health, and the fourth is a delay of girls' sexual debut and reduced high-risk sex. Thus, we operationalize "care" to include these characteristics.

7.1 Education

Improvements in school attendance and/ or performance have resulted from unconditional cash transfer programmes.

Table 5: Programme Effects on Primary and Secondary Education

	Program	Primary	Secondary
1	Brazil	+ [1]	+ [1]
2	Colombia	+ [2]	+ [2]
3	Ecuador	+ [3]	+ [3]
4	Ethiopia		
5	Ghana	universal[4]	+ [4]
6	Kenya	+ [5]	+ [5]
7	Lesotho	+ [6]	No Impact [6]
8	Malawi-SCT	+ [7]	+ [7]
9	Malawi-ZCT	details below	details below
10	Mexico	universal[8]	+ [8]
11	Mozambique		
12	Nepal	No Impact [9]	No Impact [9]
13	Nicaragua	+[10]	
14	Peru	+[11]	+[11]
15	Philippines	+[12]	No Impact [12]
16	South Africa	+[13]	
17	Zambia-CGP	+[14]	+[14]
18	Zambia-MCTG	+[15]	+[15]
19	Zambia_MSC	+[16]	+[16]
20	Zimbabwe		

[1]de Brauw et al. 2012; [2]Attanasio et al. 2010; [3]Schady & Araujo 2010: results in the paper are not split by primary & secondary, but discussion implies increases in both; [4]Handa, Park et al. 2014; [5]Merttens et al. 2013; [6]Oxford Policy Management 2014; [7]Miller et al. 2008; [8]Attanasio Meghir & Santiago 2011; [9]Adhikari et al. 2014; [10]Maluccio & Flores 2005; [11]Perova & Vakis 2009; [12]Chaudhury & Okamura 2012; [13]DSD, SASSA and UNICEF, 2012; [14]Handa et al. 2015c; [15]American Institutes for Research 2014- impacts on primary age boys- no impact on girls, while secondary impact on girls only, not boys; [16]Seidenfeld & Handa 2011: impact on secondary education only significant at 10% level.

The few programmes in which effects were not shown are programmes such as Nepal and the Philippines, which ran into problems described above. In particular, neither managed to deliver the anticipated level of transfers to recipient households, making it difficult to pay costs associated with education (which can include educational materials, uniforms, school trips, or even just having clothing appropriate for that environment).

Secondary school is expensive in terms of both time and money. In some rural communities there are simply no accessible secondary schools: only three of the 45 surveyed communities participating in Zambia's SCTS had secondary schools (AIR 2013). Further, while primary school has no tuition costs in Kenya, indirect costs can include uniforms and school supplies and even paying for the teacher. Attending secondary school can cost as much as ten times more than primary (Attah Farhat & Kardan 2013). In Lesotho, while the transfer helped children get to primary school, the amount of the transfer was not sufficient even to cover tuition to a secondary school (Oxford Policy Management 2014). Even where secondary school is free, though, the opportunity cost is higher, as secondary school-aged children can contribute household labour or they can work outside the home to generate income.

Secondary education is of particular importance for girls, but many of the evaluations of African programmes do not track secondary education achievement by sex. Out of the 12 African programmes, only five consider secondary school achievement by gender. Malawi, due in part to a system of transfers that provided increased payments to students at the secondary school level, saw increased attendance there (Miller Tsoka & Reichart 2008). In Zambia the MCTG led to significant positive impacts on enrollment of secondary school-aged girls (American Institutes for Research 2014). In Kenya no effect was noted.

The Zomba Cash Transfer Programme (ZCTP) in Malawi in 2008-09, tried various transfer modalities (Baird, McIntosh, and Özler 2011). In some cases, transfers to young women (ages 13-22) were conditional on attending secondary school, and in others the transfers were unconditional. They found that the conditional transfers did a better job of keeping the women in school, but that the unconditional transfers more strongly protected dropouts from teenage pregnancy.

7.2 Economic Self-Sufficiency

The simplest impact of cash transfers to a woman might be enabling her to take care of herself economically, and we will simply provide a few examples rather than belabouring this point. Evidence from Uganda shows that women in particular are credit-constrained, and that grants can help women "take off" (Blattman Fiala & Martinez 2013). Cultural factors also work against women's controlling assets for themselves or their children (Buvinić and Furst-Nichols 2014), which can become a vicious cycle, as women are less able to marshal sufficient resources to make it through a job-training programme, for example (Cho et al. 2013). Note that Buvinić and Furst-Nichols (2014) conclude that a small transfer is unlikely to help much: instead, they argue in favor of "interventions proven to increase young women's economic opportunities."

7.3 Mental Health

In Malawi, offers of cash transfers strongly reduced psychological distress (Baird, De Hoop, and Ozler 2013). However, these large beneficial effects declined with increases in the transfer amount offered to the parents conditional on regular school attendance by the adolescent girls.

There was also strong evidence of increased psychological distress among untreated baseline schoolgirls in treatment areas.

A related concern that is examined by some analysts is women's empowerment. Empowering women is an outcome that is good on its own, but further it can mean a lot for their children. Maternal autonomy has been linked to child nutritional status (i.e. Arulampalam Bhaskar & Srivastava 2016; Malapit et al. 2015) and Branca et al. (2015) identify female empowerment as a "key priority."

Since cash recipients are in almost all cases women, some improvements have been seen in women's status. In Mexico, women were empowered to push their doctors for better care (Barber & Gertler 2010). In Brazil, women's decision-making in general has improved (de Brauw et al. 2012). However, some analysts contend that by making women recipients, traditional gender roles are being reinforced (Molyneux 2006, Streuli 2012). Examining rural Mexico, Angelucci (2008) finds that while small transfers decrease intimate partner violence, large transfers may have the opposite effect. Bobonis, González-Brenes, and Castro (2013) find that recipients are more likely to suffer threats of violence but 40% less likely to experience partner physical or sexual violence.

One way in which women's empowerment has been supported in Latin America is by the gathering of women into groups. In Mexico, women came to collect their transfers and were required to attend "pláticas", or educational talks, often related to health and hygiene. In Colombia, women beneficiaries elect "madres lideres," beneficiary women who represent women to local authorities and programme managers but also lead care meetings and family gatherings (Soares and Silva 2010).

7.4 Sexual Health

Programme impacts on early marriage and teenage pregnancy are rarely examined. Only two evaluations look at programme impacts on age at first marriage or age at first childbirth– the evaluations of the MCTG programme in Ghana and the ZCTP in Malawi (Baird McIntosh & Özler 2011). Only the latter delays marriage. The effects of cash transfer programmes on teenage pregnancy is also unclear. Three programmes (the South Africa Child Support Grant, the Malawi BMO, and Duflo et al.'s Kenyan program) led to reduction in teenage pregnancy; in South Africa young women in recipient households have fewer sexual partners and a lower pregnancy rate, most likely as they avoid transactional sex (Cluver et al. 2014). Unfortunately two programmes (the Zambian MCTG and the Malawi Social Cash Transfer) have no effects on teenage pregnancy. The evidence from the international programmes is even scarcer, if any at all. Only the evaluation of Brazil's Bolsa Familia provides some indirect evidence regarding pregnancy where the authors conclude that the programme led to an increase in women's decision making about the use of contraception.

Recent studies (de Neve et al. 2015, Duflo, Dupas, and Kremer 2015) highlight the role that educational subsidies and school attendance can play in preventing early pregnancies and HIV exposure in the region as well. Cash transfers can keep young women in school and/ or otherwise free them from pressures to participate in transactional sex, helping them avoid early sexual debut, pregnancy, and marriage, as described above.

8 Conclusion

Cash transfers are an effective tool with great potential to improve lives in sub-Saharan Africa at a relatively low cost, but they are no "silver bullet" (Handa et al. 2014). Transfers reliably improve household consumption and dietary diversity, but this does not always translate into improved nutritional status among children (Manley, Gitter, and Slavchevska 2013). One reason may be that children are too ill to benefit from the improved food access; unfortunately many ostensibly nutrition-focused papers fail to discuss the health of the children in recipient households, making it difficult to tell.

After considering the process by which children's nutritional status develops (shown in Figure 1), we noted that one underlying cause mediates many of the connections that need to be made for the input of transfers to achieve an output in child health. That underlying cause, called simply "care" in our diagram, is a likely fault in Africa due to the fact that a large share of pregnancies occur among women whose young age makes them ill fit to be mothers.

In Africa a key time in the life cycle, and one that has so far been underserved, is adolescence (Sanghera et al. 2015). Branca et al. (2015) conclude that "adolescent girls should be at the heart of a life course approach" to improving nutrition for adults and children both. In Africa often girls become mothers at a very young age, putting their not-fully-developed bodies at mortal risk (Sanghera et al. 2015).

Their babies are also at risk, as adolescent pregnancies face a higher risk of stillbirths, neonatal deaths, early, and underweight births (Branca et al. 2015). Even if the pregnancy goes well for mother and child, a younger mother is less able to take care of a child if she is not educated, and if she lacks the economic means and psychological health to provide for herself and her offspring.

Giving money to households is a good thing to do: it increases the quantity and quality of food consumed in the household, and can also give households the flexibility to address whatever problem that they face, even when donors might not be aware of the issue.

However, a few problems have been noted. In a Kenyan program, some improvements in women's status are noted in the poorest households but in other households women are unable to control the use of the transfers and some qualitative evidence shows increased tension in the household (Merttens et al. 2013). Many others have written about women's inability to retain control over transfers (cf. Jakiela & Ozier 2015, Aker et al. 2011), although the Zambian MCTG was indeed associated with an increase in female decision-making power in many domains

including the control of own income, decisions about large purchases and visits to family and friends (American Institutes for Research, 2014).

Whereas cash transfers have often had a positive psychological effect, poor targeting can cut into those effects as in Malawi, where programme effects declined with increases in the transfer amount offered to the parents conditional on regular school attendance by the adolescent girls. There was also strong evidence of increased psychological distress among untreated baseline schoolgirls in treatment areas (Baird, De Hoop, and Ozler 2013).

Instead of simply providing transfers to a household, we recommend that adolescent girls and young women receive either direct transfers or support to attend secondary school. If incentives or support can keep young women in school, they also protect them from the need to engage in risky transactional sex: young women need the independence to resist the appeal of the "considerably older men" seeking their company (Handa et al. 2014). Further, more education improves access to health-related information that enables them to take care of infants and children. A policy providing a base benefit plus an added bonus for school attendance might be a nice compromise (where schools are accessible).

As noted by Temmerman et al. (2015), "Increasing investment in women's, children's, and adolescents' health has many benefits: it reduces poverty; it stimulates economic productivity and growth; it creates jobs; it is cost effective; and it helps women, children, and adolescents realise their basic human rights to health, wellbeing, and a sustainable future."

Women older than school age might also be targeted for more than just transfers. In addition to economic self-sufficiency, programmes may go further by grouping women and gathering them to participate in discussions. This empowers them via shared information and collective action. Along similar lines, the programmes can easily add in an educational component if resources permit, though access to medical care can constrain health impacts. Most programmes in Africa do not include nutrition-focused complementary actions such as information about feeding of infants and young children, information about preventive care and seeking of curative healthcare. The LEAP programme in Ghana enabled beneficiaries to enroll in the national health insurance scheme, but the evaluation showed that though preventive care was up, curative care was not, suggesting that outburst of infectious diseases (diarrhea) may still remain untreated. Evaluation of a programme in Zambia found that transfers' effectiveness was limited in places with little or no access to hospitals, for example (Handa et al. 2015b).

Regional targeting is inexpensive and avoids negative impacts on jealous neighbors, as shown by Haushofer, Reisinger, and Shapiro (2015) and Baird, de Hoop, and Özler (2013). Some programmes such as Malawi's Social Cash Transfer Programme allowed community representatives to participate in targeting.

Cash transfer programmes can be highly effective at a very small price. Transfer amounts in these programmes achieved impressive gains by providing young women and/ or their families

with amounts that are trivial to us in industrialized countries. In Zambia, each household received $12/ month, while in Kenya it was $25/ month. The South African programme has increased the amount over time and is now up to $30/ month per child, while the transfer in Malawi is just $3-4 per person per month. Efforts are made to keep administrative costs low but they are largely dependent on the year of the operation and how remote the targeted households are. In Zimbabwe, the operation costs are estimated to be only about 12.5% of the programme budget suggesting that the programme may be highly cost-effective (Schubert & Chirchir, 2012) while in Lesotho they range from 16 to 35%, depending on the year of operations (Kardan, Sindou, & Pellerano, 2014).

Finally, cash transfers were not wasted on non-nutritious or prestigious goods. Cash transfers were often used for productive investments. When a lump sum was delivered, the transfer was invested in accumulation of assets (some small livestock such as goats, or the purchase of fertilizer and improved seeds) thus contributing to the future economic well-being of the household.

Cash transfers are an important tool in working against poverty, and with these suggestions their effectiveness can be improved. Like any tool there are some tasks for which they are better suited than others, but the cost effectiveness of this intervention is high and results are promising. We hope that more organizations will take the plunge to invest in such interventions, and importantly we hope that they will organize their programmes such that impacts are easily observed and analysed. The more information published about programme effectiveness, positive and negative, will enable further programmes to improve their own efficiency.

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