THE TRANSFER PROJECT

RESEARCH BRIEF

Measuring Health and Well-being of Young People in the Transfer Project

Introduction

Over the past decade, more than a dozen government-run cash transfer programmes have been launched in Sub-Saharan Africa, and there is growing evidence on the ability of these programmes to improve a range of development outcomes. Traditional evaluation questions of cash transfers centre around food security and consumption, educational status, and young child health and nutrition. Given the potential for these programmes to impact broader outcomes and limited existing evidence among young people, one goal of the Transfer Project is to provide rigorous evidence of the impact of national cash transfer programmes on girls' and boys' health, development and well-being. Using a set of specially designed modules which collect data from girls and boys aged 13 to 25 in private settings, we are examining non-traditional outcomes related to sexual behaviours, mental health, hope and aspirations about the future, risk-taking, schooling, labour force participation and fertility. By comparing results from longitudinal data in four focus countries (Kenya, Malawi, Zambia and Zimbabwe) we seek to provide policymakers information on whether and though what mechanisms the transition to adulthood can be influenced by social protection programmes.

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Background

The transition to adulthood is a key stage when behaviours and events in young people's lives have lasting impacts on life trajectories, and when health and well-being can be influenced by economic and social factors. Among the key issues faced by adolescents in Sub-Saharan Africa are exposure to interpersonal violence, barriers to school enrolment and achievement, and risk of HIV. For example, adolescents face rapid developmental changes, and are entering into romantic unions for the first time where they might be at risk of intimate partner violence. Adolescents are also at risk for other types of sexual or physical abuse, and which may prevent them from reaching their full potential through educational underachievement, low self-esteem, depression, risky behaviours (e.g., early sexual debut, more sexual partners), and self-harm. Female adolescents are particularly vulnerable to not reaching their full potential, as they have increased risk of HIV as compared to male adolescents and may face early marriage and pregnancy, which often mean the end of formal schooling for girls.

Pathways

Education: The main pathway through which cash transfers affect the well-being of young people is by increasing school attendance and attainment. Cash transfers in Africa have been shown to increase the probability of secondary school attendance by 5 to 12 percentage points. Schooling has immediate, direct benefits related to cognitive, emotional, and social development and has the potential to break the inter-generational cycle of poverty through increased future earning potential. In addition, schooling is also hypothesized to have protective impacts on other outcomes such as HIV risk because school provides an environment where sex is less likely to occur. School attendance increases the likelihood that young people will have sex partners who are typically closer in age and thus less likely to be HIV infected. Education also exposes young people to knowledge related to HIV prevention and empowers them to act on this knowledge. Finally, education increases hope for the future, which may encourage young people to seek delaying pregnancy and marriage until later ages.

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Mental health: Poor mental health and mental disorders contribute significantly to the global disease burden and indirectly cause other health conditions. Cash transfers may improve psychosocial well-being of young people through reductions in insecurity and stress and can also improve future expectations and physical health. Existing evidence on the ability of cash transfers to improve adolescent mental health is mixed, however the evidence base is growing.

Poverty: Another important pathway is economic well-being, and there is robust evidence that cash transfers positively impact expenditures in beneficiary households across a range of spending categories. Increased economic well-being has implications for young peoples' school attendance, health, and future expectations.

General health and nutrition: Cash transfers also impact health and nutrition. They reduce morbidity, and may increase the use of preventative care (though the evidence on health care utilization is mixed). There is robust evidence that cash transfers increase food security. Better health helps young people stay in school and lead more productive lives.

All the pathways, improved economic well-being, education, and mental and physical health are interrelated and reinforcing. All contribute to increased general well-being of young people and reductions in risky behaviours, thereby increasing the likelihood that they will lead healthy, productive lives in adulthood. Furthermore, these improved outcomes are important in addressing the social and economic drivers of HIV, including inequality, education, food insecurity and poverty.

Modules for young people in the Transfer Project impact evaluations

In UNICEF-led impact evaluations across four countries, information is being collected directly from young people across multiple waves of data collection through specialized modules. Given the sensitive nature of some of the questions, interviews are conducted in a private setting with a same-sex interviewer, according to strict ethical guidelines. The age ranges of the young people vary according to country, however are generally between the ages of 13 to 24 at baseline. These modules are administered to in both treatment and non-treatment (control/comparison) households, so that we can measure trends over time and differences between groups, and can then attribute impacts to the cash transfer. In addition to these questions, the general household questionnaire collections questions on topics for all members on education, general health and labour force participation.

For more information on these methods, see peer-reviewed publications at www.cpc.unc.edu/projects/transfer/publications/papers.

Scales and measures utilized

We include a range of validated scales and measures in modules for young people to assess pathways and outcomes mentioned above.

Psychosocial status

To assess psychosocial status, depression and hope/agency measures are collected using the CES-D and Hope Scale, respectively. We use a 10-item version of the Center for Epidemiological Studies Depression (CES-D) Scale, which has been validated internationally and previously implemented in Africa. The Hope Scale is intended to capture hope and optimism by assessing respondents' perception of their ability to achieve a desired goal. This measure takes into account awareness, self-agency and available pathways and has also been previously implemented in Africa to measure child well-being.

Interpersonal Violence

We ask about experience of physical and sexual violence to collect direct exposure indicators. We measure physical violence using a modified Conflict-Tactics Scale, which has been validated globally and used in a variety of settings by the World Health Organization, among others. This scale asks behaviourally-specific questions, such as, "Has anyone ever punched or kicked you?" We also ask whether the young person has ever sought help to stop the violence or told someone about the violence, including a friend or family member. To assess sexual violence, we ask whether sexual debut was wanted or forced/tricked/pressured and whether anyone has ever forced them to have sexual intercourse or perform other sexual acts. In Zambia, we also asked about perpetration of sexual violence.

Aspirations

We ask questions about the future expectations of young people (what they believe will likely happen) and their aspirations (what they would like to do if they had no constraints) related to education, future employment and earnings, age at marriage, and ideal number of children. We also pose these questions to caregivers in the main household survey (asking about the young person) to study how well expectations and aspiration responses align with those of the young people under their care.

Social support and networks

Questions on social support include the number of friends and family the young person has regular contact with, whether they have people they can count on, and whether they can get help and support from someone if they need it.

Risk-taking

Given that this is a period of rapid developmental change and risk-taking, which has implications for sexual behaviours, HIV risk and substance abuse, we collect direct measures of risk-taking in these modules. We adapted a risk-taking scale from the National Longitudinal Survey of Youth 1979. Examples of these types of questions include, "I think that planning takes the fun out of things," and "I have to use a lot of self-control to keep out of trouble."

Time preference/patience

We collect time preference to examine patience and willingness to sacrifice short-term gain for long-term benefits. An example of this type of question is, "Would you rather have 1500 shillings today, or 4500 shillings in one month?"

Cognitive tests

We assess cognitive abilities using the Raven's Logical Reasoning Test, which has been validated and implemented widely, including in Africa, and measures prefrontal functioning and general cognitive ability. Detailed and comprehensive information on schooling attendance, enrolment, attainment and expenditures are collected for all young people as part of the household questionnaire.

HIV testing

We ask young people what they believe their risk of getting HIV is (no risk, low, moderate, great) and whether they have taken an HIV test either in their lifetime or the past 12 months. We discourage the disclosure of actual results of that test to the interviewer.

Self-rated health

We ask young people to rate their health (poor, fair, good, excellent), and this measure of self-rated health has been implemented widely globally and is a strong predictor of subsequent morbidity and mortality (as validated in adults).

Sexual behaviour

We ask a range of questions related to sexual behaviour, including whether the young person has ever had sex, age of first sexual intercourse, age of first and most recent partner, number of sexual partners in the past 12 months, whether relationships overlapped (concurrency), condom use at first and last sex, transactional sex (giving or receiving gifts in exchange for sex), and engagement in other sexual acts (kissing, touching, etc.).

Substance use

We ask about lifetime alcohol and cigarette use, how many times they have become drunk in the past thirty days, and number of cigarettes smoked in the past thirty days.

Photo: Schoolgirls in Malawi UNICEF © Shehzad Noorani

Future directions

We have implemented these modules in four evaluations (Kenya, Malawi, Zambia, and Zimbabwe), with plans to implement an additional evaluation in Tanzania in 2015-2016. Data collection has been completed in Kenya and Zambia, with ongoing data collection on these measures in Malawi and Zimbabwe finishing in 2016.

Questions we aim to answer include:

- What are the causal pathways through which cash transfers affect young peoples' risky behaviours, life transitions and well-being outcomes?
- Are there gendered impacts of cash transfers on young people?
- Are there heterogeneous treatment effects based on sex of the caregiver, orphan status, social support, community characteristics, and social norms?
- What is the cumulative evidence of the effect of cash transfers on the safe transition to adulthood?

Available data are currently being analysed and there are plans to present these findings in late 2015 and early 2016. More information on the Transfer Project can be found at www.cpc.unc.edu/projects/transfer/

Table 1. Summary of Data Collection in Modules for Young People

Questionnaire item	Zambia MCP (n=2098; ages 15-23)	Zimbabwe HSCT (n=1170; ages 13-21)	Malawi SCTP (n=2109; ages 13-19)	Kenya CT-OVC (n=2223; ages 15-25)
Depression (CES-D short form)	X	X	X	X
Hope scale		X		X
Cognitive test	X		X	
Time preference/patience	X		X	X
Stress (Cohen Perceived Stress)				
Sexual debut and behaviours	X		X	X
Ever taken an HIV test (results not asked)		X	X	X
Perceived HIV risk		X	X	X
Educational attainment	X		X	
Educational aspirations & expectations	X		X	
Future occupation/earnings aspirations	X		X	
Marriage aspirations & expectations	X		X	
Ideal number of children	X		X	
Social networks/social support	X		X	X
Risk-taking	X		X	
Self-rated health	X			
Alcohol & tobacco use		X	X	
Sexual violence	X	X	X	X
Experienced forced sex/sexual acts	X	X	X	X
Transactional sex	X	X	X	X
Perpetration of forced sex/sexual acts	X			
Physical violence				
Experienced physical violence		X		
Sought help		X		
Survey year	2011, 2013, 2014	2013, 2014, 2016	2013, 2014, 2015	2011

Note: In addition, the general household questionnaire collections questions on topics for all members on education, general health and labour force participation.

Zambia MCP=Multiple Categorical Grant Programme; Zimbabwe HSCT=Harmonized Social Cash Transfer; Malawi SCTP=Social Cash Transfer Programme; Kenya CT-OVC=Cash Transfer for Orphans and Vulnerable Children