

RESEARCH BRIEF



CHILD OUTCOMES OF CASH TRANSFER PROGRAMMING



Save the Children

A synthesis of the evidence around survival, education, and protection in humanitarian and non-humanitarian contexts

Written by Anjini Mishra and Francesca Battistin

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Save the Children UK
1 St John's Lane,
London
EC1M 4AR
UK
savethechildren.org.uk

Save the Children Spain
C/ Doctor Esquerdo 138
Madrid,
28007
SPAIN
www.savethechildren.es

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Edited by: Hannah Hames

Designed by: Helen Waller (icre8design)

¹ For correspondence regarding the research & methodology contact Anjini Mishra at mishra.anjini@gmail.com, for other queries contact Francesca Battistin at f.battistin@savethechildren.org.uk.

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1. INTRODUCTION

The use of cash transfer programming (CTP)² has risen in recent years to become an integral element of poverty reduction and social protection strategies in low- and middle-income countries (LICs and MICs).³ The humanitarian sector has also adopted CTP and within the past decade there has been a growing awareness of the important role that cash transfers can play as part of an effective and efficient humanitarian response.⁴ In fact, when conditions permit, cash transfers are being increasingly recommended over typical in-kind goods, as they are considered to be more cost-efficient, have the potential to support local markets (as opposed to replacing them), and enable affected populations to make their own financial choices.⁵

Within the context of child wellbeing⁶, CTP is a popular means of giving poor people additional financial resources enabling them to invest in their children's future: to help families meet their children's critical needs, develop their children's human capital, and break up the intergenerational cycle of poverty.⁷ In humanitarian situations meeting children's critical needs is often particularly difficult due to increased demands on limited resources, loss of livelihoods and increased income poverty, along with possible displacement.

Humanitarian emergencies are increasing in both frequency and duration. It is evident that children bear the brunt of these situations and that these experiences have long-lasting effects on their development and future. The figures for the number of children affected by humanitarian emergencies are worrying: in 2014, children comprised half or more of those affected by natural disasters (approximately 50 million children) and 51% of refugees were children.⁸ Additionally, 34 million children and adolescents are out of school in conflict-affected countries;⁹ nine out of ten countries with the highest rates of child marriage are fragile states;¹⁰ 60% of preventable maternal deaths and 53% of under-five deaths take place in settings of conflict, displacement and natural disasters;¹¹ and in 2013, 65% of all children living in conflict zones (i.e. 112.1 million children) were chronically undernourished.¹²

Given this pressing need for humanitarian and development assistance it is vital to have a clear understanding of what interventions have the greatest impact. Substantial evidence has been generated over the last decade on the effectiveness of cash transfers¹³ including their impacts on children¹⁴, and from within a variety of contexts including development programmes¹⁵ and humanitarian responses.¹⁶ However, as far as we are aware, no review has so far provided an overall assessment of key outcomes for children in both humanitarian and development contexts without either being limited by the number of indicators reviewed or the socio-political or geographical contexts analysed.¹⁷

This systematic review attempts to fill this evidence gap by reviewing a comprehensive list of indicators around outcomes for children in health, food security, nutrition, protection, and education. These indicators include both those that directly affect children, such as the child's health, and those that indirectly concern children, such as maternal health status. The study includes evidence from both humanitarian and non-humanitarian contexts, with no specific geographical or socio-political focus. We considered evidence generated between 2012 and 2016, as we were interested in the latest findings available on this matter¹⁸, and the available resources did not allow for a wider search.

This Research Brief offers a condensed account of the findings and conclusions of a longer full report.¹⁹ Readers interested in examining specific aspects in greater depth, are recommended to refer to the full report on "child outcomes of cash transfer programming: A synthesis of the evidence on survival, education and protection in humanitarian and non-humanitarian contexts". This full report contains a more comprehensive version of the research methods as well as of the findings, bibliographic references, and wider implications on the use of cash transfer programming for children's wellbeing and further research. It also contains the full version of the study protocol.

² CTP here refers to all programmes where cash (or vouchers for goods or services) is directly provided to beneficiaries. In the context of humanitarian assistance, the term is used to refer to the provision of cash or vouchers given to individuals, households or community recipients; not to governments or other state actors. CTP excludes remittances and microfinance in humanitarian interventions (although microfinance and money transfer institutions may be used for the actual delivery of cash) (source: online CaLP glossary).

³ F. Bastagli et al. 2016.

⁴ A humanitarian emergency (or crisis) is defined as a singular event or a series of events that threaten the health, safety or well-being of a community or large group of people (Humanitarian Coalition, 2013).

⁵ GHA 2013.

⁶ Child wellbeing being a multidimensional concept involving material wellbeing, health and safety, educational wellbeing, family and peer relationships, behaviours and risk, and subjective wellbeing (UNICEF 2007)

⁷ STRIVE 2015.

⁸ UNICEF 2015.

⁹ Ibid.

¹⁰ WRC 2016.

¹¹ Every Women, Every Child 2015.

¹² IFPRI 2015.

¹³ Bastagli et al. 2016.

¹⁴ For example, STRIVE 2015.

¹⁵ Kabeer et.al. 2012; Fiszbein and Schady 2009.

¹⁶ Doocy and Tappis 2016; Bailey and Harvey 2015; Pega et.al. 2015.

¹⁷ STRIVE 2015; CPC network 2011; UNICEF-ESARO/Transfer Project 2015; Pozarny 2016; Cooper and Stewart 2013.

¹⁸ While the literature search covers the period 2012-2016, the inclusion of evidence from meta-analysis and systematic reviews ensures that this review includes some evidence from around 2008 onwards.

¹⁹ As of date of publishing this research brief, the full report is available only as unpublished manuscript. The report can be requested by contacting the co-author Francesca Battistin (f.battistin@savethechildren.org.uk)

in 2014, children comprised half or more of those affected by natural disasters

approximately **50 MILLION** children

and **51%** of refugees were children



Additionally,



34 MILLION children

and adolescents are out of school in conflict-affected countries

9 out of 10 COUNTRIES

with the highest rates of child marriage are fragile states

60% of preventable maternal deaths and

53%



of under-five deaths

take place in settings of conflict, displacement and natural disasters



In 2013,

65% of all children living in conflict zones

112.1 MILLION children

were chronically undernourished.

2. METHODS

RESEARCH QUESTIONS

The underlying hypothesis examined by this synthesis report is that cash transfer programming (CTP) influences child outcomes by expanding households' budgets and their capacity to spend on health and education, without having to resort to negative coping behaviours that are harmful to children and their development such as child labour, early marriage, neglect of their nutritional and health needs. The ways in which CTP impacts child outcomes however are not linear and several contextual factors as well as households' specific conditions need to be considered. Hence, whilst being primarily aimed at exploring the underlying hypothesis that CTP has desired effects on child outcomes, this systematic review also attempts to describe some of these pathways and moderators of impact.

The key research questions of interest are:

- **How effective are cash transfers in addressing key outcomes related to children's survival, education, and protection?**
- **Are there any differences in impact based on the gender of either the child or the CTP recipient?**
- **What evidence exists to suggest pathways and moderators of impact?**

OVERVIEW OF THE SEARCH FRAMEWORK AND PROCESS²⁰

Below is an overview of how the search was framed, according to the dimensions Population of interest, Interventions, Comparisons, Outcomes (PICO).

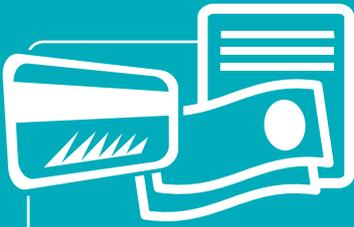
Population of Interest: the study considered evidence that relates to programmes where the target beneficiary was between 0 and 18, bearing in mind that the cash transfers may have been made to their (adult) caregivers rather than directly to the children.

Interventions: For the purpose of this study, the author divided CTP into five types of interventions that result from different combinations of two key features of CTP, namely: conditions for the receipt of the money, and restrictions on the use of the money".²¹

However, despite categorising CTP in this way, this study does not aim to establish the relative performance of these different modalities. In fact, unless a study is specifically designed to test for differences between two or more types of intervention, we cannot draw causal inferences about their relative performance from observed impact on outcomes. In conducting this review, little evidence was found that compared modalities. Hence, when reading this report, it is important to bear in mind that it is not possible to draw conclusions around the additional value of conditionalities and restrictions. Instead, this study focuses on the effectiveness of CTP more broadly.

²⁰ For a detailed review of the study protocol refer to the full report

²¹ When applied by design, conditionalities and restrictions are subject to auditing, hence compliance is explicitly monitored and non-compliance is expected to result into recipient's removal from the programme.



Unrestricted Unconditional Cash Transfers (unrestricted UCTs) provide beneficiaries with cash without the need for them either to fulfil a particular condition (unconditional), or spend the funds in a particular way (unrestricted). Of all the transfer modalities, unrestricted UCTs give recipients the maximum degree of flexibility, freeing them from the financial and non-financial costs associated with fulfilling conditions and allowing them full control over how the money is spent.

Examples of unrestricted UCTs are:

- Multipurpose cash grants (MPGs), implemented in several recent humanitarian responses²²
- Family and child allowances (including orphan and vulnerable children benefits)²³
- Scholarship benefits²⁴
- Poverty-targeted cash transfers
- Disability social pensions and benefits
- Non-contributory social pensions

Unrestricted Conditional Cash Transfers (unrestricted CCTs) provide beneficiaries with cash once they have fulfilled a specific precondition but which they are then free to use as they see fit. Beneficiaries who do not comply with the conditions are (or should be) disqualified from receiving further transfers. This mix of implementer's control over recipients' behaviour and flexibility over expenditure choices makes unrestricted CCTs a very common form of cash transfer programming, in development and humanitarian contexts alike. Unrestricted CCTs can be used to meet a wide range of aims while allowing beneficiaries a degree of autonomy.

Examples of unrestricted CCTs include:

- Transfers in exchange for work (also known as Cash for Work), remunerated based on time spent or product delivered
- Transfers in exchange for training attendance (also known as Cash for Training)

- Transfers based on attending health check-ups
- Family and child allowance, if the transfer is conditional on having attended antenatal care awareness sessions
- Scholarship benefits, if the transfer is conditional on attending school or achieving a certain grade and paid directly to households.

Restricted Unconditional Cash Transfers (restricted UCTs) are transfers given to beneficiaries without requiring any specific action from the beneficiary, but with restrictions on where (which shops or providers) and what (which commodities and services) the money can be spent. More or less rigid restrictions can be imposed through the use of commodity and value vouchers. The former are the most rigid as they require recipients to spend the money on items from a specified list of goods and services in pre-selected shops or facilities, while the latter can be used on any item sold or service offered by the pre-selected shops or facilities up to a certain total amount.

Examples of restricted UCTs include:

- Commodity or value voucher received without having to meet any conditions (for expenses related to food; water, hygiene and sanitation (WaSH); education; shelter, etc.)
- Scholarship benefits, if restricted to specific use (e.g. books, uniform, fees, a specific school)
- Funeral grants, burial allowances
- Rent subsidy/allowance

Restricted Conditional Cash Transfers (restricted CCTs) are provided to beneficiaries on performance of a specific precondition, and can only be used by the beneficiary on specific commodities or services. The high levels of rigidity make restricted CCTs very complex to set-up, administer and monitor; it is necessary to check that both the conditions and the restrictions have been met. As such, they are very rarely used, and most appropriate when the transfer is of a large amount and not recurrent.

²² MPG programmes have recently been implemented in response to humanitarian emergencies in Lebanon, Jordan, Iraq, and Ukraine. MPGs differ from other unrestricted UCTs in the way the value of the transfer is calculated, i.e. based on a Minimum Expenditure Basket.

²³ If free from conditions and/or restrictions

²⁴ If free from conditions and/or restrictions.



Examples of restricted CCTs include:

- Food (or other) voucher given with specific conditions
- Business recovery or start-up grant with restricted use and subject to a condition, e.g. Attending business management training, submitting a business plan
- Scholarship benefits, if both restricted and conditional. For instance, that have to be spent on school fees or school supplies following the attainment of a certain grade in school

Labelled Cash Transfers (either conditional or unconditional) are a subset of restricted cash transfers. These cash transfers come with 'soft' restrictions: recipients are simply recommended or nudged to

use the money on certain expenditures, but are not obliged to do so. Beneficiaries are not disqualified from receiving the assistance should they decide not to follow the recommendations. Examples of nudges include suggesting parents invest the money in their children's health or education.

Cash Plus Complementary Programmes are not a modality as such. They typically involve combining one of the above cash modalities with additional interventions or services that are intrinsic or external to the programme itself, with a view to enhancing certain impacts. For example, complementing cash transfers with behavioural change communication around infant and young child feeding practices to improve nutrition outcomes.

Comparison: All quantitative studies considered in this review included a counterfactual group against which recipients were compared. Unless otherwise specified in this review, the counterfactual group was not receiving any assistance. The study did not compare cash with in-kind transfers or any other type of intervention.

Outcomes: A comprehensive list of outcome indicators relevant to the synthesis was identified and can be found in the full report, as part of the study protocol. These were developed in consultation with sectoral and cash transfer experts and practitioners and are aligned to specific priority areas of Save the Children's work, known as the Breakthroughs. The focus has been to identify evidence of impact on as many outcome indicators as available within the scope of the synthesis. Based on the Save the Children Breakthrough terminology, the outcomes were divided into:

- **Child survival indicators** relating to preventive and curative health behaviour (maternal and child), feeding practices, child nutrition status, WaSH, food security, morbidity, mortality, and psycho-social health
- **Child education indicators** including cognitive development, school enrolment, attendance, grade progression/attainment/completion, school drop-out, school performance, social and emotional learning

(SEL), and vocational and pre-schooling outcomes

- **Child protection indicators** relating to child labour, early marriage, pregnancy and sexual debut, risky sexual behaviour, child abuse (violence/neglect), family separation, child-care arrangements, quality of care, and access to social protection services

ADDITIONAL SCREENING CRITERIA

In addition to the PICO outlined in the section above, the review protocol included also the following dimensions, based on which studies were retained for review or disregarded.

Type of Research: The synthesis primarily includes peer and non-peer-reviewed systematic reviews (SRs) as well as quantitative and qualitative evaluations not covered by those reviews (QuantE and QualE). SRs were classified based on confidence rating using a 'Systematic Review Confidence Rating Tool' developed by the International Initiative for Impact Evaluation (3ie)²⁵. Quantitative evaluations that were not part of systematic reviews have been rated from 1 to 5 according to the robustness²⁶ of the research methods using the Maryland Scientific Methods Scale (MSMS)²⁷.

²⁵ Page 43: http://www.3ieimpact.org/media/filer_public/2017/03/09/egm6-stip.pdf. This checklist is adapted from appendix 2 of B. Sniltveit et al. (2013), available at: http://www.wds.worldbank.org/external/default/WDSContentServer/1W3P/IB/2013/12/13/000158349_20131213135609/Rendered/PDF/WPS6725.pdf

²⁶ Robustness is based on an emphasis on evidence generated from counterfactual evaluation designs; that which compare outcomes between a treatment/intervention group and a comparable control/comparison group, so as to arrive at the impact of a programme in a way that takes into account all extraneous factors that might have been influencing the outcome, other than the programme itself. Designs rated at a level of 3, 4 or 5 on the MSMS are those best placed to provide an estimate of such an unbiased impact as compared to those rated at 2 and 1.

²⁷ M. Madaleno and S. Waights 'Guide to scoring methods using the Maryland Scientific Methods Scale' <http://www.whatworksgrowth.org/resources/the-scientific-maryland-scale/>

Geographical Coverage: The synthesis includes studies from low and middle-income countries (LMICs). Studies from high-income countries (HICs) are not included.²⁸

Timeline: The synthesis is limited to studies released between 2012 and 2016, inclusive. However, some of the studies contained in SRs may have been released prior to that period.²⁹

Socio/Political Context: The synthesis identifies studies from development-oriented contexts as well as humanitarian emergency contexts.

SEARCH AND SCREENING PROCESS

The study follows a systematic approach to evidence identification. A systematic search strategy has been applied to a wide range of provider databases and relevant websites to identify peer and non-peer reviewed literature. A full list of databases and websites searched is available in the study protocol in the full report. The lead author also collected additional relevant research by consulting with key Save the Children staff and external cash transfer experts and practitioners.

FINDINGS

The search and screening process produced an initial longlist of 4,800 studies, which was narrowed down to a shortlist of 106 studies for final analysis through the application of the mentioned inclusion and exclusion

criteria. Of these, 94 studies covered non-humanitarian contexts and 12 studies were from humanitarian contexts; 16 were systematic reviews³⁰ and 90 individual studies. Most of the studies from a humanitarian context were quantitative evaluations rated 2 or 1 on the MSMS; most of the studies from a non-humanitarian context were SRs given a high confidence rating and quantitative evaluations rated between 3 and 5 on the MSMS.

Studies covered Sub-Saharan Africa, North Africa, Latin America and Caribbean, South Asia, Central Asia, East Asia as well as Middle East.

With regard to CTP modalities reviewed by the studies, the majority looked at unrestricted CCT programmes (49) or unrestricted UCT programmes (29). Fewer programmes covered the other three modalities, i.e. restricted UCTs (17), restricted CCTs (12) and labelled UCTs (4). Out of the total, 73 studies reviewed single-modality programmes and 33 studies reviewed programmes including several CTP modalities, transferred either to separate groups as part of multi-treatment interventions or included in SRs covering evidence from different cash modalities.

Note for the reader: the studies in review are cited through one or more numbers, each referring to a specific outcome. The list of studies by outcome and their respective numbers can be found in APPENDIX 1: TABLE OF STUDIES INCLUDED IN THE REVIEW.



²⁸ Classification into LMICs and HICs followed the World Bank's Country Classifications; see <https://datahelpdesk.worldbank.org/knowledgebase/articles/906519>

²⁹ Two studies published in 2017 have been included in the review following experts' request, albeit falling outside of the established interval. These studies are: de Oliveira et al. 2017, and Fernald et al. 2017.

³⁰ The SRs included those employing primarily a meta-analysis (MA) or narrative-synthesis (NS) approach.

Guidelines for Interpretation of Findings:

for the purpose of the synthesis, findings have been classified into:



Positive significant impact:

where findings point to an unambiguous increase in the indicator under analysis



Negative significant impact:

where findings point to an unambiguous decrease in the indicator under analysis



Non-significant impact:

where findings indicate no change in an outcome indicator

The term “mixed findings” is used in this document where findings do not allow unequivocal conclusions to be drawn around the direction and size of the impact of an intervention.

LIMITATIONS

The review followed a systematic approach in the search of studies with a formal protocol for their inclusion and exclusion, as well as for rating both SRs and individual evaluations³¹. However, the methodological robustness of the individual studies was not subject to a risk of bias assessment³². The possible inherent methodological limitations and biases of the reviewed studies could have affected the reliability and accuracy of their findings with consequences on the quality of this systematic review. To avoid some of these issues we included mostly studies with large sample size³³ and rigorous counterfactual designs.

The protocol did not involve verifying if conditionalities and restrictions had been enforced in the evaluated programmes. This would have entailed conducting in-depth searches and interviews with programme implementers for which resources were not available. Hence, cash transfers that were said to be conditional or restricted to specific expenses have been treated as such. It is worth observing that the non-rigorous enforcement of conditionalities and restrictions throughout programme implementation implies that the cash transfers do not qualify as conditional and/or restricted, but as softly conditioned and/or restricted. In such cases, it would be inaccurate to make inferences about the presence of conditionalities and/or restrictions.

Nevertheless, other studies have shown that the trigger of behavioural change is not necessarily the enforcement of conditionalities and/or restrictions, but the understanding and perception that recipients have around the programme. This, in turn, is influenced by the messages they receive from programme implementers.³⁴ When this is the case, even the presence of a “soft” condition and/or restriction can be a factor in behavioural determination.

Moreover, as mentioned elsewhere, this study cannot make inferences on the comparative effectiveness of programmes with and without conditionalities and/or restrictions, because of the scarce evidence testing for differences between different CTP modalities. Finally, it is important to note that there was an imbalance in the different types of programme reporting on each indicator. For example, for some indicators very little evidence was found for restricted cash transfers (whether UCT or CCT) and for UCTs. This suggests that conclusions based on the available evidence should be cautiously interpreted.

While recognising the value of this narrative review in organising existing evidence and providing some informative insights around the impact of CTP on child outcomes, its limitations mean that a meta-analysis³⁵ can also be called for. This would offer an unbiased pooled assessment of the direction and magnitude of impacts for relevant outcome categories. It could also allow effective comparisons of features of programme design and implementation, such as intensities of conditionalities and/or restrictions, recipients’ and target group profile, targeting approaches and transfer amount.

³¹ Individual studies were included when not already contained in the identified systematic reviews.

³² For more details on assessing the risk of bias refer to <http://methods.cochrane.org/bias/assessing-risk-bias-included-studies>

³³ For RCTs a total minimum sample size (n) of 50, for quasi-experimental studies a total minimum sample size (n) of 100

³⁴ Bastagli et al. 2016; Davies et al. 2016.

³⁵ For more details on what a meta-analysis is refer to <https://www.campbellcollaboration.org/blog/1050-meta-analysis-what-why-and-how.html>

3. ON THE BREAKTHROUGH “SURVIVE”

FINDINGS FOR CHILD SURVIVAL OUTCOMES

Use of Preventive Healthcare Services for Children

Most of the evidence for this outcome category comes from evaluations of unrestricted CCTs.

Systematic review evidence for unrestricted CCTs report a significant increase in the uptake of preventive health check-ups (1, 2, 4) as well as of growth monitoring (2,4) for children between 0-5 years old, but non-significant impacts on vaccination coverage according to the one SR that looked at this indicator using meta-analysis (MA) (1). Two systematic reviews (3, 1) report a small but significant increase in receipt of vitamin and iron supplements following unrestricted CCTs; however, they do not report any impact on receipt of deworming pills (3). Quantitative evaluations of unrestricted CCTs report similar results. More specifically, they find a significant increase in the uptake of preventative health check-ups (5, 6, 7, 8, 9, 11, 14, 15) and growth monitoring (6, 8, 9, 10, 13), but mixed results on vaccination coverage (i.e. A significant increase according to 6, 12, 1, and no impact according to 7, 8, 10). Additionally, one quantitative evaluation finds a significant increase in sole decision-making by women on expenditures in medicines for their children (12).

Evidence is scarce and presents mixed findings for unrestricted UCTs. Out of several quantitative evaluations, only one that was reported in a systematic review (1) found a significant increase in the uptake of preventive health visits as well as in receipt of deworming drugs, vitamin A supplements and iron supplements. Other quantitative evaluations, on the other hand, report non-significant impacts of unrestricted UCTs on preventive health check-ups (16, 19) and vaccination coverage (17, 18). The impact on visits to a health facility for growth monitoring is mixed: one quantitative evaluation found an increase (17), another found a decrease (20), and a third one found no significant impact (19). No significant impact has been found by a quantitative study (21) on maternal decision making.

Evidence from two quantitative evaluations comparing unrestricted CCTs and UCTs report that, while CCTs increase preventive visits to health facilities for check-ups and growth monitoring (9, 13), UCTs either have a non-significant impact on the same indicators (19) or result in their decrease (20). This appears to show a better performance of unrestricted CCTs on these outcomes as compared to unrestricted UCTs. However, neither of these two CTP modalities seem to significantly affect vaccination

coverage, according to the available evidence.

Evidence is available for children under the age of seven, and results seem to apply the same way irrespective of the gender of the child. There is no evidence to show whether outcomes differ dependant on whom the transfer was made to (male or female parent / caregiver). No evidence was found for restricted or labelled UCTs or restricted CCTs.

Use of Preventive Healthcare Services for Mothers

As for the previous outcome category, most of the evidence for this one comes from evaluations of unrestricted CCTs.

Systematic review evidence on this CTP modality consistently report a significant increase in the use of antenatal care (24, 25, 26), skilled attendance at delivery (25, 26) as well as institutional deliveries (25, 26). Quantitative evaluations mostly report a significant increase in these indicators (27, 28, 29, 30, 33, 34), with some inconsistencies found for the uptake of antenatal care. Additionally, one quantitative study found no impact on either the use of antenatal care and skilled attendance at delivery, reportedly because the coverage was already very high at baseline (i.e. Ahead of the CCT intervention) (32). Finally, one quantitative study found that the higher the transfer amount and the larger the number of healthcare visits required as a condition, the stronger was the impact on antenatal care (29). Among the reasons cited for non-significant results by researchers are the disconnect between the conditionality and the expected behaviour (30) or the inconsistent enforcement of the conditionality across beneficiary households (31, 33).

A smaller amount of evidence is also available for restricted UCT programmes (vouchers or cash restricted for use at a healthcare facility). Systematic review evidence on these programmes report a significant increase in both the use of antenatal care as well as the delivery in a health facility (23). Additional quantitative evaluations also support these findings, and report a significant increase in a) delivery at a health facility or hospital (37, 38), b) use of skilled attendants at birth (38, 39), and c) use of antenatal care (39). In the case of antenatal care, one study highlights that usage also depends on proper programme implementation, with reimbursements being duly made to both healthcare providers and beneficiaries; on the contrary, another study shows no impact (37).

Finally, evidence from quantitative evaluations is also available for unrestricted UCTs, reporting no significant impact on the use of antenatal care or skilled attendance at delivery, with the exception of one study in which there was a significant increase in the use of skilled attendance among women with access to better community health services (36).

Use of Curative Healthcare Services for Children

Most of the evidence of impact on the use of curative healthcare for children focuses on unrestricted UCTs. However, it comes exclusively from individual quantitative studies, as no systematic reviews were found.

Available studies mostly find non-significant impacts on the use of curative healthcare for common childhood illnesses such as fever and diarrhoea (44, 45, 46, 48). However, one study finds a significant decrease in the use of healthcare for child respiratory issues (44) and another reports a significant increase in the odds of health facility visits for any “serious child illness” (whereby “serious” is not defined) (47).

Some evidence is also available for unrestricted CCTs, from quantitative evaluations. They mostly report conflicting findings on curative health visits and use of medication in the event of illness, with some studies reporting a significant increase (40, 41, 42) and others a significant decrease (43). Additionally, one study finds a significant increase for boys aged between 0-5 years old, but not for girls of the same age group (40). Finally, one study on the impact of a labelled UCT program reports no impact on the use child curative healthcare.

There is no evidence to show whether outcomes differ by whom the transfer was made to (i.e. female or male parent / caregiver) or if the cash program impacted children differently based on their gender with the exception of the one study mentioned above.

Morbidity

Existing evidence of the impact of unrestricted UCTs on morbidity comes from individual quantitative evaluations and reports either a significant decrease in morbidity for children between 0-18 years old (58, 59, 60, 61) or no significant impact (56, 58, 57). According to one study, the absence of impact is reportedly linked to an improvement in the overall health conditions of children in both treatment and control areas, limiting the opportunity for the programme to show an impact. It also appears that the earlier a child benefits from a UCT programme, the higher its impacts, particularly for boys (60). Additionally, mothers’ educational status also plays a significant role in

influencing morbidity outcomes for children, irrespective of their gender (60). A study on the impact of a labelled UCT intervention found a significant decrease in the proportion of both boys and girls aged between 0-5 years old who suffered from an illness (mostly flu or cold) (62).

Evidence of the impact of unrestricted CCTs comes from both systematic reviews and quantitative evaluations. One systematic review finds a significant decrease in diarrhoea and acute respiratory infection morbidity, but only for children in the age group of 0-5 years, not for older children between 6-17 years (50). However, most of the quantitative evaluations show non-significant impacts on morbidity for children up to 18 years of age (52, 53, 54) with the exception of a small significant increase in diarrhoea morbidity for children aged between 0-7 years old as reported by one study (52) and a significant decrease in pneumonia morbidity for children up to 5 years old as reported by another (53).

No significant impact was found by one study on HIV prevalence among young adolescent girls receiving cash transfers (55). Evidence from a systematic review on cash transfers (irrespective of the modality) also reports no impacts on HIV prevalence for younger adolescents aged between 10-16 years old³⁶ but finds a significant reduction in the age group 13-22 years (51). The impact on herpes simplex virus type 2 (HSV2) incidence is conflicting, with two studies in the review reporting no impacts for younger adolescents in the age group 10-16 years, and two others finding a significant decrease for the same age group (51).

Results on all morbidity outcomes seem to apply the same way irrespective of the gender of the child, except in cases where enrolment into the cash program is at birth. In these cases, boys are more significantly impacted. There is no evidence to show whether morbidity outcomes differ according to the sex of the CT recipient (i.e. the male or female parent / caregiver).

Most of the unrestricted CCT studies included in the mentioned systematic review (51) look at conditionalities such as utilisation of healthcare services, school enrolment and regular school attendance. One additional unique conditionality was compulsory attendance of a life-skills training as part of an intervention to prevent HIV (51). The review suggests that cash plus complementary interventions, such as psychosocial support, parental support or external visitor’s support towards children’s education could play an even bigger impact on HIV/ HSV2 outcomes than cash alone, by directly influencing children’s sexual attitudes and behaviours (51). However, no evaluation evidence is available for these programmes.

³⁶ The SR highlights that the studies might have been statistically under-powered, or that simply the effects could not be detected because impact of reduced HIV risk behaviours only affects HIV incidence later in adolescence.

Additional factors that appear to be at play are the extent of investment people have access to clean water and adequate sanitation, their hygiene practices, and the state of the built environment. Maternal education also appears to be of relevance, with children whose mothers have more than eight years of education falling ill much less than those with less.

Mortality

Most of the evidence for this outcome category comes from evaluations of unrestricted CCTs. While no systematic review evidence was found, evidence from quantitative evaluations reports a significant decrease in child mortality rates, and particularly for infants between 28 days and 1 year of age (65), as well as for children under 5 years old due to malnutrition (64). If on one hand studies report no impacts on neonatal mortality rates for children between 0-28 days (65, 66), mortality rates appear to significantly decrease in areas with high levels of family healthcare coverage (65, 66) or those with higher infant mortality rates at baseline (65). The latter appears to signify a decrease in infant health inequalities (65).

Evidence is also available from a systematic review evaluating a multi-intervention unrestricted UCT programme (i.e. A programme combining UCT and other interventions). Results show a large and significant decrease in child mortality for children aged 6-23 months receiving UCT treatment (with or without food transfer) compared to those receiving only food transfers (63).

Impacts are similar irrespective of the gender of the child. There is no evidence to show whether outcomes differ dependent on who receives the cash (i.e. female or male parent / caregiver). No evidence was found for restricted/labelled CCTs or restricted/labelled UCTs.

The pathways to child mortality are complex and income poverty is only one of the factors at play. Cash transfers increase households' disposable income and, by doing so, stimulate a greater consumption of food, and health-related commodities and services. Findings suggest that the utilisation of healthcare services by cash transfer recipients may be associated with conditionalities imposed on their uptake. A greater utilisation of healthcare services potentially leads to a reduction in malnutrition and morbidity, which in turn contributes to a reduction in child mortality.

Infant and Young Child Feeding Practices

Most of the evidence for this outcome category comes from evaluations of unrestricted CCTs. For this modality, no systematic review evidence was found.

Evidence from quantitative studies report a significant increase in maternal knowledge around the importance of exclusive breastfeeding until 6 months of age (67) as well as around the appropriate age for an infant to start eating food (other than breast milk) (69). However, the increase in knowledge on early initiation of breastfeeding (within 24 hours from birth) was not significant in one study supposedly due to high rates of this indicator at baseline (69). The CCT programmes evaluated in these studies were conditional on mothers/caregivers attending nutrition sessions (67, 69).

Two other quantitative studies did not find any impact on actual behaviour change (as opposed to mere knowledge), such as initiation of breastfeeding within 24 hrs from birth (68, 70) or exclusive breastfeeding for 6 months (70). It appears that this was due to the behaviour already being practiced at baseline in nearly all cases (68).



In terms of the dietary diversity of children over 6 months old, a significant increase in consumption of eggs and fish, but not meat, was found by one quantitative evaluation (70). A qualitative evaluation suggests that unrestricted CCTs may influence complementary feeding practices of iron and vitamin A rich foods, as well as exclusive breastfeeding during the first six months of life, and during the first hour afterbirth (71).

There is a small amount of evidence available from quantitative evaluations of unrestricted UCTs, which report a significant increase in the number of meals consumed by infants over six months (72, 73, 74), the number of times they eat (72), and their household dietary diversity score (74). Outcomes for dietary diversity for infants over 6 months appear directly proportional to the household's food expenditure and consumption patterns; they are also related to existing food habits and cultural practices or even what type and quality of food is available at the local market for households to purchase. While there is a case to be made for incorporating nutrition counselling into cash programmes, there is no evidence that isolates the benefits of nutrition counselling by comparing cash programmes with and without this component. Hence no conclusive statements and recommendations can be made.

Evidence is available for children 0-36 months, and results seem to apply the same way irrespective of the gender of the child. There is no evidence to show whether outcomes differ depending on to whom the cash is given (i.e. female or male parent / caregiver). No evidence was found for restricted/labelled CCTs or restricted/labelled UCTs.

Anthropometric Indicators

Most of the evidence for this outcome category focuses on unrestricted CCTs. No evidence was found for restricted or labelled cash transfers, with or without conditionalities.

Systematic reviews of unrestricted CCTs report a significant increase in height for age z (HAZ) scores for children 0 to 5 years of age (75, 76, 77), a significant decrease in stunting³⁷, as well as of overweight and underweight (75, 77). Evidence also shows a significant decrease in anaemia status (75,77). In reading these findings, it is important to note the considerable overlap between the evaluations covered by two of these systematic reviews (75, 77). The third systematic review found that health-specific conditions around the use of preventive healthcare are associated with a significant increase in HAZ scores for children between 0-5 years (76). On the other hand, the same review found that non-health specific conditions, such as requiring adults to work or save money, lead to a significant decrease in health for age (76). When comparing the effect on health-for-age

of cash interventions with health-specific conditionalities against that of unconditional cash interventions, the review found no significant difference (76).

Evidence from additional quantitative evaluations of unrestricted CCTs mostly finds non-significant impact on HAZ scores for children aged from 0 to 9 (79, 80, 81, 82, 83, 84, 85), with a few exceptions reporting an increase for boys (78, 81), particularly if they have been in the programme for a long period (e.g. two or three years) (81, 85). A study reports that HAZ significantly increases for children up to five years of age if their mother can read (84). A decrease in the same indicator and for the same age range was found in association with households facing income shocks and with children of school age, when school-related conditions were imposed (84).

In terms of stunting, findings of the impact of unrestricted CCTs are mostly non-significant for children up to nine years old (80, 81, 83, 87). Exceptions exist, with a significant decrease in stunting for children whose mothers have attained at least a high-school degree (83). Suggestive evidence from a level-2 quantitative evaluation (as per the MSMS rating) supports these findings and reports non-significant impacts on stunting for children aged 2 years old, but a significant increase for children whose mother have completed high school or have a tertiary education (88).

Findings are mixed for weight for height z (WHZ) scores for children between 0-5 years of age; a study finds a significant increase (79) and another reports a non-significant impact (82). A similar pattern is observed for wasting (WHZ <-2SD), with a study reporting a significant decrease (80) and another reporting a non-significant impact (87).

There appears to be a significant increase in BMI or BMI for age z scores for children under 9 (79, 83), and a significant decrease in overweight corresponding to BMI, especially for girls (81). There is also a significant decrease in underweight corresponding to BMI in children 0-46 months (80, 87), or in thinness among children between 2-7 years (83). One study reports no impact on middle-upper-arm circumference (MUAC) scores for 0-4 year olds (86).

Evidence is also available for unrestricted UCTs. While the cash intervention is found to increase HAZ scores for children under five, according to a systematic review (76), additional quantitative evaluations report the absence of impact for 0-5-year olds (90, 91, 94, 95). The intervention results in an increase in this indicator when mothers have attained an 8th grade education, as well as for children in households with a protected water source (95).

³⁷ Stunting is diagnosed when HAZ<-2.

In-terms of stunting or severe stunting (HAZ <-2SD or HAZ<-3SD), quantitative evaluations of unrestricted UCTs find no impact for children between 0-6 years old (89, 95). A similar result is found for WHZ and weight for age (WAZ) z scores in the age group 0-3 (90, 91, 94).

Additionally, while evidence shows non-significant impacts on underweight or severe underweight for children between 5-6 years old, the same intervention seems to decrease severe wasting (WHZ <-3SD) for children between 3-4.5 years (89). Finally, two studies evaluating the impact of unrestricted UCTs on combined anthropometric indicators (stunting, wasting and underweight) for children up to five years of age do not find any significant result (92, 93).

With regard to severe wasting (weight-for-length (WLZ) Z-score =< -3 and/or mid-upper arm circumference =<11.5 cm and/or bipedal oedema) and moderate acute malnutrition ($-3 \leq WLZ < -2$ and/or $11.5 \leq MUAC < 12.5$ cm) cash alone seems insufficient to generate an impact for children 6-23 months. Instead, programmes combining cash transfers with supplementary food, such as fortified blended foods or lipid-based nutrient supplements, seem to significantly decrease severe and moderate acute malnutrition (96). Suggestive evidence from a level-2 quantitative evaluation of a purely cash based intervention seems consistent with these findings, reporting non-significant impact for both WHZ and WAZ scores for children up to 10 years old. However, the same study found that children in the treatment group were less likely to be stunted (HAZ <-2SD) for their age compared to children in the control group (97). Quantitative evidence on anaemia status finds either a significant decrease for both moderate and severe anaemia for children between 6 months to 6 years (89), or non-significant impact for under 3-year olds (94).

A systematic review comparing unrestricted CCTs (with health-specific conditionalities) and unrestricted UCTs, found non-significant weaker effects of CCTs as opposed to UCTs³⁸(76).

In terms of differences based on the sex of the child, a quantitative evaluation finds a significant increase for HAZ scores for boys, but not for girls in the age group between 5-7 years (81). The same study also reports a significant decrease in overweight corresponding to BMI for girls but not for boys (81). However, there is no evidence to show whether outcomes differ according to the sex of the direct recipient (i.e. parent, caregiver).

Nutrition and food security

Most of the evidence for this outcome category is provided by evaluations of unrestricted UCTs and does not include

systematic reviews. A quantitative evaluation found a significant increase in dietary diversity for children between 1-7 years old, and in the frequency of consuming starch, meat, eggs, and dairy, but not fruits, leafy green vegetables, nuts and seeds (98). Suggestive evidence from a level-2 quantitative study reports an increase in the consumption of meat, chicken, fruits and vegetables (101). Findings from two qualitative evaluations are somewhat consistent, suggesting that unrestricted UCTs may influence children's dietary diversity, and in particular the consumption of cereals, fruits, vegetables and proteins (99, 100). One of the two studies also suggest that these transfers may help children to consume one additional meal per day (100).

Evidence on children's nutrition and food security is also available for restricted and labelled UCTs, but no systematic reviews were found. A quantitative evaluation of restricted UCTs reports a significant increase in the number of meals eaten per day by girls in the 6th grade (102). Suggestive evidence from a qualitative evaluation reports that children with severe acute malnutrition receiving a restricted UCT consumed cereals and vegetables daily, and meat and fish on five of seven days, but did not consume dairy products, which were not allowed in the voucher scheme (103). The same study also reports an acceptable food consumption score for pregnant and lactating women as well as for children with severe acute malnutrition (103).

A quantitative evaluation on labelled UCTs showed a significant decrease in children between 6 months and 17 years eating fewer or smaller meals and going to bed hungry (104). Suggestive evidence from a qualitative evaluation conducted after the same labelled UCT programme, reported that children were better fed and ate meat and bread, which their families could not afford before the intervention (105).

No comparative evidence was found between males and females children or the sex of the recipients. However, one quantitative study found a significant increase in the number of meals consumed by girls in 6th grade, when they were the direct recipients of the transfers as opposed to their parents or caregivers (102).

It appears that cash transfers contribute to increased food security by increasing households' disposable income and enabling greater food expenditures, as well as savings and investments in livestock or more diversified smallholder farming. Farming can contribute to better children's diet, making available nutrient-dense foods such as eggs and milk, as well as other home-grown food. However, the type of food consumed by children also depends on food habits and cultural practices as well as the variety and quality of food in the local market (105).

³⁸ Effect size is 0.08 smaller than unconditional although the difference is not statistically significant (p-value = 0.2)

Psychosocial Wellbeing

Most of the evidence for this outcome category focuses on unrestricted UCTs, and does not include systematic reviews. No evidence was found for restricted or labelled CCTs or UCTs. Evidence from a quantitative evaluation of an unrestricted UCT reports a significant decrease in the experience of psychological distress (anxiety, depression and social withdrawal) for girls in the age group 13–22 (108). Suggestive evidence from two level-2 quantitative evaluations found a significant increase in children's future outlook about their lives (109) as well as in their self-esteem and self-efficacy (112). Consistent findings are reported in two qualitative evaluations, which suggest an increase in children's self-esteem and expectations about their future (110) as well as a decrease in psychosocial issues such as feelings of isolation, disempowerment, and insecurity, worry, stress, as well as interpersonal trust issues (111).

Evidence related to this outcome category is also available for unrestricted CCTs, albeit not from systematic reviews. Quantitative evaluations found a significant decrease in the experience of psychological distress (anxiety, depression and social withdrawal) for girls in the age group 13–22 (106), as well as a significant increase in psychosocial health for children aged between 7-17 years old. The latter was measured according to their satisfaction with friendships and – more broadly – with their lives, as well as based on their behaviour, such as acting bothered or upset (107).

A comparative study between unrestricted CCTs and unrestricted UCTs found a stronger impact from the latter on mental health of girls in the age group 13–22 (at 5% level of significance) (108). Furthermore, the same study found that – when the transfer amount is low – CCTs and UCTs appear to be equally effective in improving children's mental health. Instead, when the transfer amount is doubled, CCTs no longer improve girls' mental health, because the transfer becomes an important income source for the family, which in turn exerts a high level of pressure on the girls, as the transfer is conditional on their school-related behaviours (108)³⁹.

Overall the findings appear to indicate that cash transfers decrease psychological distress and the experience of isolation and disempowerment for individuals in the age group 7-22. Children also seem more hopeful, confident, and happy, while also reporting greater engagement in social activities. However, the amount and robustness of the available evidence are not sufficient to conclusively link

cash transfers with the desired outcomes for psychosocial wellbeing. As such, the above outcomes must be considered suggestive at best.

CHILD SURVIVAL EVIDENCE GAPS

The main evidence gap to be addressed is around the comparative impact of different cash transfer modalities on health-related outcomes, which does not allow drawing conclusions on which one works best.

While, evidence was found on a wide range of child survival indicators, several indicators appear not to have been researched at all. Food consumption, for instance, is amply researched at the household level, but not among children. No evidence whatsoever was found on the impact of cash transfers on:

- maternal morbidity, health status, or food consumption other than indirect outcomes around antenatal and post-natal care use, safe deliveries, and BMI
- early initiation of breastfeeding or new-borns receiving colostrum
- maternal or child adherence to HIV treatment protocols
- intrauterine growth outcomes, birth defects, premature birth, or birth weight
- nutritional deficiencies other than anaemia
- indicators linking cash to WaSH or WaSH-related outcomes, such as helminth infections or tropical enteropathy.

For some other indicators, we may hypothesise some indirect impacts via other outcome categories that are directly impacted, and research should be conducted to test such hypothesis:

- children's access to timely healthcare via greater service utilization and parental knowledge about child health and nutrition
- reduced use of negative food and non-food coping strategies, via increased parental expenditures in food and other essentials for living.

SOME OBSERVATIONS ON THE USE OF CTP FOR CHILDREN'S SURVIVAL

Evidence shows that CTP can be effectively used to increase the uptake of preventive health check-ups and growth monitoring for children, particularly when conditionalities are applied that are specific to the

³⁹ Study tagged as 108 is the same as study 106; the former relates to findings around the UCT arm, whereas the latter to those related to the CCT arm.

desired health behaviours.⁴⁰ CTP can also be used when aiming to stimulate a greater uptake of preventative healthcare services for mothers but: the transfer amount should be large enough to offset either the costs of complying with conditionalities or when not imposing any conditionalities the costs of “motivation crowding out”⁴¹; and conditionalities, if applied, should match the desired behaviours and be consistently enforced. The current state of evidence does not allow to recommend the use of CTP to promote children’s vaccination, as the existing evidence mostly shows its ineffectiveness for this outcome.

Although limited, the evidence around curative healthcare services suggests that two factors contribute to determining CTP impact (or lack thereof), irrespective of the cash modality. In first place, child-specific investments aimed at improving their health may reduce child morbidity, thus resulting in lower need for curative services and a lower impact on their use. Secondly, the local supply of healthcare and medicines, or of essential services such as electricity and clean water, may be insufficient, which would also weaken the effect of CTP on the uptake of curative services.

There is limited evidence on CTP bringing about higher-level outcomes such as reductions in morbidity and mortality, as it appears moderated by multiple factors like mothers’ education, availability of healthcare and other essential services, access to nutritious food, and hygiene conditions. Neither does the availability of healthcare services automatically translate into their uptake but – when services are available – conditionalities can be used to increase uptake. To achieve substantive improvements on morbidity and mortality outcomes, CTP should be best designed in combination with other interventions.

CTP can act as an incentive for mothers to learn about breastfeeding and infant feeding practices, but actual behaviour change may depend on additional factors. Similarly, CTP can be used to ensure that infants and older

children eat more, and a more diversified diet thanks to greater expenditures on food. However, in order to achieve these desired outcomes a number of external conditions will have to be in place, e.g. Access to markets, availability of food supplies, conducive food habits, and cultural practices.

Regarding the use of CTP to achieve higher-level outcomes of children’s nutritional status, it is not possible to make conclusive recommendations, as the evidence is mixed. We may conclude, however, that several factors contribute to children’s nutritional status and that cash alone is not likely to influence these high-level outcomes. Some of these important factors are mothers’ level of education, access to clean water and sanitation, knowledge about WaSH-related best practices, intra-uterine and antenatal influences, knowledge and practices around IYCF, as well as incidence of infectious diseases in the first 24 months of life. The recommendation is to design programmes based on a comprehensive understanding of the causes behind nutritional issues and their interrelations. When adding a conditionality element to the cash transfer in a programme aimed at better child anthropometry, non-health specific conditionalities, such as saving requirements or cash for work, should be avoided. Conditionalities should be health-specific.

Overall, it is not possible to conclusively state that unrestricted CCTs as a CTP modality are always more effective than other modalities, because only few studies directly compared the effect of CCTs to other modalities.⁴² The recommendation is not to impose conditions on cash transfers per se, but to prefer certain types of conditionalities *if and when* the decision is made to apply them. All of which is part of the broader learning that to achieve substantive improvements on morbidity and mortality outcomes CTP is best designed in combination with other interventions.

⁴⁰ In this case, comparative evidence shows greater effectiveness of CCTs as compared to UCTs.

⁴¹ Discouraging beneficiaries from using health services if they consider the transfer amount insufficient.

⁴² These were focused on preventive healthcare check-ups and growth monitoring.



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4. ON THE BREAKTHROUGH “LEARN”

FINDINGS FOR CHILD LEARNING OUTCOMES

Cognitive and non-cognitive development

Most of the evidence for this outcome category focuses on unrestricted CCTs. It comes from quantitative evaluations and – overall – is quite thin, with no systematic review being available. No evidence was found for labelled or restricted CCTs or UCTs.

The existing evidence on unrestricted CCTs reports a significant increase in cognitive outcome indicators around language, vocabulary (receptive and expressive), memory (short, long and associative), processing speed, visual integration (113, 114, 115). One study also reports a significant increase in personal-social development scores (113) although unrestricted CCTs seem to have a less consistent impact on motor skills, which are found to increase in certain points of the school year, but remain unchanged in others (113).

As far as unrestricted UCTs are concerned, a quantitative evaluation reports a significant increase in cognitive outcomes, such as visual reception, receptive language, expressive language as well as total cognitive scores (a combination of these) (116). While the study does not report any impact on non-cognitive development based on the sticker test, the researcher note that this does not imply a lack of impact of cash transfers on non-cognitive development, since the test may have failed to measure non-cognitive ability as intended (116).

A study comparing three different interventions ((1) unrestricted CCTs; (2) unrestricted CCTs plus cash transfers restricted to vocational training; (3) unrestricted CCTs plus cash transfers conditional on submitting a business development plan), reports no significant differences in impact on child cognitive outcomes (113). From this it may be tentatively concluded that adding a restrictive element for vocational skills or conditionalities on entrepreneurship to a CCT, does not yield any further benefit to the cognitive development of a child.

Whilst the findings above show that cash transfers can influence higher-level outcomes of cognitive and non-cognitive development, they do not allow us to definitively conclude whether the impact is direct or indirect through other contributing factors. In other words, they do not allow us to articulate the pathways from cash transfers to cognitive and non-cognitive development.

For example, it appears that adequate IYCF practices

and health during the first 1,000 days from conception can significantly contribute towards an improvement in cognitive development (114). Cash transfers aiming to improve these nutrition and health-related factors can be expected to indirectly ultimately improve cognitive development.

Results appear to show the same pattern irrespective of the cash modality used, the gender of the child or of whom the cash is given to (i.e. female or male parent / caregiver).

School Enrolment

Most of the evidence for this outcome category focuses on unrestricted CCTs and includes systematic reviews. Evidence was also found for unrestricted UCTs, from both systematic reviews and quantitative evaluations.

Systematic reviews of unrestricted CCTs report a significant increase in school enrolment for children up to 18 years old (117, 119, 120). There is also evidence showing a significant increase in enrolment at both primary and secondary school level, with a stronger effect for the latter, supposedly due to the lower enrolment rates at baseline (119). In-terms of conditionalities, findings from one systematic review suggest that tying transfers to achievement (e.g. not failing grades) is more strongly associated with larger secondary enrolment rates⁴³ compared to the effects of the more common conditionalities of enrolment or attendance (119).

A systematic review of unrestricted UCTs reports a significant increase in school enrolment (120). This is in line with evidence from quantitative evaluations (121, 122, 123) and that suggested by a qualitative study (125). Consistent with findings related to unrestricted CCTs, one quantitative evaluation of unrestricted UCTs reports a significant increase in enrolment for children in the age group 13-17 and not for children in the age group 5-12, again, supposedly because of the higher baseline levels in the latter (122). When disaggregating findings by sex of the child, the same study also reports that the impact found in the older group is significant for boys but not for girls (122).

A limited quantity of evidence is also available for the impacts of restricted CCTs and restricted and labelled UCTs. According to a systematic review (117) and quantitative evaluations (126, 127), all three types of programmes significantly increase school enrolment.⁴⁴

⁴³ A significant increase by 11.8% points ($p < 0.01$, $SE = 0.019$) as per 18 studies.

⁴⁴ Study (117) covers restricted CCTs and restricted UCTs; study (126) covers restricted UCTs; study (127) covers labelled UCTs.

Although in this case the impact appears to be stronger at the secondary rather than the primary school level (126). At primary school level the increased enrolment rate is observed among 6-11-year-old girls in regions with limited school access and/or where not all eight grades are offered (127).

One systematic review provides evidence of a significant increase in school enrolment for a combination of unrestricted CCT, unrestricted UCT, and labelled UCT studies (118). Additionally, comparative analyses of unrestricted CCTs and unrestricted UCTs show that they are both effective in increasing enrolment rates (118, 120), although the stronger is the enforcement of conditions in CCTs, the larger is their effect size (120).

There is no evidence to show whether enrolment outcomes differ according to the sex of the direct recipient (i.e. female or male parent / caregiver).

School Attendance

Most of the available evidence on school attendance focuses on unrestricted CCTs and includes both systematic reviews and quantitative evaluations.

Three systematic reviews of unrestricted CCTs report a consistent and significant increase in school attendance for children up to 18 years old (128, 130, 131). The increase is significant at both primary and secondary school level

(130), although larger for the latter where the likelihood of school dropout is higher (130).

In terms of the relative effectiveness of conditionality types findings from two systematic review studies report that conditionalities related to achievement (e.g. not failing grades) are more effective in increasing secondary school attendance rates (in addition to the enrolment rate noted above) than those related to enrolment or attendance.⁴⁵ Additionally, evidence shows that the more rigidly the conditions are enforced, the larger the impact on attendance (129,131).⁴⁶

Findings from quantitative evaluations are mixed. Some studies found a significant increase in school attendance (132, 133, 136), whereas others report a significant decrease (134, 135, 136) or a significant increase in school absenteeism (134). The decrease in attendance could be partially explained by the fact that, in one study, the end-line survey took place around the beginning of the school year when drop-out rates are highest (134). Two studies evaluating a cash-for-work (CfW) programme (i.e. A type of CCT), found that older children engaged in the programme instead of adults in their households, (135), or replaced adults at the workplace while these were engaged in CfW activities (136) thus missing out on school. The latter was found when the CfW recipients were fathers rather than mothers (136).



Photo: Dan Stewart/ Save the Children

⁴⁵ A significant increase by 10.8% point ($p < 0.05$, $SE = 0.039$) as per 18 studies.

⁴⁶ OR 1.082, p -value=0.132 (131)

Impact evidence around school attendance exists also for unrestricted UCTs.

These are found to increase school attendance, according to one systematic review (131) and several quantitative evaluations. In particular, at primary school level one study found a significant increase in attendance rates (137) and three studies found a significant decrease in children up to 13 years old missing school (138, 139, 149). However, the impact of this type of intervention is non-significant for secondary school children (13-17 years old) (137, 138, 139) with the exception of one study that found a significant decrease in girls in this age range missing school when already enrolled (139). A qualitative evaluation supports these findings, noting that unrestricted UCTs can help children in humanitarian contexts to return to school if they had dropped-out (141).

A smaller quantity of evidence is also available for restricted CCTs and UCTs. A systematic review on these programmes reports a significant increase in school attendance (128) while evidence from a qualitative evaluation of a cash-for-rent programme (restricted UCT) reported that parents were able to send their children to school and university for at least two or three days a week (142).

A systematic review reporting evidence around unrestricted CCTs and UCTs, labelled UCTs, and restricted CCT, also found a significant increase in school attendance (129). The same study found a non-significant association between transfer amount and magnitude of impact on school attendance (129).

Grade Attainment, Progression and Completion

Grade attainment, progression and completion have predominantly been evaluated in unrestricted CCT programmes.

While no systematic review was found for grade progression, four quantitative studies were identified and reviewed. These studies found a significant increase in grade progression for both boys and girls aged between 11-14 years old (144) as well as in children being in the appropriate grade for age (145). A non-significant positive impact has been reported for highest grade completion (145), matriculation into secondary school or vocational training (147), as well as for schooling gaps among children aged 13-17 years old⁴⁷. A significant increase in the latter was found in the age group 6-12 (146).

Evidence for unrestricted UCTs is provided in two quantitative evaluations: one reports a significant increase

in grade progression as well as appropriate grade for age for children below 13 (148); and the second found a significant decrease in grade repetition for children between 5-17 years old (149).

With regard to restricted CCTs, one quantitative evaluation was found. This reported a significant increase in number of years of education girls completed, particularly among those with more than primary education (> 5 years of schooling). No significant increase was found among girls with more than secondary education (> 10 years of schooling), suggesting that the intervention may act as an incentive for girls to stay longer in school up to a point but not long enough to finish secondary education and continue with higher education (150). One quantitative evaluation of labelled UCTs reports a significant increase in grade progression for children 6-16 years, with the most effect on those between 15-16 years old (151).

A systematic review on different CTP modalities, including unrestricted CCTs and UCTs, labelled UCTs and restricted CCTs, mostly reported a significant increase in school completion rates (143). However, findings were mixed, with some studies reporting a decrease in completion rate, others finding no or very small effects, and others still reporting large and significant increases (143). The reasons behind such diversity in findings should be investigated but was beyond the scope of the current review.

It appears that increasing children's school attendance and reducing dropout are essential steps to improve grade attainment. However, barriers such as poor quality of education and poor student performance can often play against this and other "learning" outcomes so cash transfer interventions may not be sufficient in isolation.

School Drop-out

The evidence available for this outcome category is comparatively low, and primarily focused on unrestricted CCTs. A systematic review on this CTP modality reports a significant decrease in dropout rates for children at both primary and secondary school level, with a stronger impact for the latter⁴⁸ (153). Evidence from a systematic review of unrestricted CCTs and UCTs, labelled UCTs and restricted CCTs, also reports a significant decrease in dropout rates, with a slightly larger effect on girls compared to boys; however, estimates are somewhat imprecise (152).

There is no evidence to show whether outcomes differ by the sex of the direct transfer recipient (i.e. parent / caregiver). Additionally, more research is needed to show how impact unfolds and to articulate the pathways.

⁴⁷ The study does report however that the education level of parents has a strong effect on adolescents when deciding whether to attend secondary school or not, and the higher the educational level, the larger the decrease in children's schooling gap ($p < 0.01$)

⁴⁸ In-fact CCTs appear to reduce dropout rates by twice as much in secondary that in primary schooling

School Performance

Most of the evidence for this outcome category comes from evaluations of unrestricted CCTs.

A systematic review on this CTP type finds a non-significant impact on standardised test scores measuring learning in mathematics and language (155). Additional quantitative evaluations report mixed impacts: one study found a significant increase in math test scores for children between 11-14 years (157); whereas another shows a non-significant effect on the same indicator for girls aged 13-22 years old (158). It also appears that, among girls, impact does not occur on competencies that – according to the study – could be relevant in the job market, such as reading and following instructions on how to apply fertilizer, giving correct change during a hypothetical transaction, sending text messages, using the calculator on a mobile phone, or calculating profits for a hypothetical business scenario (158). However, the same study found a significant increase of English language scores for girls (158).

Evidence is also available for unrestricted UCTs. While similar to unrestricted CCTs this type of CTP does not seem to generate any impact on standardised test scores measuring learning in mathematics and language (155), one quantitative evaluation reports a significant increase in arithmetic, reading, and shape recognition scores for children up to 6 years old. The effect is the same regardless of the child being enrolled at birth or when they are 6 years old, except for math scores, where it appears that the earlier is the enrolment into the programme the larger is the impact (159).

Two quantitative studies contained in a systematic review and evaluating the impact of merit or performance-based scholarships (i.e. A restricted CCT), found a significant increase in students' performance, measured through a composite score as well as math and language-specific scores (156). A labelled UCT programme was found to have no impact on maths and English reading comprehension test scores, nor on practical competencies required in the job market,⁴⁹ among girls between 13-22 years (160).

A systematic review of evidence from multiple CTP types (unrestricted CCTs and UCTs, labelled UCTs and restricted CCTs) did not find significant impact on composite test scores, language art test scores, or math test scores (154). According to a systematic review comparing the impact of unrestricted CCTs with that of unrestricted UCTs there appears to be no significant difference between the two (155). However, these findings come from three individual quantitative evaluations only and the authors of the systematic review recommend

that more research is necessary to discern significant differences and draw robust conclusions (155). An impact evaluation comparing the effects of unrestricted CCTs and labelled UCTs given to different beneficiary groups within the same programme found that unrestricted CCTs had significantly higher impact on English reading test scores than labelled UCTs (160).⁵⁰

Overall it appears that imposing conditions on performance as opposed to enrolment or attendance and/or restricting the transfers to school expenditure or certain types of schools (e.g. private schools) can lead to a significant increase in school performance. Results seem to apply the same way regardless of the gender of the child. No evidence exists to show whether outcomes differ by the sex of the direct recipient (i.e. parent / caregiver).

CHILD LEARNING EVIDENCE GAPS

Overall, there is an evidence gap around the comparative impact of different cash transfer modalities on learning outcomes so rigorous conclusions cannot be drawn around which works best.

While evidence was found for a wide range of indicators related to the “learning breakthrough”, for the following indicators evidence is either unavailable or very scarce. As such, they should be prioritised in future impact research:

- Children's actual human capital development, and not merely their ability to pass grades or tests
- Outcomes around pre-schooling or vocational schooling
- Children's social emotional learning (SEL) or soft skill development
- Children's transition from primary to secondary school. This is particularly important as dropping out of school at this stage is critical and has wide-ranging consequences on children's health, education, and protection (and those of their children, in the case of girls).

In addition, further research should address unanswered questions around a number of pathways, including:

- Those leading to completion rate and the factors making cash transfers more or less effective in achieving this outcome
- Those involving CTP, school attendance, dropouts and child labour, to better understand how CTPs could be best used to improve children's schooling and reduce potential harm

⁴⁹ Reading and following instructions on how to apply fertilizer, giving correct change during a hypothetical transaction, sending text messages, using the calculator on mobile phones, as well as calculating profits for a hypothetical business scenario.

⁵⁰ P<0,01

SOME OBSERVATIONS ON THE USE OF CTP FOR CHILDREN'S LEARNING

While CTP seem to generally have a beneficial effect on children's education, no conclusions can be made on which modalities perform well and which ones less so. As explained in the chapter on survival outcomes, this is due to the impaired quality of evidence available for the different modalities, and the very little comparative evidence. Nevertheless, if programme designers choose to apply conditionalities to the cash transfers with the aim of improving school enrolment or performance, they should opt for conditionalities related to school performance as opposed to conditionalities on school enrolment or attendance, as the former have proved to be more effective.

There is evidence to suggest that, when added to cash, strong pro-education messaging can influence parental beliefs about the value of education and of regular school attendance (Benhassine et al., 2015). Additionally, while in several cases primary education is free (secondary is most often not), distance to schools and costs related to school supplies and transport are often beyond the reach of income-poor families. Hence, even in the apparent absence of a link between transfer amount and magnitude of impact on attendance (129), these expenses must be considered when designing a cash-based intervention for it to be child sensitive.

When using unrestricted CCTs to increase children's cognitive development, programme designers should combine these transfers with early childhood development programmes; in addition, cash transfers are best started at an early age, preferably when the child is in utero.

Finally, when designing CfW programmes – even if they appear to be relevant and appropriate – their potential for causing school dropouts and child labour must be analysed and mitigated. Possible reasons why selected CfW participants send their children in their place, may include them not being physically fit to work in the specific scheme, or them already having a regular livelihood activity. In this scenario, they may instead opt for attending CfW activities and arranging for their children to replace them in their other income-generating activity. Enticing people away from their regular livelihood activities is considered an unintended effect,⁵¹ and even more so when it triggers child labour. These possible circumstances should be adequately considered in the design stage (e.g. the transfer amount to be lower than the local market rate;⁵² targeting adults who are fit to work but unemployed or underemployed⁵³) and throughout monitoring stages, to reach and engage the intended groups, and to do no harm.

Overall, as mentioned above, the pathways involving CTP, school attendance, dropouts, and child labour must be further researched.



Photo: Save the Children

⁵¹ Mercy Corps (2007).

⁵² Mercy Corps (2007) and Coady et al. (2004).

⁵³ ILO (2012).



5. ON THE BREAKTHROUGH “BE PROTECTED”

FINDINGS FOR CHILD PROTECTION OUTCOMES

Child Labour

Most of the evidence around child labour focuses on unrestricted CCTs.

Systematic review evidence for this modality reports a significant decrease in children’s participation in wage labour (161, 162) and in the number of working hours (162). The effect is larger for boys aged 7-14 years old compared to girls (162), perhaps due to higher baseline levels in the former group. Girls, on the other hand, appear to experience a larger decrease than boys in their engagement in domestic chores (162), possibly for the same reason. However, evidence from other studies on participation in wage labour is mixed and inconclusive; some studies found a decrease (163, 164), whilst others found a non-significant impact (165, 166, 169). The latter could reportedly be explained by the low levels of wage-labour participation at baseline (165, 166). Evidence from a qualitative study suggests that unrestricted CCTs could potentially reduce children’s participation in hard labour and sex-work (170); this finding should be further explored and confirmed through quantitative research.

CfW programmes (a type of unrestricted CCTs) appear to have undesirable effects on children. They have been found to significantly increase the number of hours children spend in paid or domestic work, both when implemented as a stand-alone intervention or in combination with entrepreneurship grants. In the former case, children have been reported to fill the role left vacant by their parents in their regular work or household chores (167), and in the latter, they have been found lending a hand in their parents’ business (168).

Evidence on child labour is available for unrestricted UCTs.

According to a systematic review, children’s participation in wage labour significantly decreases as a result of unrestricted UCTs, but participation in household chores significantly increases (162). A decrease in wage labour participation is also reported by other quantitative evaluations (171, 172, 173, 174, 175, 177), with the exception of one study where the impact of unrestricted UCTs was not significant (178). An additional quantitative evaluation reports an increase in children working in their own farm and non-farm businesses; according to the authors, this is not necessarily a negative impact, if school attendance and domestic work are well balanced (176).

Suggestive evidence from qualitative evaluations hints that unrestricted UCTs may decrease children’s involvement in hard labour (180, 181) and may also encourage their return to school, while dropping work (179).

Evidence around restricted or labelled UCTs is scarcer.

Two quantitative evaluations of a scholarship programme matching restricted UCT features (182) and a labelled UCT programme (183) found a non-significant impact on children’s participation in wage labour and household chores. Girls’ participation in their own non-farm business activities was however found to increase in a significant way (183).

There is no evidence to show whether outcomes differ by the sex of the direct recipient (i.e. parent / caregiver).

Evidence is not available for restricted CCT programmes.

Overall, it appears that CTP contributes to decreasing children’s participation in wage labour and to increasing their school attendance. In fact, systematic review evidence shows that each percentage point increase in school participation is associated with a reduction in child labour of 0.31 percentage points (162). However, the existing evidence does not allow a causal or directional link to be established between the two. The pathway to reduced child labour may be explained by the increased amount of disposable income which means households can afford not to send their children to work, or at least to the extent that they don’t have to be pulled out of school or engage in hazardous work.

Early Marriage and Early Pregnancy

Evidence on the impact of CTP on early marriage and early pregnancy comes from evaluations of both unrestricted CCTs and unrestricted UCTs, and includes systematic reviews.

A systematic review found that unrestricted CCTs significantly increase age at marriage as well as reducing the probability of ever being married for adolescent girls aged between 13-22 years (184). Additionally, and for girls in the same age group, it also reports a significant decrease in the probability of childbearing and in the total number of live births (184). In line with these findings, a separate quantitative evaluation reports a significant decrease in the likelihood of girls between 14-18 years old getting married (185).

Quantitative evaluations of unrestricted UCTs also report a significant decrease in the likelihood of pregnancy for girls in the age group 12-24; inferred study found that the increased enrolment triggered by the UCT programme contributed to this impact (186). Evaluations also report a significant decrease in sexual debut or age of first time sex for both males and females between 15-25 years old (187), a significant decrease in the incidence of transactional sex and age-disparate sex for girls, as well as in the incidence of multiple partners for boys aged between 10-18 years (188). However, other risk behaviours among adolescents, such as unprotected sex or sex after drinking alcohol or taking drugs, are not impacted by cash transfers (188).

The same systematic review mentioned above in relation to unrestricted CCTs also found similar effects for unrestricted UCTs; in particular, it reports that these interventions significantly increase the age at marriage and decrease the total number of live births amongst girls aged between 13-22 years (184).

It appears that CTP contributes to decreasing early marriage and early pregnancy through improvements in girls' schooling (enrolment, attendance, grade attainment, years of schooling etc.) (186). However, it is important to bear in mind the role programme duration plays in determining its effectiveness as short-term interventions may be less effective in preventing school drop-outs or improving human capital and consequently in reducing early marriage and early pregnancy among girls.

It must also be noted that in emergency contexts, factors influencing forced/early marriage are not always exclusively economic. In situations, of war or civil unrest, parents/carers and even girls themselves may at times resort to early marriage as a protection or survival strategy. In such situations, cash alone might not prevent early marriage.

Childcare Arrangements and Separation from Parents

Childcare arrangements and separation from parents have been studied only in relation to unrestricted CCTs, and no systematic reviews have been found.

Two quantitative evaluations report a significant increase in mothers taking-on main carer responsibilities and spending more time caring for their younger children (189, 190). However, evidence shows that when the primary carers are working, responsibility for childcare is delegated to secondary carers such as grandparents or siblings older than 10 years of age. Parents do not seem to rely on extended family members, such as aunts or uncles, or on children below 10 (189). It also appears that unrestricted CCTs relieve adolescent daughters from the childcare burden, as they may be required to attend school. In such cases the childcare responsibility returns to mothers, who

are assumed to be the best possible nurturer for their own children (190). Overall the authors observe that these programmes generate benefits not only in terms of quantity but also of quality of care (190).

Suggestive evidence from qualitative evaluations reports that the cash programmes may facilitate children returning home after a separation from their parents, thanks to improved living conditions in their family of origin (192, 193). It also suggests improved child-caregiver relationships (193). However, negative side effects on childcare have also been observed. One study showed that the work requirements in CfW programmes may limit caregivers' ability to provide quality care to their children; the study reported that young children were taken to work site; some were left with older children, or even locked in the house (193). Cash transfers that are conditional on taking kinship or foster care responsibilities of orphaned or unaccompanied children, may also generate unintended consequences, according to two qualitative studies (191, 193). These reported concerns that programme recipients may opt for caring for orphans or unaccompanied children for financial reasons only. Cash transfers were found not to benefit all children equally, as some were perceived to receive lower quality of care than others; non-biological children may experience ill-treatment and neglect and may be sent to work (191, 193).

CHILD PROTECTION EVIDENCE GAPS

Compared to survival and learning outcomes, it appears that protection outcomes are the least well researched. As with the other two themes there is a gap in comparative evidence of CTP modalities which prevents the drawing of conclusions around their relative efficacy. In addition, a number of indicators have not been researched at all:

- Children's experience of physical/sexual/domestic/intimate partner violence, in households receiving CTP
- Improvements in the quality of childcare
- Reintegration of children into their family or community after a separation (e.g. As child soldiers, runaways, or participating in any other high-risk work causing them to leave home)
- Access to social protection services including case management

When investigating the impact on child labour of either CTP alone or in comparison to other interventions it would be useful for programme and policy-making decisions to disaggregate by typologies of labour, time spent working, and sex of the child.

Some other indicators may be impacted in an indirect way, via other outcome categories. Evidence should be generated to articulate pathways to higher-level protection outcomes such as:

- children receiving better care and being less neglected as a result of extra care focused on children
- foster children facing neglect or being put to work to earn a living for the family due to cash being invested solely in meeting the needs of beneficiary's biological children.

SOME OBSERVATIONS ON THE USE OF CTP FOR CHILDREN'S PROTECTION

From the available evidence it appears that the type of cash modality is not a very significant factor when it comes to influencing child protection outcomes. However, this cannot be said conclusively given the limited evidence for some modalities and the absence of comparative evaluations across CTP types.

Interestingly, child protection outcomes are best achieved in an indirect way, by ensuring children are enrolled and attend school regularly. For example, CTP can be effectively used to decrease early marriage and early pregnancy among girls by ensuring girls attend school regularly, which in turn is obtained by using transfers that are conditional on school-related requirements (see previous chapter, on child's education). These programmes are ideal when they last long enough to generate and sustain these changes over time and are able to reduce dropouts and lead to greater accumulation of human capital.

Although CTP do appear to delay sexual debut, they do not necessarily reduce all risky sexual behaviours among adolescents (such as unprotected sex or sex after drinking alcohol or taking drugs), suggesting that there are other drivers behind these behaviours in addition to monetary deprivation. Cash transfers would not be effective in isolation.

It must also be noted that in emergency contexts, factors influencing forced/early marriage are not always exclusively economic. In situations, of war or civil unrest, parents/carers and even girls themselves may at times resort to early marriage as a protection or survival strategy. In such situations, cash alone might not prevent early marriage.

When aiming at reducing child labour with either conditional or unconditional transfers programme designers should ensure that the amount of cash transferred is sufficient to help households enrol and

keep their children in school. The transfer does not necessarily have to be very large to influence this outcome in the desired direction.

Additionally, some authors have made the following recommendations, but they have yet to be validated by evidence:

- Put in place tight monitoring systems, including those that link cash transfers to case management, to ensure frequent follow-up of children's situation (particularly in the case of foster placements for separated and unaccompanied children).
- To improve childcare practices, potentially combine cash with parenting interventions, then monitor the parenting practices to assess the impact of such programmes.
- If opting for conditional transfers, conditionalities should require that parents keep their children out of child labour and combine this with case management, engagement of teachers in monitoring activities or community-based monitoring. Provision of out-of-school education in combination with cash can also potentially deter children from engaging in labour.



Photo: Colin Crowley/Save the Children

6. CONCLUSIONS

Cash transfers' role in child outcome pathways

CTP as a whole significantly and positively contribute to the key outcome areas of child survival, education, and protection. CTP have the most consistently positive impact on those outcomes most directly influenced by an influx of cash (e.g. school enrolment/attendance, food consumption or use of preventive health-care services). Positive impacts are less consistent for outcomes that are more indirectly associated with cash transfers (i.e. higher-level outcomes) and where a more complex web of factors comes into play (e.g. child anthropometry, grade attainment and progression, school performance, child labour or early marriage and pregnancy).

Factors that should be considered when analysing these longer pathways to survival, learning, and protection outcomes may be classified in five main categories: households' access to the relevant commodities and services for their children's wellbeing; their availability; their quality; their usage; and people's awareness of them (Okular Analytics, 2017). Availability and quality relate to the supply side (i.e. the providers, and the institutions and infrastructures supporting them); while usage and awareness relate to the demand side (i.e. users, caregivers' knowledge); and access to the interaction between the two.

The multi-faceted nature of pathways means that a broad range of barriers and programmatic solutions should be considered. Access may be constrained by physical obstacles, such as the distance separating users from providers; limited financial means; safety concerns; and social discrimination. Barriers to availability are associated with the production, trade, stock, and transfer of services and goods (i.e. obstacles along their value chain). Although available and accessible, the services and goods that households need for their children's wellbeing may be of poor quality; this can be due to the limited range of available options, the poor reliability in their provision, and the inadequate competences of providers. Services and goods that are accessible, available and of satisfactory quality, would still have to be appropriately and timely used to generate higher child wellbeing; this would depend on the knowledge, attitude, and practices of caregivers (e.g. health-seeking behaviour). Finally, caregivers' knowledge

can be increased through targeted awareness raising, with appropriate messages, channels and frequency. The interrelations across factors add a further layer of complexity in the pathways to child wellbeing outcomes.

According to the above, CTP address problems of financial access only. For this reason, when the pathways to a specific desired outcome are of a complex nature, CTP alone may not suffice to generate an impact.

EXAMPLES OF OTHER ISSUES TO BE CONSIDERED

Physical access issues. These, in turn, may affect the utilisation of health services and, therefore, health and nutrition outcomes. For example, when schools and healthcare facilities are located at large distance from the targeted communities it may be argued that CTP is not an appropriate intervention, as it is meant to address access issues caused by monetary constraints and assumes availability and accessibility of goods and services in the targeted area. Other interventions, such as in-kind provision of goods and services or actions to strengthen local suppliers' capacity, would be more pertinent.

Supply-side barriers. For example, poor availability and quality of healthcare services, poor availability of drinking water, or lack of diverse food items in the local markets. When these are issues poor infrastructure and weak supply side motivation must be considered⁵⁴.

In the specific case of maternal usage of healthcare services, evidence points towards the need for either complementary services (e.g. insurance schemes/cost sharing mechanisms, behaviour change communication and social marketing etc.) and/or matching supply-side interventions (e.g. result-based financing and other health system initiatives etc.) to amplify the impact of cash transfers⁵⁵ (36).

⁵⁴ The comparative impact has not been analysed between cash transfer programmes that incentivise healthcare workers and those that provide incentives only to recipients.

⁵⁵ N. Jones et al. 2011: <https://www.odi.org/sites/odi.org.uk/files/odi-assets/publications-opinion-files/7488.pdf>

For cash transfers to be effective on higher-level outcomes, it appears that they must be designed in a way to either:

- **Target and map links between key factors in that particular outcome's theory of change.** For instance, a cash transfer programme may improve girls' school attendance and thus contribute to a higher-level outcome such as delaying sexual debut. Likewise, if a cash transfer programme fails to impact on the intermediary outcome e.g. improved IYCF practices, it would not generate any improvement on child anthropometry, the desired higher-level outcome. Often, these interrelated and dependant impacts are not consistently mapped out and/or reported. Moreover, evidence of CTP impact is unavailable for some factors that are part of certain causal pathways. For instance, water, hygiene, and sanitation are important contributors to several child health- and nutrition-related outcomes. However, to date there is no robust evidence of CTP impact on these.
- **Combine CTP with other interventions within the same programme.** CTP are mostly designed and delivered as stand-alone interventions rather than in combination with others programmes / programme elements that may affect complementary parts of the causal pathways. However, this is a missed opportunity. For instance, a programme aiming at increasing child grade attainment, progression, learning and performance, could combine cash transfers with interventions improving the quality of school instruction in the targeted area for a far more significant impact. Likewise, to promote better nutritional outcomes, programmes could combine cash and interventions that promote improved IYCF practices.

Additional reasons for the absence of impact on certain outcomes of interest include limitations in the design of the cash transfer programme. This includes the cash transfer being of insufficient value to enable the recipient households to dismiss certain behaviours and coping strategies – such as withdrawing children from school, and putting them to work – that may be harmful for children.

The general recommendation is to map the pathways to outcomes for children, choosing CTP – be it as stand-alone or in combination with other interventions – only when economic barriers are identified as a significant blockage.

Comparing the effectiveness of CTP modalities is not possible

Because of the scant evidence testing for differences between two or more types of CTP modalities, it is not

possible to establish their relative performance. In addition, this review has found an imbalance of evidence in favour of unrestricted CCTs compared to other modalities which highlights the need for more research on the less explored modalities. Because of the existing evidence gaps, it is not possible to draw causal inferences around the additional value and comparative advantage (or lack thereof) of imposing conditionalities and/or restrictions.

As there are naturally many factors driving any observed patterns identifying which is key, without the control studies, is not possible. For example, conditional transfers have often been used in contexts with sufficiently functioning public services whereas unconditional transfers have tended to be adopted where such services are weaker, making direct conclusions hard to draw. Other contextual features that may explain differences in outcomes include baseline indicator levels, the value and duration of transfers, or inclusion of complementary interventions. As such, any patterns that are apparently linked to specific CTP modalities should not be attributed to the effect of conditions or restrictions.

With some exceptions, most variations in the type of cash modality used do not play a significant role in influencing outcomes for children. However, imposing conditionalities and/or restrictions around the transfers does appear to be associated with significant positive impacts on child health-seeking behaviours,⁵⁶ schooling outcomes and early marriage and pregnancy compared with not imposing any conditionalities or restrictions. Hypothesis of causality, that may be suggested by the presence of associations between variables (see below), should be tested through comparative research.

The available evidence does not allow us to isolate the impacts of the financial and the non-financial programme components, and to articulate the impact pathways of CCT programmes. Whilst cash seems to act as an incentive to recipients to take up specific behaviours that the implementer considers desirable, the question is whether beneficiaries would adopt these same behaviours if the transfers were made without conditions and with only their budgetary constraints being lifted.⁵⁷ In other words, questions remain as to whether it is the transfer itself or the condition imposed on it that leads to the desired behaviour.

It can also be argued that conditionalities may effectively discriminate against the most isolated and socially excluded recipients, who may find it more costly or difficult to access services and a greater challenge to consistently meeting the demands of conditionalities.⁵⁸ The varying

⁵⁶ In the specific case, these include: taking one's child for regular preventive health check-ups / growth-monitoring / vaccination; registering one's child at birth; enrolling in health insurance schemes.

⁵⁷ Pellerano and Barca, 2014.

⁵⁸ Davies et al. 2016.

impacts of conditionalities on different groups should therefore be more closely examined and considered to avoid doing harm to the most vulnerable. An example of significant impact in an undesired direction is that of cash for work, which appears to lead to an increase in child labour in some cases. As a general principle, conditions should not be applied and enforced when the conditioned services are not available or not affordable for recipient households.

Considerations on Value for Money

It is important to observe that should conditionalities and restrictions be used to improve certain outcomes for children, this will often involve higher implementation and administrative costs, both for the implementing organization that has to enforce such conditionalities and for recipients complying with them.⁵⁹ Accordingly, when conditionalities or restrictions are preferred, programme designers must assess and balance the trade-off between effectiveness on outcomes of interest and cost-efficiency in different contexts. This should be preferably done in light of more robust comparative evidence of different modalities and an analysis of both their 'value for money' and the possible perverse effects on the most vulnerable segments of the population. Since this study did not review and compare the cost-efficiency of different modalities, this aspect should be further researched in future studies alongside the other three dimensions of the value-for-money approach, i.e. economy, effectiveness, and equity. The latter would explore features such as perceived fairness in transfer allocation and reach, including consideration of the fact that targeting specific groups may result in exclusion errors.

Humanitarian vs. non-humanitarian contexts

Under the current state of evidence, comparisons between the impacts of various forms of CTP in these contexts must be made cautiously and it is not possible to conclude whether CTP is more effective in one or the setting. In first place, evidence of the impact of CTP on children is more widely available and more highly rated for non-humanitarian than for humanitarian contexts. In the latter, evidence is mostly available for unrestricted UCTs, and there are no comparisons available between the different modalities. Additionally, some outcomes, such as acute malnutrition or girls engaging in sex work, have been studied only in humanitarian contexts but not elsewhere.

Overall, it is important to note that evidence is mostly consistent between the two contexts (see APPENDIX 2: SUMMARY OF EVIDENCE), with a few exceptions. In fact, in humanitarian contexts, a few child outcomes seem to follow a different pattern and they are mentioned below. Since these findings are from low-rated studies, they

should be regarded as generally suggestive rather than conclusive proof of causality between cash interventions and outcomes.

- a significant reduction in acute malnutrition (weight for height, prevalence of bipedal oedema, and mid-upper arm circumference) in situations where cash is supplemented with food compared to cash only interventions
- an increase in receipt of vaccinations
- conflicting impacts for school enrolment
- a reduction in the worst forms of child labour and sex-work for girls

Many barriers and pathways to change are similar in humanitarian and development contexts, but some factors appear to be exacerbated within a humanitarian context due to the added fragility of the circumstances, or may be specific to it. These include:

- increased safety concerns about enrolling and sending children to school
- the crisis may disrupt service provision and market functioning, by causing physical damages or destruction of facilities; damages and loss of equipment; loss of human resources, who may have been injured, displaced or may have died. As a result, the availability of services and commodities may be restrained, thus limiting the potential impact of cash interventions on child outcomes
- in displacement settings, local public services (e.g. healthcare, schools) are under increased pressure due to the influx of people, and may not be able to meet the higher demand
- higher likelihood of significant income shocks due to sudden loss of livelihoods or death of an income earner
- lack of other income-generating opportunities over and above the cash transfer; meaning discontinuing cash assistance would almost inevitably cause households to resume/resort to negative coping strategies
- safety concerns for girls, leading to families seeing marrying off their girls early as the only way to protect them and/or ensure their survival.

Generally, in a humanitarian context the safety of children is far more threatened, and so programmes will have to make additional provisions for counteracting this. The barriers mentioned may affect the effectiveness of cash transfers and may warrant different responses in humanitarian versus development situations, but more research is required.

⁵⁹ Pellerano and Barca 2014; Davies et al. 2016; Benhassine et al. 2015.

General recommendations

What ultimately appears to be important in both the development and humanitarian contexts is how cash interplays with existing barriers (which are often common to both contexts) and within pathways to desired outcomes. Programmes must therefore consider:

- the specific objectives of the transfer programme i.e. whether the aim is to improve an outcome directly influenced by cash or one where other aspects in its theory of change must also be addressed, and perhaps cash alone should not be used
- The potential trade-offs between different cash modalities or between using cash alone and in combination with other programmes
- needs or capacities of the beneficiary group i.e. what cash transfer modality, frequency or combination of grants would best suit the target group and improve their capacities to capitalize on the transfer
- the relevant supply-side factors that need to be available and functioning appropriately for cash interventions to work

Additionally, on the operational side of things it's important to ensure

- fair and transparent targeting of beneficiaries
- on time and regular payments
- removal of any administrative barriers in delivering / receiving cash transfers

In terms of key indicators of impact, close monitoring of the potentially positive and negative outcomes of CTP for children of different ages and sexes is crucial to ensure that child focused organisations always put the interests of children at the core of their development or humanitarian response programming. This will involve identifying the

relevant outcome indicators and measuring these in a sufficiently disaggregated way.

Rather than having specific CTP-related outcome indicators, organisations may opt for standard indicators across different modalities, which would help comparing their relative effectiveness. In particular, it is important for organisations to assess the extent to which different interventions – including cash transfer programmes – support or don't support child safeguarding. Both qualitative and quantitative approaches can be used and participatory methods considered, dependant on the monitoring question and objective. Besides the regular monitoring of programmes, rigorous evidence should be generated in a more systematic way, with pre-agreed and consistent research protocols prioritised to address the gaps identified in this study.

Moreover, we must also be cognisant of the limitations of cash programmes, which are primarily intended to alleviate monetary constraints and, by doing so, increase access, consumption, and utilisation of essential commodities and services. As such, it is always important to bear in mind what CTP can and cannot realistically achieve under the best circumstances and with support from complimentary interventions. It might well be that for some outcomes for children cash should not be used at all, and other intervention modalities should be adopted e.g. food and nutritional supplements for anthropometry or purely pedagogical programmes for improving child school performance. Given that this report hasn't compared cash with other programmes, conclusive claims cannot be made around the benefits of cash over and above these other programmes.

Finally, whilst the scope of this synthesis undoubtedly makes it of value as a standalone document, the authors acknowledge its methodological limitations and hope that it can act as a precursor to a more robust meta-analysis.

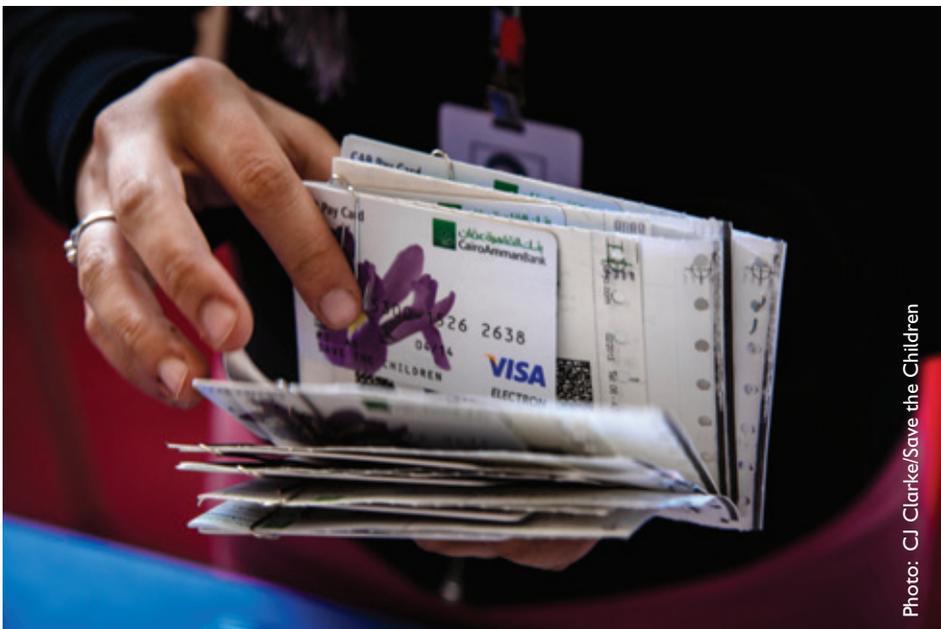


Photo: CJ Clarke/Save the Children



Photo: Dan Stewart/ Save the Children

APPENDIX 1: TABLE OF STUDIES INCLUDED IN THE REVIEW (IN SEPARATE DOCUMENT.)

APPENDIX 2: SUMMARY OF EVIDENCE (IN SEPARATE DOCUMENT.)

EVIDENCE GAP MAP: SURVIVE

Intervention/Outcome		Child Survival								
Intervention	Context	Preventive Health					Anthropometry & Nutritional Status		Mental Health	
		Use of Preventive Healthcare Services for Children	Use of Preventive Healthcare Services for Mothers	Use of Curative Healthcare Services for Children	Morbidity	Mortality	Young Child and Infant Nutrition Practices	Anthropometric Indicators	Food Security	Psychosocial Wellbeing
Unrestricted CCTs	Development	10 (Q), 3 (SR), 1 (Q)	7 (Q), 3 (SR), 1 (Q)	3 (Q)	2 (SR), 4 (Q)	3 (Q)	4 (Q), 1 (Q)	3 (SR), 11 (Q)		2 (Q)
	Humanitarian	1 (SR), 1 (Q), 1 (Q)	1 (Q)	1 (Q)						
Unrestricted UCTs	Development	1 (SR), 6 (Q)	1 (Q)	4 (Q)	1 (SR), 6 (Q)		2 (Q)	7 (Q), 1 (SR)	1 (Q), 1 (Q)	3 (Q), 1 (Q)
	Humanitarian	1 (Q)		1 (Q)		1 (SR)	1 (Q)	1 (Q)	1 (Q), 1 (Q)	1 (Q), 1 (Q)
Restricted CCTs	Development						1 (Q)			
	Humanitarian									
Restricted UCTs	Development		3 (Q), 1 (SR)		1 (SR)				1 (Q)	
	Humanitarian								1 (Q)	
Labelled UCTs	Development			1 (Q)	1 (SR), 1 (Q)				1 (Q), 1 (Q)	
	Humanitarian									

- Systematic Reviews
- Quantitative Evaluations
- Qualitative Evaluations



EVIDENCE GAP MAP: LEARN

Intervention/Outcome		Child Learning					
Intervention	Context	Cognitive & non-cognitive Development	School enrolment	School attendance	Grade Attainment, Progression and Completion	School drop-out	School Performance
Unrestricted CCTs	Development	3	4	4 4	1 4	2	2 2
	Humanitarian			1			
Unrestricted UCTs	Development	1	2 1	2 4	2 1	1	2 1
	Humanitarian		2 1	2			
Restricted CCTs	Development	1	1	2	1 1	1	2
	Humanitarian						
Restricted UCTs	Development	1	1 1	1			
	Humanitarian						
Labelled UCTs	Development		1 1	1	1 1	1	1 1
	Humanitarian						

- Systematic Reviews
- Quantitative Evaluations
- Qualitative Evaluations



EVIDENCE GAP MAP: BE PROTECTED

Intervention/Outcome		Child Protection		
Intervention	Context	Child Labour	Early Marriage and Early Pregnancy	Child care arrangements and separation from primary care-givers
Unrestricted CCTs	Development	2 (SR), 6 (QE)	1 (SR), 1 (QE)	2 (SR), 2 (QE)
	Humanitarian	1 (SR), 1 (QE)		1 (QE)
Unrestricted UCTs	Development	1 (SR), 6 (QE)	1 (SR), 3 (QE)	1 (QE)
	Humanitarian	2 (QE), 3 (QE)		
Restricted CCTs	Development	1 (QE)		
	Humanitarian			
Restricted UCTs	Development	2 (QE)	1 (SR)	
	Humanitarian			
Labelled UCTs	Development	1 (QE)		
	Humanitarian			

- Systematic Reviews
- Quantitative Evaluations
- Qualitative Evaluations

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⁶⁰ This list is the reduced list of references appearing in this Research Brief. The full bibliography is available in Appendix 1 to this Research Brief, as well as in the full report “Synthesis report: child outcomes of cash transfer programmes. A synthesis of the evidence around survival, education and protection in humanitarian and non-humanitarian contexts”.

CHILD OUTCOMES OF CASH TRANSFER PROGRAMMING



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