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Review of the global evidence on SOCIAL PROTECTION supporting childhood development outcomes

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SUMMARY

This review of the global evidence on social protection supporting childhood development outcomes was developed as part of a wider project to strengthen Save The Children Australia's social protection policy and advocacy engagements in the Pacific region.

It focuses on how social protection supports reductions in stunting, increases access to primary education, improves cognitive, social and emotional development, and reduces violent discipline against children in the home. The review draws on evidence identified through a methodical literature search of systematic reviews and meta-analyses to identify high-quality single country studies. The available evidence was heavily biased towards studies of conditional cash transfers in Latin America and focused largely on the impact of social protection on children's nutrition and education. In the areas of cognitive, social and emotional development and violence against children, the evidence base was much thinner and provides initial insights which warrant further research. The review is based on a purposive sample of 30 studies of social protection programmes (conditional cash transfer, unconditional cash transfer and public works) from 11 countries.

Key findings include:

- Providing cash alone is rarely sufficient for delivering substantial progress childhood development outcomes in contexts where these are significantly depressed. Complementary measures such as information sessions or behavioural change interventions are particularly important for achieving improvements in feeding practices, and encouraging a more nurturing approach to parenting.
- Cash transfers for pregnant women and children under two years can make a critical contribution to early childhood development.
- Conditional cash transfers can generate both positive and negative effects on childhood development outcomes, which confirms the importance of considering impacts on programme recipients, non-recipients and service providers during the design of social protection policies and programmes.
- Transfer adequacy, and the accessibility and quality of supply side services, were further identified as critical determinants of the impact of social protection on children's outcomes.

Although the review successfully identifies a range of empirically grounded insights, it is important to recognise that project resource limitations, combined with a paucity of country-specific studies that address multiple child outcome measures, necessarily resulted in rather thin coverage of each of the child outcome areas in which Save the Children has a strategic interest. More in-depth, outcome-specific evidence reviews would likely unearth additional insights and important nuances. Furthermore, the limited availability of high-quality evidence from comparable socio-economic, socio-cultural and institutional contexts means that care should be taken when considering the generalisability of results in the research identified in this review to Pacific Island Countries (PICs). Nonetheless, the available research provides critical insights into the factors that should be considered when designing, implementing and evaluating context-appropriate social protection programmes for children and families in the Pacific.

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CONTENTS

1. INTRODUCTION

In the last two decades, significant progress has been made in the number of low and middle-income countries working to develop their social protection systems to support social and economic development objectives. In 2020 in particular, the importance of social protection came into global focus as virtually all countries took action to introduce social protection measures to protect incomes, health and jobs, in response to the COVID-19 pandemic (ILO, 2021). The critical role of social protection for social and economic development, and the realisation of human rights, is further underscored by its inclusion in a number of international frameworks including the Sustainable Development Goals[1] and the ILO Social Protection Floors Recommendation, 2012 (202[2]).

However, many of the measures introduced in response to the COVID-19 pandemic were only temporary, and only 47% of the global population is currently covered by any social protection benefit.[3] The proportion of children and their households receiving child or family benefits is even lower, at only 26% of the global population of children.[4]

Save the Children has committed at a global level to promoting the expansion of child-sensitive social protection systems as a key prerequisite for the realisation of children's human rights and reducing multi-dimensional poverty (Save the Children, May 2020). And while coverage of social protection benefits is highly varied between and within regions of the world, social protection systems supporting children and their households are particularly underdeveloped in the Pacific Island Countries (PICs): only 4 of 15 countries in the PICs region - Cook Islands, Niue, Tokelau and Fiji - provide cash benefits for children or their families[5] and, as a result, only 1.3% of children in the PICs receive child or family cash benefits.[6] As such, objectives to develop social protection systems feature prominently in a number of Save the Children's country level strategies in the PICs, and in Save the Children Australia's regional social protection policy and advocacy engagement.

This review of the global evidence on social protection supporting childhood development outcomes aims to support Save The Children Australia to strengthen its social protection policy and advocacy engagements in the Pacific region. The review is a foundational component and has been accompanied by in-depth country-level analysis of social protection systems in Papua New Guinea, Solomon Islands and Vanuatu.

1 Sustainable Development Goals, Goal 1 End poverty in all its forms everywhere, Target 1.3 https://sdgs.un.org/goals/goal1 (Accessed 23 September 2022)

2 R202 – Social Protection Floors Recommendation, 2012 (No. 202), Recommendation concerning National Floors of Social Protection, Adoption: Geneva, 101st ILC session (14 June 2012)

3 'Population covered by at least one social protection benefit' (2020) SDG indicator 1.3.1 - Proportion of population covered by social protection floors/systems (%). ILOSTAT (downloaded 18th October 2022)

4 'Children/households receiving child/family cash benefits' (2020) SDG indicator 1.3.1 - Proportion of population covered by social protection floors/systems (%). ILOSTAT (downloaded 18th October 2022)

5 Other countries do provide other kinds of important support for children and their households (e.g., school feeding programme in the Marshall Islands or secondary school scholarships in Nauru) but these are separate from tax-financed social protection benefits.

6 Own calculations based on ILOSTAT data 'Children/households receiving child/family cash benefits' (2020) SDG indicator 1.3.1 - Proportion of population covered by social protection floors/systems (%). (Downloaded 18th October 2022) for the Federated State of Micronesia, Fiji, Kiribati, Nauru, Palau, Papua New Guinea, Marshall Islands, Samoa, Solomon Islands, Tonga, Tuvalu, Vanuatu)

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1.1 OBJECTIVES AND SCOPE

The overall objective of this review is to analyse and assess available empirical evidence on the role of social protection in supporting child development outcomes. The review is intended to provide Save the Children Australia with a high quality and relevant evidence base to support its engagement on social protection with national governments and other stakeholders in the PICs countries.

Specifically, the overarching research question is:

What does the global empirical research tell us about the role of social protection in supporting specific child development outcomes including nutrition, education and child protection?

The sub-questions are:

- What are the features of social protection design and implementation that deliver better outcomes for children?
- What is the global evidence on social protection supporting childhood development outcomes during times of covariate shock?

The scope of the evidence review was narrowed to focus on 1) a limited number of child development outcome indicators, 2) a defined set of social protection schemes, 3) certain sources of empirical evidence, and 4) contexts considered to be of highest relevance to the PICs. Details of each area are explained below. This approach aimed to produce relevant and quality information for Save the Children Australia, within the available time and limited resources.

1. Childhood development outcomes

There are a large number of childhood development outcomes under the broad areas of nutrition, education and child protection. Following guidance from Save the Children Australia, it was agreed that the evidence review would focus on social protection supporting four interlinked childhood development outcomes which are of particular relevance for Papua New Guinea, Solomon Islands, Vanuatu, and the Pacific region more broadly. These are:

- **Stunting rates.** Low height-for-age, also known as stunting, is the most frequently used indicator for chronic undernutrition in children. A stunting rate of more than 2.5% in a population indicates a deficient growth environment. In Marshall Islands, Papua New Guinea, Solomon Islands and Vanuatu, the prevalence of stunting in children under five is particularly high, ranging between 32% and 48%.
- **Access to primary school education.** Access to primary school education is measured by enrolment and attendance figures. Although universal access to primary school education has been largely achieved in many PICs, attendance rates remain low in some countries. The most recent UNICEF data on primary school attendance shows that 66% of primary school age children were reported to be attending school in the Solomon Islands, and 77% in Vanuatu. This compares with a school attendance figure of 95% for the broader East Asia and Pacific region.
- **Cognitive, social and emotional development.** Early childhood is a critical period for cognitive, social and emotional development. At a global level, progress is measured using the Early Childhood Development Index (ECDI). Of the PICs , only Fiji, Kiribati, Marshall Islands, Samoa, Tonga and Tuvalu have ECDI data. The proportion of children developmentally on track in these countries ranges from 83% in Fiji to 69% in Tuvalu.
- **Violent discipline against children in the home.** Violent discipline refers to psychological aggression and physical means of punishing children. Psychological aggression refers to the action of shouting, yelling or screaming at a child, as well as calling a child offensive names, such as 'dumb' or 'lazy'. Physical (or corporal) punishment is an action intended to cause physical pain or discomfort, but not injury. All countries in the Pacific with available data have high proportions of children who have experienced violent discipline by caregivers. For example, 86% of children between 1-14 years in the Solomon Islands, and 84% in Vanuatu, reported experiencing violent discipline.

2. Type of social protection scheme

This evidence review focuses on tax-financed social protection schemes. The review will consider evidence from schemes directly targeted at children, as well as those which are more broadly targeted and indirectly benefit children. The latter includes social protection schemes targeted at households (such as public works schemes) or categorical schemes targeted at other age groups (such as social pensions).

Although some international and national actors include other elements in their preferred definition of social protection (including social care services, fee waivers, livelihood services, health and education services, etc) these are not the focus of this review.

Disability-targeted social protection schemes for children are also not included in this review due to time and resource limitations which made it impossible to do justice to this complex topic.

3. Source of the evidence

The review aimed to identify high quality research on social protection supporting specific childhood development outcomes. For this reason, it focuses on the identification of single country studies from systematic reviews and meta-analyses, and high-quality literature reviews published by non-academic research institutions. A detailed description of the methodological approach to the evidence review is described in section two.

4. Relevance of the evidence for the Pacific Island Countries

Due to time and resource constraints, the number of studies to be included in the evidence review was limited to 30. The final list of selected studies aimed to provide a range of insights and perspectives to answer the research questions. The selection criteria included the type of social protection intervention, relevant geographic and income country grouping, the extent that the studies covered the specific childhood development outcomes, and the extent of evidence on social protection supporting children during times of covariate shock. This is explained in more detail in section two.

1.2 THEORY OF CHANGE FOR SOCIAL PROTECTION SUPPORTING CHILD DEVELOPMENT OUTCOMES

This section presents a theory of change for how social protection supports childhood development outcomes. It is centred around the four areas identified in section 1.2.2 and builds upon a theory of change proposed by Arriagada et al. (2018). It was further developed and tailored for this review through an iterative process drawing on the interconnected childhood development challenges described in Table 1.

Table 1: Possible causes and consequences of childhood development challenges

1. Stunting	
Possible causes: A high prevalence of stunting in a population is associated with poverty, low maternal education, food insecurity, poor sanitation, hygiene and food preparation methods. Weak immune systems from malnutrition and repeated illnesses, as well as long term conditions such as HIV, contribute to delayed growth. Inadequate antenatal healthcare and poor diets during pregnancy also contribute to low birth weight which is associated with stunting.	**Possible consequences:** Stunting is associated with delayed child development and has an impact on school readiness and educational outcomes. It is the strongest predictor of child mortality in children under 2 years of age. Stunting is associated with poor health outcomes in later life, including chronic diseases and predisposition to being overweight, and is linked with reduced earnings in adulthood. High prevalence of stunting can impede economic and national development.
2. Lack of access to primary school education	
Possible causes: Low enrolment and attendance rates are associated with long distances to school and associated transport costs; prohibitive formal and informal school fees (including the cost of uniforms and books etc); teacher absences; lack of trained teachers and learning materials. Households living in, or close to, poverty may also prefer their children to work to supplement household income, carry out household tasks, or care for other family members.	**Possible consequences:** Lack of primary school education negatively impacts individuals, society and economies. It hinders progress in reducing poverty and unemployment and sustainable economic development. Lack of education is associated with poor nutrition and health. Upon reaching adulthood, individuals who have low levels of education are more likely to make poor choices about their own children's health and development, perpetuating the cycle of poverty.
3. Delayed cognitive, social and emotional development	
Possible causes: The effect of poverty on children's brain development is less well understood, but delayed cognitive, social and emotional development has been associated with poverty, inattentive caregiving, exposure to violence, malnutrition and deficiencies in certain nutrients.	**Possible consequences:** Delayed cognitive development has been associated with poor educational performance and learning. Delayed social and emotional development may result in difficulty regulating emotions, aggression, and violent outbursts. If delays continue into adulthood, individuals may face challenges in further education, work, relationships and overall functioning in society.
4. Violent discipline against children in the home	
Possible causes: Violent discipline against children in the home has been associated with parents and caregivers having unrealistic expectations of their children's cognitive abilities, which can lead to frustration and anger. Caregivers may rely on violent discipline to teach children self-control and acceptable behaviour because they are unaware of non-violent methods. Cultural and social acceptance of violent discipline in parenting can reinforce the use of this method. Financial, health or other life stresses may cause parents and caregivers to resort to violent discipline.	**Possible consequences:** Children who have experienced violent discipline are more likely to experience physical and mental ill-health, impaired cognitive and socio-emotional development, poor educational outcomes, and are more likely to resort to aggression and perpetration of violence in adulthood.

The theory of change diagram (Figure 1) and narrative describes the social protection programme interventions, and their immediate and intermediate outcomes in relation to the childhood development outcome areas described above.

Figure 1: Theory of change on how social protection programmes support childhood development outcomes

SOCIAL PROTECTION PROGRAM INTERVENTIONS	IMMEDIATE OUTCOMES	INTERMEDIATE OUTCOMES	RELEVANT CHILD OUTCOMES
CASH TRANSFERS	Purchase of nutritious food for children and pregnant women	Reduced hunger	Reduced disparities among children in the following child outcome areas: • birthweight • nutrition and growth • cognitive development • language skills • motor skills • socio-emotional skills • educational attainment
		Increase in consumption of higher protein foods and dairy products	
	Increase ability to meet travel costs and purchase of medicine	Increased uptake/healthcare seeking behaviours	
	Investment in play and learning materials	More nurturing, stimulating and responsive parenting/reduced reliance on harmful parenting approaches	
	Decreased parental stress		
	Payment of indirect education costs (fees, uniforms, etc)	Increased enrolment, attendance and progression at school	
	Reduction in child labour		
CASH TRANSFERS MADE CONDITIONAL UPON BEHAVIOURAL CHANGE	Young children receive childhood vaccinations and supplements	Reduced childhood illness	
	Young children attend regular preventative health checks		
CASH TRANSFERS COORDINATED WITH SOCIAL AND BEHAVIOURAL CHANGE INTERVENTIONS	Improved understanding of hygiene and sanitation	Improved hygiene and sanitation practices	
	Improved knowledge of optimal child feeding	Increased adoption of optimum infant feeding practices	
	Improved knowledge of emotional regulation alternatives to harsh discipline	Reduction in violence against children in the home	

Adapted from Arriagada et al (2018)

The primary programme intervention is cash transfers, which increase household purchasing power or sustain purchasing power in times of crisis. Cash transfers enable households to increase the quantity and quality of food for children and pregnant women, thereby increasing the consumption of higher protein foods and dairy products, which contributes to reductions in stunting. With increased cash income, households can purchase medicine, pay for the costs of traveling to health clinics, and purchase hygiene products. This decreases the incidence of illness in children and pregnant women, contributing to reductions in stunting.

Cash transfers help households pay indirect education costs such as uniforms, materials, informal school fees and transportation costs. Increased cash income to a household may reduce the need for child labour which can free up children to attend school.

With increased cash income, caregivers and parents may be more likely to purchase play and learning materials for children, which contributes to a more stimulating and nurturing home environment for children, thereby supporting cognitive development, language and motor skills. Improved nutrition may also support cognitive development. Cash transfers can decrease financial stress for parents in turn supporting a more nurturing and responsive approach to parenting.

Some social protection programmes (conditional cash transfers) require recipients to meet certain conditions in order to receive their transfer. Health-related conditions may include the requirement for young children and pregnant women to attend regular preventative health checks and immunise children. These are intended to reduce the incidence of low birthweight and childhood illness, and in turn contribute to reductions in stunting. Education-related conditions require children to be enrolled in school and to attend school for a specified minimum amount of time per week. The aim of this approach is to financially incentivise the use of health, nutrition and education services.

Social and behavioural change interventions are increasingly coordinated with social protection programmes in order to increase parents' and caregivers' knowledge of childhood development and to encourage positive behaviour change. These can range from several parenting classes, to monthly or one-off information sessions. In conditional cash transfer programmes, attendance at parenting classes is sometimes a condition for programme participants to receive their payments. Social and behavioural change interventions aim to build knowledge among parents and caregivers on how to improve children's diets, how to apply correct hygiene, sanitation and food preparation methods, and identify and treat common illnesses. Imparting knowledge on more nurturing approaches to parenting and discipline, and how parents and caregivers can engage children in stimulating activities, supports cognitive, social and emotional development and may reduce violence in the home.

This theory of change is of course dependent on a number of assumptions at different levels. At the level of the social protection programme, it is assumed that:

- The most vulnerable families with children are reached.
- Social transfer payments are adequate to mitigate the impact of idiosyncratic and covariate shocks while also providing sufficient incentive to overcome direct and opportunity costs of accessing services and changing behaviour.
- Social transfer payments are accessible, regular and reliable.
- The most vulnerable children are not excluded as a result of the imposition of any conditions.
- Additional household income is used for the benefit of children.
- Increased knowledge results in behavioural change.
- Households do not simply substitute parental wage income for social transfers.
- Participation in the social protection programme does not induce other behavioural changes among household members which are harmful to children.

Beyond the social protection programme itself, it is assumed that:

- Health, education, water and sanitation services are available, accessible and of sufficient quality.
- Local markets are adequately developed such that goods and services are readily available for purchase and transport costs are not prohibitive.
- Social and cultural beliefs support households to seek healthcare, vaccinations and educational opportunities for children regardless of their gender, ethnicity, race, caste or socioeconomic status.

While this theory of change is useful for facilitating a deeper understanding of how the social protection interventions relate to the change pathways towards the desired childhood development outcomes, it is important to be mindful of the interplay of multiple social, economic and political factors which may influence the outcomes both positively and negatively.

2. METHODOLOGY

2.1 RESEARCH DESIGN

A rigorous but pragmatic approach was used to systematically identify high-quality single country studies on the impacts of social protection on child wellbeing and development from contexts that are relevant to the Pacific. The identification of the single country studies involved three steps:

- **Literature search.** This involved firstly searching for existing peer-reviewed systematic reviews and meta-analyses on social protection and children, followed by ancestry searches of their reference lists and bibliographies. Systematic reviews and meta-analyses involve a rigorous and transparent method to identify all relevant studies on a particular topic, and critically appraise studies for quality and risk of bias. This approach therefore aimed to increase the likelihood of finding all available, high-quality single country studies of relevance for this literature review.
- **Assessment of the scale of the evidence.** This step determined the extent and comprehensiveness of the available evidence on social protection supporting the identified childhood development outcomes. This would help to identify research gaps and inform the selection of single country studies.
- **Selection of single country studies.** Due to the project's time and resource constraints, the number of studies to be included in the evidence analysis and synthesis was limited to 30. Purposive sampling was used to select studies of a range of social protection programmes from different geographic regions, based on specific selection criteria. This approach intended to provide a range of insights and perspectives to answer the research questions.

Photo: LJ Pasion/Save the Children

2.2 LITERATURE SEARCH

Initial searches were conducted of peer-reviewed journals accessed through the academic databases JSTOR, ScienceDirect, Web of Science, ProQuest, Scopus, Cochrane Library and Campbell Collaboration. Database queries were run to identify journal articles with the title or abstract containing one search term from the following domains set out in the table below:

Table 2: Search terms used for the literature search

Domain 1: Literature type	Domain 2: Target group	Domain 3: Social protection instrument
Systematic* Meta* Review	Child* Adolescent* Girl*	Cash transfer* Social protection Voucher Safety net* Benefit* Pension* Tax credit* Welfare Cash for work Public works Social assistance

Employment of the above search strings generated a total of 108,329 hits. This was subsequently narrowed down to 3,893 hits by including only search strings which had less than 500 hits. An open web search was conducted using Google Scholar to identify any recent (2021 and 2022 only) peer-reviewed systematic reviews or meta-analyses that have not yet been captured in the academic databases. No additional papers were found through this exercise. Finally, an open web search was conducted for systematic reviews and meta-analyses published by research-focused non-academic institutions with a track record of publishing on social protection. Searches focused on databases of the International Food Policy Research Institute, Overseas Development Institute, Oxford Policy Management, Save the Children's Resource Centre, UNICEF Innocenti, the World Bank Open Knowledge Repository and the World Food Programme. Table 3 summarises the final search results for each of the databases after deduplication.

Table 3: Summary of search results for systematic reviews/meta-analyses

Database	Total number of hits	Number of hits after excluding search strings with more than 500 hits
JSTOR	2,238	77
ScienceDirect	34,351	1,219
Web of Science	37,915	1,207
ProQuest	1,625	234
Scopus	26,576	625
Cochrane library	2,351	136
Campbell collaboration	3,273	395
Non-academic institution databases	27	27
Total number of hits after excluding search strings with more than 500 hits:		**3,920**

The titles and abstracts of the systematic reviews and meta-analyses were screened against the below inclusion/exclusion criteria, reducing the number of relevant papers to 247. Next, the full texts were scanned to check for relevance against the inclusion criteria and this further reduced the list of systematic reviews/meta-analyses to 38.

Table 4: Inclusion criteria used for screening the systematic reviews and meta-analyses

Inclusion criteria for systematic reviews and meta-analyses	
Intervention type	Cash Public works Vouchers Child/family tax credits
Childhood development outcome areas	Stunting Access to primary school education Cognitive, emotional and social development Violence against children in the home
Age of children targeted by the intervention	0–11 years
Date of publication	2010–2022
Language	English only
Other	Available on-line (within Manchester Metropolitan University library access limitations) or open access Peer reviewed only

Ancestry searches of the reference lists and bibliographies of the 38 systematic reviews were carried out using the same inclusion criteria listed in Table 4. This resulted in 181 single country studies. A targeted open web search was carried out to crosscheck for any research on impacts of social protection from Small Island Developing States (SIDS) which may be of particular relevance for the PICs. The search produced 2 studies from Fiji and 2 from Haiti. However, the studies were not peer-reviewed and so could not be included in the final list of single country studies.

Assessment of the scale of the evidence

Assessment of the 181 single country studies revealed that the literature was highly skewed towards studies of conditional cash transfers in Latin America. The vast majority of which were from large conditional cash transfer programmes in Mexico (27), Brazil (12), Colombia (12), Ecuador (12) and Nicaragua (12) and focused largely on the impact of social protection on children's nutrition and education.

The majority of the studies were of conditional cash transfer programmes (Table 5), followed by unconditional cash transfers. Nearly all of the studies of unconditional cash transfers were of child grants; only one study was of a social pension, the Benefício de Prestação Continuada (BPC) in Brazil. Public works programmes featured less prominently. The type of social protection programme shown in Table 5 refers to the primary intervention. For example, public works programmes usually feature unconditional cash transfer sub-components (sometimes known as 'direct support') for households with limited labour capacity (usually those with pregnant women, people with disabilities or older people). Some experimental studies were also identified which compared the impact of different interventions - such as unconditional cash transfers, vouchers and food aid.

Table 5: Number of single country studies by type of social protection programme

Type of social protection program	Number of studies
Conditional cash transfer	104
Unconditional cash transfer	69
Public works	7
Voucher	1
Total	**181**

Ninety-five of the studies were from Latin America, followed by 52 from sub-Saharan Africa (Table 6). Only 17 of the studies were from the East Asia and Pacific region, of which only 2 were from a PICs country (Fiji). In general, there is a large amount of evidence on how social protection supports stunting and access to primary education (Table 7). However, in the areas of cognitive, social and emotional development and violence against children, the evidence base was much thinner.

Table 6: Number of single country studies by geographic region

Region	Number of studies
East Asia and Pacific	17
Europe and Central Asia	1
Latin America and Caribbean	95
Middle East and North Africa	3
South Asia	13
Sub-Saharan Africa	52
Total	**181**

Table 7: Number of single country studies by outcome area

Outcome area	Number of studies*
Stunting	103
Access to primary school education	100
Cognitive, social and emotional development	23
Violence against children in the home	18

**Note that some studies address more than one outcome area*

The bias towards research on conditional cash transfers stems from a surge in research activities that accompanied the expansion of CCTs across Latin America in the late 1990s, and their subsequent promotion by the Word Bank, in other parts of the world. The programmes generated interest from policymakers, international financial institutions and researchers for their potential to reduce poverty and improve human development outcomes. The large-scale implementation and coverage of CCTs also made them highly attractive for research as they provided vast amounts of quantitative data. The majority of the study designs were randomized control trials or quasi-experimental research designs, considered to be the 'gold standard' at the time for evaluating the effectiveness of policy interventions.

The bias towards research on children's nutrition and education stems from a number of factors. First, there has been a global consensus on indicators and measurement approaches for children's nutrition and education for a number of decades. WHO and UNICEF first began collaborating on standardized indicators for monitoring children's health and nutrition in the 1980s. While standardized indicators were developed for monitoring access to education in the late 1990s through collaborative efforts by UNESCO, UNICEF and the World Bank. Furthermore, many social protection programmes are explicitly designed to achieve objectives on nutrition and access to education (among other objectives).

In contrast, cognitive, social and emotional development is a less well studied area and only became part of global development initiatives when it was included in the Sustainable Development Goals in 2015. Work to improve the measurement and collection of data in this area is being led by UNICEF, however there is considerably less consensus on measurement approaches, and data is often not systematically collected at national level. Furthermore, cognitive, social and emotional development objectives are rarely specific objectives of social protection programmes.

Similarly, while a number of studies exist on the links between social protection and child protection issues such as early marriage, child labour and gender-based violence, little attention has been paid to the potential of social protection to reduce violent discipline against children in the home. This reflects the inherent difficulty of researching such a complex topic which takes place in private settings. And while positive parenting interventions intended to reduce harsh parenting approaches (among other objectives) are often included in social protection programmes (most commonly in conditional cash transfers) their impact on reducing violent discipline against children in the home has rarely been studied.

Selection of single country studies

Due to time and resource constraints, the number of studies included in the evidence analysis and synthesis was limited to 30. Purposive sampling was used to select studies of a range of social protection programmes from different geographic regions, based on specific selection criteria set out in Table 8. This approach was intended to provide a range of insights and perspectives to answer the research questions set out in 1.2.1.

Table 8: Criteria used for selecting the single country studies

Selection criteria	Explanation
Social protection intervention type	Studies providing evidence from a range of social protection programmes e.g. conditional cash transfer, unconditional cash transfer, public works.
Geographically relevant countries	Given the diverse levels of development between and within the Pacific Island Countries, a somewhat crude approach was used to select 'geographically relevant countries' based on two criteria: - Evidence from PICs would be prioritised as far as possible. - Evidence from countries with similar income levels (low-middle income or lower income) would be prioritised as far as possible.
Childhood development outcomes	Study provides evidence on how social protection supports one or more of the childhood development outcomes identified as highly relevant for the Pacific (reductions in stunting; increased access to primary school education; improved cognitive, social and emotional development; and reductions in violence discipline against children in the home).
Covariate shock	Study provides evidence on how social protection schemes support children during times of covariate shock.

There was no single study which covered all of the above criteria. Instead, a range of studies was selected which covered the different criteria based on evidence from social protection programmes from 11 countries. Table 9 provides a summary of the studies organised by country and the name of the social protection programme, intervention type, geographic region and country income grouping, and the outcome areas which are covered by the studies. The full list of studies which met the final inclusion criteria and relevance assessment are shown in Annex A.

Five of the social protection programmes were conditional cash transfers, four were unconditional cash transfers and two were public works programmes. The study of Brazil's social pension was excluded from the final list because it did not meet the criteria for similar income country grouping.

In terms of geographical relevance, the two single studies from the Pacific region (Fiji) which were generated through the literature search were excluded from the final list because they did not provide evidence on how social protection supports the identified childhood development outcomes. Two of the social protection programmes were from countries in the wider East Asia and Pacific region (Indonesia and the Philippines). One programme was from South Asia (Bangladesh), five from Sub-Saharan Africa (Ethiopia, Ghana, Kenya, Rwanda and South Africa), two from Latin America (Ecuador and Nicaragua) and one from the Caribbean (Jamaica).

In relation to income country grouping, the majority of the countries were low-middle income or lower income. Three were from the upper middle-income category, these were Ecuador, Jamaica and South Africa. The reason for including these, despite them not meeting the income country grouping criteria, were the following:

- Ecuador provided an example of an UCT which had been adapted in response to a covariate shock (2016 earthquake)
- Jamaica was the only country from the Caribbean region which had evidence of social protection supporting childhood development outcomes. It was viewed to be important to include a case study from the Caribbean considering the potential for relevant learning from a small island state.
- South Africa was included as it is has one of the longest-running social protection programmes targeting children, and is considered to have one of the most important and comprehensive social protection systems in the world.

No single study covered all of the childhood development outcomes. Although the intention was to have a more even distribution of studies from across the four childhood development outcomes, there was not enough evidence to make this possible. In the end the focus of the studies reflected the bias towards studies of social protection supporting reductions in stunting and increase in access to education. Nineteen of the studies included evidence on reductions in stunting, nine on access to education, five on cognitive, social and emotional development and four on violence against children.

Six of the single country studies provided evidence on social protection programmes in the context of a covariate shock or stress. Of these, three of the studies concern economic shocks and stresses (Ghana, Nicaragua and South Africa), two relate to sudden environmental shocks (earthquake – Ecuador and typhoon – Philippines) and one to seasonal drought (Ethiopia).

Whilst there is growing discourse on how long-term social protection systems can be designed to better respond to covariate shocks, these are largely focused on practical and functional aspects such as adjustments to eligibility criteria, benefit levels, or coverage in times of shock, and/or coordination with existing emergency response systems, including both government-led and international humanitarian responses. See for example, O'Brien et al. (2018) and TRANSFORM (2020). The evidence gap on how social protection can support children's development outcomes during times of covariate shock is largely due to the methodological, logistical and ethical challenges of undertaking studies which measure impact during crises (Aurino and Giunti, 2022).

Table 9: Summary of single country studies for review

Country	Number of studies	Social protection programme name	Social protection intervention type	Geographic region	Income country grouping	Outcome areas included in the studies				Covariate shock
						Reductions in stunting	Access to primary school education	Cognitive, social & emotional dev	Violent discipline against children in the home	
 Bangladesh	2	Transfer Modality Research Initiative (TMRI)	UCT	South Asia	Lower middle	✓				
 Ecuador	5	Bono de desarollo humano (BDH)	UCT	Latin America & Caribbean	Upper middle	✓		✓	✓	✓
 Ethiopia	3	Productive Safety Net Programme (PSNP)	Public works	Sub-Saharan Africa	Low	✓	✓			✓
 Ghana	2	Livelihood Empowerment Against Poverty (LEAP)	UCT	Sub-Saharan Africa	Lower middle	✓	✓	✓		✓
 Indonesia	2	Programme Keluarga Harapan (PKH)	CCT	East Asia & Pacific	Lower middle	✓	✓			
 Jamaica	1	Programme of Advancement through Health and Education (PATH)	CCT	Latin America & Caribbean	Upper middle		✓			
 Kenya	3	Cash transfer for orphans and vulnerable children (CT-OVC)	UCT	Sub-Saharan Africa	Lower middle	✓	✓			
 Nicaragua	4	Red de Proteccion Social (RPS) / Atención a Crisis	CCT	Latin America & Caribbean	Lower middle	✓		✓	✓	✓
 Philippines	4	Pantawid Pamilyang Pilipino Programme (Pantawid)	CCT	East Asia & Pacific	Lower middle	✓	✓			✓
 Rwanda	1	Vision 2020 Umurenge Programme (VUP)	Public works	Sub-Saharan Africa	Low			✓	✓	
 South Africa	3	Child Support Grant (CSG)	UCT	Sub-Saharan Africa	Upper middle	✓	✓		✓	✓

3. EVIDENCE ON SOCIAL PROTECTION SUPPORTING SPECIFIC CHILDHOOD DEVELOPMENT OUTCOMES

This section synthesises and summarises the evidence on how social protection supports reductions in stunting, access to primary school education, improvements in cognitive, social and emotional development, and reduction of violent discipline against children in the home. Each section provides a table summarising the evidence on impact and the potential pathways to impact described in the single country studies, followed by more detailed description of the studies' findings. To provide background and context for the evidence, the main features of the cash transfer programmes are set out below in Table 10.

Photo: Allison Joyce/Save the Children

Table 10: Main features of the cash transfer programmes included in this review

BANGLADESH

Programme name: TRANSFER MODALITY RESEARCH INITIATIVE (TMRI)

Years of operation: MAY 2012 - APRIL 2014

SUMMARY OF PROGRAMME

Objective: Cost-effectively improving food and nutrition security and livelihoods among the ultra-poor. (Two-year randomised control trial).

Intervention type: Primarily unconditional cash transfers. Participants receive food transfers depending on which research group they are assigned to.

Eligibility and targeting: Ultra-poor households headed by women, having at least one child aged 0-24 months, and not part of any other government or NGO programme. Geographic targeting (random selection of 1) Upazilas 2) villages), cluster sampling of ten households based on village surveys on household demographics, poverty indicators.

Grantee: Mothers.

Monthly transfer amount at the time of the studies: 1,500 Taka in 2012 (US$19 per household). Approximately 25% of the average monthly consumption of poor rural households in Bangladesh (Ahmed et al., 2019).

Households were randomly selected to receive a monthly transfer from one of the following treatment arms:

- cash only (NW)
- food only (NW)
- cash and food combined (NW)
- cash and nutrition behaviour change communication[7] (NW)
- food and nutrition behaviour change communication (S)

Conditions: Attendance at the BCC sessions was a 'soft' condition for receipt of transfers. In practice, if a recipient failed to attend the BCC session then a community health worker will make a home visit to communicate the information they have missed. (Ahmed et al., 2019).

Coverage (most recent data available): 4,000 ultra-poor women and their households (21,600 beneficiaries).

7 The BCC training sessions cover basic nutrition, control and prevention of micronutrient deficiencies, infant and young child feeding practices, health care, maternal nutrition, and hygiene.

ECUADOR

Programme name: BONO DE DESARROLLO HUMANO (BDH)

Years of operation: 2003-ONGOING

*The studies included in this review use data from the following years: 2016 (Beazley et al., 2017); 2007-2009 (Buser et al., 2016); 2003-04 and 2005-06 (Fernald and Hidrobo, 2011); 2003-04 and 2005-06 (Paxson and Schady, 2010) and 2003-04 and 2005-06 (Hidrobo et al., 2016)

SUMMARY OF PROGRAMME

Objective: Promote the accumulation of human capital and reduce the persistence of poverty.

Intervention type: Unconditional cash transfer.

Eligibility and targeting: Households in extreme poverty with children under 16 years old, adults over 65 years old and people with disabilities. Poverty-targeted. Means-tested. Families are surveyed and assigned to a poverty index (Selben) which assesses their eligibility for BDH. Only families in the first two quintiles of Selben are eligible.

Grantee: Mothers.

Monthly transfer amount at the time of the studies: US$15 in 2005, increased to US$30 in 2007. The transfer represents approximately 11% of household expenditure. (Buser et al., 2016).

Conditions: The BDH was originally planned to be conditional on taking children younger than age six for bi-monthly visits to public health clinics and sending school-aged children to school. However, for a variety of logistical reasons, the conditionality was never implemented. (Paxson and Schady, 2010).

Coverage (most recent data available): 1.03 million in 2016 (Approximately 6.3% of the population).[8]

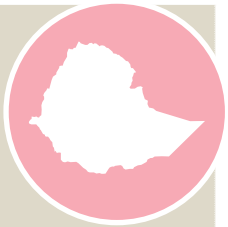
8 ECLAC Non-contributory Social Protection Programmes Database Latin America and the Caribbean 'Bono de Desarrollo Humano (Human Development Grant) (2003-)' Accessed 8th May 2023 https://dds.cepal.org/bpsnc/programme?id=15

ETHIOPIA

Programme name: PRODUCTIVE SAFETY NET PROGRAMME (PSNP) AND INTEGRATED NUTRITION–SOCIAL CASH TRANSFER (IN-SCT) PILOT

Years of operation: 2005-ONGOING (PSNP); 2015-2018 (IN-SCT)

*The studies included in this review use data from the following years: 2002, 2006 and 2009 Porter and Goyaly, 2016) and 2011-2012 and 2014 (Gebrehiwot and Castilla, 2019) for the PSNP. 2016-2018 (Gilligan et al., 2020) for the IN-SCT pilot.



SUMMARY OF PROGRAMME

Objective: To provide transfers to the food insecure population. Prevent household asset depletion and create community assets. The programme operates seasonally, but predictably.

Intervention type: Public works with direct support components.

Eligibility and targeting: Food-insecure households, defined as those that reside in one of the chronically food-insecure woredas (districts) and who have faced three or more months of food shortage over the last three years, or who are unable to support themselves. Geographic – chronically food insecure regions of Ethiopia. Community-based targeting to identify chronically food-insecure households. Programme components:

- **Labour-intensive Public Works:** Chronically food insecure households with able-bodied adults receive a transfer for their participation in public work
- **Direct Support: Chronically food insecure households who cannot provide labour to public works and have no other mea**ns of support are provided an unconditional transfer. These include, but are not limited to, orphans, pregnant and nursing mothers, people living with disabilities, the elderly, chronically ill individuals and female-headed households that are labour poor (Wiseman et al., 2010).
- **Food Assistance:** given primarily in the lean season between June and August (assistance available up to 6 months per year).

Grantee: Head of household.

Monthly transfer amount at the time of the studies: Households are provided transfers of cash, food, or a temporal mix of both. In 2009, the daily cash wage rate was 10 birr and the food transfer was 3 kg of cereal. (Wiseman et al., 2010). Average monthly transfers for both direct support and public works in 2009 was equivalent to US$11.40, approximately 25% of average per capita income for Ethiopia (Porter and Goyaly, 2016).

Conditions: Public works participants are required to work, but there are no conditions in terms of child nutrition and health.

Coverage (most recent data available): 5 million in 2005 (Wiseman et al., 2010); 8 million in 2015 (MOA, 2014).

Integrated Nutrition–Social Cash Transfer (IN-SCT) pilot component:

The IN-SCT programme was piloted with existing PSNP participants in two woredas in each of the SNNPR and Oromia regions of Ethiopia. The objective was to enhance the implementation of PSNP through integrating nutrition and health services. All programme criteria remained the same apart from the inclusion of the following conditions:

Health

- **Children 0-2 years:** monthly growth monitoring, immunisations, Vit A, deworming.
- **Children 0-5 suffering acute malnutrition:** attend clinics for supplementary and therapeutic feeding.
- **Pregnant women:** four antenatal care visits; one postnatal care visit at six weeks after birth; attend monthly nutrition BCC sessions.

Education

- Ensure that school-age children are enrolled in school and attending at least 80% of school days.

The conditions were labelled as 'co-responsibilities' and were not enforced. Although Gilligan et al. (2020) found that some woredas were independently imposing fines for non-compliance with IN-SCT conditions.

GHANA

Programme name: LIVELIHOOD EMPOWERMENT AGAINST POVERTY (LEAP)

Years of operation: 2008-ONGOING

*The studies included in this review use data from the following years: 2010 and 2012 (de Groot et al., 2015); 2017 (Palermo et al., 2018)

SUMMARY OF PROGRAMME

Objective: To alleviate short-term poverty by delivering direct cash payments, and to push long-term human capital development, by providing health insurance and encouraging school enrolment.

Intervention type: Unconditional cash transfer.

Eligibility and targeting: Households are eligible for LEAP if they are considered poor and have a household member who is: a single parent with an orphan or vulnerable child; an elderly person (over 65 years old); a person with a disability and who is unable to work; a pregnant woman; or a child below one year of age. Geographic targeting and proxy means test.

Grantee: Head of household (LEAP), pregnant women or mothers of children under 15 months (LEAP 1000).

Monthly transfer amount at the time of the studies: Households received between Ghanian cedi 16-30 (approximately US$11-21) in 2010 depending on the number of eligible household members. This represents just over 11% of average household consumption (de Groot et al., 2015).

In 2015, the transfer amount received by LEAP households with two eligible members was Ghanian cedi 38 per month (approximately US$24), around 12.5% of average household consumption (Palermo et al., 2018).

LEAP participants are also entitled to free health insurance through the National Health Insurance Scheme (NHIS), giving them access to free out-patient and in-patient services, dental services, and maternal health services.

Conditions: None.

Coverage: 116,000 households in December 2015 (de Groot et al., 2015).

INDONESIA

Programme name: PROGRAMME KELUARGA HARAPAN (PKH)

Years of operation: 2007-ONGOING

*The studies included in this review use data from the following years: 2007 and 2009 (Alatas et al., 2011); 2007, 2009 and 2013 (Cahyadi et al., 2020)

SUMMARY OF PROGRAMME

Objective: Alleviating short-term poverty and promoting investments in education and health.

Intervention type: Conditional cash transfer.

Eligibility and targeting: Poor households and poor and vulnerable persons (pregnant and/or lactating woman, with children aged 0–15 years, and/or with children aged 16–18 years who had not completed nine years of basic education). Families are surveyed and assigned to the Social Assistance Unified Database that assesses their eligibility by proxy means test.

Grantee: Child caregiver, in most cases the mother.

Monthly transfer amount at the time of the studies: In 2007, disbursement amounts varied between IDR 50,000 and 183,000 depending on the number of eligible children in the household. Equivalent to approximately US$5 and US$18. Approximately equal to 15-20% of the estimated consumption of poor households. (Cahyadi et al., 2020)

Conditions:

Health

- **Children 0-6 years:** Childhood immunisations, monthly growth monitoring check ups, Vitamin A capsules.

Education

- **Children 7-21 years:** Enrolment in primary/secondary with an attendance rate of at least 85%.

According to programme rules, one violation would result in a warning letter, the second would result in a 10% cut in benefits, and a third would lead to programme expulsion. In practice conditions were not always enforced.

Coverage: 432,000 households in 2007 (pilot phase); 810,000 households in 2010 (Alatas et al., 2011); 10 million households in 2018.[9]

9 Directorate General of Social Protection and Security, Ministry of Social Affairs, Republic of Indonesia. https://kemensos.go.id/en/program-keluarga-harapan-pkh Accessed 8th May 2023

JAMAICA

Programme name: PROGRAMME OF ADVANCEMENT THROUGH HEALTH AND EDUCATION (PATH)

Years of operation: 2000-ONGOING *The studies included in this review use data from the following years: 2000 and 2011 (Levy and Ohls, 2010)

SUMMARY OF PROGRAMME

Objective: Alleviating short-term poverty and promoting investments in education and health.

Intervention type: Conditional cash transfer.

Eligibility and targeting: Child Assistance Grant for poor children up to age 17. Social Assistance Grant to poor pregnant or lactating mothers, elderly poor (over age 60), and poor, disabled, and destitute adults under age 65. Families are surveyed and assigned to the Beneficiary Identification System (BIS) that assesses their eligibility by proxy means test.

Grantee: Family representative / direct beneficiary.

Monthly transfer amount: US$6.50 per eligible individual in 2000 data. This represents approximately 4% of the minimum wage (Levy and Ohls, 2010).

Conditions:
Health

- **Children 0-2 years:** bi-monthly check-ups.
- **Children 2-6 years:** 6-monthly check-ups.

Education

- Children 6-17: attend school at least 85% of school days.

Coverage: 180,000 in 2000 (Levy and Ohls, 2010); 349,000 in 2018.[10]

10 ECLAC Non-contributory Social Protection Programmes Database Latin America and the Caribbean 'Programme of Advancement Through Health and Education (PATH)' https://dds.cepal.org/bpsnc/programme?id=21 Accessed 8th May 2023

KENYA

Programme name: CASH TRANSFER FOR ORPHANS AND VULNERABLE CHILDREN (CT-OVC)

Years of operation: 2004-ONGOING

*The studies included in this review use data from the following years: 2018 (Guyatt et al., 2020); 2007-2009 (Kenya CT-OVC Evaluation Team, 2012); 2007-2009 (Ward et al., 2010)

SUMMARY OF PROGRAMME

Objective: To strengthen the capacity of poor people to care for and protect orphans and vulnerable children (OVC); encourage the fostering and retention of OVC within their families and communities; and promote the development of human capital of OVC.

Intervention type: Conditional cash transfer.

Eligibility and targeting: Poor households with at least one OVC aged 0–17 years with at least one deceased parent, or whose parent or main caregiver is chronically ill or has a severe disability. Geographical targeting. Community-based targeting: meets at least 8 out of 17 poverty characteristics.

Grantee: Caregiver.

Monthly transfer amount: US$20 per household (2010 data) irrespective of the number of orphans or individuals in it. Approx. 22% of average household consumption. Benefits are paid every two months and payments are made through post offices.

Conditions:
Health

- **Children 0-1 years:** immunisations, bi-monthly health check-ups, Vitamin A supplement.
- **Children 1-5 years:** 6-monthly health check-ups, Vitamin A supplement.

Education

- **Children 6-17 years:** enrol in school, attend school at least 80% of effective days.
- **Family development/awareness:** one adult parent or caregiver should attend awareness sessions once per year.

For logistical and human resource reasons, penalties for non-compliance were only implemented in 3 of the 7 districts.

Coverage: 353,000 beneficiaries in 2019.[11]

11 Kenya Social Protection Sector Annual Report 2018-2019

Photo: Elvis Gonzalez/Save the Children

NICARAGUA

Programme name: RED DE PROTECCIÓN SOCIAL (RPS) / ATENCIÓN A CRISIS

Years of operation: RPS: 2000-2004 / ATENCIÓN A CRISIS: 2005-2006

*The studies included in this reviewuse data from the following years:
2000-2004 and 2009-2011 (Barham et al., 2012); 2000 and 2001-2002 (Gitter et al., 2011);
2000 and 2002 (Gitter et al., 2013);
2005-2006 and 2008-2009 (Macours et al., 2012)

SUMMARY OF PROGRAMME

Objectives: Alleviating short-term poverty and promoting investments in education and health.

Intervention type: Conditional cash transfer.

Eligibility and targeting: Families in extreme poverty. Geographic targeting. Identification of communities in extreme poverty. Officially, all households within the communities were eligible but in practice less "deserving" were excluded if for example, they owned a vehicle, or consisted only of able-bodied single men or women.[12]

Grantee: Mother.

Monthly transfer amount:

- **Grant for food** - US$15 per household.
- **Grant for school** - US$7 for households with a child between the ages of 7-13 years who has not completed fourth grade.
- **Grant for enrolment** - one off payment of US$21 per child for enrolling the child at start of school year (2004 data).

Notes: The transfer amounts were reduced during later years of the programme to conserve costs and extend RPS to more households. RPS also provides a conditional supply-side grant to local schools and health clinics.

Conditions: Health

- **Children 0-2 years**: monthly check-ups.
- **Children 2-5 years:** bi-monthly check-ups.
- **Children 0-5 years:** complete vaccination schedule; Must maintain adequate weight; Grantee must attend bi-monthly training sessions.

Education

- Children aged 7–13 at least 85% school attendance per month.
- Children must be enrolled in school at the beginning of the school year.

Atención a crisis did not have a specific BCC component but included repeated information and communications during programme enrolment and pay-days about varied diets, health and education.

Coverage: Approx. 3000 households (Macours et al., 2012). The programme was discontinued in 2006.

12 Moore C, 2009, Nicaragua's Red de Protección Social: An exemplary but short-lived conditional cash transfer programme. International Policy Centre for Inclusive Growth

PHILIPPINES

Programme name: PANTAWID PAMILYANG PILIPINO PROGRAMME (PANTAWID)

Years of operation: 2008 – ONGOING

*The studies included in this review use data from the following years: 2013-2014 (Bowen, 2015); 2011 (Kandpal et al., 2016); 2008 and 2011 (Onishi et al., 2013); and 2017 (Orbeta et al., 2021)

SUMMARY OF PROGRAMME

Objectives: The programme aims to break the intergenerational cycle of poverty by encouraging households to invest in their children's health and education.

Intervention type: Conditional cash transfer.

Eligibility and targeting: Recipients are identified using a household targeting system which assesses households and predicts income through proxy means testing. Households must include at least one child aged 0-18 years or a pregnant household member.

Grantee: The grantee is defined as "mother or the most responsible adult member of the household authorized to withdraw or receive the grants" (Orbeta et al., 2021).

Monthly transfer amount

Education grant (provided for up to three children per household)

- US$11 for each child in high school.
- US$7 for each child in elementary.

Health grant

- US$11 per household (2012 data) 23% of average income of beneficiary households.

Conditions: Health

- **Children 0-2 years:** complete vaccination schedule.
- **Children 2-5 years:** bi-monthly preventive health check-ups.
- **Children 6 to 14 years**: Deworming pills.
- **Pregnant women**: Attend antenatal health check-ups.

Education

- **Children 3-5 years:** enrolment in day-care or Kindergarten and at least 85% attendance per month.
- **Children 6-18 years:** enrolment in Elementary or High school and at least 85% attendance per month.
- **Family Development:** Attendance in monthly Family Development Sessions (FDS) by Pantawid Pamilya grantee and/or spouse.

Coverage: Started with 300,000 beneficiaries in 2008. Expanded to 4.9 million by 2018.

RWANDA

Programme name: VISION 2020 UMURENGE PROGRAMME (VUP) AND SUGIRA MURYANGO PILOT

Years of operation: 2008 – ONGOING (12-16 WEEKS INTERVENTION FOR SM)

*The studies included in this review use data from the following years: 2018 (Betancourt et al., 2020)

SUMMARY OF PROGRAMME

Objectives:

- **VUP** – to contribute to the country's goal of reducing extreme poverty.
- **Sugira Muryango pilot** – father-engaged early years and violence-prevention home-visiting programme for VUP beneficiaries.

Intervention type: Public works with direct support components.

Grantee: Head of household.

Eligibility and targeting: unconditional cash transfer (UCT) : Extremely poor and labour-constrained households. Cash for work for extremely poor households with labour capacity. Two versions: Classic Public Works (cPW) which provides cash for (typically hard) manual labour, and the newer Expanded Public Works (ePW) which provides cash for (typically lighter) labour and access to livestock. Community-based targeting based on Ubudehe vulnerability index households placed into one of five categories from poorest to richest.

Monthly transfer amount:

- **Direct support** – up to US$35.
- **Public works** - up to US$3 per work day (2011 data).

Conditions: None.

Coverage: 263,000 households in 2019 (World Bank, 2019).

SOUTH AFRICA

Programme name: CHILD SUPPORT GRANT

Years of operation: 1998 – ONGOING

*The studies included in this review use data from the following years: 2010-2011 (DSD, SASSA and UNICEF, 2012); 2007 (Plagerson et al., 2011); 2005-2008 (Zembe-Mkabile, 2016)

SUMMARY OF PROGRAMME

Objectives: To reduce poverty and promote investments in the physical, social and human capital of poor children.

Intervention type: Unconditional cash transfer.

Grantee: Primary caregiver of a child under 18 years (a parent, grandparent or anyone who's mainly responsible to look after the child).

Targeting: Means-tested.

Monthly transfer amount at the time of the studies: US$30 per eligible child (2008 data).

Conditions: None.

Coverage: 11,953,974 children (over 65 % of South Africa's child population) (2015).

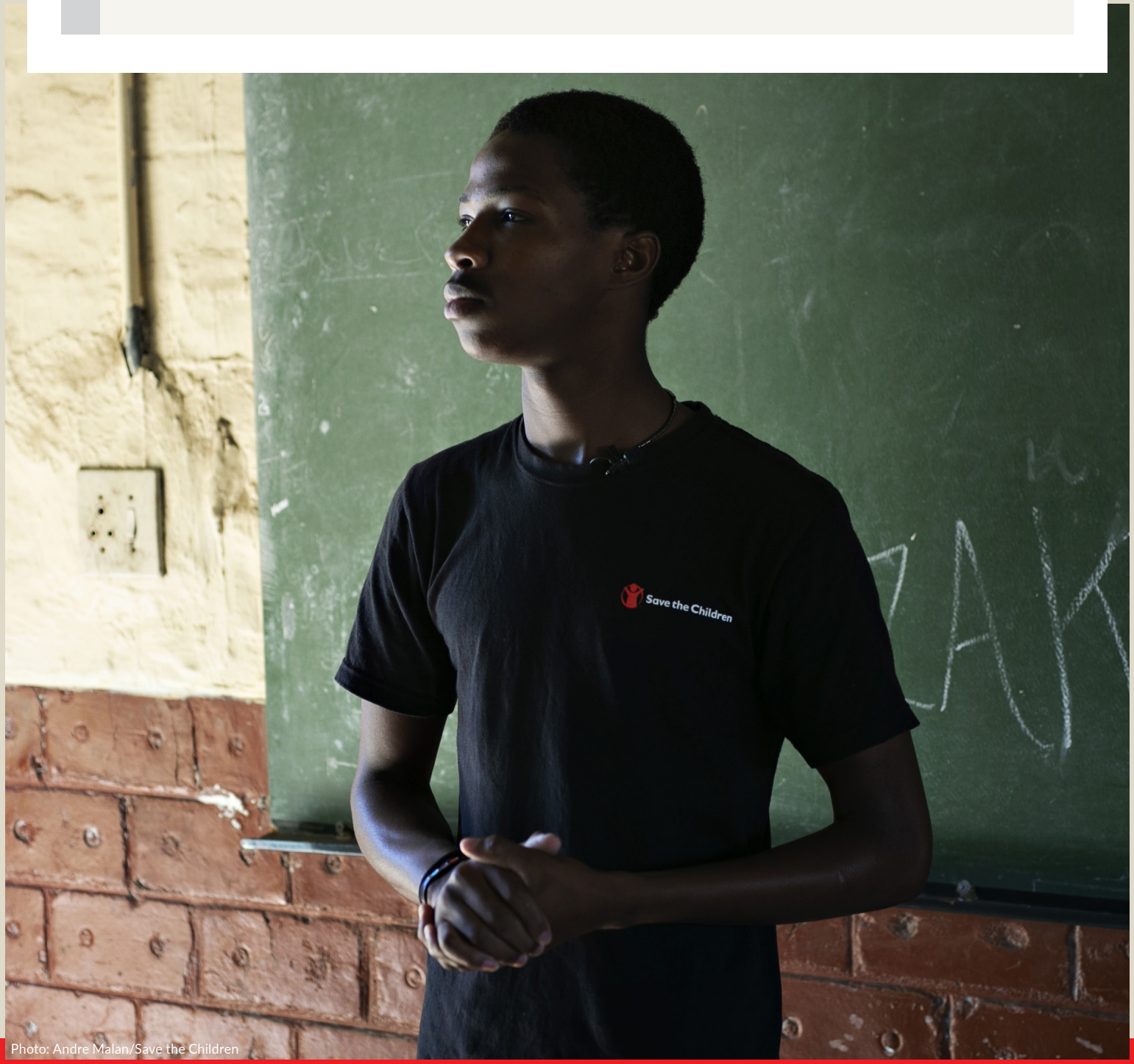


Photo: Andre Malan/Save the Children

3.1 SOCIAL PROTECTION SUPPORTING REDUCTIONS IN STUNTING

Main findings

Cash transfer

- ✓ Increased income led households to purchase more and better-quality foods for children, particularly high protein foods and dairy products.
- ✓ Reductions in stunting were only found in programmes that included nutrition information/behavioural interventions, or in households where the mother had higher levels of education or in the context where households were *extremely* food insecure, and the additional income increased households' access to food.
- × Low transfer amounts, inflation and income shocks meant households in some countries were unable to afford nutritious foods.
- × Delays in the payment of cash transfers resulted in an irregular intake of quality foods.

Complementary interventions

- ✓ Children were healthier in contexts where households had frequently attended preventative medical check-ups, sought treatment for children's illness, and completed the vaccination programme, which may have contributed to reductions in stunting.
- ✓ Nutrition information delivered through both structured family development sessions and through interaction with medical professionals at regular health checks had positive effects on parents' and caregivers' child feeding practices and contributed to increases in protein intake.
- × In programmes where maternal health and nutrition components were weak or were under-utilised, children missed out on nutrition support in the 1,000 days window and birth weights were low.
- × Poor drinking water and sanitation remained a problem that contributed to the frequency of children being unwell, with negative consequences for stunting.
- × In cases where there were no information sessions or behavioural interventions, there was little impact on child feeding practices. Either the programme design did not include any behavioural interventions, or programme staff were unable to deliver information sessions due to resource and operational limitations.

Stunting is the result of chronic or recurrent undernutrition, usually associated with poor socioeconomic conditions, poor maternal health and nutrition, frequent illness, and/or inappropriate infant and young child feeding and care in early life. Stunting holds children back from reaching their physical and cognitive potential.[13]

Reducing stunting, as part of broader improvements in nutrition, is a common objective of social protection programmes. Measures range from simply providing regular cash transfers, to requiring parents or caregivers to bring their children for regular health checks and growth monitoring, vitamin and nutrition supplements, to nutrition information or education sessions aimed at improving caregiver practices in child feeding, nutrition and hygiene.

Height-for-age Z (HAZ) scores are used in all of the studies included in this literature review to report the effect of cash transfers on stunting. In some studies, the authors report the proportion of children of the study population who are stunted comparing treatment and control groups. In other studies, they separately report changes in height-for-age and HAZ scores over time of the study population groups or sub-groups.

Denominators also vary between studies, largely as a result of programme design factors and the availability of data. For example, many of the studies only report findings for children aged from 6-24 months, possibly because children below six months are included in other components of the programme or maternal cash grants. Other studies report findings for the so-called critical period of the first 1,000 days, whilst others report findings for children 0-60 months, and others for only 3-7 years.

From the 30 single studies included in the literature review, 19 included evidence on social protection and stunting from programmes in nine countries. Table 11 provides a summary of the evidence by individual social protection programme, focusing on the pathways of change which may have led to a programme's successes or failures. More detailed evidence is provided after the table.

13 World Health Organisation Malnutrition fact sheet, updated 9/6/21 https://www.who.int/news-room/fact-sheets/detail/malnutrition (accessed 1/9/22)

Table 11: Summary of the evidence on social protection supporting reductions in stunting

	Programme	Impact	Potential pathways
BANGLADESH	**Transfer Modality Research Initiative (TMRI)** · Unconditional cash transfer and food assistance · Complementary programs: Two of the 'treatment arms' included behaviour change communication	· The treatment arm 'cash and behaviour change communication' resulted in a 7.3% reduction in stunting among children who were aged less than 48 months old at endline. The other treatment groups had no impact on reductions in stunting (Ahmed, 2016).	· Both treatment groups involving behaviour change communication resulted in positive change in maternal knowledge of childcare practices (nutrition, sanitation and childhood illness) resulting in reduced illnesses and improved nutrition. However, the treatment group receiving only food assistance were unable to increase dietary diversity, particularly in protein intake, as they were limited by what was provided in the food packs (Ahmed, 2019).
ECUADOR	**Bono de Desarrollo Humano (BDH)** · Unconditional cash transfer **Note that BDH was originally designed with conditions but these were dropped due to supply-side constraints* · Complementary programs: None	· Modest effects of the BDH on children aged 3-7 years (Paxson and Schady, 2010). · No overall evidence of increased height-for-age among children aged 12-35 months. But, a significant effect on a sub-group of children whose mothers thought that receipt of the cash transfer was conditional on taking their children for health checks (Fernald and Hidrobo, 2011). · Children under six years in urban households in receipt of BDH were less likely to be stunted than those not receiving BDH (Gitter, 2011).	· The children did not receive the BDH during the so-called critical period of the first 1,000 days. Height-for-age may be difficult to change for children past infancy (Paxson and Schady, 2010). · The transfer size was small compared with other conditional cash transfer programmes in the region. The sub-group of children who had been taken for health checks, may have had less incidences of ill health (Fernald and Hidrobo, 2011). · BDH helped with food purchases for urban families who were highly reliant on purchasing food (Gitter, 2011).
ETHIOPIA	**Productive Safety Net Programme (PSNP) / IN-SCT pilot** · Public works and unconditional cash transfers for 'labour-constrained households'. **Note that the complementary programmes introduced in the IN-SCT pilot were not conditions, but were framed as 'co-responsibilities' and no penalties were imposed.* · Complementary programs: None (Main PSNP program); Maternal nutrition and health checks, Preventative children's health checks and Vitamin A supplement, deworming (0-2yrs), Monthly nutrition behaviour change communication sessions (IN-SCT pilot)	**Main PSNP program:** · Significant positive impact of 0.2 standard deviations on height-for-age of children who had ever been enrolled in PSNP. The impact was higher among children who were aged 2-5 years when the household were in receipt of PSNP than for households where children were above five years at the time or receiving PSNP. Longitudinal data was collected in 2002, 2006 and 2009. They did not have data for children less than two years (Porter and Goyaly, 2016). · No effect on height-for-age of children aged 6-24 months using longitudinal panel data from 2012 and 2014 (Gebrehiwot and Castilla, 2019). **IN-SCT pilot:** · Negative impact on stunting for children aged 6-23 months who participated in the IN-SCT pilot compared with participants of the main PSNP programme. (Gilligan, 2018).	**Main PSNP program:** · The increased income improved food security in extremely food insecure households which had a large potential for a 'catch-up' response. But it did not increase dietary diversity. A more child-sensitive and nutrition focused programme could have had a greater impact (Porter and Goyaly, 2016). · A particularly severe drought between 2012-2014 may have reduced the impact of the PSNP on reductions in stunting. Access to food is not enough to address child malnutrition, and the PSNP alone may be inadequate by itself to compensate (Gebrehiwot and Castilla, 2019). **IN-SCT pilot:** · Operational challenges may have contributed to the negative impact on stunting. This included social workers being unable to deliver nutrition trainings due to delivery and budget gaps. Payment delays and the small transfer size may also have hindered impacts (Gilligan, 2018).

	Programme	Impact	Potential pathways
GHANA	**Livelihood Empowerment Against Poverty (LEAP)** · Unconditional cash transfer · Complementary programs: Free health insurance providing access to free outpatient and in-patient services, dental and maternal health services.	· Marginal reduction in stunting in the treatment group of 2% (from a baseline of 28.2% in 2015 to 26.2% in 2017). The comparison group baseline of 28.4% in 2015 reduced by 0.9% to 27.5% in 2017, resulting in an overall treatment effect of 1.1% (Palermo, 2018).	· Results were marginal because the programme did not address child-feeding practices. Drinking water and sanitation remained poor (Palermo, 2018).
INDONESIA	**Programme Keluarga Harapan (PKH)** · Conditional cash transfer · Complementary programs: Children 0-6 yrs: Vaccinations, monthly growth monitoring, Vitamin A capsules. Children 7-21 yrs: Enrolment in primary/ secondary with an attendance rate of at least 85%.	· Reduction in stunting of 2.8%, and reduction in severe stunting by 2.3% for children aged 0-60 months two years from baseline (Cahyadi et al., 2020).	· Increase in health-seeking behaviours, and interaction with medical professionals as a programme requirement may have led to improved mother's behaviour towards child nutrition and care. Children had less incidences of ill health and improved intake of protein (Cahyadi et al., 2020).
KENYA	**Cash Transfer for Orphans and Vulnerable Children (CT-OVC)** · Conditional cash transfer · Complementary programs: Children 0-5 yrs: immunisations, health check ups, Vitamin A supplement; Children 6-17 yrs enrol in school, and attend school at least 85% of days; Family development/awareness session (single annual session)	· No improvement in measures of nutrition for children aged 0-59 months at baseline, compared with two years later (Ward et al., 2010). · Low birth weight was the most important risk factor for stunting in children aged 0-23 months. Children aged 12-23 months were 3-4 times more likely to be stunted comparing with children aged 0-11 months (Guyatt et al., 2020).	· Although the programme had increased dietary diversity and intake of high protein foods this did not by itself translate into improvement in nutrition measures. Health services were underutilised (despite it being a programme condition) and may have contributed to children being in poorer health. Family development sessions were not frequent or informative enough (Ward et al., 2010). · The transition from breastfeeding to weaning is a critical time for nutrition and stunting when children's diets changed from highly nutritious breast milk to high-starch and low-protein foods. Caregivers lacked nutrition education and were unable to make correct decisions about timing, adequacy, safety and proper complementary feeding practices (Guyatt et al., 2020).

	Programme	Impact	Potential pathways
NICARAGUA	**Red de Protection Social (RPS) / Atención a Crisis** · Conditional Cash Transfer · Complementary programs: Children 0-5 yrs: regular health checks, complete vaccination schedule; Children 7-12 years: enrolment at the beginning of the school year, at least 85% attendance; Grantee must attend bi-monthly training sessions	· Decline in child height-for-age as a result of an economic crisis (Gitter et al., 2011). · Declines in child height-for-age for younger children were greater in households where younger children had older school age siblings (Gitter et al., 2013).	· The amount of RPS was not adjusted in response to the crisis, families were unable to meet their food needs (Gitter et al., 2011). · Compliance with programme conditions was not relaxed during the crisis. Families were still required to send children to school (with additional costs for transport, and school materials) and had to reduce the amount of expenditure on food, which affected the adequacy of nutritional intake for younger children (Gitter et al., 2013).
PHILIPPINES	**Pantawid Pamilyang Pilipino Programme (Pantawid)** · Conditional cash transfer · Complementary programs: Maternal nutrition and health checks; Vaccinations (0-2yrs); Preventative health checks (0-5 yrs); Deworming pills (6-14yrs); Enrolment & attendance in daycare/ kindergarten (3-5yrs); Enrolment & attendance in school; Family development sessions (monthly series includes nutrition, sanitation and early years development information components)	· 3% decrease in incidence of stunting, and 10% decrease in incidence of severe stunting in children 6-36 months using impact data from 2009 (Onishi, 2013). · Results from 2013 data, showed 42.7% of children who joined Pantawid at two years or older were stunted (12.5% severely stunted), comparing with 39.5% of children who had benefited from the programme for the first 1,000 days of their life (9.5% severely stunted) (Orbeta, 2021).	· Increased income combined with improved knowledge on nutrition and feeding, led to parents feeding their children more high-protein foods (Onishi, 2013). · In addition to above, improved treatment-seeking behaviour as a result of knowledge gained in family development sessions, combined with regular preventative health checks and vaccinations meant that children were healthier (Kandpal, 2016). · Maternal nutrition and healthcare contributed to reductions in stunting (Orbeta, 2021).
SOUTH AFRICA	**Child Support Grant** · Unconditional cash transfer · Complementary programs: None	· No overall effect of the CSG on child height-for-age. But a large improvement in height-for-age for the sub-group of children whose mothers have eight or more grades of schooling (DSD, SASSA and UNICEF, 2012). · No overall association between receipt of the CSG and reductions in stunting among children aged 22 months. Positive association between better educational attainment of mothers and linear growth of children. Negative association between low birth weight and increased likelihood of stunting (Zembe-Mkabile, 2016).	· Better-educated mothers have more knowledge of food and sanitation. In households where mothers have less education, BCC interventions should be used to close this knowledge gap. Simply providing cash alone is not enough (DSD, SASSA and UNICEF, 2012). · Food price inflation during the study period could have eroded the potential effect of the cash transfer. Poor nutrition and health during pregnancy contributed to low birth weight. Mother's HIV positive status contributed to stunting as a result of children's compromised immune systems (Zembe-Mkabile, 2016).

The evidence on social protection supporting reductions in stunting is mixed. Of the nine countries included in this evidence review, the **Philippines'** Pantawid conditional cash transfer reports the largest reductions in stunting. In the first impact evaluation of the Pantawid which assessed impacts over a two-year period (2009-2011), Onishi et al. (2013) found a 3% decrease in incidence of stunting, and a 10% decrease in incidence of severe stunting among children aged 6-36 months.[14] In statistical terms the impact on severe stunting was stronger and more conclusive than the results on moderate stunting.[15] The authors theorise that the provision of cash combined with education on nutrition and feeding practices through the programme's Family Development Sessions led to parents feeding their children more high-protein foods.

In further analysis of the 2009-2011 impact evaluation data, Kandpal et al. (2016) note that children in households participating in Pantawid were more likely to have received age-appropriate health services than children in the control households. This included regular growth monitoring (where parents also received additional advice on children's health, nutrition and care), receipt of an MMR vaccination and treatment-seeking for fever, cough and diarrhoea. The authors suggest that these improvements in children's health and care, and reduction of illness, combined with the improvements in diet, may have collectively contributed to reducing stunting prevalence.

In a follow up study of the Pantawid, Orbeta et al. (2021) located 2,265 households of the original programme treatment and control groups from 2009-2013 to investigate the impact on child development outcomes for children who had been part of the programme for the first 1,000 days of life comparing with children who had joined the programme from two years old. The first 1,000 days of life, roughly beginning from conception until a child's second birthday is a critical period for timing of nutrition and health interventions and lays the foundations for optimal health, growth and brain development across the life course (Cusick 2013). Christian et al. (2013) estimate that 20% of stunting is determined by conditions during pregnancy.

Orbeta reports that 43% of the control group (children who joined the programme at two years or older) were stunted compared with 40% of the treatment group (children who had been part of the programme for the first 1,000 days of life). 13% of the control group were found to be severely stunted compared with 10% of the treatment group. In statistical terms the impact on severe stunting was stronger and more conclusive than the results on stunting. However the authors describe the results on stunting as 'underwhelming' and suggest that Pantawid could have had far more impact on stunting if the maternal health and nutrition component was stronger. The study had found a lack of improvement in utilisation rates of both prenatal and postnatal health care services.

In **Ghana,** one of the key objectives of the LEAP programme is to reduce the incidence of stunted growth in children. LEAP is an unconditional cash transfer which provides monthly cash transfers, health insurance and 'encourages' school enrolment. LEAP is a proxy means tested programme, and Palermo et al. (2018) used the PMT test scores to compare the impact of LEAP on children aged 4-59 months in households just below the test score cut off point (households in receipt of LEAP) with those just above the cut off point (households not in receipt of LEAP). The authors found only a marginal reduction in stunting in the treatment group of 2% (from a baseline of 28.2% in 2015 to 26.2% in 2017). The comparison group baseline of 28.4% in 2015 reduced by 0.9% to 27.5% in 2017, resulting in an overall treatment effect of 1.1%. The authors propose that the marginal effect of LEAP on stunting may be linked to the lack of programme impacts on child feeding practices, drinking water and sanitation and conclude that cash and health insurance alone are not enough.

Using data from a longitudinal cohort study conducted in **Ethiopia,** Porter and Goyaly (2016) find a significant positive impact of 0.2 standard deviations on height-for-age of children who had ever been enrolled in PSNP over an eight-year period. They find the impact to be higher in households who received the cash transfer when children were between ages 2-5 years, compared with households who received the cash transfer when children were older (5-8 years, and 12-15 years age brackets). They did not have data for children less than two years. The authors additionally found that while dietary diversity had not improved, food security had significantly improved. They suggest that the additional income from PSNP increased households' access to food, and that the positive impact was possible because children who have experienced large periods of severe food insecurity have large potential for catch-up response.

In later analysis of the PSNP using data from a panel household survey conducted in 2012 and 2014, Gebrehiwot and Castilla (2019) find no effect on height-for-age of children between 6 and 24 months. They also found a negative effect on long-term nutrition between the two data collection points, and suggest that this could have been caused by a particularly severe drought which occurred during this time period. The authors further point out that there are different factors beyond simple access to food that could affect child nutrition and suggest that the PSNP may be inadequate by itself to compensate.

In order to address the shortcomings of the PSNP, UNICEF and the Government of Ethiopia launched a pilot in 2015 to strengthen the programme's nutrition component and coordination with quality health services. The Integrated Nutrition-Social Cash Transfer (IN-SCT) programme was piloted in Oromia and SNNP regions of Ethiopia. The programme introduced several 'co-responsibilities' including health checks for pregnant women and children under two, and nutrition behaviour change communication sessions (see programme summary table for full details).

14 Although Pantawid is targeted at households with children from 0-14 years, at the time of programme roll out the oldest child was 5 months. This is why findings are only reported for children 6-36 months.

15 The impact on severe stunting was statistically significant $p > 0.05$, while the result on stunting was not statistically significant. In the latter case this does not mean that it had no impact, only that the evidence in inconclusive. The results are still useful in providing an indication of potential impacts

Photo: Hariandi Hafid/DEC

An impact evaluation of the IN-SCT pilot, Gilligan et al. (2020) compared baseline anthropometric data from 2016 with endline data collected 2018. The study found an unexplained statistically significant negative impact on stunting for children aged 6-23 months who participated in the IN-SCT pilot compared with participants of the main PSNP programme. Although the impact evaluation was unable to determine what had caused this negative impact, it highlighted a number of operational challenges which may have limited the effectiveness of the programme. For example, gaps in delivery and budget which prevented social workers from travelling to the communities to provide nutrition trainings. Payment delays and the small transfer size may also have hindered impacts.

The TMRI experiment in **Bangladesh** also included a nutrition training component as part of the fourth treatment arm of the randomised control trial. Ahmed et al. (2016) found that the treatment arms 'cash only', 'food only', 'cash + food' and 'food + behaviour change communication (BCC)' had no impact on height-for-age and reduction in stunting. Whereas the treatment arm 'cash + behaviour change communication (BCC)' resulted in a reduction in stunting of 7.3% among children who were less than 48 months old at endline.[16]

A follow up study by Ahmed et al. (2019) looked in more detail at the underlying mechanisms which contributed to this positive result. They find that both treatment groups involving BCC led to increases in maternal knowledge of good care practices, and resulted in reduction of children's illnesses and increased energy intake. However, 'cash + BCC' resulted in large intakes of protein, whereas the 'food + BCC' group were limited to the food bundle provided by the programme. Protein is linked to child growth in resource-deprived settings, and the authors highlight that although they cannot specifically identify if increased protein consumption contributed to linear growth in this example, it does show a positive correlation.

In an impact assessment of the CSG in South Africa, DSD, SASSA and UNICEF (2012) found no effect of the grant on child growth. However, upon further analysis the authors found a large improvement in height-for-age scores for children whose mothers have eight or more grades of schooling. The authors suggest that better educated mothers have more knowledge of food and sanitation and how to use these to ensure that children grow at a healthy rate. They conclude that simply providing cash alone is not sufficient to improve anthropometric status but requires 'complementary inputs'. In households where mothers have less education, BCC interventions may be required to close this knowledge gap.

In a 2016 study, Zembe-Mkabile compared the effect of the CSG on stunting in three diverse areas in **South Africa** and found no association between receipt of the CSG and reductions in stunting among children aged 22 months. Overall the effect of the CSG on nutritional status was found to be weak in this study and the authors suggest that the potential effect of the CSG could have been eroded by food price inflation during the study period. However upon further disaggregation, the authors do find a positive association between better educational attainment of mothers and linear growth of children (as was the case in the 2012 impact evaluation). They also find an association between low birth weight and an increased likelihood of stunting, highlighting the effect of poor nutrition and health during pregnancy. A strong correlation was also found between stunting and mothers' HIV positive status. Stunting has been linked to HIV exposure in children as a result of a compromised immune system.

16 The reduction in stunting was statistically significant at $p > 0.05$.

In **Indonesia,** Cahyadi et al. (2020) used household survey data taken at baseline, two years and six years to compare impacts of the conditional cash transfer PKH on children's development outcomes. They observed a decline in stunting by almost 2.8% between baseline and two years for children age 0-60 months, and by 8.9% at the six-year point. For severe stunting, the decline was 2.3% at the two-year point and 10% at the six-year point.[17]

The authors suggest that the increase in health-seeking behaviours (pre and postnatal visits, weighing, etc) required by the programme increased mothers' interaction with medical professionals which in turn may have led to improved maternal behaviours towards child nutrition and care. They also suggest that increases in protein intake among children aged 18-60 months may have contributed to improvements in nutrition.

In an impact evaluation of the CT-OVC in **Kenya**, Ward et al. (2010) found no evidence that the programme had had an impact on measures of the health and nutritional status of children when comparing children 0-59 months at baseline in 2007 and two years later. This was despite the programme increasing food expenditure and dietary diversity, particularly intake of high protein foods. The authors suggest that it may take more time for the improvements in household dietary diversity to translate into improvements in child nutrition. They also propose that other complementary interventions may be required such as nutrition education and more effective growth monitoring. Utilisation of health services (which included growth monitoring) was found to be particularly limited. The qualitative component of the impact evaluation found that this was 'not generally considered a priority by recipients, health workers or Programme staff' (Ward, 2010: 52). Compliance with programme conditions had also proved difficult to implement, potentially impacting the use of health services.

Guyatt et al. (2020) undertook a more detailed study of the CT-OVC focusing on the major predictors of undernutrition in children aged 0-23 months, including caregiver education and low birth weight. The analysis was based on survey data collected in January 2018 in South East Kenya. The authors found low birth weight to be the most important risk factor for stunting in children aged 0-23 months. They also found that children aged 12-23 months were three or four times more likely to be stunted and underweight than those aged 0-11 months, which was related to the transition from breast-feeding to weaning, when nutritious breast milk is replaced by high-starch and low-protein foods, and children lose passive immunity from their mothers. The authors suggest that social protection programmes should be developed to target pregnant women including promoting healthy diets and utilisation of health services. They also propose the introduction of nutrition education for caregivers to make correct decisions related to the timing, adequacy, safety and proper complementary feeding practices.

In **Ecuador,** the staged roll out of the BDH allowed Paxson and Schady (2010) to randomise parishes into treatment and control groups to compare development outcomes on children aged three to seven years. They found only modest treatment effects of the BDH on height-for-age and suggest that this may have resulted from the relatively older age of the children (3-7 years) which is above the so-called critical age for nutrition interventions of the first 1,000 days. As a consequence, child height may be difficult to change in the short run, for children past infancy.

Fernald and Hidrobo (2011) found no evidence of increased height-for age among children aged 12-35 months in the BDH. The authors point out that the transfer amount was far lower (10% of the average monthly consumption of enrolled households) when compared with other comparable cash transfers in the region (Mexico, Nicaragua) and this may have hindered progress. However they did find a significant effect on height-for-age for one sub-group: children whose mothers believed that receiving the cash transfer was conditional on taking their children for health checks. Although the BDH was originally conceived as a conditional cash transfer the conditions were never enforced. Only one quarter of BDH participants believed they would be penalised for not carrying out the health care and education requirements. The authors question whether the programme could have had greater effects if the transfer size amount was larger or if the receipt of cash had been more strongly linked to positive health behaviours.

In 2009, the Government of Ecuador revised the poverty index that establishes eligibility for the BDH resulting in 200,000 families losing the transfer which they had received for seven years, and a similar number becoming eligible. Buser et al. (2016) used this major programme change, and consequent income shock on BDH families to estimate the impact on childhood outcomes. They found that children under six years old in families who had recently lost the transfer were 12% more likely to be stunted than families who were still part of the programme. The authors explain how food intake would have been greatly affected by the programme changes. In the study sample, the households were from urban areas and largely reliant on purchasing food. The average family spent around 61% of their transfer on food purchases, making it likely that the income gap would lead to a reduction in food expenditures.

In two studies Gitter et al. (2011) also investigated the effect of a negative income shock in **Nicaragua**. The 'coffee crisis' occurred when coffee prices fell steeply from 2001 – 2003 to less than one-third of their high point. The loss of income devastated so-called 'coffee communities' which were almost entirely dependent on the cash crop. The authors found a decline in child height-for-age and per capita consumption among coffee communities in receipt of the RPS.

More importantly, whilst the RPS could potentially have provided an income buffer, Gitter et al. (2013) found the programme appeared to exacerbate the negative impact of the shock. They suggest that in the context of rising food prices, households transferred resources to older siblings to meet the programme's education conditions, and spending on nutritious foods for younger children decreased. The authors suggest that the fixed transfer amount, regardless of the number of children in the house, may also limit household choices.

Given the potential pathways required to achieve child development outcomes as described in the theory of change it is unsurprising that the reported outcomes of social protection programmes on stunting are mixed. The above findings mentioned several design and implementation features that had an effect on the programme outcomes. These are explored in more detail in Section 4.

17 The impact on severe stunting was statistically significant at p≥ 0.07, while the result on stunting was not statistically significant. In the latter case this does not mean that it had no impact, only that the evidence in inconclusive. The results are still useful in providing an indication of potential impacts

3.2 SOCIAL PROTECTION SUPPORTING ACCESS TO PRIMARY SCHOOL EDUCATION

Main findings

Cash transfer

✓ Cash transfers improved school attendance by helping households meet the additional costs of going to school including 'unofficial fees', transportation, lunch, uniform and shoes. Although many of the education policies of the countries featured in this review do not require uniforms and shoes to be compulsory part of school attendance, many schools still require this.

✓ Cash transfers can reduce the reliance on children as income-earners, freeing them up to attend school.

✓ In some countries, school enrolment decreased as children approached 12 years of age, the usual age of transition from primary to secondary school, as higher levels of schooling have higher costs. Some programmes included additional education grants for secondary school children to incentivise enrolment and completion of primary level.

✓× Cash transfers had minimal impact on primary school enrolment rates because enrolment rates were already high in all of the countries. However, receipt of cash transfers from early childhood contributed to children enrolling in primary school at the appropriate age.

× When payment schedules were not aligned with the beginning of the school year parents were unable to pay additional fees to register children for school.

Complementary interventions

✓ Improved coordination between social and education sectors at community level contributed to increases in school attendance through the identification of school-age children who were absent.

✓ None of the studies reported specifically on the impact of information sessions or behavioural interventions on school attendance. However, several studies highlighted that the importance of education was communicated as part of information broadcasts during enrolment and on paydays.

× Public works programmes may impact negatively on schooling through increase in children's labour, domestic responsibilities and childcare, as they substitute for parents' or caregivers' absence from the household.

Improving enrolment, attendance and progression in school is a common objective of social protection programmes aimed at children, with the longer-term objective of improving human capital. Conditional cash transfers often include enrolment and attendance at primary school as conditions for being part of the programme and receiving regular cash payments. While enrolment and attendance figures provide useful and measurable short-term impact indicators, they do not reveal anything about the quality of education provided nor educational attainment.

Evidence on primary school education from the social protection literature included in this review largely focuses on access to primary school education. The most commonly included indicators are primary school enrolment and attendance, particularly in studies of conditional cash transfers as these are directly related to the programme conditions. Two studies also look at whether children were enrolled in primary school at the appropriate age.

In all of the countries included in this section, primary school education is compulsory and free. However in most cases families are faced with additional costs to send their children to school including 'unofficial' fees, costs for compulsory uniforms and shoes, transportation, materials, books and school lunches. These costs increase for children in secondary school level. School attendance may also present a short-term opportunity cost for households. This can include a reduction in income earnt by working children as well as loss of children's domestic and care work which would otherwise enable adult household members to engage in productive activities.

The studies in this literature use varying denominators to measure school attendance and enrolment. For example Gilligan et al. (2020) report results for children 7-14 years in Ethiopia, while Onishi et al. (2013) report results for children aged 6-11 years in the Philippines. Where the studies include disaggregated results for the primary school age group these are included, otherwise figures are included for a broader age range and any caveats of these results are highlighted.

From the 30 single studies included in the literature review, 10 included evidence on social protection and access to primary school education from programmes in seven countries. Table 12 provides a summary of the evidence on social protection and access to primary school education based on enrolment and attendance data, along with the pathways of change which may have led to the programmes' successes or failures. More detailed evidence is provided after the table.

Table 12: Summary of the evidence on social protection supporting access to primary school education

	Programme	Impact	Potential pathways
ETHIOPIA	**Ethiopia: Productive Safety Net Programme (PSNP) / IN-SCT pilot** · Public works and unconditional cash transfers for 'labour-constrained households'. **Note that the complementary programmes introduced in the IN-SCT pilot were not conditions, but were framed as 'co-responsibilities' and no penalties were imposed.* · Complementary programs: None for the main PSNP program; Maternal nutrition and health checks, Preventative children's health checks and Vitamin A supplement, deworming (0-2yrs), Monthly nutrition behaviour change communication sessions for the IN-SCT pilot	**IN-SCT pilot:** · No increase in enrolment for children in the IN-SCT pilot compared with children on the main PSNP programme. Increase in attendance related to schools being open an additional half day per week (Gilligan, 2018).	**IN-SCT pilot:** · Enrolment rates may have been difficult to increase beyond the already high rates of 95% and 96% respectively for the two comparison groups. · Increased coordination between social workers and teachers, as well as house to house visits to record numbers of school age children could have helped increase demand for the school to be open (Gilligan, 2018).
GHANA	**Ghana: Livelihood Empowerment Against Poverty (LEAP)** · Unconditional cash transfer · Complementary programs: Free health insurance providing access to free outpatient and in-patient services, dental and maternal health services.	· No overall large differences in enrolment rates for the treatment and comparison group. But LEAP did reduce the likelihood of enrolment rates dropping as children neared 12 years old and the transition age from primary to secondary. · LEAP increased the likelihood of attending school by 10.5% by children aged 5-12 years (De Groot, 2015).	· LEAP may have helped to improve attendance by paying for the indirect costs such as school supplies and uniforms (De Groot, 2015).
INDONESIA	**Indonesia: Programme Keluarga Harapan (PKH)** · Conditional cash transfer · Complementary programs: Children 0-6 yrs: Vaccinations, monthly growth monitoring, Vitamin A capsules. Children 7-21 yrs: Enrolment in primary/ secondary with an attendance rate of at least 85%.	· No increase in enrolment rates due to difficulty of improving on the already high baseline enrolment rate of 94%. · Improvement in attendance rates by children spending an additional 20 minutes per week in class (Alatas, 2011). · At six year follow up study, the programme was shown to have increased enrolment by 4% in children aged 7-15 years. Potentially suggesting that the programme helped to address the reductions in enrolment as children neared the transition from primary to secondary school (Cahyadi, 2020).	· The cash transfer may have helped pay for additional costs such as uniforms and materials. The threat of financial penalties for non-compliance may have helped to increase attendance (Alatas, 2011). · Payment schedules had been changed to align with the start of the school year so parents were able to pay for additional costs. Payment structures had also been improved so that different payment amounts were made according to the size of the household and age of the children (Cahyadi, 2020).

	Programme	Impact	Potential pathways
JAMAICA	**Programme of Advancement through Health and Education (PATH)** · Conditional cash transfer · Complementary programs: Children 0-6 years: health check ups. Children 6-17 years: attend school at least 85% of school days.	· No increase in enrolment rates due to the already high baseline enrolment rate of 97%. · Increase of 0.48 days school attendance over the 20-day reference period for children aged 7-17 years in receipt of cash transfers from PATH (Levy and Ohls, 2010).	· PATH provided families with the resources for additional school costs such as transportation and school lunches.
KENYA	**Cash Transfer for Orphans and Vulnerable Children (CT-OVC)** · Conditional cash transfer · Complementary programs: Children 0-5 yrs: immunisations, health check ups, Vitamin A supplement; Children 6-17 yrs enrol in school, and attend school at least 85% of days; Family development/awareness session (single annual session)	· CT-OVC had no impact on primary school enrolment which remained at 88%. · CT-OVC had a marginal effect on attendance. Children from households receiving CT-OVC missed a slightly smaller average number of days (around one third of a day in the 10 days preceding the survey) compared with the baseline results (Ward, 2010). · Approximately 25% of primary school age children must pay 'extra fees', 50% must wear uniforms and 77% must wear shoes to be allowed to attend school. Children from households in receipt of CT-OVC missed fewer days of school than children from the control group (Kenya CT-OVC Evaluation Team, 2012).	· Age and sex of the child, household size, distance to school, district and religion are important factors preventing the remaining 12% from enrolling in primary school, and could also be affecting attendance (Ward, 2010). · Income from the CT-OVC helped households to pay for the additional costs of primary school (Kenya CT-OVC Evaluation Team, 2012).
PHILIPPINES	**Pantawid Pamilyang Pilipino Programme (Pantawid)** · Conditional cash transfer · Complementary programs: Maternal nutrition and health checks; Vaccinations (0-2yrs); Preventative health checks (0-5 yrs); Deworming pills (6-14yrs); Enrolment & attendance in daycare/ kindergarten (3-5yrs); Enrolment & attendance in school; Family development sessions (monthly series includes nutrition, sanitation and early years information components)	· Primary school enrolment rate among households in receipt of Pantawid increased from 93% at baseline to 97% after two years of the programme. The enrolment rate of 93% remained the same for households not in receipt of Pantawid. · 95.5% of children in households receiving Pantawid were also attending primary school 85% of school days per month, comparing with 91.2% of children in non-Pantawid households (Onishi, 2013).	· The threat of financial penalties for non-compliance may have helped to increase enrolment and attendance (Onishi, 2013).
SOUTH AFRICA	**Child Support Grant** · Unconditional cash transfer · Complementary programs: None	· No overall effect of the CSG on whether children were enrolled in school at the appropriate age. However, the CSG did have effect on two sub-groups: it reduced delayed entry for girls by 26.5%, and by 31.8% for children whose mothers have less than eight grades of schooling (DSD, SASSA and UNICEF, 2012).	· Households may have delayed school entry for children because they cannot afford the additional expenditures associated with school attendance. Where resources are limited, boys may be prioritised over girls to attend school. Income from the CSG helps households to pay for additional school expenditures.

Photo: Mark Njuguna/Save the Children

In **Ethiopia**, school fees were removed for grades 1-10 in all government run schools in 1995. While the main PSNP programme does not include a component on access to education, the IN-SCT pilot which ran from 2016-2018 introduced an education condition which required parents/caregivers to ensure that school-age children are enrolled in school and attending at least 80% of school days. Part of the IN-SCT programme design was to strengthen community level coordination involving social workers, school directors and teachers.

Investigating impacts of the IN-SCT for children aged 7-14 years, Gilligan et al. (2020) found no impact on school enrolment of children in IN-SCT houses compared with children on the main PSNP programme. Enrolment rates in both these groups were already high at 95% versus 96%. However they did find a marginal effect on attendance which was related to schools being open an additional half day per week. They suggest that increases in social workers attending meetings with school officials to discuss if children were attending school, and teachers making house-to-house visits to record numbers of school age children could have contributed to this improvement. However the study also reported gaps in delivery and budget shortages for social workers which may have limited the programme having a greater impact on school attendance.

In **Indonesia** the 2007 PKH pilot phase took place in randomly selected sub-districts of six provinces which were considered to be 'supply-side ready'. In an impact evaluation of the PKH pilot, Alatas et al. (2011) found an improvement in attendance rates among primary school students, with students spending an additional 20 minutes per week in class. However, similar to the Ethiopia study, the authors did not find any evidence that enrolment had increased for primary school age children from the already high baseline of 94%.

Primary schools in Indonesia do not have school fees but may require payment for additional fees, uniforms, books and other supplies. The authors suggest that the programme's payment schedule, which did not coincide with the academic year, meant that families did not have funds to pay for these additional costs.

Over the following years, the programme expanded to cover all provinces of Indonesia but maintained the approach of treatment and control groups. This enabled a follow up study in 2013, after six years of the PKH, in which Cahyadi et al. (2020) found the programme increased enrolment by 4% in children aged 7 to 15 years. While the authors do not elaborate on what could have caused this increase in primary school enrolment, it is worth noting that by this point households were receiving transfers on a quarterly basis, payments were being made on time, and different amounts were allocated according to household size and age of the children. Furthermore, the pilot phase had taken place during the 2008-2009 financial crisis. By the time of the follow up study in 2013, the financial situation in Indonesia was more stable.

Primary school education in **Jamaica** is universal and free, and while enrolment is generally high, attendance has been erratic. One of the main objectives of the PATH programme was to improve school attendance. In their analysis of household survey data Levy and Ohls (2010) found primary school enrolment to be similarly high in both treatment and comparison groups (97% and 96%) at baseline. School attendance was lower, with 73% of the treatment group and 74% of the comparison group children aged 7-17 years reported to attend school between 17-20 days in a typical 20-day period.

Analysis of detailed household surveys 18 months after the programme began reported an increase of 0.48 days school attendance during a typical 20-day period among PATH participants compared with the comparison group.[18] When asked why their children had been absent from school, PATH families were much less likely to mention 'money problems' than the comparison group (12% versus 22%) and were more likely to report that children were absent due to illness. The authors suggest that PATH had been successful in encouraging attendance through providing families with the resources for additional school costs such as transportation and lunch money.

Similar to Jamaica, primary school enrolment is already fairly high in the **Philippines**, due in large part to education being free and mandatory from grades 1-12. In the programme impact evaluation for 2009-2011, Onishi et al. (2013) found the baseline rate of primary school enrolment in 2009 to be 93% for both treatment and control group households. By the time of the follow up survey in 2011, the primary school enrolment rate among the treatment group had increased to nearly 97% (in comparison the enrolment rate did not increase for the control group). However only 62% of the children had actually been enrolled at the appropriate age of six years, leading to a delay in the total number of years of schooling they would receive. The programme also improved school attendance for children aged 6-11 years: 95.5% of children in households receiving Pantawid were attending primary school 85% of school days per month, comparing with 91.2% of children in non-Pantawid households.

In **Kenya**, one of the main objectives of the CT-OVC is to increase the enrolment, attendance and retention in 'basic school' (grade 1 – 8). In an impact evaluation of the programme using data gathered in 2007 and 2009, Ward et al. (2010) found that 88% of children aged 6 to 13 years participating in the CT-OVC were enrolled in basic school in 2009. While the amount seems high, there had been no increase from the baseline starting point. In further analysis, the authors found that age, sex of the child, household size, distance to school, district, and religion all to be important determinants constraining the remaining 12% of appropriately aged children from enrolling in school. The authors did not elaborate any further, but suggest that additional analysis is needed to properly understand how these areas may be preventing children from enrolling, considering that these children are likely to be among some of the most disadvantaged.

In their analysis of school attendance data, Ward et al. (2010) found only marginal effects of the CT-OVC. Children from households receiving CT-OVC missed a slightly smaller average number of days (around one-third of a day in the 10 days preceding the survey) compared with the baseline results. The proportion of children who had an attendance rate of more than 80% of effective days was also found to be high and had not changed since baseline.

In further analysis of the CT-OVC, the Kenya CT-OVC Evaluation Team (2012) investigated the additional costs for households to send children to primary school. They found that approximately 25% of primary school age children must pay 'extra fees', 50% must wear uniforms and 77% must wear shoes. The authors found that income from the CT-OVC programme had a strong impact on households that faced these large costs.

This section has so far focused on results for the conditional cash transfer programmes featured in this review. Turning now to the unconditional cash transfers and their impacts on school enrolment and attendance, De Groot et al. (2015) found no large differences in enrolment rates for the treatment group of the LEAP programme in **Ghana** between 2010 and 2012. School enrolment remained stable at 93%, reflecting the already high enrolment rates which potentially leave little room for improvements. However the authors did find a slight decrease in enrolment for the comparison group, particularly between the ages of 8-13 years, this is in line with broader literature that has shown school enrolment to decrease as children near the so-called critical age for drop out when children transition from primary to secondary school. De Groot et al. (2015) also found that LEAP reduced the overall likelihood of missing school by 10.5% among children aged 5-12 years but did not elaborate further on this point.

In their impact assessment of the CSG in **South Africa,** DSD, SASSA and UNICEF (2012) investigated the impact of the grant on school enrolment. Specifically, they looked at whether early receipt of the CSG contributed to children enrolling at the appropriate age. While they found no impact on the study group as a whole, they did find that early receipt of the CSG reduced delayed school entry for girls by 26.5%. It also reduced a delay in school entry for children whose mothers have less than eight grades of schooling by 31.8%. The authors suggest that early receipt of the CSG may help to narrow the gap in schooling between children whose mothers have less education and those who have more.

18 Statistically significant P ≥ 0.01

3.3 SOCIAL PROTECTION SUPPORTING COGNITIVE, SOCIAL AND EMOTIONAL DEVELOPMENT

Main findings

Cash transfer

✓ Households in receipt of a cash transfer were more likely to have learning materials and toys for children in their house.

✓ No difference was found in cognitive, social and emotional development outcomes for households who were part of a hard manual labour public works programme, compared with those on a less intensive public works programme, even though the former group may have less time to spend in responsive parenting.

× Lower levels of cash transfers meant households had to use it for basic daily survival and could not pay for learning materials or toys.

× Low transfer levels did not go far enough to relieve income pressure, and parents/caregivers had to spend time out of the house in income-generation rather than in responsive parenting.

Complementary interventions

✓ Caregiver engagement improved across all measures of cognitive, social and emotional development in programmes featuring an intensive home-delivered and structured parenting programme.

✓ In the absence of a behavioural change component, 'social marketing' encouraged programme participants to use their cash transfers for children's diets and educational materials.

× Programmes that only provided cash and did not include any behavioural interventions or information sessions reported far lower levels of change in tests of children's cognitive and behavioural outcomes.

× In the absence of behavioural interventions or information sessions, children's cognitive and behavioural outcomes were far lower for children whose mothers had not completed primary school, compared with children whose mothers had primary or higher levels of schooling.

Cognitive, social and emotional development is a less common objective of social protection programmes and the impact of social protection on this area of childhood development is a less studied topic. Even though some of the social protection programmes in this review do include family development or parenting information sessions (e.g. Philippines' Pantawid, Kenya's CT-OVC), the impact of these interventions has not been studied in evaluations or research.

There are a variety of ways in which improvements in cognitive, social and emotional development are measured. Organisations such as UNICEF are working to improve the measurement and collection of data in this area, however unlike in the area of nutrition, there is less consistency and consensus on the use of measurements and data collection at the national level.

The literature on social protection supporting cognitive, social and emotional development uses a number of different measures ranging from intermediate outcomes such as investments in learning and play materials, and observations of parenting behaviours and caregivers' self-reported engagement in stimulating activities with the child. While other studies focus on child outcome level in terms of early language skills and cognitive development, social-personal, fine motor and gross motor skills.

From the 30 single studies included in the literature review, five included evidence on social protection supporting cognitive, social and emotional development from programmes in four countries. Table 13 provides a summary of the evidence on social protection and cognitive, social and emotional development based on the available measures in the studies, along with the pathways of change which may have led to the programmes' successes or failures. More detailed evidence is provided after the table.

Table 13: Summary of the evidence on social protection supporting cognitive, social and emotional development

	Programme	Impact	Potential pathways
ECUADOR	**Bono de Desarrollo Humano (BDH)** · Unconditional cash transfer · Complementary programs: None	Children aged 3-7 years in households in receipt of BDH had 10% higher treatment effect on five measures of cognitive and behavioural interventions than children in control group households. For children in the poorest quartile the effects were even larger, ranging between 22-28% across the five measures. · Results varied for children in BDH households depending on the mothers' education level. For children whose mothers had not completed primary school the treatment effect was 14%, for mothers who had completed primary or higher levels of schooling, it was 29% (Paxson and Schady, 2010). · No impact of the BDH on intermediate outcomes (investments in learning materials) for the whole sample, but participation in BDH was associated with the increased probability of buying a toy for the rural households. · Receipt of the BDH during a child's first two years of life was associated with a significantly higher score on the Communicative Development Inventory (Fernald and Hidrobo, 2011).	· Increased income from the BDH could affect cognitive, social and emotional development through several pathways; increased income could lead to improved diets for children (there is a large body of evidence indicating that nutritional deficits adversely affect cognitive development, motor development and social and behavioural outcomes). Increased income from the BDH may also lead to households being able to seek timely treatment for diseases such as diarrhoea, pneumonia and malaria, which have been associated with cognitive impairments. Finally, parents may spend more on materials or activities that stimulate children or enrol them in educational activities. Higher incomes could reduce stress among parents leading to more nurturing behaviours (Paxson and Schady, 2010). · In this example, spending on materials or activities did not appear to be an important pathway for cognitive, social and emotional development. The additional income may have contributed to improved nutrition and reduction in diseases, in turn contributing to higher developmental scores, as noted above (Fernald and Hidrobo, 2011).
GHANA	**Livelihood Empowerment Against Poverty (LEAP)** · Unconditional cash transfer · Complementary programs: Free health insurance providing access to free outpatient and in-patient services, dental and maternal health services.	· Marginal impacts on six input indicators for cognitive, social and emotional development focused on home support for learning for children aged 36-59 months participating in LEAP (Palermo, 2018).	· LEAP did not provide any family development sessions or behaviour change communication, which could have provided a platform to communicate messages on cognitive, social and emotional development and positive parenting. The median value of the transfer was low at approximately 11% of household consumption level which was not enough to relieve the income pressure and potentially allow parents to spend more time with their children in responsive parenting (Palermo, 2018).

Photo: Save the Children

	Programme	Impact	Potential pathways
NICARAGUA	**Red de Protección Social / Atención a Crisis** · Conditional cash transfer · Complementary programs: Vaccinations (0-2yrs); Preventative health checks (0-5 yrs); Deworming pills (6-14yrs); Enrolment & 85% attendance in school (7-13 years); Bi-monthly training sessions about diet, health and education **Note that Atención a Crisis did not have a training session component.*	· Children under 36 months in households in receipt of Atención a Crisis cash transfers were 20% more likely to have higher scores on the test of receptive vocabulary. Households in receipt of cash transfers were also more likely to engage in cognitive/language inputs (Macours, 2012).	Although the Atención a Crisis programme did not include a training session component, the 'social marketing' element of the programme may have transmitted knowledge about positive parenting practices. · The additional income may have contributed to improved nutrition and reduction in diseases, in turn contributing to higher developmental scores (Macours, 2012).
RWANDA	**Vision 2020 Umurenge Programme (VUP) / Sugira Muryango pilot** · Public works, unconditional cash transfer · Complementary programs: Parenting coaching programme	· Caregiver engagement had improved across all measures of cognitive stimulation for households who were part of the Sugira Muryango pilot. No differences were found between households who were part of the classic public works and the expanded public works (Betancourt, 2020).	· Caregivers received intensive coaching in the families' homes on various topics including responsive caregiving and the importance of play. This led to increases in caregiver engagement in activities that contribute to cognitive, social and emotional development (Betancourt, 2020).

The BDH in **Ecuador** provides cash transfers without any conditions and, at the time of the available studies, did not provide any specific complementary programmes or behavioural interventions. In their study of the BDH in Ecuador, Paxson and Schady (2010) used five measures of cognitive and behavioural outcomes to analyse the impact of the programme on cognitive, social and emotional development.[19] The study measured results for a sample of children aged between three and seven years old who had been receiving BDH for several years. They found a 10% programme effect for children in the treatment group compared with the control group, with effects even larger for the poorest households (between 22-28% treatment effect on the individual measures). Further disaggregation of results for children in the poorest quartile also found programme effects on cognitive and behavioural measures were larger for girls at 39%, while for boys it was 11%.

Paxson and Schady (2010) also compared treatment effects by mother's education level. For children whose mothers had not completed primary school the treatment effect on cognitive and behavioural measures was 14% compared with 29% for children whose mothers had completed primary or higher levels of schooling. These results show the importance of education, and highlight why behavioural interventions may be necessary to close the knowledge gap.

19 1) Test de Vocabulario en Imágenes Peabody (TVIP), the Spanish version of the Peabody Picture Vocabulary Test (PPVT) for children 36 months and older. 2) Long-term memory, 3) short-term memory and 4) visual-spatial processing based on Woodcock-Johnson-Muñoz battery and 5) assessed behaviour problems with a commonly-used scale, which is based on mother's reports of the frequency that a child displays each of the behaviours.

In later analysis of the BDH, Fernald and Hidrobo (2011) investigated the impact of the programme on intermediate outcomes (cognitive/language inputs: whether a household owned a story book; whether a child was bought a toy in the last six months; or whether a child attended day care) as well as children's language outcomes.[20] The authors found that participation in the BDH was not associated with the probability of buying a toy, owning a children's book, or attending day care for the whole sample. However it did significantly increase the probability of buying a toy in the rural sample, suggesting that the greater effect in rural areas could be because the programme had started five months earlier there, or because rural households were a lot poorer and in greater need than in urban areas. The authors did find that receiving the BDH programme in the first two years of life was associated with a significantly higher score on the Communicative Development Inventory.

In **Nicaragua,** Macours et al. (2012) used data from assessments of social-personal, language, fine and gross motor skills in young children to assess the impact of Atención a Crisis (follow up to the RPS) on cognitive, social and emotional development outcomes.[21] The main programme feature was the regular cash transfers and although it did not provide any structured behavioural interventions, as part of the 'social marketing' of the programme, participants were told that the transfers are intended for children's diets and to buy school materials. \

The programme only ran for one year (2005-2006) and the authors used baseline and endline data as well as a follow up data from assessments carried out on programme participants in 2008, two years after the programme had finished. The authors found positive programme effects across all outcome measures in 2006, in particular a 20% treatment effect on the test of receptive vocabulary among children under 36 months. In terms of cognitive/language inputs, treatment households surveyed in 2006 were also more likely to tell stories, sing to, or read to their children, and to have pen, paper and toys for children in the house.

The follow up assessment in 2008 found smaller but still positive effects of the programme after two years. While it is likely that cognitive/language inputs would have reduced after the programme ended, and consequently reduced the effect on the outcome measures, the authors suggest that the 'social marketing' element of the programme may have transmitted knowledge about positive parenting practices which continued after the programme ended.

In an impact evaluation of the LEAP programme in **Ghana,** Palermo et al. (2018) analysed baseline and endline data on six input indicators for cognitive, social and emotional development,[22] specifically focused on home support for learning for children aged 36-59 months and found only marginal impacts on any of these indicators.

While the authors do not elaborate on this lack of impact, there are possible barriers in the design of LEAP which may have limited the impact. First, LEAP did not provide any complementary programmes, such as family development sessions or behaviour change communication, which could have provided a platform to communicate messages on cognitive, social and emotional development and positive parenting. Second, the median value of the transfer was low at approximately 11% of household consumption level which was not enough to relieve the income pressure and potentially allow parents to spend more time with their children in responsive parenting. Third, they may have been unable to afford learning materials for the home, such as books. The authors highlight that their sample was a group of participants just below the proxy means test cut-off point, and were therefore not among the poorest households in the programme, for whom the situation would have been even worse.

In **Rwanda**, a randomised trial was undertaken in 2018 to assess the impact of 'Sugira Muryango', a 12–16-week experimental programme to reduce violence and increase father engagement in play and caregiving.[23] Training and information were delivered by trained and supervised Community Based Coaches (CBCs) in the families' homes for a session of approximately 90 minutes per week. Sugira Muryango used the existing VUP public works programme as a platform to randomly select families for the intervention. Families were participants either in the classic public works (cPW) which provides cash for (typically hard) manual labour, or the expanded public works (ePW) which provides cash for (typically lighter) labour and access to livestock. The control group was made up of households only participating in VUP.

Betancourt et al. (2020) found that for children in households receiving Sugira Muryango, caregiver engagement improved across all measures of cognitive stimulation.[24] This included an increase in stimulating activities compared with households only participating in VUP. Results were also compared with groups who were participating in cPW and those on ePW. As the cPW is more time intensive than the ePW, we might expect parents or caregivers to have less time available to spend with children, face higher stress levels, and we may expect to see different results for these groups. The authors found no difference in any of the measures of cognitive, social and emotional development between the cPW and ePW groups.

20 Children's score on the Spanish version of the short form of the MacArthur-Bates Communicative Development Inventory (CDI) which measures the early language skills of children between the ages of 12-35 months using parental report.

21 All children were assessed using the Denver Developmental Screening. For children aged 36 months and above additional tests were used for short-term memory, associative memory and behavioural problems.

22 Home support for learning is proxied by six different activities that were collected both at baseline and endline: reading books to, or looking at picture books with the child; telling stories to the child; singing songs to or with the child, including lullabies; taking the child outside the home, compound, yard or enclosure; playing with the child; and naming, counting, or drawing things to or with the child.

23 Sugira Muryango offers active coaching by Community Based Coaches (CBC) of caregivers to promote early stimulation, play, nutrition, hygiene, responsive parenting, nonviolent interactions among house-hold members, and engagement of both female and male caregivers. CBCs also help families navigate formal and non formal resources (e.g. health and nutrition services and social support)

24 Three tools: Observation of Mother-Child Interaction (OMCI), an adapted 43-item version of the infant/toddler Home Observation for Measurement of the Environment (HOME) Inventory, and the Multiple Indicator Cluster Survey (MICS) Family Care Indicators (FCI)

3.4 SOCIAL PROTECTION SUPPORTING REDUCTIONS IN VIOLENT DISCIPLINE AGAINST CHILDREN

Main findings

Cash transfer	Complementary interventions
× None of the studies included specific evidence on whether cash alone reduced household stress. × The probability of children being exposed to harsh discipline was higher for children whose households were part of a hard manual labour public works programme, compared with households in a less intensive public works programme.	✓ An intensive home-delivered parenting coaching programme significantly reduced the probability of children being exposed to harsh discipline. × Two programmes provided cash and complementary programmes related to health and nutrition, but did not include any behavioural intervention. In both these cases the programmes had no impact on measures of violence against children. However in both cases only the mother's parenting approach was assessed due to data limitations.

While a number of studies have examined links between social protection and broader child protection issues such as early marriage, child labour and gender-based violence, little attention has been paid to the potential of social protection to reduce violent discipline against children in the home. Although poverty is among the risk factors for child protection violations, there is little rigorous evidence to demonstrate if this relationship is causal (Peterman et al., 2017). Some studies suggest that violent discipline against children may be more indirectly related to poverty compared with other child protection issues with direct links such as child labour and early marriage (Barrientos et al., 2014).

The two main pathways for social protection to theoretically reduce violence against children in the home are through 1) increased income reducing household stress levels and lowering the risk of intra-household conflict, and 2) complementary information and communication interventions which aim to address social and cultural norms around parenting practices. (It is important to note that although parenting interventions are a common intervention for challenging attitudes and social norms on violence and reducing harsh parenting, they are rarely explicitly linked to social protection programmes.)

From the 30 single studies included in the literature review, four included evidence on social protection supporting reductions in violence against children from social protection programmes in four countries. Three of the studies (Ecuador, Nicaragua and Rwanda) provide evidence on violent discipline against children using the Home Observation for Measurement of the Environment Inventory (HOME) which includes 11 items related to harsh parenting, and the UNICEF multiple indicator cluster survey module on child discipline. The study from South Africa provides some evidence on the role of increased cash income reducing household stress levels.

Table 14 provides a summary of the evidence on social protection and violent discipline against children in the home based on the available measures in the studies, along with the pathways of change which may have led to the programmes' successes or failures. More detailed evidence is provided after the table.

Table 14: Summary of the evidence on social protection supporting reductions in violence against children

	Programme	Impact	Potential pathways
ECUADOR	**Bono de Desarrollo Humano (BDH)** · Unconditional cash transfer · Complementary programs: None	· The baseline scores on harsh parenting for both the treatment and control groups were relatively low (2.5 and 2.4 respectively, on a scale of 0-11 where 11 signifies the harshest parenting). There was minimal change after two years: the score was 2.7 for the treatment group and 2.5 for the control group (Fernald and Hidrobo, 2011).	· BDH simply provided cash and had no parenting interventions. It could have had a greater impact if it was expanded from a cash transfer (Fernald and Hidrobo, 2011).
NICARAGUA	**Red de Protección Social/Atención a Crisis** · Conditional cash transfer · Complementary programs: Vaccinations (0-2yrs); Preventative health checks (0-5 yrs); Deworming pills (6-14yrs); Enrolment & 85% attendance in school (7-13 years); Bi-monthly training sessions about diet, health and education **Note that Atención a Crisis did not have a training session component.*	· The baseline scores on harsh parenting for the group receiving cash from Atención a Crisis was relatively low at 3.76, on a scale of 0-11 where 11 signifies the harshest parenting. After one year of the programme the score had changed to 3.83. This is a minimal increase and possibly reflects measurement inaccuracies rather than actual change as a result of the programme (Macours, 2012).	· Atención a Crisis programme provided cash and had no parenting interventions. It could have had a greater impact if it included a parenting component (Macours, 2012).

	Programme	Impact	Potential pathways
RWANDA	**Vision 2020 Umurenge Programme (VUP) / Sugira Muryango pilot** · Public works, direct support · Complementary programs: Parenting coaching programme	· The odds of children being exposed to harsh discipline was 29% for families participating in Sugira Muryango compared with 45% for families only participating in the main VUP programme. · The odds of children being exposed to violent discipline was 32% for families on the classic public works programme, compared with 26% on the expanded public works programme (Betancourt, 2020).	· The intensive coaching programme resulted in caregivers using a more nurturing approach to parenting and discipline. · The relatively less intensive nature of the ePW may have meant family members were less stressed and tired, and were able to spend more quality time with their children.
SOUTH AFRICA	**Child support grant** · Unconditional cash transfer · Complementary programs: None	· The odds of caregivers suffering from depression or anxiety was 60% lower in households where some of the children received the CSG, and 84% lower in households where all the children received the CSG, compared with households not receiving any CSG. · CSGs were portrayed as a material and psychological safety net. Mental distress was frequently linked to the absence of options in the face of difficulty or need (Plagerson et al., 2011).	· The long-term nature and reliability of the grants emerged as a key aspect of the grants' potential to provide psychological support (Plagerson et al., 2011).

In **Ecuador**, Fernald and Hidrobo (2011) analysed data collected on harsh parenting from the BDH programme. They used two subscales from the Home Observation for Measurement of the Environment Inventory (HOME) to measure mothers' parenting approach and participants were scored between 0-11, with higher scores indicating the harshest parenting.[25] For both the treatment and control groups, the HOME scores were relatively low (2.4 and 2.5 respectively) and there was minimal difference between the groups after the programme had been operational for two years. The authors suggest that the BDH could have a greater effect if it was expanded from simply a cash transfer programme to include parenting classes.

In **Nicaragua**, Macours et al. (2012) also used the HOME inventory to measure mothers' parenting approach for families participating in the Atención a Crisis programme. The HOME scores were relatively low at 3.76 for the baseline measurement in 2006, with only a minimal increase to 3.83 observed by end line in 2008. Like the BDH, Atención a Crisis did not include parenting classes. Instead they relied upon a very light touch approach through repeating information and communications during programme enrolment and paydays about the importance of varied diets, health and education. It was not clear if this included any information about parenting.

In **Rwanda**, Betancourt et al. (2020) investigated the effects of the Sugira Muryango experimental programme to reduce violence and increase father engagement in play and caregiving. Data from the UNICEF multiple indicator cluster survey showed that the probability of children being exposed to harsh discipline was 29% for families participating in Sugira Muryango compared with 45% for families only participating in the main VUP programme. Further analysis of the data by the type of public works programme the families were enrolled in (classic public works or expanded public works) found that in cPW families the odds of children being exposed to violent discipline was 32%, comparing with 26% in ePW. While the authors do not elaborate on the mechanisms which could have led to these difference between the two groups, it is worth considering that the relatively less intensive and more flexible nature of the ePW may have meant family members were less stressed and tired, and were able to spend more quality time with their children. On the other hand, another factor to consider is that ePW households tend to be single-female headed households and therefore potentially less predisposed to resort to violent discipline.

In relation to the potential of cash transfers to reduce financial stress on parents and caregivers, Plagerson et al. (2011) study of the CSG in **South Africa** revealed that parents or caregivers of households in receipt of the CSG were between 60 – 84% less likely to be suffering from depression and anxiety than households who did not receive the CSG. Furthermore, the authors found that the CSG reduced recipients' reliance on strained and insecure relationships, a factor which could be contributing to household stress and potential for domestic violence and harsh parenting.

25 Harshness is defined as either extensive or excessive deprivation (time-out longer than two hours; deprivation longer than two days) or physical punishment (firmly grasping the child, spanking then talking, or talking then spanking). National Longitudinal Surveys, The HOME (Home Observation Measurement of the Environment), U.S. Bureau of Labor Statistics https://www.nlsinfo.org/content/cohorts/nlsy79-children/topical-guide/assessments/home-home-observation-measurement (accessed 26.09.2022)

3.5 SOCIAL PROTECTION SUPPORTING CHILD DEVELOPMENT OUTCOMES DURING TIMES OF SHOCKS

Main findings

Cash transfer

- ✓ Cash transfers helped stabilise child nutrition during times of crisis by enabling households to maintain an adequate level of food consumption. This occurred in situations of drought and of economic stress.
- × During an economic shock, households which were part of a conditional cash transfer had to spend a larger proportion of their reduced income on indirect education costs in order to meet the programme conditions for school attendance and remain in the programme. This reduced the amount of cash available to spend on food which impacted negatively on the nutrition status of younger children in the household.

Social protection plays an important role in supporting children during large-scale emergencies or crises. There is now general recognition that crises are caused by events (shocks or increasing stresses) such as earthquakes and droughts, economic downturns or political incidents, combined with pre-existing vulnerabilities (Levine and Sharp, 2015).

From a broad perspective, there are two pathways through which social protection can support children during times of covariate shock or stress. The first is by reducing vulnerabilities before an event, which minimises the impact of shocks or stresses. The second is the ability of a social protection programme to respond to seasonal fluctuations, or sudden spikes in demand. This can include design tweaks and contingency plans to enable existing social protection programmes to continue to function in the event of a shock, for example if recipients may have lost their identity documents or are internally displaced, or payment infrastructure has been damaged. Substantial adaptations may also be needed to increase the benefit value, add new beneficiaries to a programme, or set up a new temporary response programme for those who do not participate in a regular social protection programme (Beazley, 2020).

From the 30 single country studies included in the literature review, six contain information on social protection programmes in the context of a covariate shock or stress. Four of these include specific (albeit limited) evidence on how social protection supported childhood development outcomes during times of economic shock (Ghana, Nicaragua and South Africa) and seasonal drought (Ethiopia). The remaining two studies only include information on the practical and functional aspects of social protection programme response to shocks (earthquake – Ecuador, and typhoon – Philippines) so these are discussed in Section 4 which focuses on social protection design and implementation features.

Table 15 provides a summary of the evidence on social protection supporting childhood development outcomes during times of covariate shock, along with the pathways of change which may have led to the programmes' successes or failures. More detailed evidence is provided after the table.

Table 15: Summary of the evidence on social protection supporting children's development outcomes in times of covariate shock or stress.

	Programme	Impact	Potential pathways
ETHIOPIA	**Productive Safety Net Programme (PSNP) / IN-SCT pilot** · Public works and unconditional cash transfers for 'labour-constrained households'. **Note that the complementary programmes introduced in the IN-SCT pilot were not conditions, but were framed as 'co-responsibilities' and no penalties were imposed in cases of non-compliance.* · Complementary programs: None for the main PSNP program; Maternal nutrition and health checks, Preventative children's health checks and Vitamin A supplement, deworming (0-2yrs), Monthly nutrition behaviour change communication sessions for the IN-SCT pilot.	· Famine prone areas of Ethiopia suffered a particularly devastating drought during 2015 resulting in food shortages, increased food prices and decreased income for farmers. Despite this, child nutrition remained stable in households in receipt of the PSNP, suggesting that the cash income prevented child nutrition from worsening in the event of a crisis (Gilligan et al., 2020).	· The cash income reduced the pressure on households to reduce food quality and quantity, thereby preventing malnutrition.

	Programme	Impact	Potential pathways
GHANA	**LEAP** · Unconditional cash transfer · Complementary programs: Free health insurance providing access to free outpatient and in-patient services, dental and maternal health services.	· Ghana suffered high levels of inflation during 2015-2017 which led to an approximately 20% loss in real value of the cash transfer. The authors suggest this may have contributed to there being no positive impacts on child nutrition (Palermo et al., 2018).	· The transfer amount was not periodically reviewed and adjusted against inflation, which decreased household purchasing power (Palermo et al., 2018).
NICARAGUA	**Red de Protección Social / Atención a Crisis** · Conditional cash transfer · Complementary programs: Vaccinations (0-2yrs); Preventative health checks (0-5 yrs); Deworming pills (6-14yrs); Enrolment & 85% attendance in school (7-13 years); Bi-monthly training sessions about diet, health and education. **Note that Atención a Crisis did not have a training session component.*	· Coffee prices fell steeply to one-third of the price they had been at the highest point, causing an income shock for households in so-called 'coffee communities'. This resulted in a decline in child height-for-age among RPS households containing both children under six years and children of school age (Gitter et al., 2013).	· As the RPS programme was a conditional cash transfer, households would only receive their cash if children were meeting certain conditions including 85% school attendance. Despite the massive reduction in income caused by the coffee crisis, the RPS was not adjusted to take into account the new financial hardship. Gitter et al. (2013) suggest that in this context households had to make difficult choices about how to spend limited funds, and prioritised paying for indirect school costs (to ensure they would continue to receive the RPS grant) but had to reduce the quantity and quality of food in the household which caused a decline in children's height-for-age.
SOUTH AFRICA	**Child support grant** · Unconditional cash transfer · Complementary programs: None	· Inflation may have been one of several reasons why there was a lack of association between the CSG and reductions in stunting. The study was focused on locations in South Africa where almost all of the households were receiving CSG or other welfare grants and were totally reliant on these grants for their basic food needs. In the context of high unemployment and rising food prices, the cash transfer was unable to meet their needs (Zembe-Mkabile et al., 2016).	· The transfer amount was not adjusted in spite of rising food prices and high unemployment.

Photo: Hanna Adcock/Save the Children

Ethiopia is particularly susceptible to drought, with one occurring every three to five years. Serious droughts, and often famine, have occurred several times and affected millions of people. The PSNP is aimed at addressing the needs of chronically food insecure households in famine prone areas of Ethiopia. The programme finances labour-intensive public works of up to five days per month, per household member, for six months a year during the 'lean period' when households tend to run out of food. Famine prone areas of Ethiopia suffered a particularly devastating drought during 2015 resulting in food shortages, increased food prices and decreased income for farmers. At the time of the drought, PSNP had been moving from cash-based payments to electronic payments through intermediary agents. Due to initial problems with the management information system and payment database, households experienced payment delays, reducing the protective effect of the PSNP. Despite this, child nutrition remained stable in households in receipt of the PSNP, suggesting that the cash income prevented child nutrition from worsening in the event of a crisis (Gilligan et al., 2020).

In **Nicaragua**, the 2003 'coffee crisis' occurred when coffee prices fell steeply to one-third of the price they had been at the highest point, causing an income shock for countries across Central America. The loss of income devastated so-called 'coffee communities' which were almost entirely dependent on the cash crop. The RPS programme in Nicaragua was not designed to cope with shocks, and resulted in a negative effect on young children's development outcomes. Gitter et al. (2013) explain how enrolled households received a fixed transfer amount per household, plus additional grants for eligible school age children. Receipt of the education grants was linked to children attending school at least 85% of school days per month. In the context of the massive loss of income, households which had both children under six years and children of school age, had to choose how to distribute limited resources. The authors suggest that resources were prioritised to meet conditions for older children (school uniforms and materials, transport) in order not to lose the education grant. This meant that less money was available to spend on food and healthcare for younger children. The authors suggest this contributed to a decline in child height-for-age among RPS households containing both children under six years and children of school age.

Both Ghana and **South Africa** were affected by inflation which reduced the purchasing power of households enrolled in LEAP or the CSG. In both cases, no improvement was found in children's nutrition status for households who were in receipt of the grant. Palermo et al. (2018) and Zembe-Mkabile et al. (2016) suggest this may have partially resulted from households being unable to purchase the adequate amount of quality foods for children.

4. ROLE OF SOCIAL PROTECTION DESIGN AND IMPLEMENTATION FEATURES

This section describes how the design and implementation features of social protection programmes could affect childhood development outcomes. While all the studies provided a basic level of information about the main programme features, of the 30 studies included in this review, only 17 contained more detailed information about design and implementation features including the intervention type, targeting approach, payments, complementary interventions and supply-side services, and how programmes were adapted in the event of a shock or stresses.

Photo: Roy Rey/Save the Children

4.1 INTERVENTION TYPE

Main findings

- Evidence from across different types of social protection programmes demonstrated the importance of complementary interventions for achieving childhood development outcomes regardless of the intervention type. A key issue is whether participation in complementary programmes should be compulsory, or simply, but actively, encouraged.
- Positive impacts on children's development outcomes were reported from conditional cash transfers using a variety of approaches ranging from participants being required to join in wide-ranging and intensive complementary activities to a less demanding light touch approach.
- Conditional cash transfers varied in how strict they were in penalising non-compliance with conditions. Despite this, positive impacts on children's development outcomes were still reported from across the spectrum of strict to lenient enforcement.
- A 'developmental' approach to enforcing conditions was used as an alternative way to address the root causes of non-compliance rather than financially penalising households.
- The quality and availability of supply-side services are critical for programme participants to be able to meet conditions. In the case where costs of participating in a social protection programme outweigh the benefits, some households may self-select out of conditional cash transfer programmes.

The majority of intervention types included in this review are conditional cash transfers and unconditional cash transfers. There are two public works programmes (Ethiopia PSNP and Rwanda VUP) and both of these have unconditional (direct support) components for households with limited labour capacity.

Conditional cash transfers

Conditional cash transfer programmes require participants to meet certain conditions in order to receive their regular transfer. The conditional cash transfer approach assumes that caregivers may not have enough information or education to make the most appropriate decisions, they may not act in the best interest of their children, or they may favour immediate benefits over longer-term investments in children's health and education. Financial incentives are intended to provide an external motivation for behaviour change.

The most common requirements are for caregivers to take very young children for regular health check-ups, complete childhood vaccination schedules and nutrition supplementation. For older children, caregivers must ensure that they are enrolled in school and attending at least 80% of school days. In some programmes, caregivers are also required to attend information sessions on aspects of childhood development including nutrition, sanitation, childhood illness, stimulation and play.

Studies of the Pantawid and PKH CCTs both report reductions in stunting partly attributed to the combination of cash, incentivised use of healthcare services, and attendance of caregivers at nutrition trainings. Pantawid also saw improvements in school enrolment, and PKH in school attendance (Onishi et al., 2013; Alatas et al., 2011). However the type of conditions and degree of enforcement are highly varied between the two programmes. For example, Pantawid required caregivers to attend a series of 10 Family Development Sessions, while PKH used a lighter touch approach by using medical professionals to communicate information about children's health and nutrition during health checks.

Programme rules also vary in how participants are penalised for non-compliance, ranging from exclusion from the programme (usually preceded by several warnings), to having a portion of the monthly transfer deducted. In some cases, conditions may not be actively enforced at all. Pantawid used a 'hard' approach to enforcing conditions, meaning it was strict in financially penalising participants for non-compliance with conditions. In contrast, PKH used a 'soft' approach to enforce conditions. So while it had rules and penalties set out for non-compliance, it did not strictly enforce these. These two examples demonstrate how the approach to conditions and enforcement can vary in intensity, yet still result in positive outcomes.

In two other examples from Ecuador and Kenya, researchers were able to test the effect of conditions within a social protection programme. Due to a staggered roll out of the Ecuador BDH and late changes to the programme design, programme participants in some locations thought they must comply with conditions in order to receive their cash payment, while others thought the programme was unconditional. Fernald and Hidrobo (2011) reported an improvement in height-for-age only for the sub-group of BDH participants whose mothers thought that receiving programme transfers was conditional on taking their children for health checks.

In contrast the Kenya CT-OVC programme was designed so that compliance with conditions would be required of participants in only three districts and one sub-location of Nairobi. This allowed Ward et al. (2010) to make a crude comparison of areas where conditions had and had not been imposed and they found no significant impact of conditions on health indicators.

Another approach to enforcing conditions is the 'developmental' approach. Rather than punishing programme participants for non-compliance, this approach seeks to address the root causes of non-compliance. In the conditional cash transfer component of the IN-SCT pilot (PSNP) in Ethiopia, social workers made house visits to identify children who were absent from school, and to support their attendance. Social workers also met regularly with school officials to discuss and address teacher absences. These improved linkages between social sectors led to an increase in schools being open an additional half day per week, and an increase in the number of days children were attending school (Gilligan et al., 2020). In this example conditions were framed as 'co-responsibilities' rather than 'conditions'.

The quality and availability of supply-side services is critical for programme participants to be able to meet conditions. In some cases these services may be non-existent, inaccessible or such poor quality that households choose not to use them. Gilligan et al. (2020) found limited improvement on maternal health in the IN-SCT component of the PSNP which they partly attribute to supply-side challenges in maternal support services. Even Pantawid, which was relatively successful in improving children's nutrition and education outcomes, had weak maternal health and nutrition components which impacted negatively on the programme's overall objectives (Orbeta et al., 2021). The issue of supply-side quality and availability as it relates to social protection programmes is explored further in Section 4.5.

Even when supply-side services may be adequate, conditional cash transfers create additional work for health facilities and schools to regularly monitor and report on compliance to the social protection managing agency responsible for calculating and making payments. If there are delays in submission of compliance reports, then payments may be erroneously calculated, and potentially reduce a household's monthly cash transfer amount. This was found to be the case in Pantawid, and resulted in participants losing a portion of their transfer as the compliance records were not up to date (Onishi et al., 2013). Difficulties in timely reporting led to some conditional cash transfer managing agencies choosing not to penalise non-compliance with conditions such as in the case of Indonesia's PKH and some locations of the CT-OVC in Kenya. In Ecuador's BDH, the programme was originally designed as a conditional cash transfer, but was changed to an unconditional cash transfer due to logistical challenges.

The indirect costs of complying with conditions can also create difficulties for programme participants. In Kenya, Ward et al. (2010) suggest that the high costs of meeting programme conditions in remote parts of the country, such as transport costs to reach the health clinics, could lead to families self-selecting out of social protection programmes.

In the case of Jamaica's PATH, participants were unable to pay for medical certificates to prove that non-attendance in school was due to genuine illness (Levy and Ohls, 2007). The authors found that approximately 26% of PATH households had their benefits reduced at some point, most often for non-attendance at school. In the qualitative component of the study, parents said that children had been absent due to illness but that they were unable to meet PATH requirements to provide a costly doctor's certificate as proof of an 'allowable' school absence. They also highlighted that in the case of proven compliance errors, the PATH programme did not make a retroactive payment.

Administrative capacity, supply-side limitations, and increased private costs for programme participants are just several of many factors that are considered when deciding whether programme participants should be required to comply with certain conditions in order to receive their payment. And while the financial cost of monitoring compliance with conditions can be high, they may outweigh the impact that conditions could have on achievement of the programme objectives. In some contexts, conditions may be included in programme design because they are seen to be more politically acceptable with the public, and dilute perceptions of dependence.

The following section provides evidence on the relative successes and failures of unconditional cash transfers and questions whether it is necessary to include the threat of financial penalties to motivate participants to engage with complementary programmes, or whether simply providing the cash and the complementary programme is enough.

Unconditional cash transfers

In contrast to conditional cash transfers, unconditional cash transfers do not make such strong assumptions about households' ability to make appropriate health and education choices for their children. Unconditional cash transfer programmes do not require participants to undertake specific activities in order to receive their regular cash transfer.

This approach had mixed results across different children's development outcome areas. In the outcome area of reductions in stunting, unconditional cash transfers only reported impact in the cases where the mother had relatively high levels of education (South Africa CSG: DDA, SASSA and UNICEF, 2012), in the cases where an information / behaviour change component was included as part of the programme (Bangladesh TMRI: Ahmed, 2019), or where households were extremely food insecure and the additional income increased households' access to food (Ethiopia PSNP: Porter and Goyaly, 2016).

The absence of complementary programmes was highlighted as a shortcoming of the programme reaching its intended objectives on children's nutrition in the CSG South Africa (Zembe-Mkabile, 2016), LEAP Ghana (Palermo et al., 2018) and PSNP Ethiopia (Porter and Goyaly, 2016). In the latter case, the pilot IN-SCT in Ethiopia was introduced to fill the gap in complementary interventions.

In the area of access to education, the studies reported no impacts on school enrolment, largely because enrolment rates were already very high in all the featured countries. Whether a programme is unconditional or conditional did not appear to make a large difference on school attendance as increases in primary school attendance are reported from studies of both types of cash transfers. De Groot et al. (2015) compared results on school attendance for the unconditional cash transfer LEAP in Ghana with conditional cash transfers from Tanzania and Colombia and found results to be in the same range.

Public works programs

Public works programmes are the one intervention type which may have a discernible negative or limited impact on stunting, school enrolment and attendance. The public works component of the PSNP showed no effect on stunting and in their 2016 study, Porter and Goyaly explain how this could be related to the income and substitution effects of public work programmes compared with only the income effects of an unconditional cash transfer. They suggest that the typically hard labour requirements of public works programmes may mean that adults are hungrier and a greater portion of the cash transfer ends up being spent on food for adults, and less is spent on food for young children.

The requirement of parents to engage in works as part of the PSNP could also increase the time that children spend working in housework, family enterprise and childcare, and decrease the time which parents can spend with their children. This can also lead to children missing school due to an increase in their home responsibilities. Children have also been found working on public works projects to help the household meet their requirement for the public works transfers (Gilligan et al., 2020).

Photo: Hariandi Hafid/DEC

4.2 TARGETING APPROACH

Main findings

- Social protection programmes in the review either targeted children as members of household units, or targeted children as individuals under a certain age.
- All social protection programmes in the review include a method of poverty targeting, and in some cases geographic targeting, although it is important to note that this may more reflect a bias in the interests of research funders than the global pattern of policy preferences.
- Five programmes used proxy means test to determine financial eligibility for the programme. However, the strict cut off point meant not all eligible poor households were included. This led to the selection process for the programme to be deemed unfair and unclear.
- In some cases, community representatives/coordinators for community-based targeting approaches had been selected by local officials rather than elected by community members, perpetuating local patronage structures.
- In some cases, community representatives/coordinators for community-based targeting approaches were not aware of all of the households under their geographic area of responsibility.

The main purpose of targeting is to ensure that scarce resources go to those who need them the most. It aims to reduce inclusion errors (giving cash transfers to those who are not poor) and exclusion errors (failing to give a cash transfer to those who are poor).

The majority of the social protection programmes in this review target children as members of household units, or individual children as members of a 'vulnerable group'. The conditional cash transfers focus primarily on children, and occasionally on pregnant women, as members of household units. While the unconditional cash transfers are generally targeted at individual children under a certain age. The public works programmes in this review focus on individuals that can supply labour, with the expectation that the income will support the household. All of these social protection programmes also include a method of poverty targeting, and some include geographic targeting. Due to the design and objectives of the social protection programmes and the studies, none specifically compared variation in childhood development outcomes by targeting approach. However some of the individual studies highlighted the benefits and challenges of different targeting approaches, and what this means for the inclusion or exclusion of children and their households from the social protection programmes.

Proxy means test

The majority of the conditional cash transfers in this review follow a similar approach to poverty assessment. Proxy means tests are used to measure poverty based on observable measures of poverty such as assets and location, and vulnerability, such as household characteristics. Households are assigned to a poverty index or database which assesses their eligibility for the programme based on a statistical equation that estimates the probability that a household is poor. Households below a certain cut off point on the poverty index score (or in some cases in the bottom quintile of the index) are then included in the programme. The BDH in Ecuador, PKH in Indonesia, PATH in Jamaica and Pantawid in the Philippines all use slight variations of this approach. One unconditional cash transfer - LEAP in Ghana - also uses proxy means tests.

One of the perceived advantages of proxy means testing is to reduce inclusion and exclusion errors. However, Alatas et al. (2010) describe how in the PKH not all eligible poor households had been included due to being above the established cut-off point of the proxy means test. In the qualitative component of their impact evaluation of PATH, Levy and Ohls (2007) found recipients were questioning the process. Recipients felt that the information used to determine selection for the programme was inadequate, and spoke of knowing individuals who are in need but whose applications were rejected, and some better off households who should have not been in the programme. In their impact evaluation of LEAP, Palermo et al. (2018) found that among recipients of LEAP, 79% said the selection process was clear and 75% said the process for being included in the programme was fair. In contrast, 29% of respondents in the comparison group (who did not receive LEAP) thought the process was clear, and only 24% thought it was fair. While proxy means tests can reassure programme administrators and funders that funds are reaching the 'right' people, it can potentially lead to social division.

Another challenge of the proxy means test approach is that the poverty assessment criteria needs regular updating and households have to be re-surveyed which is time consuming and costly. In Ecuador in 2009, the poverty index (which establishes eligibility for the BDH) was revised and led to 200,000 families suddenly losing the transfer they had been receiving for seven years (Buser et al., 2016).

Community-based targeting

The Kenya CT-OVC and the direct support components of the PSNP in Ethiopia and VUP in Rwanda, used community-based targeting to determine eligibility for the programmes. In this method, community groups or in some cases a community representative, are responsible for identifying recipients for the cash transfer. In their impact evaluation of the CT-OVC, Ward et al. (2010) found that supposedly elected community representatives were sometimes selected by local officials, who had the power to choose who would be part of the programme. Community based targeting can perpetuate local patronage structures at the detriment to the poorest households. The authors also found indications that the community representatives were not aware of all the households containing orphans and vulnerable children in the communities they were responsible for.

Geographic targeting

The TMRI in Bangladesh, PSNP, CT-OVC and Nicaragua's RPS also used geographic targeting as the first step, focusing on the most food insecure regions (in the case of TMRI, PSNP and CT-OVC) or the poorest regions (RPS). In the case of RPS, grants were made available to all households within the poorest regions. However, programme administrators began to make ad hoc decisions to exclude so-called 'less-deserving' households if for example, 'they owned a vehicle, or consisted only of able-bodied single men or women' (Moore, 2009, page 7).

Categorical targeting and unverified means test

The CSG in South Africa originally used a combination of categorical targeting, providing grants to children from birth to their 18th birthday, and poverty assessment. Eligibility is determined via a simple unverified means test. The CSG had originally required applicants to provide a number of documents to verify their eligibility for the grant, including marriage certificate, proof of personal income, children's birth certificate and proof of residency. The poorest households were often unable to afford the cost for obtaining the documents. After the verification rules were relaxed, the programme's uptake rate increased by 500% (Samson et al., 2006).

4.3 PAYMENTS

Main findings

- The social protection programmes included in this review ranged from a simple fixed amount per individual or household, to more complex designs providing a bundle of separate grants for children of different ages, plus a general household grant, and a bonus for enrolling school-age children on time.
- The value of grants varied from 10% to 25% of the average consumption level of households.
- In some cases, high levels of inflation and rising food prices affected the real value of the cash transfer.
- Regular and reliable payment schedules enabled participants to plan expenditures. In the case of delayed payments, some recipients resorted to taking credit to cover their expenses.
- Conditional cash transfers experienced delays in reporting of compliance and in updating databases. This led to fluctuations in average monthly payment amounts, making it difficult for recipients to plan spending and borrowing.
- Seven of the 11 social protection programmes included in this review provide a transfer for 'pregnant and lactating women', so that children are covered by social protection from conception and covering the critical first 1,000 days of life.
- A key challenge highlighted in several studies was the distance of paypoints for some recipients, and the time and financial costs incurred to reach them.
- Despite the drawbacks of cash payments, gatherings of recipients on paydays were used as an opportunity to distribute programme information.

A key area for social protection programmes is the design of payment arrangements which ensure that recipients receive adequate transfers, that are timely and reliable, and will be received by the person who uses it most effectively in line with the programme objectives. Table 16 provides an overview of the monthly amounts and calculation basis for the social protection programmes featured in this review, and illustrates the varied approaches used.

Table 16: Calculation basis and transfer amounts in the featured social protection programmes

BANGLADESH	**TMRI**	Fixed amount per household	US$19 (2012)	25% of average monthly consumption of poor rural HH
ECUADOR	**BDH**	Fixed amount per household	US$15 (2005)	11% of the average monthly consumption of enrolled households
ETHIOPIA	**PSNP**	Fixed amount per household	US$11 (2009)	25% of per capita income.
GHANA	**LEAP**	Calculated on the number of eligible HH members	Between US$11 – 21 depending on the number of eligible household members (2010)	Maximum amount is approx. 12.5% of average household consumption.

	Programme	Calculation basis	Monthly amount (USD) at the time of the studies	Proportion of HH income, consumption or expenditure[26]
INDONESIA	**PKH**	Calculated on the number of eligible HH members	Between US$5 - 18 per household (2007)	Equivalent to 15-20% of household expenditure.
JAMAICA	**PATH**	Fixed amount per eligible HH member	US$6.50 per eligible individual (2000) E.g. a household with two children eligible for the health grant, two children eligible for the education grant, and one eligible adult would receive US$32.50 (five x US$6.50) per month	Approx. 4% of minimum wage
KENYA	**CT-OVC**	Fixed amount per HH	US$20 (2010)	Approx. 22% of average HH consumption
NICARAGUA	**RPS / Atención a Crisis**	Fixed amount per HH and additional grants if the HH has eligible school age children	US$15 per HH US$7 per HH if the HH has a child between 7-13 years who has not completed 4th Grade US$21 one off payment per child for enrolling children at the start of the school year (2004)	Not given
PHILIPPINES	**Pantawid**	Fixed amount per HH and additional grants for school age children	US$11 health grant per HH US$7 for each child in elementary US$11 for each child in high school (2012)	Average amount from the grant: 23% of average income of beneficiary HH
RWANDA	**VUP/SM**	Fixed amount per HH or per day	US$35 per HH for direct support US$3 per day for public works (2011)	Not given
SOUTH AFRICA	**CSG**	Fixed amount per eligible child	US$30 (2008)	Not given

26 Information in this table is taken from the studies included in this review, which have been undertaken at different time periods and use different measures to calculate the proportion of the cash transfer amount per household or individual. While they are useful for illustrating the difference in transfer amounts, they are not directly comparable

Transfer amount and adequacy

Across the social protection programmes included in this review, the transfer amount and basis for calculating the amount was varied. This ranged from the simple approach used for the South Africa CSG which provides a fixed amount per month per child, to the Kenya CT-OVC which provides a fixed amount per household regardless of the number of orphans or individuals in it, and LEAP in Ghana which provides a household transfer calculated on the number of eligible household members (up to a maximum of four per household).

Transfer amounts in conditional cash transfers are more complicated and generally tied to the programme conditions. In the Philippines, Pantawid provides an 'education grant' for up to three children per household with differing amounts for children in high school and for children in primary school, as well as a 'health grant' per household. If participants fail to meet a condition tied to a specific grant, then they lose that portion of the grant.

The adequacy of the grants also varied. The lower amounts were 10% of the average monthly baseline consumption of enrolled households in the BDH in Ecuador, and 12.5% in LEAP Ghana, compared to 25% in the TMRI in Bangladesh. Palermo et al. (2018) propose that the transfer amount was a key determinant of the marginal effects of LEAP on child nutrition outcomes, highlighting its relatively low amount compared with other cash transfer programmes in sub-Saharan Africa. Fernald et al. (2011) also call attention to the low amount of the BDH in Ecuador (10%) compared with other similar conditional cash transfers in Latin America such as Mexico's Oportunidades (22%).

In the Philippines, Onishi et al. (2013) highlight a wide gap between the amounts programme participants are eligible for (23% of average income of beneficiary households) compared with the amounts they actually received. Non-compliance with conditions was only one factor that led to a reduction in payment amounts. Schools and health facilities were not always reporting on compliance verification, and updates to the programme databases to link compliance to payments was irregular.

Palermo et al. (2018) call attention to the high levels of inflation which occurred in Ghana over the study period (2015-2017) and led to an approximately 20% loss in real value of the transfer. The transfer amount was not periodically reviewed and adjusted during the study period. In South Africa, Zembe-Mkabile et al. (2016) similarly suggest that inflation may have been one of several reasons why there was a lack of association between the CSG and reductions in stunting. The study was focused on locations in South Africa where almost all of the households were receiving CSG or other welfare grants and were totally reliant on these grants for their basic food needs. In the context of high unemployment and rising food prices, the cash transfer was unable to meet their needs.

In Nicaragua, RPS provided a fixed transfer size per household, and a fixed size 'education grant' if households have a child between 7-13 years, regardless of the numbers of children. An additional $20 per year per child was provided for enrolling in school at the start of the year, but this was not enough to compensate households for the full opportunity cost of sending children to school (Gitter et al., 2013). Payments were focused on household level and intentionally kept low to avoid incentivising fertility.

Determining the appropriate cash transfer amount requires knowledge of the socio-economic status of programme participants and their existing income strategies, the economic position and administrative capacity of the country. Smaller wide-reaching transfers can make a material contribution to improving living standards, but may not be enough to bring households up to the poverty line. While larger targeted transfers with strict conditions may make more impact on health and education targets, they could be challenging to implement in countries with low administrative capacity.

Regularity, reliability and timing of payments

The regularity and reliability of payments is a key element of the transfers. The majority of the programmes made payments on a monthly or bi-monthly basis. In the LEAP programme, Palermo et al. (2018) found the bi-monthly payments to be very regular with high coverage of 98% of beneficiaries per payment. The regularity and reliability of the payments enabled participants to plan their expenditures and borrowing patterns around the payment schedule. In South Africa, the long-term nature and reliability of the grants emerged as a key aspect of the grants' potential to provide psychological support (Plagerson et al., 2011).

In contrast, Gilligan et al. (2020) found payments to be delayed for the PSNP, even during the peak food shortage period, with some recipients reporting taking credit to cover their expenses during the delay. Levy and Ohls (2007) found PATH payments were sometimes delayed up to one week past the announced date which meant money was not available for lunch or transport for school aged children, who would have to miss out on school. Conditional cash transfers are susceptible to payment delays if programme officials are required to input compliance verification data (which itself is often delayed) before the next payments are initiated. This was also the case in the Philippines Pantawid and led to fluctuations in the average monthly payment amounts, making it difficult for recipients to plan spending and borrowing.

In the PKH, Alatas et al. (2011) found a mismatch between the timing of the payment delivery and the programme objectives. One of the main objectives of the programme was to promote investments in education, however the quarterly payments did not coincide with timing of when parents were required to pay school registration fees. The authors recommend that disbursements should be timed to arrive shortly before school registration fees are due.

In terms of when in a child's life they should enter a social protection programme, 7 out of the 11 social protection programmes included in this review provide some kind of transfer for 'pregnant and lactating women', so that children are covered by social protection from conception and covering the critical first 1,000 days of life. For three of the conditional cash transfers (Indonesia PKH, Jamaica PATH and Philippines Pantawid), pregnant and lactating women were classified as eligible household members, with payment conditional on attending prenatal and antenatal health checks. The importance of the first 1,000 days is highlighted by Orbeta et al. (2021) study of Pantawid in the Philippines which found that 43% of the control group (children who joined the programme at two years or older) were stunted compared with 40% of the treatment group (children who had been part of the programme for the first 1,000 days of life).

In Ghana, the LEAP programme initially focused on poor households with orphans and vulnerable children, elderly and disabled. This resulted in the programme missing out households with children under five years old who needed support, particularly the first 1,000 days. Recognising the shortcomings of the main LEAP programme, 'LEAP 1000' pilot was launched targeting households with pregnant women and infants under 12 months of age. The pilot has since been integrated into the main programme (Palermo, 2018).

In the public works programmes in Ethiopia and Rwanda, pregnant and lactating women fall under the category of 'labour-constrained' households and are exempt from the public works component. Instead, they will receive a temporary unconditional cash transfer up until the child reaches six months old.

While South Africa does not provide a separate grant for pregnant and lactating women, the Child Support Grant is available from the date of the child's birth. The South Africa Social Security Agency (SASSA) also provides access to Social Relief grants which pregnant women could apply for in the absence of a main income earner in the household.

The regularity and reliability of payments are critical for the effectiveness of social protection programmes. If recipients know when to expect payments, they will be better able to manage their finances and not resort to informal credit or selling assets. Only one of the studies included in this review mentioned timing of the payment delivery (e.g. monthly, bi-monthly, quarterly or a one-off payment) as an important factor for supporting children's school attendance (Alatas et al., 2011).

The studies in this review also highlight an increase in the inclusion of pregnant and lactating mothers in the eligibility criteria of both conditional and unconditional cash transfers – Ghana's LEAP and the introduction of complementary programmes focused on maternal health and nutrition in the PSNP. This likely reflects the growing understanding of the impact of maternal health and nutrition on children's development, and the potential for social protection programmes to contribute to improvements in maternal health and nutrition.

Delivery mode and payment recipient

The delivery of social protection transfers is largely dictated by the availability of payment infrastructure including banks, post office networks, digital payments and mobile networks, and the relative sophistication of the programme's management information system and administrative capacity. Options for programme participants to withdraw their payments include ATMs and EFTPOS machines in shops, which give participants more flexibility to choose when they collect their cash. Withdrawal through post offices and temporary paypoints where cash is distributed usually require recipients to collect their cash on a specified day.

A combination of these methods can be used within the same programme in order to meet the needs of different geographic locations with varied payment infrastructure. Onishi et al. (2013) report that in Pantawid, 43% of recipients withdrew their grants from ATM machines, 30% withdrew from an EFTPOS machine in a shop, and 27% withdrew over the counter at bank branches.

The majority of the studies included in this review provide little detail on how different payment delivery modes may affect the success of a programme. However, a key area highlighted in several was about the distance of the paypoints, and the consequent time and financial costs to reach them. Ward et al. (2020) found recipients of the CT-OVC in remote Garissa County, Kenya, spent an average of 19.2 hours making a return trip, and 83% had to spend at least one night out of home. On average they spent about 30% of their transfer amount on collecting it.

During the 2015-2017 study period of their impact evaluation of the LEAP programme in Ghana, Palermo et al. (2018) describe how the programme transitioned from cash payments at Post Offices to e-payments. In the new system, recipients received biometric cards and payment service providers set up temporary paypoints in communities with EFTPOS machines and fingerprint scanners. While the system did increase security and accountability of payments, it made little difference to the travel times and costs for programme participants. About 20% of recipients travelled up to one hour, 18% up to two hours and 12% over two hours to reach the temporary paypoints. Twenty-three per cent of households also incurred financial costs to reach the paypoints.

In Jamaica, where PATH payments were delivered via cheque through post offices, Levy and Ohls (2007) found that in the case of delayed payments, recipients had to make numerous trips to the post office to enquire about their payment, incurring time and travel costs.

Despite the drawbacks of cash payments, gatherings of recipients on paydays to collect their payment was used as an opportunity to distribute information. RPS in Nicaragua used paydays to distribute information to recipients about the importance of varied diets, health and education (Gitter et al., 2013). CT-OVC staff in Kenya highlighted the missed opportunities that payments at post offices could have provided for setting up temporary clinics and HIV/AIDS testing (Ward et al., 2010).

The majority of the conditional cash transfers included in this review pay the grants directly to mothers (TMRI, BDH, RPS and Pantawid) on the premise that improving women's control of resources translates into increased investments in children. PKH and PATH provide grants to the main caregiver, which in most cases is the mother. These CCTs are modelled on Mexico's Oportunidades programme where the effect of giving transfers to mothers has been widely studied and shown to increase intra-household bargaining power and expenditures on children (Parker and Petra, 2017).

This effect is not explicitly explored by the studies in this review possibly due to the small size of comparator groups of caregivers (e.g. fathers, grandparents). However, in their study of the PKH, Alatas et al. (2011) analyse differences in impacts of female-headed households compared with male-headed households on maternal care. They find that women in female-headed households in receipt of the PKH are more likely to attend pre-natal visits (21% increase) and have assisted delivery (25% increase) compared with women in male-headed households (9% increase on pre-natal visit and no increase in assisted delivery). While there are undoubtedly other factors at play, these figures suggest that the cash transfers have some way to go in improving women's intra-household bargaining power in this example.

4.4 COMPLEMENTARY INTERVENTIONS AND SUPPLY-SIDE SERVICES

Main findings

- Including complementary interventions in social protection design is important for achievement of childhood development outcomes, regardless of the type of social protection programme.
- Behavioural interventions ranged from 12 weekly sessions of 90 minutes conducted in the families' homes by community coaches, to lighter touch approaches which relied on medical professionals to communicate information on child nutrition and care during compulsory medical checks.
- The success of social protection programmes supporting childhood development outcomes depends in large part on there being accessible and adequate supply side services.
- Two programmes provided free health insurance to social protection programme beneficiaries, but its potential impacts were undermined by the accessibility and poor quality of health services.
- One programme provided bonuses to teachers and private health service providers to compensate them for increased workload created by the social protection programme.

There is increasing evidence that providing cash alone is not sufficient to reduce the interrelated risks and vulnerabilities that social protection recipients face, and additional support is needed (Watson and Palermo, 2016). Therefore, social protection programmes are increasingly coordinated with complementary interventions or intentionally linked to supply side services which aim to help the programme achieve its objectives. Complementary interventions can be provided as integral elements to a social protection programme, such as additional in-kind transfers, information or behaviour change communication, or they may intentionally link beneficiaries to supply side services provided by other sectors (Roelen et al., 2017).

Complementary interventions

Complementary interventions often involve social and behaviour change communication activities which aim to build parents and caregivers' knowledge and inform life choices related to children's nutrition, healthcare and education, and parenting practices.

About half of the programmes featured in this review included behavioural interventions such as information sessions or parenting programmes to increase knowledge on parenting practices. Several of the studies highlighted greater impacts of social protection programmes on child development outcomes for children whose mothers have higher levels of education (Zembe-Mkabile, 2016; Paxson and Schady, 2010; Guyatt, 2020; Alatas, 2011). Behavioural interventions and information sessions can be seen as a means to close the knowledge gap for households with lower education levels.

The content of the behavioural interventions varied according to the programme objectives. The 10-week Family Development Sessions of Pantawid were the most wide-ranging and intensive: 'Nutrition was a major topic covered in these sessions; parents were actively encouraged to increase children's consumption of nutrient-rich foods, particularly dairy, and deemphasise the consumption of packaged foods. In addition, these sessions provided information on good parenting practices, such as exclusive breastfeeding and prompt treatment seeking, as well as imparting information on home remedies for basic illnesses such as diarrhoea' (Kandpal et al., 2016).

In Bangladesh the behavioural change component of TMRI was focused more on nutrition and healthcare for children and pregnant women. It consisted of six weekly sessions: '(1) the importance of nutrition and diet diversity for health; (2) how hand washing and hygiene improve health; (3) diet diversity and micronutrients; (4) breastfeeding; (5) complementary foods for children 6-24 months; and (6) maternal nutrition' (Ahmed et al., 2019). Only programme participants attended the first session, while other household members were invited to join the remaining sessions to create support for changes at household level. A trained community nutrition worker also made home visits twice a month to follow up on topics and discuss specific concerns.

In Rwanda, the Sugira Muryango behavioural intervention of VUP comprised 12 approximately 90-minute sessions delivered in the families' homes by trained community-based coaches. The programme focused on five areas: '1) education on children's development, nutrition, health, and hygiene promotion; 2) coaching caregivers in active stimulation (play and communication) and responsive parenting; 3) reducing family violence via father engagement, improved conflict resolution and parental emotion regulation skills; 4) strengthening problem-solving skills and social support through access to available informal and formal resources; and 5) building skills in positive parenting and coping skills to promote healthy family functioning' (Betancourt et al., 2020).

Both the Bangladesh TMRI and Rwanda's Sugira Muryango reported positive effects of behavioural interventions on parental behaviours and childhood development outcomes. However, both involved intensive support from social workers or community coaches, including home visits, which are intensive and time-consuming for community workers and programme participants and may be challenging to replicate at scale.
Other programmes took a lighter touch approach to behaviour interventions and information sessions. Ethiopia's IN-SCT required participants to attend monthly sessions, while Kenya's CT-OVC required caregivers to attend only an annual information session. The RPS in Nicaragua did not have a specific nutrition information component but relied on repeated information and communications during programme enrolment and paydays about the importance of varied diets, health and education. In some areas PKH relied on medical professionals communicating information on child nutrition and care during compulsory monthly check-ups, rather than structured information sessions (Alatas et al., 2011).

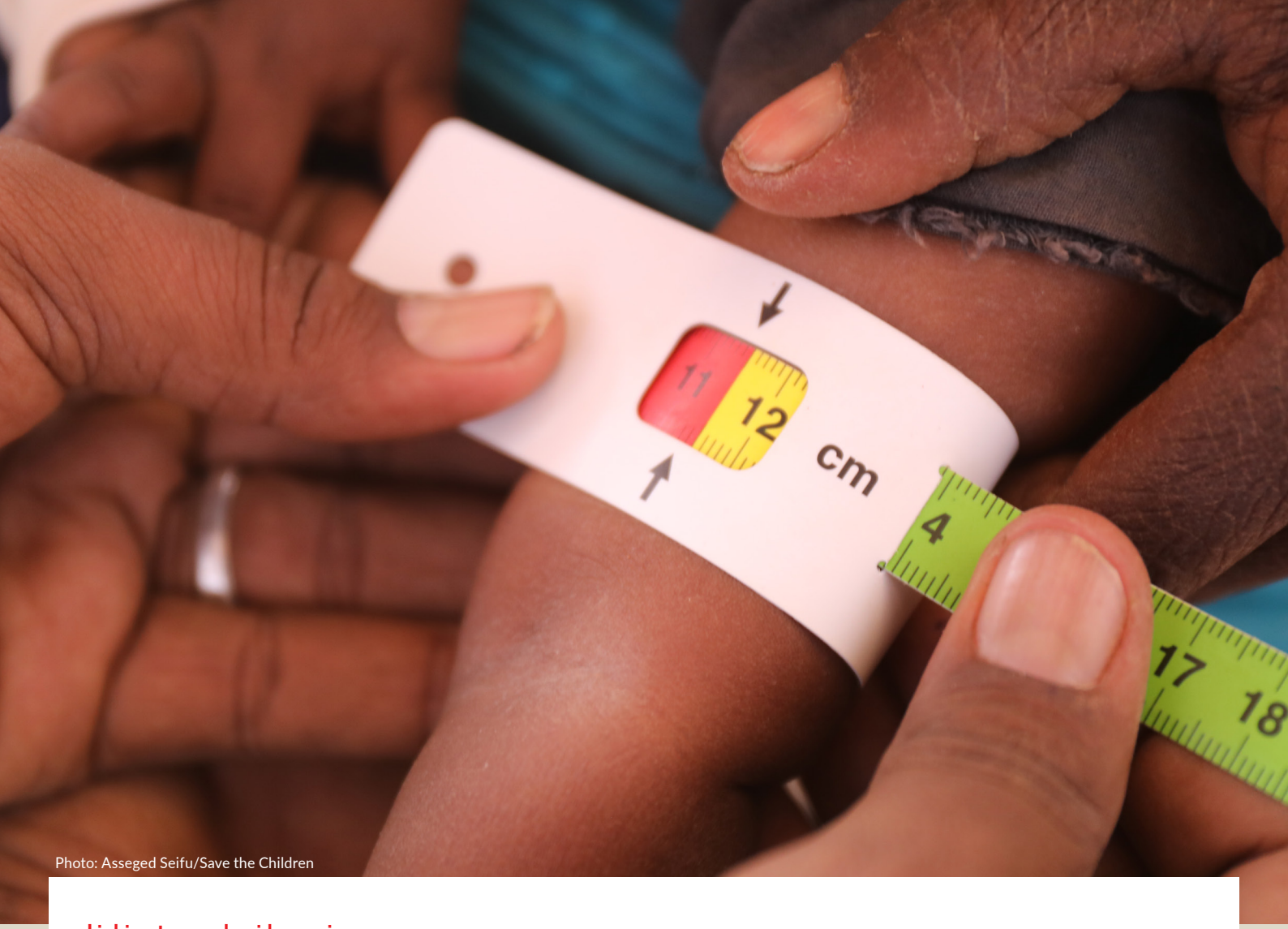


Photo: Asseged Seifu/Save the Children

Linking to supply-side services

All of the conditional cash transfers featured in this review explicitly linked programme participants with supply-side services through the requirement for them to meet certain conditions. This included linking to healthcare services through requiring children to attend regular growth monitoring and preventative health screenings, and receive immunisations, supplements and deworming medication. Programme participants were linked to schools through the requirement for children to be enrolled in school and attending between 80 to 85% of school days. In the case of Pantawid, enrolment and 85% attendance in day-care was also a requirement for children aged three to five years.

Ghana's LEAP programme and the Philippines' Pantawid also automatically enrol programme participants in free health insurance which is intended to improve participants' uptake of health services by providing them with free out-patient and in-patient services, dental services, and maternal health care.

However, the success of social protection programmes in supporting childhood development outcomes is highly dependent on there being accessible and adequate supply-side services. Failure to improve health, education and other services can undermine programme objectives. In the case of the Philippines' Pantawid, Onishi et al. (2013) report an overall positive effect on childhood development outcomes but found considerable variation between provinces. This was related to the varied quality and availability of government health services, and lack of standardisation of the family development sessions. In the latter case, community workers were provided with a thematic manual but no standardised guidance on methods of instruction.

In Ghana, LEAP participants are automatically provided with free health insurance to programme participants. However, the potential of the free health insurance was undermined by the accessibility and quality of services. Palermo et al. (2018) report that although approximately half of the impact evaluation respondents could reach the nearest health facility within 30 minutes, the rest had more difficulty reaching, and 11% had to travel between 1.5 and 4.5 hours. Even though the cost of services was in theory free, clinics lacked qualified personnel, and respondents faced additional costs for medicines and medical supplies.

In Indonesia, locations where supply-side services were not deemed to be accessible or adequate were not included in the programme. During the PKH pilot phase, sub-districts were only included if they were considered to be 'supply-side ready' (Alatas et al., 2011). Although this was probably intentional in order to test the pilot model, it meant that locations where services were deemed to be inadequate were excluded, to the detriment of the people who needed the programme the most.

Linkages with non-government service providers faced similar challenges. The impact evaluation of the CT-OVC in Kenya found that supply-side services were offered by non-governmental organisations in a haphazard way. Ward et al. (2010) found that in some areas, non-governmental organisations were working with orphans and vulnerable children, but there was rarely significant coordination with the CT-OVC programme objectives. CT-OVC staff highlighted several examples of missed opportunities for providing family planning education, information on parenting for grandparent caregivers, setting up temporary clinics outside post offices on paydays and HIV/AIDS testing.

Photo: LJ Pasion/Save the Children

4.5 SOCIAL PROTECTION SYSTEMS RESPONDING AND ADAPTING IN THE EVENT OF A SHOCK

Main findings

- Countries faced a dilemma between making use of 1) existing social protection registries which did not cover the entire population, but could have provided a timely transfer of cash after the shock, and 2) creating a new social registry or update the existing registry which would have ensured that a greater proportion of all shock-affected households were reached, but would have resulted in significant delays to the response.
- Existing social protection management information and payment systems were used by humanitarian agencies to deliver top up grants to affected households.
- Special protocols were developed to allow social protection programmes to be flexible in the event of a shock, for example by temporarily suspending conditions and collecting payments in their temporary place of residence.
- Crisis response was considerably more effective when there were already strong links between the ministries responsible for social protection and those for disaster risk management.

Social protection programmes are increasingly viewed as playing an important role in supporting children during large-scale emergencies or crises. This section provides evidence from six of the studies on how social protection programmes were adapted to respond to covariate shocks or increasing stresses.

Three of these studies included evidence on how social protection programmes were adapted during times of economic shock. In Nicaragua, thousands of so-called 'coffee communities' suffered a sudden and devastating loss of income in 2003 when coffee prices fell steeply. The RPS programme was a conditional cash transfer and had not been designed to cope with shocks, which contributed to a negative effect on children's nutrition. Gitter et al. (2013) explain how enrolled households received a fixed transfer amount per household, plus additional grants for eligible school age children. Receipt of the education grants was linked to children attending school at least 85% of school days per month. In the context of the massive loss in income, households which had both children under six years and children of school age, had to choose how to distribute limited resources. The authors suggest that resources were prioritised to meet conditions for older children (school uniforms and materials, transport) in order not to lose the education grant. This meant that less money was available to spend on younger children's diets and healthcare. As a consequence, the authors found a decline in child height-for-age among RPS households containing both children under six years and children of school age. Gitter et al. (2013) suggest that RPS should have provided higher payments in times of shock, temporarily relaxed requirements to meet conditions and provided transfers relative to the size of the family, tying payments to the family structure at the time of entering the programme, to avoid pro-fertility effects.

Ghana and South Africa both suffered high levels of inflation during the study periods which led to a reduction in purchasing power of LEAP and the CSG. In both cases the transfer amount was not reviewed or adjusted against inflation, which partly contributed to the programme having no impact on children's nutrition status.

Ethiopia is particularly susceptible to drought, with one occurring every three to five years. The PSNP aims to address the needs of chronically insecure households in famine prone areas of Ethiopia. During a particularly devastating drought in 2015 many households adapted by reducing dietary quality. Gilligan et al. (2020) found that 72% of households in the SNNP and Oromia regions were consuming less preferred foods, 33% reported consuming wild foods, and 72% reported consuming their seed stock. The authors found that there was no change in child nutrition outcomes in households in receipt of the PSNP, signifying that whilst there was no improvement in child nutrition from the baseline, in the event of a shock, child nutrition had not become worse. The PSNP's specific focus on supporting households during the 'lean season', combined with its Risk Financing Mechanism enables the programme to scale up in times of unpredicted shocks (World Bank Group, 2013). Furthermore, the programme involves a protective element for households by focusing the public works projects on soil and water conservation projects to increase resilience to climate-related shocks.

The Philippines is currently ranked as the country with the eighth highest level of disaster risk in the world (Aleksandrova et al., 2021). As such, it has developed an advanced disaster risk management framework with strong links to social protection. The lead agency for social protection in the Philippines – the Department of Social Welfare and Development (DSWD) – is embedded into the national disaster risk management framework and is the lead agency for disaster response.

Super Typhoon Haiyan was one of the strongest-ever recorded storms to make landfall. It hit the Philippines in November 2013, displacing 4.1 million people and destroying homes and livelihoods. At the time of Typhoon Haiyan, the Philippine's main social protection programme, Pantawid, had been operational for five years, and reached over 4.4 million households.

After Haiyan struck, there were a number of design adjustments which enabled the Pantawid to be delivered during the early recovery and recovery phases of the disaster. The requirement to meet programme conditions were suspended for a limited period of time. Aware that many Pantawid participants were not residing in their usual localities, DSWD also made arrangements for participants to claim their benefits in the locality where they were residing. They also used the Pantawid database to identify participants in the case that they had lost their identification documents. The World Food Program and UNICEF also used the Pantawid system to deliver additional grants to affected households. However, households that were not part of the Pantawid programme could not be reached and missed out on cash grants (Bowen, 2015).

In contrast, when Ecuador was hit by a 7.8 magnitude earthquake in April 2016, the country's national emergency response plan was still being developed. More than one million people were affected and homes and livelihoods destroyed, however coordination was initially poor, and in the beginning line ministries developed their own tools, processes and systems.

Rather than use the social registry developed for the main social protection programme (BDH), the government decided to create a new single register. The social registry provides a list of households ranked according to their well-being, and while it would not have included all households in the area affected by the earthquake, it was the most comprehensive mechanism at the time. The creation of a new single register was a lengthy process which delayed the distribution of cash by one month after the disaster occurred.

However, the emergency response did leverage the existing BDH banking system used for making payments. The existing payment system already had reasonably wide coverage, was relatively simple and easy to scale up. Once recipients had been identified by the new single register, and the management information system adapted, cash could be distributed reasonably quickly (Beazley, 2017).

4.6 GENDER ANALYSIS

While gender analysis was not a specific objective of the review, a number of the single country studies reported differences in childhood development outcomes by gender of the child and/or gender of the household head, as well as examples of gender-responsive design and implementation. This section highlights the key evidence from the studies.

Evidence from the CT-OVC conditional cash transfer in Kenya found that being male was an important risk factor for stunting (Ward et al., 2010). In a later study of the CT-OVC, Guyatt et al. (2020) found a higher percentage of boys (26%) were stunted compared with girls (20%). The authors highlight that the findings are in line with other studies of stunting in sub-Saharan Africa which finds that prevalence of stunting in children under five is consistently higher among boys than girls, and suggest that boys may be more vulnerable to health inequities than their female counterparts, particularly among the poorest groups.

Paxson and Schady (2010) find that the BDH programme has a consistently larger effect on outcomes for girls than boys, both for the poorest children and for relatively better off children. They suggest this could be because parents use cash transfers in a way that favours children of one gender over the other. They highlight the common practice in social protection programmes of payments being made to mothers, which has been shown to increase intra-household bargaining power and expenditures on children, particularly girls (Parker and Petra, 2017).

The gender of the household head may also make a difference to childhood development outcomes. Alatas et al. (2011) suggest that female-headed households are more likely to lack a second wage-earner and therefore removing children from work so that they can attend school would have a higher cost than for male-headed households. They recommend that household composition should also be considered when designing social protection programmes in order to avoid negative coping strategies.

5. STUDY LIMITATIONS

Although this study provides valuable insights into the role of social protection in supporting children's development, it is important to understand the implications of a number of limitations to its design and implementation for how the findings presented should be interpreted and applied in Save the Children's policy and programmatic engagements in the Pacific and beyond.

Firstly, the number of country-specific studies included in the review had to be capped due to time and resource constraints. While this was necessary to ensure the review remained focused and manageable, the absence of relevant studies addressing multiple child development indicators resulted in rather thin coverage of each of the child outcome areas in which Save the Children had a strategic interest, namely stunting, access to education, social, emotional and cognitive development and covariate shocks. Basing the literature search on existing systematic reviews and using assessment criteria to select the 30 studies aimed to effectively capture relevant themes, trends and debates. However, variations in the study designs, methodology and measurements between the single country studies, the differing social protection programme design and features, and the highly varied national contexts in which the studies were conducted, nevertheless makes it challenging to draw definitive conclusions.

Secondly, the evidence base was heavily biased towards studies of social protection programmes supporting children's health and education outcomes, which made it possible to draw on evidence from 10 social protection programmes providing a diversity of social protection intervention types from varied contexts. In contrast, the evidence on social protection supporting children's social, emotional and cognitive development, and in reducing violent discipline against children in the home came from just five social protection programmes, making the findings less generalisable.

Thirdly, the evidence on social protection supporting childhood development outcomes during times of covariate shock was also extremely limited. There are considerable methodological, logistical and ethical challenges in undertaking studies which measure impact during crises (Aurino and Giunti, 2022). These may affect the validity and reliability of results, and mean that studies are less likely to meet the inclusion criteria for systematic reviews.

Finally, the initial literature search was conducted in July 2022 and may have missed out key studies published after this date, including for example, UNICEF's recently published book on Social Protection in East Asia and Pacific which aims to strengthen the amount of available evidence on social protection in the region (Rossi A and Villanueva, Eds, 2023).

Photo: Elvis Gonzalez/Save the Children

6. SUMMARY OF FINDINGS AND CONCLUSIONS

The overall objective of this review was to research and analyse the global evidence on social protection supporting childhood development outcomes in the areas of reductions in stunting; increased access to primary school education; improved cognitive, social and emotional development; and reductions in violent discipline against children in the home. It further considered how the features of social protection design and implementation affected the pathways to change for childhood development outcomes, and the extent that social protection supported children during times of covariate shock.

6.1 EVIDENCE OF SOCIAL PROTECTION PROGRAMMES SUPPORTING CHILD DEVELOPMENT OUTCOMES

The available evidence on social protection supporting childhood development outcomes is heavily skewed towards reductions in stunting and access to primary school education. The large number of studies and reasonably comparable measures for these two areas means that the findings are relatively more reliable. In contrast, the evidence on social protection supporting improved cognitive, social and emotional development, and reductions in violent discipline against children in the home is extremely limited. Nevertheless, it provides an initial understanding of these topics and provides a foundation for further research.

Reductions in stunting

One of the strongest findings from the review was the association between parents or caregivers' level of knowledge and reductions in stunting. Reductions in stunting were only found in social protection programmes where either the mother had a relatively higher level of education, or where the programme included complementary information sessions or behavioural change interventions. With better education and information, parents and caregivers are able to make positive choices in relation to children's nutrition, whilst the increased income provided households with the means to purchase increased quantities of better-quality food. In contrast, social protection programmes which only provided cash or were accompanied by inadequate information sessions, reported marginal or no effect on reductions in stunting. The exception was the case where households were extremely food insecure and there was large potential for a 'catch-up' response.

Reductions in stunting were also found in households where children had regularly attended preventative medical check-ups, completed vaccination programmes, and sought treatment for children's illnesses. In the case of the medical check-ups and vaccinations, these were specific requirements of conditional cash transfer programmes, suggesting conditions could contribute to positive outcomes on children's nutrition status. Increased treatment seeking for children's illnesses can result from parents or caregivers having improved knowledge of children's health, which may have come about through education and information sessions.

Photo: Sarah Waiswa /Save the Children

Increased access to primary education

The strongest finding from the review was that the increased income from social protection programmes supported access to primary school education across a number of contexts and intervention types regardless of whether there were complementary information sessions or behavioural change interventions. In the majority of countries, primary school enrolment levels were already high, suggesting that in general (not considering barriers related to gender inequality, social and cultural norms) parents or caregivers needed less convincing about the benefits of education. The challenge for accessing social protection was therefore financial and cash transfers enabled households to pay for 'unofficial fees', transportation and lunch. One social protection programme introduced different payment amounts according to the age of the school children, reflecting the higher costs associated with secondary school. Cash transfers may also have reduced the reliance on children as income-earners, freeing them up to attend school, however this was not specifically explored as part of this review.

In conditional cash transfers, the threat of financial penalties for children not attending school may also have helped to increase attendance. In other cases, improvements in school attendance were related to supply-side factors, with schools being open for more days per week. This was attributed to an objective component of the social protection programme which specifically intended to improve coordination between social protection and education sectors at local level.

Improved cognitive, social and emotional development

Social protection programmes were associated with marginal improvements in cognitive, social and emotional development in a few cases. Unlike the childhood development outcomes of stunting and access to education, the pathways of change between social protection programmes and improvements in cognitive, social and emotional development are less clear. For example, the increased income could have led to improved diets for children, and enabled households to seek timely treatment for diseases, reducing nutritional deficits and incidence of diarrhoea, pneumonia and malaria which have been associated with cognitive impairments.

Social protection programmes which provided complementary interventions were associated with improved parenting practices, such as increased caregiver engagement and provision of toys or learning resources, however the studies could not determine the extent that these contributed to childhood development outcomes.

Reductions in violent discipline against children

Violent discipline against children in the home has been associated with lack of knowledge on non-violent parenting methods, cultural and social acceptance of violent discipline in parenting, and financial, health or other life stresses which may cause parents and caregivers to resort to violent discipline.

Only one study reports an association between the increased income from a social protection programme and a reduction in financial stress among parents and caregivers, which may reduce incidence of violent discipline against children.

A limited number of studies in this area suggest an association between caregivers or parents' attendance at complementary information sessions or behavioural change interventions and reductions in violent discipline against children. The intensive parenting coaching programme provided by VUP, Rwanda, was strongly associated with a reduction in children being exposed to violent discipline. Only two other studies measured changes in harsh parenting among participants of a social protection programme (RPS, Nicaragua; BDH, Ecuador). Neither of these programmes provided complimentary interventions, and did not report any changes in harsh parenting between the control and treatment groups.

6.2 SOCIAL PROTECTION DESIGN AND IMPLEMENTATION FEATURES

Whilst the findings of this review provide important insights into the potential of social protection programmes to support childhood development outcomes, it is crucial to consider how design and implementation features can support or potentially undermine progress in these areas.

Intervention type

Evidence of positive and negative effects on children's development outcomes were reported from studies of both conditional and unconditional social protection programmes. Studies of conditional cash transfers reported reductions in stunting and increases in access to education as a result of the combination of cash, requirements for pregnant women and children to attend health and education services, and in some cases compulsory behavioural change interventions.

However, a key finding from the studies was that programme conditions also resulted in negative outcomes. In some cases, the indirect costs of complying with conditions, such as long distances to reach health clinics or the cost of medical certificates resulted in programme participants losing a portion of their benefit. Programme conditions have also resulted in stunting increasing among children, in cases where households invested all their efforts in the child that was enrolled in the social protection programme and neglected the health and wellbeing of younger children. This effect was also reported in a recent impact evaluation of Pantawid, Philippines (ADB, 2020).

The studies also highlighted how monitoring of conditions creates an additional administrative load for health and education services. Delays in submission of compliance reports resulted in payments being incorrectly calculated and households losing a portion of their monthly income. Difficulties in timely reporting led to some conditional cash transfers choosing not to penalise non-compliance with conditions or taking the decision to completely remove programme conditions.

Encouraging behaviour change is an important part of a social protection programme and has been shown to contribute to positive change in childhood development outcomes. However, requiring households to meet strict conditions may be counterproductive to the programme objectives if it results in negative outcomes, and may not be necessary. Softer approaches have been used in unconditional cash transfers such as information sessions or behavioural 'nudges' to encourage households to spend cash transfers on children's nutrition and health. These may prove to have greater overall impact when weighed against the negative outcomes associated with meeting conditions.

Targeting

The majority of conditional cash transfers featured in this review use proxy means testing to assess eligibility for a programme, as a means to reduce inclusion and exclusion errors. However, eligible households were found to be excluded due to being above the established cut-off point for a proxy means test, as well as some better off households being included. The proxy means test assessment process was also deemed to be unclear and unfair by programme recipients which can potentially lead to social division. The poverty assessment criteria for proxy means tests is also costly, time-consuming and quicky becomes outdated.

Categorical targeting based on a child's age, and a simple poverty assessment, was shown to be a far simpler approach to targeting. This approach provided clarity for programme recipients regarding eligibility, supported programme transparency and accountability, was less likely to contribute to social divisions, and was less costly and time-consuming for programme administrators.

Payments

A key finding from the review was the importance of providing a social protection programme that covered a child's first 1,000 days (from conception to their second birthday), considered a critical window of opportunity for a child's growth, development and long-term outcomes. While the majority of the conditional cash transfers featured in this review provided grants covering the first 1,000 days, the majority of the unconditional and public works programmes did not. Recognising this omission, two programmes later introduced components covering pregnant women and children 0-2 years.

The review highlighted a clear association between the adequacy of the grant and effects on childhood development outcomes. The transfer amounts were highly varied between social protection programmes featured in this review, ranging between 10-25% of the average monthly baseline consumption of enrolled households. Low transfer levels were associated with limited impacts on child nutrition outcomes whilst the programme reporting the greatest successes on child nutrition had the highest transfer amount. Inflation considerably reduced the purchasing power of cash transfers with negative consequences on childhood nutrition. Adequate transfer amounts are a critical factor for programme success or failure, however social protection programmes commonly lack a mechanism for periodically reviewing or adjusting transfer amounts due to budget constraints, political factors, or administrative and data gaps.

Conditional cash transfer payment amounts are complex and can result in unpredictable monthly transfers if social protection programmes lack the capacity to effectively administer them. In one conditional cash transfer, a wide gap was reported between the amount that programme recipients were eligible for and the amount they actually received due to delayed reporting on compliance verification and delayed updates to programme databases.

Delays in distributing payments also impacted on childhood development outcomes, with the irregular intake of quality foods negatively impacting on reductions in stunting. In contrast, the long-term nature and reliability of payments provides psychological support for parents and caregivers by reducing financial stress.

Complementary interventions

The findings of this review support the idea that providing cash alone is insufficient for reducing the vulnerabilities faced by social protection programme recipients. Information sessions and behavioural change interventions had a strong impact on reductions in stunting, cognitive, social and emotional development, and reductions in violence against children across all intervention types. They appeared to be less important for improving access to primary school education.

Apart from two outliers (incredibly well-resourced experimental programmes) there was no clear association between the approach taken to information sessions or behavioural change interventions, and impacts on childhood development outcomes. Interventions varied from a 10-week intensive parenting programme covering a wide-range of topics (Pantawid, Philippines), to simply disseminating information during enrolment and paydays. Although the effect of different approaches on childhood development outcomes was not directly comparable, it does highlight that information sessions and behavioural change interventions can be tailored according to the programme or country's resources, social and cultural context, and programme objectives.

Supply-side services

The critical role of accessible and quality supply side services for achieving positive impacts on childhood development outcomes cannot be overemphasised. Conditional cash transfers explicitly link programme participants with supply-side health and education services. In other cases, programme participants were automatically enrolled in a free health insurance programme. However, the potential impact of such initiatives was hampered by the accessibility and quality of supply side services. Considerable variation was reported in childhood development outcomes between different provinces due to the varied quality and availability of supply side services. Poor quality drinking water and weak sanitation services contributed to children having frequent illnesses, and health services lacked qualified personnel and charged additional costs for medicines.

One social protection programme took an active approach to improve the quality and availability of supply side services by providing direct bonuses to incentivise teachers and private health service providers. This approach aimed to encourage service providers to have an active interest in the success of the programme, however in reality it would only make modest improvements to systemic inadequacy in supply-side services.

Social protection systems responding to covariate shocks

The main finding from the limited evidence was the negative impact of inflation and economic shocks on children's development outcomes. This was linked to social protection programmes lacking mechanisms to adjust payment amounts or relax programme conditions during times of crisis. In one positive case, the increased income from cash transfers was found to stabilise children's nutrition status during a severe drought and prevented stunting levels from worsening.

While two other cases did not explicitly investigate childhood development outcomes, they highlighted the operational adaptations which enabled social protection programmes to continue functioning in times of crisis. In the more successful example, the social protection programme was closely integrated in the country's disaster risk management framework, which facilitated rapid design adjustments including suspension of programme conditions. In the less successful case, cash transfers were delayed by one month after the crisis occurred due to the government choosing to create a new single register rather than make use of the existing one.

6.3 EVIDENCE GAPS

This review has revealed a number of critical evidence gaps. First, the amount of rigorous evidence is highly unequal across geographic regions. The majority of peer-reviewed studies are from conditional cash transfers in Latin America. Comparatively fewer studies exist from the East Asia and Pacific region, and none from social protection programmes in Pacific Island Countries. There is a need for rigorous research to be undertaken on social protection programmes in the Pacific Island Countries in order to inform policy and programme design and improve their impact on childhood development outcomes in the region.

Second, while there is a strong evidence base on social protection supporting reductions in stunting, and in supporting access to primary school education, there is very limited evidence on the role of social protection in supporting cognitive, social and emotional development, and reductions in violent discipline against children in the home. Parenting intervention are a common approach for addressing both of these areas, and since the mid-2010s a number of social protection programmes have provided complementary parenting interventions.[27] However their effectiveness in supporting cognitive, social and emotional development, and reductions in violent discipline against children in the home have not been comprehensively evaluated or studied using robust methods. These programmes offer an important opportunity to understand how social protection programmes can be better designed to support these important areas of childhood development.

Third, the quality and availability of supply side services is critical for the ability of social protection programmes to support childhood development outcomes, however the included studies barely touched on this topic. More research is needed to understand the challenges facing supply-side services and how this supports or disrupts potential pathways to achieving childhood development outcomes.

Fourth, although social protection programmes are increasingly viewed to play an important role in supporting children during large-scale emergencies or crises across the areas of building resilience, system preparedness and responding to shocks, there is currently limited robust evidence in this area. Very few studies focus on how government social protection programmes responded in crisis situations.

Finally, greater attention could be paid to gender analysis. The majority of the studies did not include gender analysis, and of those that did the approach appeared ad hoc rather than based on particular theoretical underpinning.

6.4 CONCLUSIONS

This review provides a helpful insight into the state of empirical evidence on the role of social protection in supporting child development outcomes, with the strongest evidence being related to stunting, and access to primary education. A more limited evidence base was identified on social protection supporting cognitive, social and emotional development, and reductions of violent discipline against children. This suggests that targeted research in this area would be of particular value.

Providing cash alone is insufficient for reducing the vulnerabilities faced by social protection programme recipients, and the inclusion of complementary interventions such as information sessions or behavioural change training is particularly important for achieving improvements in nutrition and encouraging a more nurturing approach to parenting. There was no strong association found between type of complementary intervention and child development outcomes, implying that information sessions and behavioural change interventions can be tailored according to country resources and social and cultural context.

Cash transfers are evidently important for enabling households to meet the indirect costs associated with access to education. However, a lack of coherence and coordination across social protection and education policies at different levels of government can potentially hinder access to education for the most marginalised households. Social protection is unlikely to effectively compensate for deficiencies in education policy.

Conditional cash transfers have resulted in both positive and negative effects on children. Therefore, when designing a social protection programme, careful consideration must be given to the use of strict conditions to promote behaviour change, weighed against the risk of unintended consequences and the additional heavy burdens placed on social protection recipients and administrative staff. Furthermore, since conditionality is typically only imposed within poverty-targeted social protection programmes, the decision on whether to introduce conditions is inherently tied up with the administrative feasibility and appropriateness of poverty targeting, including consideration of the creation of poverty traps, stigmatisation and impacts on social cohesion. Indeed, the available evidence suggests that creating synergies with complementary social and behavioural change interventions will often offer a more feasible, appropriate, and lower-risk approach to enhancing the impact of social protection programmes on child development.

In order to effectively support childhood development outcomes, social protection programmes must improve coverage. Not all social protection systems or programmes aimed at children specifically cover pregnant women. Coverage must be extended to include children for their first 1,000 days (from conception to 2 years of age), a critical window for childhood development.

Transfer amounts must also be adequate in order for social protection programmes to have an impact on childhood development outcomes. However challenging trade-offs need to be managed in terms of coverage and depth of assistance, particularly in times of rapidly changing economic conditions. This is particularly challenging in the face of limited fiscal resources. Here's once again, it is important to understand that transfer size and targeting policy may also be related to one another, with larger transfers often avoided within narrowly-targeted schemes due to the potential for creating poverty traps and the potential for creation of perverse incentives.

Finally, the provision of accessible and quality basic and social services remains critical for social protection programmes to effectively support childhood development outcomes, and serve as a catalyst for social progress and longer term sustainable development. Engagement on child-sensitive social protection must, therefore, be complemented by advocacy for expanded and more efficient investment in services for children in the Pacific.

27 See Rawlings et al. (2020) for descriptive summaries of 19 recent cash transfer programmes which include behavioural interventions for parents and caregivers to build knowledge and inform choices and parenting practices.

ANNEX A: LIST OF STUDIES INCLUDED IN THE REVIEW (Alphabetical, by author surname)

1. Ahmed, A., Hoddinott, J., Roy, S, et al., (2016) Which Kinds of Social Safety Net Transfers Work Best for the Ultra Poor in Bangladesh? Operation and Impacts of the Transfer Modality Research Initiative. Dhaka: International Food Policy Research Institute and World Food Programme.
2. Ahmed, A., Hoddinott, J. and Roy, S. (2019) Food transfers, cash transfers, behavior change communication and child nutrition: Evidence from Bangladesh. Report No. :01868
3. Alatas et al., (2011) "Program Keluarga Harapan: Main Findings from the Impact Evaluation of Indonesia's Pilot Household Conditional Cash Transfer Program." The World Bank. World Bank Jakarta Office.
4. Barham, T., Macours, K. and Maluccio, J.A. (2012) "More schooling and more learning? Effects of a 3 Year Conditional Cash Transfer in Nicaragua after 10 years," Working Paper.
5. Beazley, R. (2017) Study on Shock-Responsive Social Protection in Latin America and the Caribbean: Ecuador case study
6. Betancourt, T.S., Jensen, S.K.G., Barnhart, D.A., Brennan, R.T., Murray S.M., Yousafzai, A.K., et al. (2020) Promoting parent-child relationships and preventing violence via home-visiting: A pre-post cluster randomised trial among Rwandan families linked to social protection programmes. BMC Public Health. 2020; 20:1–11
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14. Gebrehiwot, T., & Castilla, C. (2019) Do safety net transfers improve diets and reduce undernutrition? Evidence from rural Ethiopia. Journal of Development Studies, 55(9), 1947– 1966
15. Gilligan, D.O. et al. (2020) Impact Evaluation of Improved Nutrition through Integrated Basic Social Services and Social Cash Transfer Pilot Program (IN-SCT) in Oromia and SNNP Regions, Ethiopia: End-line Impact Evaluation Report. UNICEF, MOLSA, IFPRI
16. Gitter, S. R., Manley, J., & Barham, B. L. (2011) The Coffee Crisis, Early Childhood Development, and Conditional Cash Transfers. Inter-American Development Bank Working Paper IDB-WP-245 [Nicaragua]
17. Gitter, S. R., Manley, J., & Barham, B. L. (2013) Early-Childhood Nutrition and Educational Conditional Cash Transfer Programs. J Dev Stud, 49(10), 1397-1411 [Nicaragua]
18. Guyatt, H., Muiruri, F., Mburu, P. & Robins, A. (2020) Prevalence and predictors of underweight and stunting among children under 2 years of age in Eastern Kenya. Public Health Nutrition: 23(9), 1599–1608
19. Hidrobo, M., Peterman, A., & Heise, L. (2016) The effect of cash, vouchers and food transfers on intimate partner violence: evidence from a randomized experiment in Northern Ecuador. American Economic Journal Applied Economics
20. Levy, D. & Ohls, J. (2010) Evaluation of Jamaica's PATH conditional cash transfer programme, Journal of Development Effectiveness, vol. 2, no. 4, pp. 421-441.
21. Macours, K., Schady, N. & Vakis, R. (2012) Cash Transfers, Behavioral Changes, and Cognitive Development in Early Childhood: Evidence from a Randomized Experiment. American Economic Journal: Applied Economics, 4 (2): 247-73 [Nicaragua]
22. Onishi, J. et al., (2013) Philippines Conditional Cash Transfer Program: Impact Evaluation 2012, The World Bank, Report Number 75533-PH.
23. Orbeta Jr, A. C., Melad, K. A. M., & Araos, N. V. V. (2021) Longer-term Effects of the Pantawid Pamilyang Pilipino Program: Evidence from a Randomized Control Trial Cohort Analysis (Third Wave Impact Evaluation). PIDS Discussion Paper Series 2021-01
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30. Zembe-Mkabile, W., Ramokolo, V., Sanders, D., Jackson, D. & Doherty, T. (2016) The dynamic relationship between cash transfers and child health: can the child support grant in South Africa make a difference to child nutrition? Public Health Nutr. 2016

ANNEX B: LIST OF STUDIES INCLUDED IN THE REVIEW (by country)

Bangladesh	Ahmed, A., Hoddinott, J., Roy, S. et al. (2016) Which Kinds of Social Safety Net Transfers Work Best for the Ultra Poor in Bangladesh? Operation and Impacts of the Transfer Modality Research Initiative. Dhaka: International Food Policy Research Institute and World Food Programme.
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