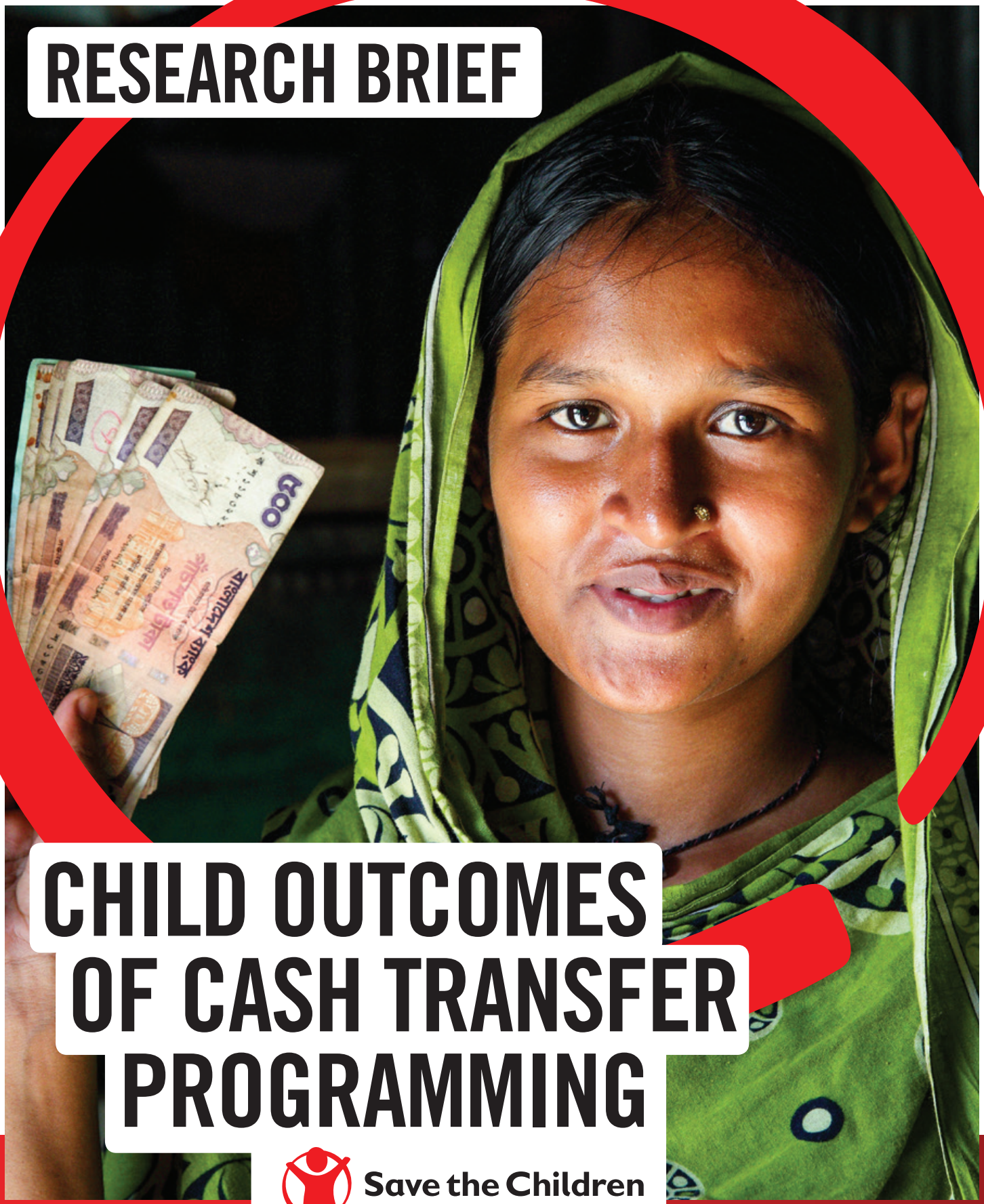
RESEARCH BRIEF



CHILD OUTCOMES OF CASH TRANSFER PROGRAMMING

Save the Children

What works and what doesn't for children in humanitarian and development contexts

Anjini Mishra

Acknowledgments

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1. INTRODUCTION

The use of cash transfer programmes (CTP)[1] has risen in recent years to become an integral element of poverty reduction and social protection strategies in the developing world (F. Bastagli et al. 2016). The humanitarian sector has more lately adopted CTP and within the past decade there has been a growing awareness of the important role that cash transfers can play in an effective and efficient humanitarian response.[2] In fact, when conditions permit, cash transfers are being increasingly recommended over typical in-kind goods, as they are often more cost-efficient, have the potential to boost local markets (as opposed to replacing them) and enable affected populations to make their own financial choices (GHA 2013).

Within the context of children's wellbeing[3], CTP are a popular means of giving poor people additional financial resources enabling them to invest in their children's future: the idea is to help families meet their children's critical needs, develop their children's human capital, and break up the generational cycle of poverty (STRIVE 2015). In humanitarian situations meeting children's critical needs is often particularly difficult due increased demand on limited resources, loss of livelihoods and increased poverty, along with possible displacement. As such, cash potentially has an even more substantial role to play to help meet these needs.

Humanitarian emergencies are increasing in both frequency and duration. It is evident that children are bearing the brunt of these situations and that these experiences are having long-lasting effects on their development and future. The figures for the number of children affected by humanitarian emergencies are worrying: in 2014, children made-up half or more of those affected by natural disasters (around 50 million children) and 51% of refugees were children (UNICEF 2015). Additionally, 34 million children and adolescents are out of school in conflict-affected countries (UNICEF 2015); nine out of 10 countries with the highest rates of child marriage are fragile states (WRC 2016); 60% of preventable maternal deaths and 53% of under-five deaths take place in settings of conflict, displacement and natural disasters (Every Women, Every Child 2015); and in 2013, 65% of all children living in conflict zones (i.e. 112.1 million children) were chronically undernourished (IFPRI 2015).

Substantial evidence has been generated over the last decade on the effectiveness of cash transfers[4] including its impact for children[5] and from within a variety of contexts including development programmes[6] and humanitarian responses.[7] However, no single work has provided an overall assessment of key outcomes for children in both humanitarian and development contexts without being limited either by the number of indicators reviewed or the socio-political or geographical contexts analysed.[8]

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 indirectly concern children, such as maternal health status, as well as those that directly affect children, such as the child's health. It also expands the scope to include evidence from both development and humanitarian contexts, generated between 2012 and 2016.[9]

This Research Brief offers a condensed account of the findings and conclusions of the study. Readers interested in examining these aspects in depth, are recommended to refer to the full report. The latter 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 integral version of the study protocol.

1 CTP refers to all programs 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, household or community recipients; not to governments or other state actors. CTP covers all modalities of cash-based assistance, including vouchers. This 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).

2 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).

3 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)

4 Most recently F. Bastagli et al. 2016.

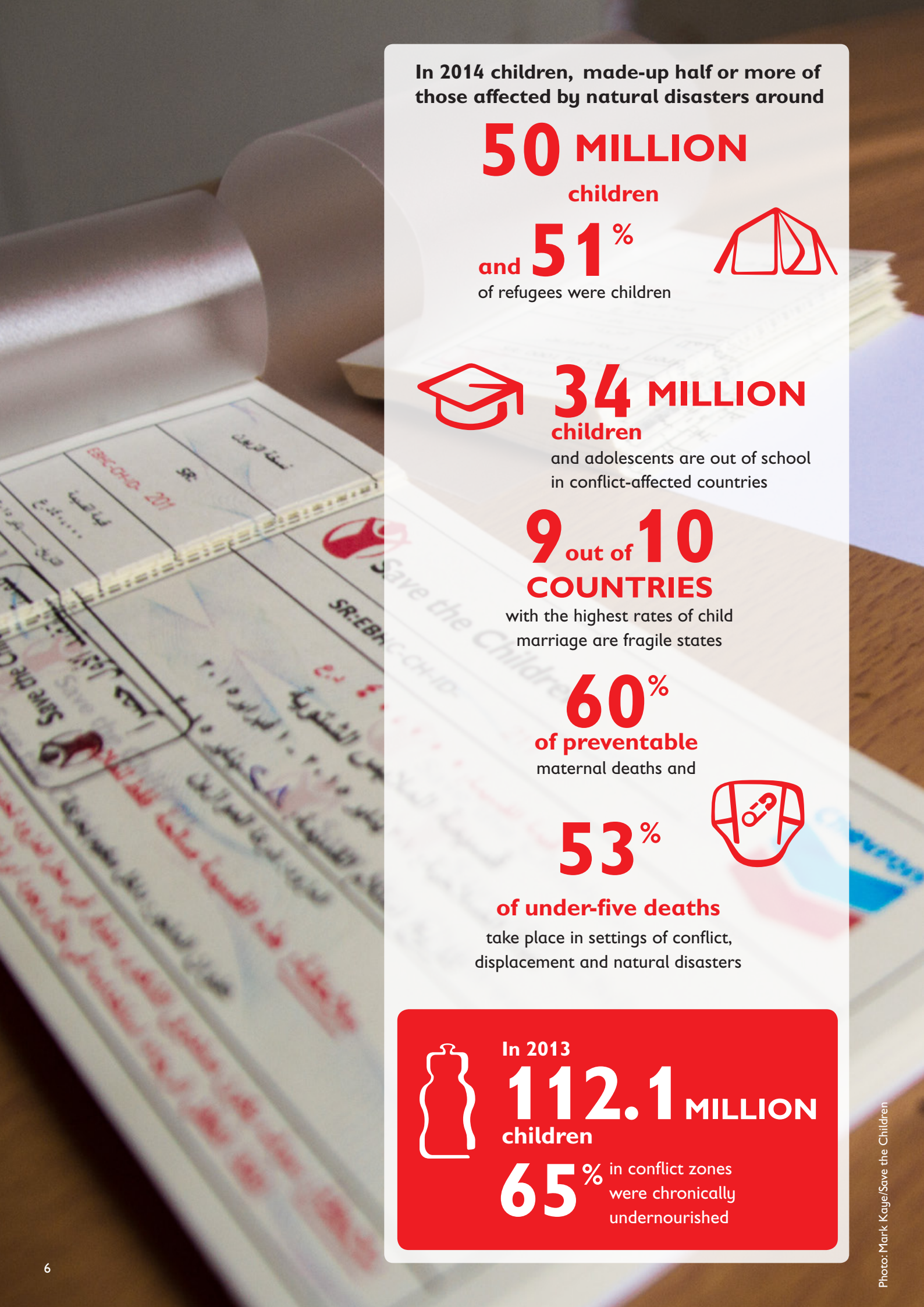
5 Most recently STRIVE 2015.

6 Recently Kabeer et.al. 2012; Fiszbein and Schady 2009.

7 Most recently Doocy and Tappis 2016; Bailey and Harvey 2015; Pega et.al. 2015.

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

9 While we limited our search for studies to the past 5 years, and this might have caused us to miss out on additional relevant research from before, our inclusion of systematic and literature reviews published from 2012 onwards, helped us overcome this limitation to an extent, given that these often-included studies from much before (on an average between 2008-2012).



In 2014 children, made-up half or more of those affected by natural disasters around

50 MILLION
children

and 51%
of refugees were children

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%
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In 2013
112.1 MILLION
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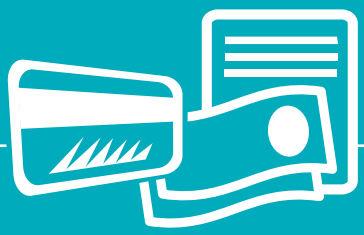
65% in conflict zones were chronically undernourished

Photo: Mark Kaye/Save the Children

2. METHODS



DEFINITIONS

A note on the definition of CTP modalities: for the purpose of this study, the author divided CTP into five types of interventions. These are the result of combining in different key features of CTPs: "conditions for the receipt of the money", and; "restrictions on the use of the money".[10]

Unrestricted Unconditional Cash Transfers (unrestricted UCTs) provide beneficiaries with cash without the need for them either to fulfil a particular condition, or spend the funds in a particular way. Of all the transfer modalities, UCTs grant the maximum degree of flexibility for recipients, freeing them from the financial and non-financial costs associated with fulfilling conditions and allowing them full control over how the money is spent. The most common example of UCTs are the so-called multi-purpose cash grants (MPGs), as implemented in several humanitarian responses over the recent past (e.g. Lebanon, Jordan, Iraq, Ukraine). They differ from other Unrestricted UCTs in the way the value of the transfer is calculated.

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 make unrestricted CTSs 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 CCT include: cash (in exchange) for work; cash (in exchange) for training attendance; transfers based on attending health check-ups; transfers given in exchange for school attendance.

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) 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.

Restricted Conditional Cash Transfers (restricted CCTs) are provided to beneficiaries upon performance of a specific precondition, and can only be used by the beneficiary on specific commodities or services. An example of restricted CCTs is a transfer to be spent on school fees or school supplies following the attainment of a certain level of school attendance or a particular grade. 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.

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. 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 social services and/or programmes whether they are led by the government or NGOs. Among these complementary interventions are behavioural change communication programmes which can be designed to promote the use of cash and other household resources for children's wellbeing.

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

INDICATORS

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, the so-called 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 breakthroughs terminology, we divided the outcomes into:

- **Child survival indicators** relating to preventive and curative health behaviour (maternal and child), child nutrition status, anthropometry, WaSH, food security, morbidity, mortality, and psycho-social health.
- **Child education indicators** including on 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.

REVIEW PROTOCOL INCLUSION AND EXCLUSION CRITERIA

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, in Annex 1. The author also collected additional relevant research by consulting with key Save the Children staff and external cash transfer experts and practitioners.

The review protocol included the following dimensions, defining the inclusion and exclusion criteria based on which studies were retained for review or disregarded.

Type of Research: The study primarily includes peer and non-peer-reviewed systematic or literature reviews/meta-analysis (SRs/LRs/MAs) and impact evaluations (IEs) intended as quantitative studies using experimental or quasi-experimental design, which accounted for confounding factors. In addition to these, the lead author reviewed also studies employing other quantitative methods (OQM) and qualitative evaluations (QE). It distinguishes between those generating high rated evidence (based on methodological designs of the included evaluations) from those generating moderate and low rated evidence (ratings range from 7 to 1).

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

Timeline: The synthesis is limited to studies released over the five-year period between 2012 and 2016.

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

Photo: Save the Children

RESULTS OF THE SEARCH AND SCREENING PROCESS

The search and screening process led to the identification of a total of

4,800

initial studies

which were narrowed down based on the inclusion/exclusion criteria to

131

studies for the final analysis.

Out of these

115

studies were from a development context, and

16

studies

were from a humanitarian context. This implies an imbalance of evidence and highlights the need for more evidence from the latter context.

In terms of types of studies, the author found

18

systematic reviews, meta-analysis and literature reviews (SR/MA/LR), and

113

individual studies.

The latter included

88

impact evaluations (IEs);

3

evaluations employing other quantitative designs (OQDs); and

22

qualitative evaluations (QEs).

Most of the studies from within the humanitarian context were LRs, OQDs or QEs, and most from within the development context were

Studies were found from developing regions of the world:

15

from multiple regions;

56

from Sub-Saharan Africa and North Africa;

32

from Central and South America;

13

from South Asia;

1

from Central Asia;

8

from East Asia;

7

from the Middle East.

With regard to CTP modalities reviewed by the studies:

73

evaluated unrestricted CCTs;

70

evaluated unrestricted UCTs;

6

evaluated restricted CCTs;

12

evaluated restricted UCTs; and

5

evaluated labelled UCTs.

These were evaluated as standalone programmes or as one arm of a multi-treatment cash programme.

Guidelines for Interpretation of Findings:

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

Positive significant impact:

this refers to findings pointing to a quantitative increase of the indicator under analysis.

Negative significant impact:

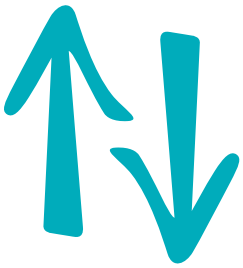
this refers to findings pointing to a quantitative decrease/reduction of the indicator under analysis.

Non-significant impact:

this refers to findings pointing to no change in an outcome indicator.

Mixed impact:

this refers to findings that do not allow one to draw any unequivocal conclusion around the direction and size of the impact. Some findings show a significant increase, some findings show a significant decrease, and some others do not show any significant change.



Conflicting impact:

this refers to opposite, significant findings, whereby some are positive and some are negative.

3. ON THE BREAKTHROUGH "SURVIVE"

FINDINGS FOR CHILD SURVIVAL OUTCOMES

Use of Preventive Healthcare Services for Children

The literature review found that unrestricted CCTs generally resulted in significant increases in incidences of taking children for preventive health check-ups and growth monitoring. On the other hand, unrestricted UCTs generally produced non-significant or conflicting impacts on these same indicators. In other words, evidence seems to suggest that unrestricted CCTs are more effective than unrestricted UCTs in increasing the use of preventive health care and growth monitoring. Nevertheless, we cannot conclusively state this, given that no comparative study is available on the two modalities.

Both unrestricted CCTs and unrestricted UCTs appear to predominantly lead to non-significant changes in the uptake of immunisation services. Additionally, unrestricted CCTs do not have significant effects on the uptake of deworming and vitamin supplements, while evidence shows conflicting results in the case of unrestricted UCTs. A small body of evidence, on the other hand, shows that unrestricted CCTs significantly increase incidences of women making independent decisions about how they invest in their children's health. Unrestricted UCTs were not found to have the same impact.

Imposing conditionalities that require parents / caregivers to seek proper health care for their children increases the uptake of these positive behaviours. Examples of conditionalities are: taking their children for regular health check-ups or growth-monitoring; registering children at birth; enrolling in health insurance schemes; taking children for vaccinations. However, it is important to note that requiring parents or care-givers to take their children to get vaccinated, for instance, does not necessarily result into children actually being vaccinated if vaccinations are unavailable. In other words, these interventions are not effective when there are barriers to the supply of the goods and services of which greater utilization is sought for.

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. The gender of the adult receiving the transfer seems not being relevant either, as 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 Preventative Healthcare Services for Mothers

Unrestricted CCTs and unrestricted and restricted UCTs were all found to significantly increase incidences of institutional delivery, and the use of skilled birth attendants. As for their impact on use of antenatal services, unrestricted CCTs were found to increase it while the evidence for the impact of UCTs, with or without restrictions, was mixed. No evidence was found for the impact of restricted CCTs on any of these indicators.

It appears that making it a conditionality of the transfer that mothers use maternity services, is what's driving an increase in this behaviour for unrestricted CCTs. However, it seems that the cash transfer must be large enough to offset any additional private costs of complying with conditionalities or even "motivation crowding out".[11] Other factors at play appear to be supply-side barriers or social and cultural norms that either support or hinder the take-up of services.

Use of Curative Healthcare Services for Children

There is limited evidence for this outcome. However, the evidence that does exist appears to show conflicting impacts on use of health-care and medicines during child illness for children 0-18 years old. This is reported irrespective of the cash modality used (evidence was found for all modalities except restricted CCTs & restricted UCTs) and the gender of the child.

Two factors appear to be at play in determining the impact on the above outcomes of interest: either a reduction in morbidity due to child specific investments that improve health, driving up impacts; or a weak supply of health services and drugs (e.g. Oral Rehydration Solution, medical doctors or nurses, laboratories for testing), or even of essential services such as electricity and clean water, driving down impacts. There is also no evidence to show whether outcomes differ by whom the transfer was made to (i.e. female or male parent / caregiver).

Morbidity

Mixed impacts were found on diarrhoea, respiratory illness, fever or malaria morbidity in children 0-18 years old, for all cash modalities. There does appear to be a significant reduction in the prevalence of HSV2, as well as the risk of contracting HIV, resulting from unrestricted CCTs and labelled UCTs. No evidence was found for restricted CCT programmes on any morbidity outcomes.

11 Discouraging beneficiaries from using health services if they do not attribute value to the cash amount

Additionally, the only study on the impact of restricted UCTs on HIV/HSV2 outcomes did not find any significant effect of transfers that were given directly to girls for school fees without conditionalities. Instead, it does appear that giving cash transfers directly to girls under the condition that they attend school (i.e. through unrestricted CCTs), or labelled for their education (i.e. labelled UCT), can significantly reduce HIV or HSV2 prevalence. Although it is interesting to note that the labelled UCTs appear to have an impact (according to one IE and one LR), whereas the restricted UCTs (as per one IE only) do not, it is not possible to conclude that labelled UCTs are more effective than restricted UCTs for this outcome, given the limited amount of evidence for restricted UCTs and the lack of comparative studies.

Results on all morbidity outcomes seem to apply the same way irrespective of the gender of the child. The only exception is the prevalence of HIV/HSV2, for which evidence is only available for girls (and not for boys) between 12-22 yrs. There is no evidence to show whether morbidity outcomes differ by who the cash was given to (i.e. the male or female parent / caregiver).

Factors that appear to be at play for morbidity outcomes in general appear to be the extent of investment people are able to make in clothing and shoes for children as a result of cash transfers as well as whether they 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

There is limited evidence for the impact of cash transfers on mortality. However, there is evidence of a decrease in mortality for children between 0 and 5 years old, apparently as a result of unrestricted CCTs (with the exception of one study in which the impact on neo-natal mortality is non-significant). For unrestricted UCTs, the impact on mortality (only researched in one study) is non-significant. No evidence was found for restricted CCTs or restricted/labelled UCTs. Impacts that have been researched are the same 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).

The factors potentially at work appear to be income improvements, created by cash transfers, and consequent increase in access to food and other health-related goods, along-with use of and access to health services, particularly influenced by conditionalities imposed on health care take-up. This potentially leads to a reduction in malnutrition and disease morbidity, which then contributes to a reduction in child mortality.

Infant and Young Child Feeding Practices

Evidence suggests that when combined with a nutrition counselling component, unrestricted transfers – with or without conditionalities[12] – lead to an increase in maternal knowledge around IYCF. However, this does not necessarily translate into improved IYCF practices, and it is the case particularly for practices related to breastfeeding. It appears that the non-significant impacts on breastfeeding practices could be because mothers have already been complying with prescribed breastfeeding practices at the start of the programme. Additionally, unrestricted CCTs show mixed impacts on infant diet quantity and diversity, whereas, unrestricted UCTs are found to increase the same indicators. Outcomes for dietary diversity[13] 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 could be 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 statement and recommendation can be made in this regard.

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 dependant on whom the cash is given to (i.e. female or male parent / caregiver). No evidence was found for restricted CCTs or restricted/labelled UCTs.

Anthropometric Indicators

Evidence was available for all modalities except for restricted CCTs. None of the evidence reviewed for this study reports significant impacts of cash transfers on several indicators of children's growth, i.e. height for age for children 0-5 years as well as weight for height and weight for age for children 0-14 years.. Evidence from all these modalities however does show a significant decrease in severe stunting and severe wasting for children between 2-9 years, a significant decrease in stunting for those children whose mothers have secondary or high school education, as well as a decrease in stunting for children whose households have access to clean water. Additionally, there are mixed impacts on incidence of anaemia for children 0-6 years. here is no evidence to show whether outcomes differ by the gender of the child or whom the cash is given to (i.e. female or male parent / caregiver).

Evidence suggests that imposing conditionalities, such as regular growth monitoring for children, is as effective in improving anthropometry as not having any conditionalities in place, or having restrictions and labels that require cash to be used for child health purposes. What appears to be far more important than the cash modality used are other factors e.g. maternal education, access to clean water, intra-uterine and antenatal influences, breastfeeding and IYCF practices, as well as incidence of infectious diseases in the first 24 months of life. There is no evidence to show whether outcomes differ by the gender of the child or whom the cash is given to (i.e. i.e. female or male parent / caregiver).

12 With condition of taking children for monthly growth monitoring.
13 Only for infants over 6 months of age

Food security

Evidence on food security indicators is available for children between 6 months and 17 years old, but only for unrestricted UCTs and restricted UCTs Overall, the findings appear to show cash transfers lead to a significant increase in diet quantity and frequency (i.e. the number of meals consumed and food quantity) as well as a significant decrease in incidences of eating fewer meals. Instead, the impact on diet diversity indicators is mixed, not allowing conclusive statements in that regard. No comparisons are reported between girls and boys, so we cannot conclusively state any difference in impact or lack thereof according to the sex of the child. There is also no evidence to show whether outcomes differ by whom the cash is given to (i.e. female or male parent / caregiver, or the child), except for one study, that finds a significant increase in the number of meals consumed by 12 years old girls, when they are directly given cash for school expenses as opposed to cash being given to their parents.

It appears that cash transfers contribute towards increased food security by providing money that enables households to buy food, as well as sometimes make savings (e.g. putting money in saving schemes) and invest in livestock or more diversified smallholder farming. This can often help improve children's diet, and make available nutrient dense foods like eggs or milk (through investments in chicken/cows etc.) as well as other home grown food. However, what children consume also depends a lot on existing food habits and cultural practices as well as what type and quality of food is available at the local market for households to purchase.

Psychosocial Wellbeing

Overall the findings appear to show that unrestricted CCTs and UCTs lead to a decrease in psychological distress and the experience of isolation and disempowerment for children between 7-17 years old. Children also appear to be more hopeful, self-confident, and happy to get their needs met, while also reporting an increase in their social engagements. However, there is not enough evidence and particularly high rated evidence to conclusively link cash transfers with the desired outcomes for psychosocial wellbeing, and the above outcomes must be considered suggestive at best. Additionally, no evidence is reported for restricted CCTs or restricted or labelled UCTs.

CHILD SURVIVAL EVIDENCE GAPS

While, the author found evidence for the impact of cash across a wide range of child survival indicators, several indicators appear not to have been researched at all. In the case of food consumption, evidence is widely available on household food consumption, but not specifically on food consumption by children.

With regard to gaps, there is no evidence of 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 can assume some indirect impacts (even though there is no research evidence for this) via other outcome categories that are directly impacted; indirectly impacted indicators include:

- children's access to shelter via giving their parents money to pay house rent
- children's access to timely health-care via an increase in health-care utilization and parental knowledge about child health and nutrition
- increase in maternal education via an improvement in education outcomes for girls
- prevention of negative food and non-food coping strategies, via increased parental expenditures in food and other essentials for living.

Photo: Mark Kaye/Save the Children

HOW TO USE CASH TRANSFER PROGRAMMING FOR CHILDREN'S SURVIVAL

Below, is the account of significant evidence pointing at a univocal increase or at a decrease in certain survival indicators; mixed, conflicting or non-significant evidence is not reported.

Whilst from the table below it appears that unrestricted CCTs are more consistently coming up as modality that causes significant impacts on survival outcomes, it is not possible to conclusively say that unrestricted CCTs are more effective than other modalities, because no study directly compared the effect of different types of interventions and because there is less evidence for some modalities than others.

Evidence	Modality used or compared	Evidence-based recommendations
Increase in take-up of preventative health services for children: 1 MA (reviewing evidence from 5 IEs), 1 SR (reviewing evidence from 2 IEs), 1 LR (reviewing evidence from 6 IEs) as well as 12 individual IEs	Unrestricted CCTs	• When using unrestricted CCTs, adopt conditionalities specific to health behaviours to incentivise the take-up of preventative health services for children
Decrease in child HAZ scores when conditionalities were other than health: 1 MA reviewing evidence from 6 IEs	Unrestricted CCTs	• Avoid using non-health specific conditionalities, such as saving requirements or cash for work, if seeking to improve child anthropometry
Increase in take-up of maternal health services: 1 IE of an unrestricted CCT program for the treatment arm that used the highest cash amount as opposed to other treatment arms using a lower cash amount.	Unrestricted CCTs	• Ensure the cash amount is adequate when trying to influence take up of maternal health-care, so as to offset additional private costs of complying with conditionalities or "motivation crowding out"[14] when not imposing any conditionalities

14 Discouraging beneficiaries from using health services if they do not attribute value to the cash amount

Photo: Rosie Thompson/Save the Children

EVIDENCE GAP MAP: SURVIVE

Intervention/Outcome								
Intervention	**Context**	**Preventive Hea**						
		Preventive health check-ups & growth monitoring	Receipt of vaccination	Receipt of nutrition supplements & deworming	Maternal decision-making on child health investments	Maternal knowledge (IYCF)	Early initiation of breastfeeding/ newborn receiving colostrum	Exclusive breastfeeding (0-6 ms)
Unrestricted CCTs	Development	1, 2, 9	6	2	1	1	No Evidence for any intervention	2
	Humanitarian	1	1					1
Unrestricted UCTs	Development	4	2	1	2	1		
	Humanitarian			1	1			
Restricted CCTs	Development							
	Humanitarian							
Restricted UCTs	Development							
	Humanitarian							
Labelled UCTs	Development							
	Humanitarian							

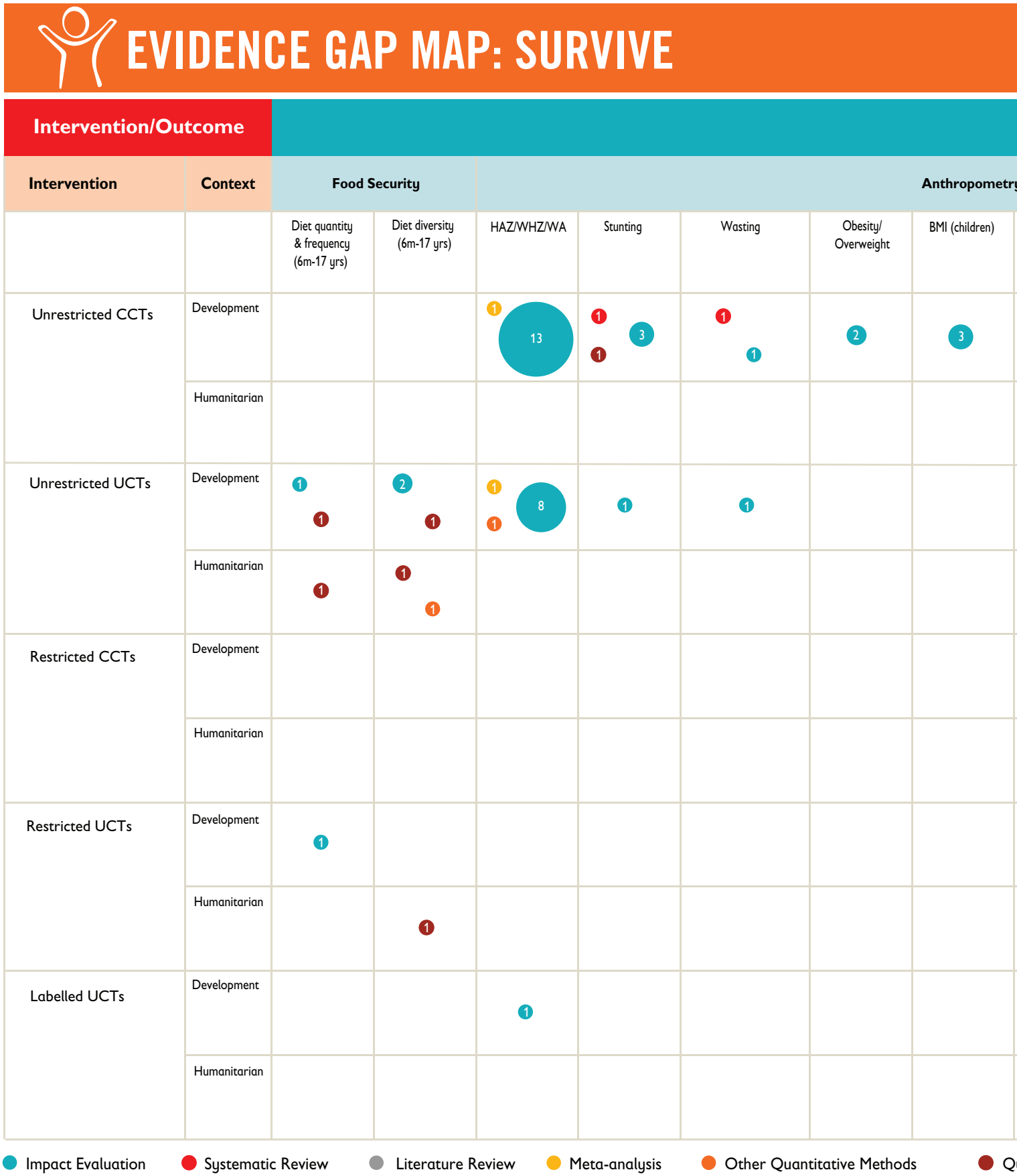
Impact Evaluation Systematic Review Literature Review Meta-analysis Other Quantitative Methods Q

Child Survival

ılth							Morbidity			Mortality
Diet diversity & introduction to solid/semi-solid food (6-36 ms)	Use of anenatal health check-ups	Use of skilled birth attendants	Institutional delivery	Use of curative health-care services for children	Adherence to HIV treatment protocols by mother or children	Maternal food consumption & diet diversity	General morbidity (children)	General morbidity (mother)	HIV acquisition/ HSV2 prevalence (children)	Child mortality (0-5 yrs)
2	1 1 2 9	6	5	3	No Evidence for any intervention	No Evidence for any intervention	1 3	No Evidence for any intervention	1 2	5
1			1	1						
3	2	2		5			8			
1				1						1
	1 2	2	1 3						1	
				1			1		1 1	

Qualitative Evaluation

EVIDENCE GAP MAP: SURVIVE



Child Survival

y & Nutritional Status						Psychosocial Wellbeing			
BMI (mother)	Acute malnutrition (bipedal oedema, WHZ & MUAC)	Incidence of Anemia	Nutritional deficiencies other than Anemia	Intrauterine growth outcomes or birth defects	Premature birth or birth weight	Psychological distress	Self-confidence & positive outlook	Happiness	Experience of isolation & disempowerment
			No Evidence for any intervention	No Evidence for any intervention	No Evidence for any intervention	2	1		
		3				1	2	3	
	1 1							1	1
		1							
1									

ualitative Evaluation

Photo: Save the Children

4. ON THE BREAKTHROUGH "LEARN"

FINDINGS FOR CHILD LEARNING OUTCOMES

Cognitive and non-cognitive Development

Overall, evidence around the impact of cash transfers on cognitive and non-cognitive development for children 4-6 yrs, leans towards an improvement in several outcome areas e.g. language, associative and short term memory, fine motor skills, visual reception and social personal development, verbal and memory scores. Conversely, impact is non-significant for other outcomes e.g. gross motor skills or scores on the sticker test. Additionally, for outcomes such as the scores of the Peabody Picture Vocabulary Test (PPVT) and leg motor skills, while initially there appears to be an increase, this does not appear to last on a longer-term basis. It is important to state that these findings do not discuss the pathways leading from cash transfers to cognitive and non-cognitive development. It may well be that the impact of cash transfers on these outcomes is not direct (instead impacting lower level factors that then affect development) but what is relevant is that cash transfers do have an effect on these higher-level outcomes.

Results appear to show the same pattern irrespective of the cash modality used, the gender of the child or whom the cash is given to (i.e. female or male parent / caregiver). There is no evidence available for labelled or restricted UCTs, and – as a whole – the evidence base is small.

It appears that adequate IYCF practices and health during early childhood (the first 1,000 days after birth) can significantly contribute towards an improvement in cognitive development. This depends on the quality of a child's diet (children 6 months and over) especially the consumption of protein and dairy, the use of latrines and handwashing and exposure to stimulation in early childhood. Cash transfers aiming to improve these nutrition and health-related factors can be expected to indirectly and ultimately improve cognitive development.

School Enrolment

Evidence from four MAs and 16 IEs points to an increase in school enrolment for children 6-18 yrs as an effect of cash transfers and irrespective of the modality. Evidence for this outcome is available for all cash modalities. It does appear however, that other conditionalities can have much larger impacts on school enrolment as compared to the commonly used enrolment or attendance conditionalities. In particular, alternative conditionalities can be based on achievement such as not failing grades, or can be specific to certain categories of children e.g. girls, under-performers or younger children. . There is also no evidence to show whether enrolment outcomes differ by whom the transfer is made to (i.e. female or male parent / caregiver).

School Attendance

A large body of evidence of 4 MAs, 14 IEs and 4 QEs shows that cash transfers contribute to higher attendance rates and a decrease for school absenteeism for children 5-18 yrs, irrespective of the cash modality, and evidence is available for all cash modalities.

The only exception was for cash for work programmes (a type of CCT) that – according to the findings of two IEs – appear to have a perverse effect on school attendance, leading to a decrease in number of hours spent by children in school. This is true particularly when the transfer is made to fathers as opposed to mothers, since children are often covering for their parents (generally fathers), whilst these are engaged in wage labor elsewhere.

Grade Attainment, Progression and Completion

For this outcome category, evidence from two MAs on restricted CCTs and one IE on a restricted UCT shows a significant increase in school performance outcomes such as grade/school completion, grade for age and grade repetition. Instead, impacts of unrestricted CCTs were mixed on highest grade attained and high school matriculation for children 5-18 yrs. Evidence for other cash modalities is mixed for all outcome indicators and there is no evidence available for labelled UCT programmes. There is also evidence showing that girls score relatively more than boys for school completion rates for both unrestricted CCTs and UCTs, and for restricted UCTs only when the cash transfer is given for > 5 years during schooling. There is no evidence to show whether outcomes differ by whom the transfer is made to (i.e. female or male parent / caregiver).

It appears that an increase in school attendance and a reduction in school drop-out are key factors that lead to an increase in grade attainment for children. However barriers such as poor quality of education and poor student performance can often hinder children from achieving these indicators.

School Drop-out

The evidence available for this outcome category, although considerably low, mostly finds a significant decrease in school dropout rates for children 6-18 yrs for unrestricted CCTs and UCTs as well as labelled UCTs. No significant changes are reported for restricted CCT programmes, and no evidence is available for restricted UCT programmes. Results seem to apply the same way irrespective of the gender of the child and there is also no evidence to show whether outcomes differ by whom the transfer is made to (i.e. female or male parent / caregiver). More research is needed to show how impacts appear to be taking place.

School Performance

Overall, the impact of unrestricted CCTs and labelled UCTs on school performance for children 6-18 years (measured by various test scores) is mixed. On the other hand, a significant increase was seen following the use of restricted CCTs (scholarships conditional on school performance/merit) as reported in two MAs, as well as restricted UCTs (vouchers for free access to private schools) as reported by one IE. Additionally, no significant impacts are reported for unrestricted UCTs.

It appears that imposing conditionalities on performance and restricting cash to school specific expenditure or certain types of schools e.g. private schools, can lead to significant impacts in the desired direction for school performance. More standard cash modalities, such as unrestricted UCTs and CCTs (with conditionalities around enrolling in school or attending school) are not as effective. Results seem to apply the same way irrespective of the gender of the child and there is no evidence to show whether outcomes differ by whom the transfer is made to (i.e. female or male parent / caregiver).

CHILD LEARNING EVIDENCE GAPS

While the author found evidence for the impact of cash across a wide range of learning indicators, several indicators appeared to not have been researched at all so there is no evidence to show the direct impact of cash transfers on them. These indicators are:

- children's actual human capital development, and not merely passing 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.

There is a very small amount of evidence for this, and a lot more research is needed, particularly because this is a very important milestone: dropping out of school during this time is critical and has wide ranging impacts on outcomes for children's health, education and protection (and those of their children, particularly when it is girls dropping out).

HOW TO USE CASH TRANSFER PROGRAMMING FOR CHILDREN'S LEARNING

It appears from the evidence, that the type of cash modality is not a very significant factor when it comes to influencing child learning outcomes. This cannot be said conclusively however as there is limited evidence for some modalities and very few studies have compared modalities.

Photo: Dan Stewart/ Save the Children

Evidence	Modality used or compared	Evidence-based recommendations
Increase in school enrolment: • Larger increases in this outcome when conditionalities based on achievement such as not failing grades as opposed to conditionalities around simply enrolling in school (1 MA (reviewing evidence from 12 IEs) and 1 individual IE evaluating unrestricted CCTs). • Larger increases in this outcome for restricted CCTs as opposed to those evaluating unrestricted CCTs and restricted UCTs (1 MA (reviewing evidence from 6 IEs).	• Unrestricted CCTs with conditionalities around school performance as opposed to simply school enrolment. • Restricted CCTs versus unrestricted CCTs or restricted UCTs.	Employ unrestricted CCTs (with conditionalities on school performance as opposed to only school enrolment) or restricted CCTs (scholarships conditional on school performance) to substantially increase schooling enrolment.
Increase on children test scores: 2 MAs (1 reviewing evidence from 2 studies, another reviewing evidence from 10 studies)	Restricted CCTs	Employ restricted CCTs (scholarships conditional on school performance) to significantly increase child school performance.
Increase in cognitive development: • when cash combined with early childhood development, not when cash alone (1 IE). • Among children exposed to the intervention starting in utero as opposed to those exposed to the program in their second year of life or later (1 IE).	Unrestricted CCTs	• Combine unrestricted CCTs with early childhood development programmes, or; • Cash transfers to be started at an early age (preferably in utero)

Additionally, some study authors have made the following statements, which have yet to be validated by evidence:

- Since access to primary schools is generally free of charge, cash transfer programmes should be targeted towards influencing outcomes for secondary school students as opposed to outcomes from primary school students.
- Where cash for work programs are being used, it might be useful to allocate unrestricted UCTs specifically for children (in addition to the cash for work for their parents) or give cash for work transfers to parents on the (additional) condition that that they send their children to school regularly, so as to combat the negative effects cash for work can sometimes have on increasing child labour and reducing school attendance.

EVIDENCE GAP MAP: LEARN

Intervention/Outcome									
Intervention	**Context**		**Cognitive development**						**Non-cognitive development**
		Associative, long-term & short-term memory	Processing speed	Language development	Visual reception & integration	TVIP scores	Motor skills	Social & personal development	Sticker test score
Unrestricted CCTs	Development	3	2	3	2	1	1	2	
	Humanitarian								
Unrestricted UCTs	Development	2		2	2	1	1		1
	Humanitarian								
Restricted CCTs	Development	1		1		1	1	1	
	Humanitarian								
Restricted UCTs	Development								
	Humanitarian								
Labelled UCTs	Development								
	Humanitarian								

● Impact Evaluation ● Systematic Review ● Literature Review ● Meta-analysis ● Other Quantitative Methods ● Q

Child Learning

SEL/ soft skill development	School enrolment	School attendance		Grade Attainment, Progression and Completion					Pre-schooling/ vocational schooling outcomes	School drop-out	School Performance	
		Attendance	Absenteeism	Grade/school completion	Grade for age	Grade repitition	Highest grade attained	Transition from primary to secondary school			Test scores	Actual learning & human capital development
No Evidence									No Evidence			No Evidence

ualitative Evaluation

Photo: Save the Children

5. ON THE BREAKTHROUGH "BE PROTECTED"

FINDINGS FOR CHILD PROTECTION OUTCOMES

Child Labour

It appears from reviewed evidence that the impact on child participation in wage labour for children 5-18 years is mostly mixed irrespective of the cash modality used, making it impossible to draw conclusive recommendations.

However, there is a small body of low-rated evidence (i.e. qualitative evaluation) on unrestricted UCTs and CCTs in humanitarian contexts that does consistently report a reduction in the worst forms of child labour and sex-work for girls. Conversely, cash for work programmes appear to lead to a significant increase in child participation and hours spent in wage labour.

In terms of children's participation in unpaid household/family farm or business work, impacts of cash transfers are conflicting: sometimes they appear to significantly increase children's participation in labour, while at other times they decrease it. This is true irrespective of the cash modality used. In addition, it appears that a reduction in children's participation in wage labour is associated to an increase in their participation in household farm activities and household chores; as a result, children's leisure time does not increase as desired.

There is evidence to show that each percentage point increase in school participation is associated with a reduction in child labour of 0.31 percentage points (J. De Hoop and F.C. Rosati 2013) and cash is often able to reduce child labour through increased attendance However, this is not always the case in that schooling does not necessarily reduce child labour, because poor households often cannot get by without having their children engage in some form of child work, even if it is within their own home.

Results seem to apply the same way irrespective of the gender or age of the child and there is no evidence to show whether outcomes differ by whom the transfer is made to (i.e. female or male parent / caregiver). Evidence is not available for restricted CCT programmes.

Early Marriage and Early Pregnancy

The overall consensus for this outcome category is leaning towards a decrease in indicators related to early marriage and pregnancy for girls and young women (10-25 years) for unrestricted CCTs, while appearing mixed for unrestricted UCTs. No evidence was found for the other two cash modalities. Additionally, evidence from unrestricted UCTs show a significant decrease in early sexual debut and rates of transactional and age-disparate sex, but not of other risky sexual behaviour e.g. unprotected sex, multiple partners, and sex while drunk or after taking drugs.

It appears that improvements in schooling for girls (enrolment, grade attainment, years of schooling etc.) – often influenced by conditionalities imposed on cash transfers – are one of the key factors in delaying marriage, sexual debut and pregnancy. Additionally, improvements in the economic status of households and girls potentially allow them to avoid risky sexual behaviours such as transactional sex or age-disparate sex.

However, cash doesn't necessarily reduce all risky sexual behaviours on the part of girls and boys (e.g. unprotected sex, multiple partners, or sex after drinking alcohol or taking drugs), suggesting that drivers other than cash might also be pertinent for adolescents. 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 sometimes resort to early marriage as a strategy for protection and/or survival. In such situations cash alone, might not be able to prevent early marriage.

Child Care Arrangements and Separation from Parents

The overall consensus for this outcome category is leaning towards a decrease in children being separated from their parents and an increase in child-care by parents, close family members, or siblings over 10 years of age (as opposed siblings under 10 years old). There is also some evidence to show that cash for work programmes allow mothers to avoid migrating for work, and increase the time they spend caring for their children, including breastfeeding their infants. Additionally, cash programmes that are conditional on increased schooling for girls, increase the time mothers spend caring for their younger children, relieving adolescent girls of this task.

In contexts where cash transfers are conditional on people taking care of orphans/unaccompanied and separated children, this behaviour appears to increase. It was observed that funds are also used to meet the needs of the beneficiary's biological children, which is a collateral benefit of cash transfers in these situations. However, in some instances cash transfers aimed at supporting care of orphans/unaccompanied and separated children are associated with some negative consequences such as making fostered children work to earn an income for the family or completely neglecting their needs to focus exclusively on those of their biological children. In addition, when cash grants are given to support institutional care as opposed to strengthening families they can sometimes lead to an undesired increase in children being separated from their families and put into institutional care.

Evidence for this category is only available for unrestricted CCTs and this evidence is limited in size and many studies are low rated. More research is needed to make stronger conclusions around these outcomes.

CHILD PROTECTION EVIDENCE GAPS

While, the author found evidence for the impact of cash on a wide range of protection indicators, several indicators appeared not to have been researched at all and there is no evidence to show the direct impact of cash transfers on these. These indicators are:

- children's experience of physical/sexual/domestic/intimate partner violence
- improvements in the quality of childcare
- reintegration of children into their family or community after they have been separated from their parents/family e.g. as child soldiers, runaways or participating in any other high risk work that results in them leaving home
- access to social protection services including case management

When investigating the impact of cash (and non-cash) interventions on child labour, it would be informative from a programmatic and policy point of view to disaggregate by possible typologies of labour, time spent working and sex of the child.

For some other indicators, we can assume some indirect impacts (even though there is no research evidence for this) via outcome categories that are directly impacted. Indirectly impacted indicators may be:

- children receiving better care and less neglect due to an increase in parents taking more care of their children compared to other family members or siblings
- 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

HOW TO USE CASH TRANSFER PROGRAMMING FOR CHILDREN'S PROTECTION

It appears from the evidence, that the type of cash modality is not a very significant factor when it comes to influencing child learning outcomes. This cannot be said conclusively however, given that there is limited evidence for some modalities and no studies have compared modalities.

Evidence	Modality used or compared	Evidence-based recommendations
Decrease in early marriage: 2 IEs evaluating unrestricted CCTs. Decrease in early pregnancy: 1 SR (reviewing evidence from 4 IEs)	Unrestricted CCTs (conditions related to schooling)	Employ unrestricted CCTs with conditionalities linked to participation in school, so that girls don't get married and pregnant during adolescence.
Larger cash amounts is not associated with a larger reduction in child labour: 1 MA (reviewing evidence from 3 IEs) Positive evidence by 1 individual IE, that relatively small expenditures (for example the costs of school uniforms) are sufficient to keep children in school and out of child labour. Increase in school participation associated with a reduction in child labour: 1 MA (reviewing evidence from 8 IEs)	Unrestricted CCTs & UCTs	When aiming at reducing child labour, ensure that the quantity of cash is sufficient to help households increase the school participation of their children. This doesn't necessarily have to be very large to influence this outcome in the desired direction.

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

- Have in place tight monitoring systems, including those that link cash 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 child-care practices potentially combine cash with well-designed educational talks or awareness building around positive parenting. Parenting practices should be monitored to assess the impact of such programs.
- Employ conditionalities requiring parents to 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 be a deterrent to children engaging in labour.

SPOTLIGHT: IMPACT OF CASH ON CHILD SURVIVAL, EDUCATION AND PROTECTION WITHIN A HUMANITARIAN RESPONSE

Cash transfers have similar patterns of impact for most child survival, education and protection outcomes, in both humanitarian responses and development interventions. However, in humanitarian contexts, some outcomes follow a very different pattern as compared to development contexts. Overall, since most evidence from humanitarian contexts was low rated, findings showing links between cash interventions and impacts are only suggestive rather than proof of causality. This observation is applicable to all instances below where evidence is indicated as merely suggestive.

- a significant reduction in acute malnutrition (weight for height, prevalence of bipedal edema and mid-upper arm circumference) in situations where cash is supplemented with food compared to cash only.
- an increase in receipt of vaccinations, but evidence is only suggestive.
- conflicting impacts for school enrolment, but evidence is only suggestive
- a reduction in the worst forms of child labour and sex-work for girls, but evidence is only suggestive
- an increase in separation of children from family and into institutional care under circumstances when cash grants have been given to support institutional care as opposed to supporting families, but evidence is only suggestive

Many barriers/pathways to change are similar in humanitarian and development contexts, but some factors appear to be exacerbated within a humanitarian response. These increasing challenging issues are:

- increased distance to schools and increased safety concerns surrounding enrolling and sending children to school
- 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 could almost inevitably cause households to resume/resort to negative coping strategies.
- safety concerns for girls, leading to families seeing marring off girls early as the only way to protect them and/orensure their survival

EVIDENCE GAP MAP: BE PROTECTED

Intervention/Outcome								
Intervention	**Context**	**Child Labour**				**Early Marriage and Early**		
		Paid wage labour	Unpaid household/family farm or business work	Sex work	Worst forms of child labour	Early Marriage	Early pregnancy	Sexual debut
Unrestricted CCTs	Development	2, 1, 6	1, 4			3, 1	1, 1	
	Humanitarian	1	1	1	1			
Unrestricted UCTs	Development	1, 6	5			1	3	2
	Humanitarian	2, 1	1	3	3			
Restricted CCTs	Development							
	Humanitarian							
Restricted UCTs	Development	1						
	Humanitarian							
Labelled UCTs	Development	1	1					
	Humanitarian							

Impact Evaluation · Systematic Review · Literature Review · Meta-analysis · Other Quantitative Methods · Q

Child Protection

Pregnancy		Experience of physical/sexual/ domestic/ intimate partner violence	Child care arrangements and separation from primary care-givers							Access to social protection services
Transactional & age- disparate sex	Risky sexual behavior		Child-care by parents or grandparents	Child-care by older (>10 yrs old) as opposed to younger siblings	Child-care by adolescent girls	Care of foster children by adoptive family	Strategic family seperation	Reintegration with one's family or community	Quality of child-care received	
		No Evidence	1 2	1	1	1	1	No Evidence	No Evidence	No Evidence
						1				
1	1									

Qualitative Evaluation

Photo: Colin Crowley/Save the Children

6. CONCLUSIONS

The importance of considering different levels of outcomes

CTP as a whole appears to significantly and positively contribute to the key outcome areas of child survival, education and protection. CTP have the most consistent 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). There is less consistent positive impact for outcomes that are less immediately associated with cash (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).

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

- *Target 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, which is the higher-level outcome. Often, these interrelated and dependant impacts are not consistently mapped out and / or reported. For instance, cash does not consistently appear to reduce child morbidity or increase child diet diversity, which potentially plays an important role in improving child cognitive development. Moreover, evidence of CTP impact is unavailable for some factors that are part of certain causal pathways. For instance, water, hygiene, and sanitation (WaSH) are important contributors to several child health- and nutrition-related outcomes. However, to date there is no robust evidence of CTP impact on these.
- *Be combined with some other intervention within the same programme.* CTP are mostly designed and delivered as stand-alone interventions and not in combination with others programmes / programme elements that may affect complementary parts of the causal pathways. 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 consistent 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 as well as supply-side barriers in the markets or service supply systems and non-monetary access issues. Design features of CTP that can lead to a lack of impact include 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.

On the other hand, supply-side barriers relate to the poor availability or poor quality of the commodities and services that contribute to meeting certain outcomes. Examples of these barriers in relation to different outcomes are poor availability and quality of health-care services, poor availability of drinking water, or lack of a variety of food items in the local markets. Access may be constrained by issues related to distance and safety, rather than to economic barriers within a household. For instance, schools and healthcare facilities may be located at large distance from the targeted communities. In such circumstances, it may be argued that, CTP is not an appropriate intervention, as it is meant to address access issues caused by monetary constraints, assuming 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.

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 major blockage.

Comparing CTP modalities

With some exceptions for a number of outcomes, overall most variations in the type of cash modality do not play a very significant role in influencing outcomes for children. However, imposing conditionalities and/or restrictions around the transfers does appear to generate significant positive impacts on child health-seeking behaviours, schooling outcomes and early marriage and pregnancy as opposed to not imposing any conditionalities or restrictions.

In this regard, cash seems to act as an incentive to recipients to take up specific behaviours that the implementer considers desirable. However, the question is whether beneficiaries would adopt these same behaviours if the transfers were made without conditions, only as a result of their budgetary constraints being lifted (L. Pellerano and V. Barca 2014). In other words: is it the transfer itself or the condition imposed on it that leads to the desired behaviour?

It is also worth noting that a particular form of CCT – cash for work – appears to have a significant impact in an undesired direction, leading to an increase in child labour.

However, conclusive statements about the relative efficacy of various CTP modalities cannot be made as there is a lot more evidence available for unrestricted CCTs than for other modalities, and there is scant evidence that compares modalities within the same programme. It is therefore difficult to conclusively claim that imposing conditions or restrictions are better or worse methods than imposing no conditionalities or no restrictions. More research is needed to explore the impact of the less researched cash modalities on several outcome indicators as well as more comparative research between modalities to be able to draw definitive conclusions.

As a general principle, conditions should not be applied and enforced when the conditioned services are not available or not accessible to the recipient households. Other considerations for the choice of conditional versus unconditional transfers, or restricted versus unrestricted transfers, are related to the relative costs associated to these modalities, some of which are borne by the recipients as well as the implementing organizations.

Considerations on Value for Money

It is also important to observe that should we decide to use conditionalities and restrictions to improve certain outcomes for children, this will often involve higher implementation and administrative costs, both for the implementing organization and for recipients complying with conditionalities. Accordingly, when conditionalities or restrictions appear to be more effective, programme designers will have to 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 their 'value for money'. Since this study did not review and compare the cost-efficiency of different modalities, this aspect will have to be further researched in future studies.

Development vs humanitarian contexts

Evidence of the impact of CTP on children is more widely available and more highly rated for development contexts than for humanitarian contexts. As such, any comparisons drawn between the impacts of various forms of CTP in these contexts must be made cautiously. However, it should be noted that comparisons drawn between humanitarian and development contexts have so far shown that there is relatively little difference in the pattern of cash transfer impacts.

Some outcomes, such as acute malnutrition or girls engaging in sex work have been studied only in humanitarian contexts but not in development contexts; a significant decrease was found for the former outcome and a decrease was suggested for the latter by low-rated evidence. Hence, it is not possible to conclude whether cash transfers are more effective in one or another context. In other instances, impact on the same outcome varies between the two contexts; for example, while school enrolment appears to significantly increase as a result of CTP in development contexts, the impact is mixed within humanitarian contexts.

Additionally, in humanitarian contexts, evidence is mostly available for unrestricted UCTs, and there are no comparisons available between the different modalities. It is thus difficult to conclusively claim what type of cash modality works best in response to humanitarian emergencies.

Barriers related to access to and availability of commodities and services are also likely to be exacerbated within a humanitarian context due to the added fragility of the circumstances, and they may affect the effectiveness of cash transfers. For instance, safety issues may not allow parents to send their children to school or may cause parents to get their girls married off early. Under a humanitarian context the safety of children is far more threatened, and so programs will have to make additional provisions for counteracting this under a humanitarian context versus a development context. Such barriers may warrant a different response in humanitarian versus development situations.

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. It is also important to be clear as to the potential trade-offs between different cash modalities or between using cash alone and in combination with other programs.
- 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 also need to be available and functioning appropriately

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 them for different age groups and across boys and girls.

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 will be 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 could 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.

Last but not least, we must also be cognizant of the limitations of cash programmes, which are primarily intended to alleviate monetary constraints and, by doing so, increasing access, consumption and utilization of essential commodities and services. As such, it is always important to bear in mind what they 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 must not be used at all, and maybe we should adopt other intervention modalities e.g. food and nutritional supplements for anthropometry or purely pedagogical programs for improving child school performance. Given that in our report we haven't compared cash with other programs, we cannot make conclusive claims around the benefits of cash over and above these other programs.

Photo: CJ Clarke/Save the Children

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15 This list is the reduced list of references appearing in this Research Brief. The full bibliography is available in the full report "Synthesis report: child outcomes of cash transfer programmes. What works and what doesn't for children in humanitarian and development contexts".

CHILD OUTCOMES OF CASH TRANSFER PROGRAMMING

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