



ADDRESSING LIFECYCLE VULNERABILITIES OF BENEFICIARIES IN THE MALAWI SOCIAL CASH TRANSFER PROGRAMME

August 2020



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of NORTH CAROLINA
at CHAPEL HILL

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Acknowledgements

The research team thanks the strong engagement of the professional staff of the Ministry of Gender, Community Development and Social Welfare of the Government of Malawi, who provided excellent input through the entire duration of the study. Thanks also to development partners in Malawi for their open discussion of programmatic and policy issues around the Social Cash Transfer Programme, particularly Kreditanstalt für Wiederaufbau (KfW), UNICEF-Malawi, and the World Bank. This report was commissioned by UNICEF-Malawi to the Centre of Social Research at the University of Malawi, UNICEF Office of Research, and the University of North Carolina at Chapel Hill.

List of Abbreviations

ECD	Early Childhood Development
FGD	Focus Group Discussion
GoM	Government of Malawi
IDI	In-Depth Interview
IHS	Integrated Household Survey
IRB	Institutional Review Board
KII	Key Informant Interviews
MIS	Management Information System
MoGCDSW	Ministry of Gender, Community Development and Social Welfare
SCTP	Social Cash Transfer Program
TA	Traditional Authority
VC	Village Cluster

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Executive Summary

The Malawi National Social Support Programme (MNSSP II) provides the strategic vision and implementation framework for the provision of social support in the country. The MNSSP II explicitly recognises social, demographic and life-cycle vulnerabilities in the population, and uses these vulnerabilities (and others) to develop a framework for action. The first of the three pillars of the Programme is consumption support and a key recommendation of the MNSSP II is to “*Develop a programme that maximises poverty and vulnerability alleviation by getting the basics of consumption support right and increasing the coverage of interventions (page 9).*” The Social Cash Transfer Programme (SCTP) is the largest direct consumption support intervention in the country, that aims to reach 10 per cent of the population. The objective of this report is to provide evidence and policy options on how the SCTP can strengthen its approach to addressing lifecycle vulnerabilities as mandated by the MNSSP II.

The study entails a qualitative component consisting of Focus Group Discussions (FGDs) and in-depth interviews (IDIs) with three groups of individuals living in SCTP households. These groups were identified during the initial phase of the study as being an important subset of beneficiary household residents and/or having unique vulnerabilities that potentially required further support within the SCTP: 1) Adolescents and young people age 15-24 years; 2) Elderly household heads with special needs or a chronic health condition; 3) children under age five years. The qualitative data was complemented with a quantitative survey of 1500 SCTP households administered in the districts of Salima, Mangochi and Nkhata Bay. An Inception Workshop was held in Lilongwe with the Study Reference Group in May 2019, followed by a Writing Workshop in September 2019 in Salima, also with the Reference Group, to discuss the interpretation and policy implications of the results, and to suggest further analyses.

SCTP targeting with respect to lifecycle vulnerability:

The SCTP *indirectly* reaches many individuals who display social, demographic and life-cycle vulnerability as identified in the MNSSP II. These include the elderly, the specially abled, and female headed households. However, none of these are explicit eligibility criteria of the programme. High dependency among families is considered a demographic vulnerability in the MNSSP II and is a key eligibility criterion of the SCTP. The unique demographic composition of ultra-poor labour constrained households in Malawi leads to a disproportionate number of female-headed households, and elderly with disability or chronic illness. An important vulnerable group as identified in the MNSSP II, young children, are neither indirectly nor directly reached through

the SCTP. Those that do end up in SCTP households are often the grandchild or the great grandchild of the main recipient, with a very young caregiver, which carries its own set of risks and vulnerabilities.

Elderly caregivers:

SCTP recipient households are older, more likely to be female and have disproportionately more adolescent and young adults than the typical ultra-poor rural household. Fifty-eight per cent of recipients suffer from either a chronic health condition, disability or both, a much higher per cent than among all ultra-poor rural households. Female heads were more likely to suffer from a chronic illness relative to male's health condition, while the most common physical disability was walking or climbing steps. IDIs indicate that elderly heads have weak social networks to depend on, and their physical capacity makes it hard to engage in *ganyu* and other income-generating activities. While the cash transfer alleviates some of the financial constraints, the near-constant health issues and associated financial costs of health care lead to difficult choices in terms of how to use the transfer and relying on other household members, often adolescents, for care and income- support.

Adolescents and young people:

Ultra-poor labour-constrained households face a harsh trade-off when it comes to the long- term development of adolescents and young people. As the typical recipient is elderly, and as noted above 58 per cent have some health condition, young people are often called upon for caregiving and income generation, which leads to school drop-out. Having a head with a disability is associated with a 20 percentage point increase in domestic chores and a 25 per cent increase in *ganyu* for young people, and a corresponding reduction in school enrolment of 28 percentage points. This is in spite of the school bonus. A key issue is that the school bonus itself represents just 10 per cent of the estimated out-of-pocket cost of attending school.

Children under five years:

This group comprises 12 per cent of all household members and represents a vulnerable group because of their strict dependence on others, and the fact that this is a period of tremendous development and growth. Developmental deficits in this stage of life have far-reaching consequences throughout the life-course. Given the profile of the typical SCTP household, a significant portion of preschool children are not the child of the main recipient, but rather the grandchild or great grandchild of the main recipient. In other words, there is an important sub-

family within the SCTP beneficiary household consisting of a young child and young mother, who do not receive any direct support from the programme. While preschool children of these young mothers do not show significant worse outcomes than other preschool children, this is mostly because overall outcomes for all children in this age group are quite low.

Young mothers:

The research team interviewed young mothers in order to identify the unique challenges they faced in caring for their child. As any intervention aimed at improving the well-being of young children would naturally need to account for the circumstances of the mother, the report also highlights the circumstances of this group. Most had their child at age 15, and subsequently dropped out of school. Although most would like to return to school, given their current age, they did not feel that formal schooling was an option. Social isolation was also an important concern, and not being able to meet or talk to other people that shared their life circumstances and experiences. This group do not have direct access to the cash transfer because they are not the main recipient of the programme.

The effect of vulnerability on household welfare:

There are important, statistically significant associations between the vulnerabilities analysed in this report and overall household welfare as measured by consumption. The strongest (negative) association is having a young mother of a child under age five years, which is associated with a 26 per cent reduction in per capita food consumption and 24 per cent reduction in total consumption of the household. Having a head with a chronic illness or disability is also associated with lower consumption by 17 per cent and a 20 per cent reduction in food consumption. As mentioned earlier, adolescents and young people in these households also have significantly higher school drop-out and rates of *ganyu*. The key conclusion of the analysis is that not all SCTP households are the same, and the programme is significantly less protective for households with these vulnerabilities.

A narrowly targeted, small programme or a broad-based, inclusive, large programme:

The key strategic decision facing the Ministry of Gender, Community Development and Social Welfare (MoGCDSW) is whether it remains a narrowly targeted, small programme aiming to reach just 10 per cent of the population, or whether it wants to transition to a broad-based social protection programme that addresses lifecycle vulnerabilities. Typically, as countries build their social protection systems, they move from narrowly targeted programmes to a broad, inclusive

programme. Such a programme would directly target lifecycle vulnerabilities such as preschool children, the elderly, disability and chronic illness. The report provides simulations of coverage and costs for alternative programmatic options. A child grant targeting all children age 0-2 years in rural, ultra-poor households would cost about the same as the current programme and reach slightly more households than the current programme. A programme that targeted rural, ultra-poor households with an elderly, a disabled person or a child under age five would cover 13 per cent of households, double the number of households relative to the current programme (14 per cent versus 7 per cent). An important benefit of such programmes is that they are much more transparent which reduces targeting costs, are easier to explain to the public, and of course directly address lifecycle vulnerabilities.

Policy options:

The research team and reference group discussed policy options based on the findings of the research. These options are described below.

- Directly target lifecycle vulnerability: The current SCTP targeting uses a very narrow approach, focused on the concept of labour-constraints. The application of this theoretical idea leads to households with high dependency ratios and with individuals with specific lifecycle and social vulnerabilities. Instead of reaching these vulnerable individuals indirectly (and thus excluding many others), the MoGCDSW could consider directly targeting lifecycle vulnerabilities, using a categorical approach such as age, and/or health status. Such an approach is likely to significantly reduce targeting costs. The decision in part depends on the overall strategic vision of the MoGCDSW for the SCTP, whether it will remain a narrowly targeted, relatively small programme, or whether it will become a more inclusive, broad-based and much larger programme that reaches a range of constituents.
- Support specific vulnerabilities within the current targeting approach: If the MoGCDSW is not ready to make a significant change in the eligibility criteria as described above, the alternative is to ensure that individuals and households within the current programme with particular vulnerabilities receive adequate support. Of particular concern is the situation of households with heads who are either specially abled or chronically sick—these households, and young people within them, are significantly worse off than other SCTP households. One approach, currently used in Zambia, is to provide an additional top-up if

the recipient (or any member) is specially-abled or has a chronic illness. Linkages and referrals would also be appropriate, but these may be outside the influence of the Ministry.

- Nutrition bonus for children age 5 years and under: The current SCTP targeting approach tends to exclude families with preschool children. In addition, while families with school-age children are provided a 'school bonus', no similar support is provided for families with preschool children, who also have unique needs related to nutrition and preventive health care. A 'nutrition bonus', which would be analogous to the 'school bonus', could be considered for all children age 5 and under. This would recognise the vulnerability and developmental needs of all children in SCTP households, not just children age six years and above, and would bring the SCTP in line with the recommendations of the MNSSP II. The nutrition bonus would automatically convert to the current school bonus once the child turns 6 years old.
- Support to mother-child sub-families within SCTP households: Young mothers with preschool children in SCTP households are an important vulnerable group, as they do not have direct access to the cash transfer. The nutrition bonus described above would support the child, but additional services should be considered for the young mother, such as linkages with adult or non-formal educational services, peer groups and other social support networks.

1. Background

Malawi's Social Cash Transfer Programme (SCTP) is one of the largest cash transfer programmes in sub-Saharan Africa, and currently reaches 7 per cent of the population. The SCTP is an unconditional cash transfer targeted to ultra-poor and labour-constrained households. The programme began as a pilot in Mchinji district in 2006 and has since had positive impact on household welfare, consistent with the program's theory of change. Since 2009, the programme has expanded progressively in breadth and depth, and achieved national coverage in all districts in 2018. In 2019, the SCTP reached an estimated 282,213 beneficiary households with approximately 1,194,473 members in total. More than half (56 per cent) of the individual beneficiaries are children between the ages of 0-18 years, with equal representation of males and females.

The motivation behind the scaling up of the SCTP stems from the acknowledgement by the Government of Malawi (GoM) of the widespread prevalence of poverty and deprivation in Malawi, and its consequences for the growth and development of the nation. To elucidate further, Malawi ranks 170 out of 188 countries according to the United Nations Human Development Report (United Nations Development Program, 2018). Furthermore, the Malawi Integrated Household Survey (IHS) of 2016/2017 (The World Bank, 2019) found that approximately 51 per cent of the population was living below the national poverty line; this figure essentially remained unchanged from the poverty rate of 50.7 per cent in 2010 as reported in the IHS3 (National Statistical Office, 2012).

The SCTP provides households with an average monthly payment of Malawi Kwacha (MK)7000, (approximately USD 9.4) including an unconditional school bonus for children. The transfer each household receives per month is based on the number of people living within a household: 1 person: MK2600, 2 people: MK3300, 3 people: MK4400, 4 people and above: MK5600. The cash transfers are intended to financially enable and support the targeted households to increase food security, and to support child nutrition, school enrolment and retention.

The SCTP is primarily targeted at labour constrained households who are ultra-poor. The concept of labour-constraints is operationalized in the SCTP targeting guidelines as households with a high dependency ratio. Based on secondary analysis of the 2013-2016 SCTP impact evaluation, SCTP households have a large number of adolescents and young adults, few prime-

age adults, and large number of elderly (age 60+ years).¹ A more detailed comparison of household composition between SCTP eligible households and the rural ultra-poor in Malawi shows that the SCTP selects a unique subset of the ultra-poor. Heads of household in the SCTP are more likely to be female, older (58 years versus 43 years) and widowed (43 versus 13 per cent) relative to other ultra-poor households in rural Malawi. The proportion of residents 65+ years of age in SCTP households is 14 per cent compared to just 3 per cent among the rural ultra-poor in Malawi, and the proportion age 55+ years of age is 16 per cent compared to just 5 per cent among all rural ultra-poor. Households heads in the SCTP are also more likely to have no schooling (72 versus 26 per cent).

SCTP household heads are also more vulnerable in terms of health compared to other rural ultra-poor households in Malawi. Over half (47 per cent) of SCTP heads have a disability and 45 per cent have a chronic illness, compared to just 15 and 8 per cent of all rural ultra-poor heads. A more detailed breakdown shows that the disability stems from ambulatory conditions (walking) and vision. The health condition among SCTP household heads is a key vulnerability affecting these households.

Past studies, policies and implementation related to the SCTP have mainly focused on the household level. There is little clarity regarding how the SCTP affects individuals' specific vulnerabilities. The deprivations faced by an individual and their vulnerabilities shift, evolve, decrease, increase over the course of an individual's life. The overall needs of a SCTP household might not capture the unique vulnerabilities of each individual living under the same household, including the evolution of their needs overtime. Considering that poverty in Malawi is dynamic and that vulnerabilities vary greatly between the different categories living within a household, information on 'which categories are indeed living in SCTP households', 'what are their respective vulnerabilities', and 'how can these vulnerabilities be addressed' is necessary to understand and address in order to consider options for making SCTP more effective and/or efficient.

SCTP households are also significantly more likely to have older children and young adult residents. Over a third (35 per cent) of all residents are age 10-24 years in SCTP households, compared to 30 per cent among rural ultra-poor in all Malawi. Among resident children age 0-18 years, 35 per cent are orphans in SCTP eligible households compared to just 12 per cent of the same age group in rural ultra-poor households. In addition, children of all school ages, but

¹ All reports from the 2013-2016 impact evaluation of the SCTP are available at the Transfer Project website: <https://transfer.cpc.unc.edu/tools/reports/malawi-reports/>.

particularly those age 14-17 years, are significantly more likely to temporarily withdraw from school compared to children from other ultra-poor households in Malawi (13 versus 4 per cent).

The secondary analysis of the 2013-16 IE data reveals that while the typical recipient of the grant is an elderly widow, often caring for orphans or older children. These adolescents and young adults also have young children in the household. Pre-school children, those age 0-5 years, represent 13 per cent of all residents in SCTP households, and about one-third are not the child of the main recipient, but rather grandchildren or grand-nieces/nephews of the main recipient. The mothers of these children tend to be the children or grandchildren of the household head and experience unique vulnerabilities. For example, the average age of these 'non-recipient' mothers is 21 years, only 18 per cent are married or have a stable partner, and 70 per cent cannot read or write. These mother-child dyads are embedded within SCTP households but do not themselves receive the grant or any special recognition or services.

Based on this secondary analysis of the existing quantitative data from the 2013-2016 IE, the following groups were identified as the focus of this study due to their vulnerability and need to complementary services along with the SCTP:

1. Elderly heads of household (age 55+ years) with disability or chronic conditions
2. Adolescent/young adult males and females
3. Children under age 5 whose caregivers are non-recipients

Groups one and two represent a large proportion of beneficiary households and have unique vulnerabilities that cannot be addressed solely by a cash transfer, or by a transfer at the existing level. For example, chronic illness and disability appears to be a key issue among the elderly, while adolescents and young adults face a range of constraints that will affect their successful transition to adulthood, including access to further education, but also work, marriage, and, particularly for females, reproductive health.

The last group, children age 0-5 years, make up 13 per cent of SCTP households, and while this is a lower proportion relative to all rural ultra-poor (18 per cent), this group is particularly vulnerable, being fully dependent on the adults in the household for their survival and development. And the subset of pre-school children whose caregivers are not the main recipient of the cash are particularly vulnerable in the sense that the effects of the cash would need to trickle down to them from the main recipient herself. Moreover, the qualitative component of the 2013-16 IE study revealed that early pregnancy was an issue among adolescents and young adults living in SCTP households. As described above, caregivers of these very young children

are themselves in a vulnerable position compared to non-caregiver, with additional needs to cater for young children. The study focused on children under age 5 whose caregivers are not the main recipient of the transfer.

Against this background, the University of North Carolina at Chapel Hill (UNC), the UNICEF Office of Research (OoR) – Innocenti, and the Centre for Social Research (CSR) at the University of Malawi were engaged as partners to conduct this study. The goal of this research was to identify the key marginal category of individuals in the household as well as their respective vulnerabilities. This document is the report of the research and describes the methodological approach, study instruments, field operations, characteristics of the sample, and the findings of the research. The document also includes simulations of various policy options that can be adopted to address the vulnerabilities evidenced in the research.

2. Study design, survey implementation and output

2.1. Selection of study sites

The study was conducted in three districts: Salima, Mulanje and Nkhata Bay. The decision on the number of districts was based on financial and logistical considerations. The choice of these districts was purposive to satisfy geographical and other criteria related to past inclusion in impact evaluations and sources of support for the SCTP. Malawi is divided into three regions with twenty-eight administrative districts. Nkhata Bay represents a region from the North of Malawi and is one of the districts supported by the World Bank. Salima represents both the Central Region and one of the districts which was covered in the impact evaluation of the SCTP that accompanied the expansion phase between 2012 and 2016. Including such a district affords the research team to get household specific data collected during the impact evaluation and use it for this study. Further, Salima is a Kreditanstalt für Wiederaufbau (KfW) supported district. Mulanje represents both the Southern Region and is an EU supported district. An additional reason for selecting Nkhata Bay and Mulanje is because they have not been studied as much as the other districts in the programme since 2012.

In each district, two Traditional Areas (TAs) were covered. For Salima, the study visited the same TAs that were included in the impact evaluation, namely Ndindi and Maganga. For Nkhata Bay and Mulanje, two TAs each were randomly selected from the list of available TAs during the inception meeting held in Lilongwe on May 15. The selected TAs were Nkanda and Mthiramanja for Mulanje and Fukamapiri and Mankhambera for Nkhata Bay. Annex A provides additional details on the procedure for selecting the TAs.

Overall, data was collected from 6 TAs in 3 districts across 3 regions. This is considered adequate to provide enough breadth and variability in experiences such that the findings would be reasonably representative of the national picture.

2.2. Quantitative study design

2.2.1 Sample size determination

The total sample size for the study was determined to be 1500 households, comprising of 500 households from each of the districts. Details of the sample size calculation are given in Annex B. The minimum sample size required was calculated to be 1293 households, but this was increased to 1500 to allow for a non-response rate of up to 10 per cent, or to provide more precision if the parameters used for the sample size determination are achieved.

2.2.2 Sampling frame, sample allocation and sampling

The sampling frame for Salima was the list of treatment households that were interviewed during the last round of data collection for the impact evaluation in 2015/2016. For the two new districts, the sampling frame is the most recent list of SCTP beneficiary households provided by the implementing partners.² An initial screening criterion was applied to restrict the frame to only households with at least one child or young adult of school going age (age 6 -25 years). This was considered necessary to ensure all households would have some information to contribute regarding education.

For each district, the sample of 500 households was allocated to the two TAs in proportion to the number of eligible households in each TA. In Mulanje for example, there were a total of 2679 households comprising 1021 from Mthiramanja and 1658 from Nkanda. The resulting sample allocation was therefore 196 and 317 for Mthiramanja and Nkanda, respectively, after the allocation was rounded up for each village cluster (VC) selected. Table 1 gives the details of the number of eligible households in each TA and the corresponding number of households allocated (*see Table 1*).

Within each TA, the sample was further allocated to the VCs based on the share of households in each VC. Nkhata Bay and Salima has a total number of 9 and 7 village clusters respectively, whilst Mulanje has 39 village clusters. Sampling 500 households from 39 VCs in Mulanje will lead to an over dispersion of the sample spread across a wide geographic area. To mitigate this concern, 10 VCs were randomly selected from the two TAs in Mulanje. For Nkhata Bay and Salima, all the VCs were included in the sampling framework for the survey. Once the

² This is the most recent administrative database that contains the list of all beneficiary households.

sample allocation was done, selecting of the households was by simple random sampling. Overall, there were 4363 eligible households out of which 1520 were sampled.

Table 1: Distribution of households in frame and the sample allocation

District	TA	Number of VC's	Number of eligible households	Number of households allocated
Mulanje	Mthiramanja	12	1021	196
	Nkanda	27	1658	317
Nkhata Bay	Fukamapiri	4	454	235
	Mankhambira	5	523	271
Salima	Maganga	4	313	222
	Ndindi	3	394	279
Total		55	4363	1520

2.2.3 Survey instruments

The main household survey instrument is modelled along the lines of the instrument used for the impact evaluation. The instrument had information on household demographics, education, health, time use, consumption and household dwelling characteristics among others.

2.3 Qualitative study

2.3.1 Sample

The qualitative component of the study consisted of 32 in-depth interviews in 4 traditional authorities (TAs) within two districts (see Table 2). The sample included three population groups:

1. Elderly members age 55+ years of age with disability or chronic conditions
2. Adolescent/young adult males and females
3. Children under age 5 whose caregivers are non-recipients of the SCTP

The first two groups represent a large proportion of beneficiary households and have unique vulnerabilities that cannot be addressed solely by a cash transfer, or by a transfer at the existing level. Chronic illness and disability are key issues among the elderly, while adolescents and young adults face a range of constraints that affect their healthy and safe transition to adulthood. These constraints include access to education, as well as child labour and marriage, and particularly for females, reproductive health. While access to schooling may be partially addressed through the SCTP, there are non-financial barriers to schooling that have different

consequences for male and female members of a household and require interventions beyond a cash transfer. The last group, children age 0-5 years, make up 13 per cent of SCTP beneficiary household composition. While this is a lower proportion relative to the rural ultra-poor (18 per cent), this group is particularly vulnerable, as they are entirely dependent on the adults in the household for survival and development. Additionally, the subset of pre-school children whose caregivers are not the main recipient of the cash are further at risk as the effects of the cash transfer may not reach them. Moreover, the qualitative component of the 2013-16 IE study revealed that early pregnancy is an issue among adolescents and young adults living in SCTP households. As described above, caregivers of these young children are themselves in a vulnerable position which is furthered by the additional needs to cater to children under the age of 5. Given this, the study focused on children under age 5 whose caregivers were not the main recipient of the transfer. Interviews were conducted with these non-recipient caregivers of children under age 5, who were referred to as Young Mothers.

Table 2: Qualitative Sample

	Salima	Mulanje	Total
Elderly with chronic conditions/disability	5 IDIs	6 IDIs	11 IDIs
Caregivers of adolescent/youth	5 IDIs	6 IDIs	11 IDIs
Young Mothers	5 IDIs	5 IDIs	10 IDIs

2.3.2 Recruitment

The sample from Salima, in TAs Ndindi and Maganga, was randomly drawn from the existing list of households already in the 2013-16 evaluation sample since this district was included in that sample frame. Households from Mulanje were selected from the roster of beneficiaries provided by the Ministry of Gender, Community Development and Social Welfare (MoGCDSW). The TAs, Nkanda and Mthirimanja, were randomly selected for the sample.

Upon arrival in each traditional authority, the research team would seek out SCTP committee members or other community leader. To build trust, the team would explain the purpose of the study after which the selected individual would be the primary point-of-contact for the research team. The individual would assist in finding respondents from the sample lists and book them for interviews. Sometimes respondents from the sample list could not be located because they had moved out of the community, passed away, or just were not around on booking days. In those instances, the committee members would help the research team find an alternate

participant who fulfilled the criteria for the study. These replacement participants were not randomly selected. This convenience sampling potentially introduced selection bias. It is possible that those replacement participants are different than those who didn't participate.

2.3.3. Data Collection

Three interviewers conducted 32 audio recorded interviews between June 17-28, 2019. Each interviewer was assigned to one population group; meaning one male interviewer conducted all Elderly IDIs, one male interviewer conducted all Caregiver of Adolescent IDIs, and one female interviewer conducted all Young Mother IDIs. The interviews were conducted in Chichewa, and all three interviewers were fluent in both Chichewa and English.

Prior to the start of data collection, interviewers participated in a five-day training in Zomba that included a review of qualitative research methods as well as the design of the Life Cycle study and study aims. Each interviewer also familiarized themselves with the interview guides and practiced conducting the interviews.

The semi-structured interview guide included open-ended questions and probes. The guides for Elderly and Caregivers of adolescent/youth participants covered a range of topics including household structure, recent shocks, and impact of the SCTP. The interview guide for Young Mothers covered similar topics with additional questions on the experience of becoming a caregiver at a young age. The goal of the interview was to understand the vulnerabilities of the three groups and assess how the SCTP responds to those vulnerabilities. The interviews were semi-structured and were typically conducted in the participants' households. Typically, the IDIs lasted anywhere between 60 and 90 minutes. For data analysis, each interview was translated into English and transcribed.

2.3.4 Data Analysis

The research team developed a fieldnote template that mirrored the content and structure of the interview guide (Annex C and D). Fieldnotes were taken in the template following each IDI using a combination of memory, written notes and audio review. These templates allowed for preliminary analysis in the field while data was still being collected. The fieldnotes also facilitated rich discussion at the daily debriefs during fieldwork.

For analysis, the research team reviewed fieldnotes (written in English) and organised main themes, such as challenges and shocks experienced by participant households as well as

perceptions and impact of SCTP, into a matrix informed by the structure of the fieldnote template to compare key findings within and across each group. Next, the research read the translated interview transcripts to understand, interpret and present the themes in their required context and added relevant quotes to support our argument. In some cases, comparisons were made across the three groups. Through this process, the research team identified common vulnerabilities for each group and their perceptions of whether the SCTP adequately addresses those vulnerabilities.

To triangulate the individual interviews with caregivers of youth, the research team analysed data from focus groups with in and out-of-school youth and caregivers collected for another study. These data were analysed following a similar approach to the one described, including review of fieldnotes and transcripts and use of matrices to organise and visualize the data. Relevant findings have been integrated throughout.

2.4 Output of fieldwork, sample weights and analytic methods

Despite several challenges, especially the difficult terrain in Nkhata Bay, the fieldwork was very effectively coordinated to yield a high response rate. Table 3 shows the number of households allocated in each TA and the number successfully interviewed (*see Table 3*). Overall response rate was 99 per cent with Fukamapiri having the lowest response rate of about 97 per cent. Next, we checked for how many of the interviewed households had at least one child or youth of school going age. This gave us the effective sample size in each VC. A total of 37 of the 1505 households interviewed did not have any child of school going age, reducing the effective sample size to 96 per cent.

As described in Section 2.2.2, the sample is not self-weighting due to the multiple stages of sampling. It was therefore necessary to compute sampling weights to use in the analysis. Base sampling weights were generated as the inverse of the inclusion probabilities at the VC level. This comprised of the probability of selecting a household within a chosen VC, combined with the probability of selecting a VC for Mulanje since not all VCs were selected in Mulanje.

Table 3: Output of quantitative data collection

District	TA	Number of households allocated	Number of households interviewed	Response rate
Mulanje	Mthiramanja	196	194	98.98
	Nkanda	317	316	99.68
Nkhata Bay	Fukamapiri	235	227	96.60
	Mankhambira	271	270	99.63
Salima	Maganga	222	221	99.55
	Ndindi	279	277	99.28
Total		1520	1505	99.01

2.5 Secondary sources of data

The study also draws on the Education Management Information System (EMIS) compiled by the Directorate of Education Planning of the Ministry of Education, Science and Technology. EMIS covers the universe of both primary and secondary schools in Malawi and the data is collected and compiled yearly. Information contained in EMIS include enrolment, school infrastructure, teachers, and other indicators. In few instances, additional sources such as the World Bank Development Indicators is used to complement analysis. To provide context in the interpretation of results, where necessary, the study sample is compared to rural ultra-poor households from the most recent Malawi Integrated Household Survey (IHS4).

2.6 Limitations of the study

A limitation to the quantitative component of the study was not having sufficient sample size and, consequently, power for district level analysis, which would have allowed for the identification of heterogeneity across districts or even traditional authorities. In addition, the number of households identified for each vulnerable group may not be adequate to make conclusive statements about the group. Another limitation is the fact that the vulnerabilities are overlapping in many households and it is therefore difficult to conclusively isolate the marginal effect of each vulnerability.

Isolating specific vulnerabilities was also a challenge in the qualitative interviews as these vulnerabilities are intersecting and interconnected. However, understanding the intersectional nature of these vulnerabilities is also important for programmers and policy makers. Another

limitation was the short time available for fieldwork. The research team engaged in rich debriefing during fieldwork which aided in the identification of robust and relevant findings. An additional limitation was that sampling young mothers of children under 5 was challenging, which led to the inclusion of both young mothers at the time of the study as well as women who had been young mothers. Ultimately, both were able to speak to their experiences and provide insights into their unique vulnerabilities. Finally, by only interviewing individuals from SCTP households, we are not able to compare findings with youth from non-beneficiary households. This decision was made to facilitate depth and saturation of information among those in the programme and to keep within the scope of the time and resources available for the study.

2.7 Ethical considerations

To ensure that the study complies with the ethical standards for doing research with human subjects, ethical approval for the study was sought from the research ethics review board at the University of North Carolina as well as the College of Medicine Research Ethics Committee ([COMREC](#)), an independent scientific and ethics committee of the National Commission for Science and Technology ([NCST](#)) in Malawi. These institutions reviewed the survey protocols and granted approval upon satisfaction with the ethical standards proposed. Survey instruments were translated to the dominant local language (Chichewa) in accordance with ethical requirements.

Participation in the survey, in-depth interviews and focus groups was voluntary with no financial or material incentives, and informed oral consent was sought from all participants in both the quantitative and qualitative interviews. Interviewers would read the consent form to the potential participant and answer any questions. By obtaining oral consent, participants did not have to provide their name in writing on any study documents, which served to protect their confidentiality. All focus group participants agreed to maintain confidentiality at the beginning of the discussion. Data collection teams were taken through the required ethical standards to ensure confidentiality and privacy of respondents. No personal information or identities of participants would ever be shared outside of the research team, and respondent identities have been disguised even in the direct quotes presented in this report.

3 Sample Characteristics and Study Population

This section presents the characteristics of the study sample including household composition, participation in economic activities, time use, shocks and coping to shocks, and access to social safety nets.

3.1 Sample Distribution

Figure 1 and Figure 2 age distribution and age-gender composition of all household members respectively (see Figures 1 & 2). Data is presented from the study sample and those from the IHS4 rural ultra-poor sample from the study districts. The analysis that SCTP households have fewer members in the age group 0-4 years but larger shares in the age group 10 – 19 years. In addition, the SCTP households have more women who are 50 years or older.

Figure 1: Distribution of the Study Sample and IHS4 Rural Ultra-Poor by Age

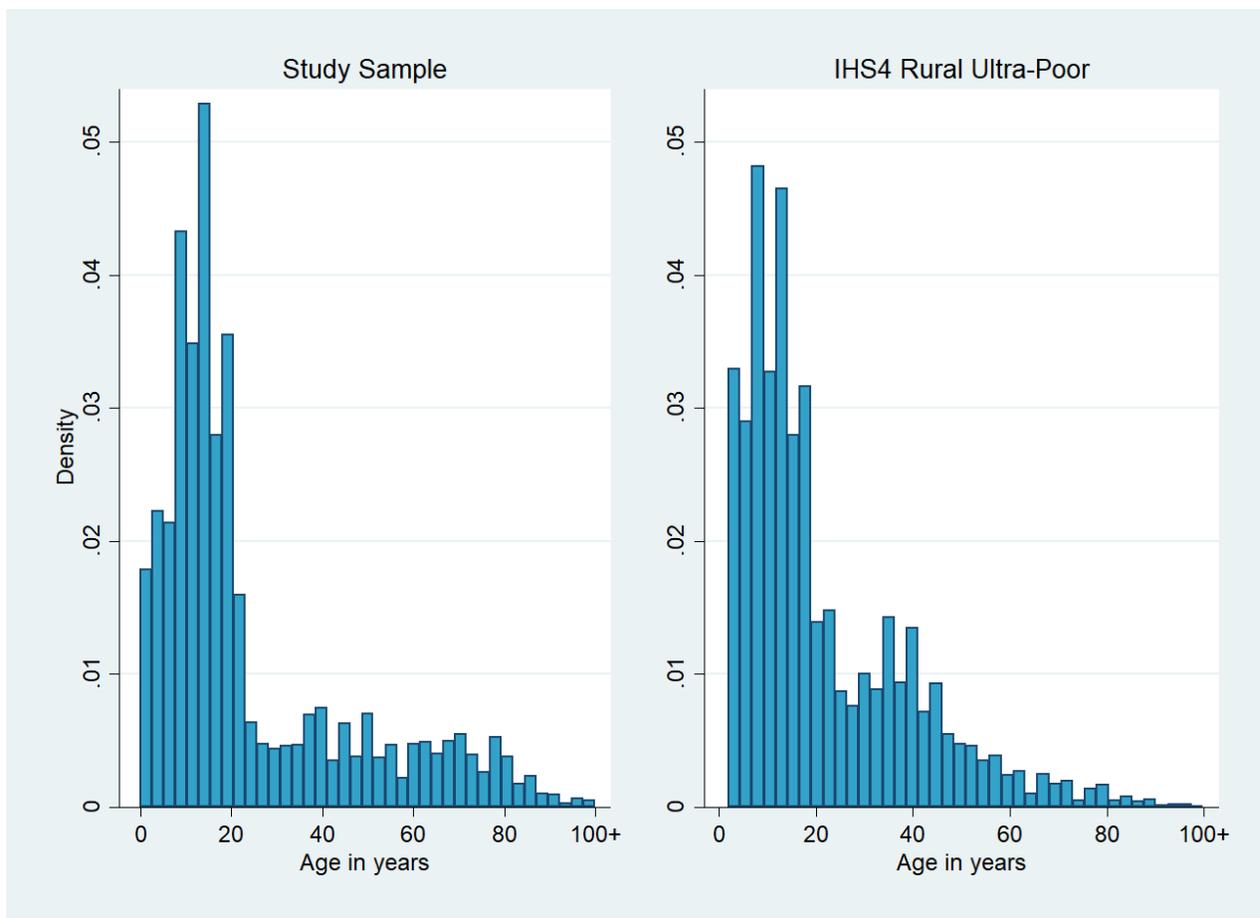
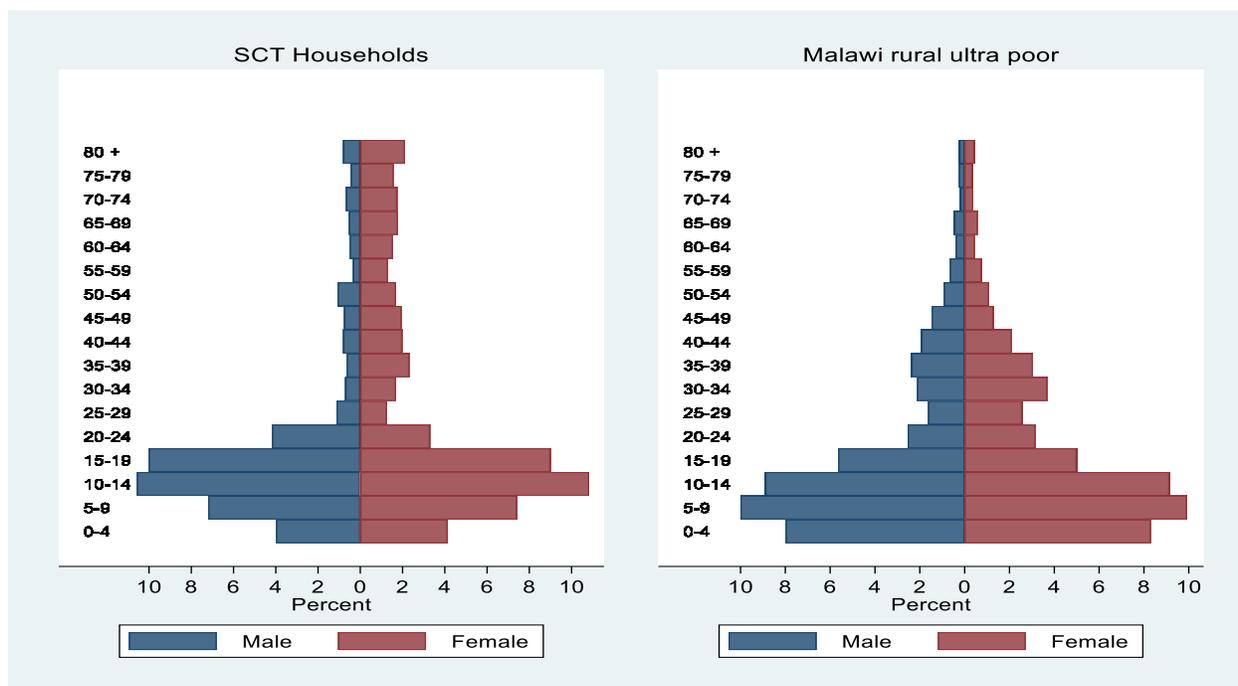


Figure 2: Study Sample and IHS4 Rural Ultra-Poor Sample Pyramid by Age and Gender



3.2 Household composition

The report further compares the characteristics of household head and of all household members in the study sample to the IHS4 rural sample for the selected districts (see Table 4). Household size ranged from 1 to 20 persons with a median of 6 members. With regards to the heads of household, the average age was 57 years with 70 per cent of them being female while 78 per cent identify as Christians. On marital status and education attainment, 35 per cent of them are currently married and 61 per cent ever attended school respectively. Close to 4 in 10 of them have a chronic health condition and 15 per cent have some form of disability. In contrast, the average age of heads of household from the IHS4 sample was 45 years with 32 per cent being female while 66 per cent are currently married and 16 per cent have a chronic condition (see Table 4). This highlights the fact that the SCTP sample is quite different from the typical rural household in terms of the characteristics of the head of household. It is however instructive to note that the characteristics of the household members are quite comparable except for the share of members with a chronic condition.

Table 4: Household composition

Characteristic	Study sample		IHS4 comparison sample	
	Household Head	All Household members	Household Head	All household members
Age (years)	57.12	25.72	44.77	22.39
Female	0.70	0.56	0.32	0.53
Christian	0.78	0.57	0.83	0.55
Married (age 18+)	0.35	0.32	0.66	0.62
Ever attended school	0.61	0.84	0.82	0.84
Has a disability	0.15	0.05		
Has a chronic condition	0.38	0.14	0.16	0.08
<i>N</i>	1,505	8,364	1,071	4,969

*IHS4 households in rural areas of selected districts

4 Vulnerabilities of Key Groups

4.1 Qualitative findings on vulnerabilities within households with adolescents

4.1.1 Economic conditions and shocks

The caregivers of adolescents were the most educated group in the qualitative component of the Life Cycle Study with 8 of the 11 participants having completed Standard 5 or higher. Their households tended to be relatively large, with an average of 7 members (range 4-11). The number of adolescents in the household ranged between 2 to 8.

Adolescent caregivers managed their households on extremely limited budgets, sometimes managing to save money or investing in items like building materials or livestock. By buying livestock with the SCTP money, the caregivers secured an asset to sell at times when money was required. However, their financial situations were so precarious, and a single shock had the potential to quickly use up any savings or investment. Examples of shocks mentioned by caregivers of adolescents included severe or chronic illness, poor harvest yield, loss of livestock, and property damage from heavy rains. Given the constant exposure to shocks, it could be difficult for participants to make progress. The transfer money was used to cover the fallout from a shock or for day-to-day living expenses, but rarely was it enough for both. As participants were often living from transfer to transfer with no safety net, even a relatively mild shock could affect the household's stability for months.

While all shocks negatively impacted households, chronic illness was described as having the greatest impact on long-term household productivity and wellbeing, especially if the main breadwinner became sick. Illness required money to be diverted to cover medical related costs including transport to the hospital, medication, and other health-care related expenses. When the caregivers of adolescents got sick, they might miss days or even weeks of work, which could determine whether or not the household would have enough food. Caregivers also described that they may miss work to take care of other sick family members.

As an example of the impact of both chronic and acute illness on households, a male caregiver in Salima who was blind and unable to do *ganyu* (casual work) expressed guilt for his disability, which also reflected normative perceptions on the role of the male head of household.

“Since I am disabled as head of a family it’s like I have left these children in suspense with no help because currently am not able to assist them.”

His wife, who was the sole breadwinner of the household, had fallen ill for two weeks earlier that year. She noted that since she was unable to work or tend to household needs, “everything stopped moving and we had to suffer.” As reflected in this example, sudden healthcare needs are a large burden for households, and when combined with lack of income, leads to extreme deprivation.

4.1.2 Daily struggles: Food and Education

Beyond shocks, caregivers of adolescents worried most about the daily issues of education and food. In addition to *ganyu*, many would also do some sort of small business or agriculture. When asked about her greatest worries for her children, a caregiver in Salima reflected on the guilt she felt when struggling to provide for the 6 children in her house,

“Fees and food. All these children look at me as their hope so when I fail to do casual works or fail to do business it means they have suffered. This means that after receiving SCTP I have to invest it into business and after failing to succeed in that area I have to start looking for casual works. I do this to make sure that my children eat and have clothes. This means that I have to share the money into buying food, clothes, exercise books and many more.”

Caregivers felt guilt as they struggled to cope with shocks and meet daily needs like food, which negatively impacted their wellbeing.

Education was also a source of stress for the caregivers. Each household included in the study had a combination of in-school and out-of-school youth. Caregivers of adolescents were constantly juggling the tasks of keeping the school-going children engaged in school and encouraging those who had dropped out to go back. They voiced fears that they would not have enough money for all of their children to continue their education, especially if they made it to secondary school. Beyond school fees, education related expenses included preparatory and final exams, school supplies (pencils, notebooks, etc.), clothing, shoes, and personal hygiene products such as lotion and soap to encourage children to attend school looking presentable.

Caregivers of adolescents often had to decide whether the long-term benefit of their children finishing school outweighed the short-term benefit of them dropping out in order to contribute to the household’s current needs. A caregiver of in-school youth in Mulanje explained in a focus group why her children’s education was a priority for her.

“It is important, as I don’t know how to read and write and sometimes when I get an SMS, they help me read, the same for the letters. So, they help us in communication and if they go further they can help us, as we are growing old, and can’t work, so if they get something, they will get paid and help you.”

Many caregivers wanted their youth to earn a decent or stable income, regardless of their educational status, to ensure the adolescents financially support them in the future. For caregivers, the extent of the youth’s success, however measured, translated into their own individual success, both financially and socially.

Another female caregiver in Mulanje explained her understanding of the importance of her children finishing school and how it affected her when her children failed to go to class,

“The challenge I have is when they fail to go to school. I do remind them and tell them that school is very important. It’s where one learns how people live and it’s your future. It’s future to them. So, if they stay at home without going to school, it pains me. My wish is to see them getting educated and they proceed with life. This is my wish.”

Though she clearly valued education, the reality of her financial situation made her question her ability to see her children through school.

“If [my son] goes to secondary school, I will not be able to pay his fees. I do source money through casual work. So, I cannot make it to pay the fees. Had it been that I have a solid source of money I would have said that I will make it.”

Sometimes the reasons for school dropout were not solvable with money alone. Caregivers of adolescents cited several factors such as the child’s disinterest and poor academic performance as barriers to their children’s education. These issues were echoed in focus group discussions with out of school youth and caregivers in the Education Study. For example, an out of school male in Mulanje said he was uninterested in school despite doing well academically.

“I was just bored to stay in school. I think it was an evil spirit on me. I just stay home”, he said, adding, “I just decided to quit, I just decided to stop attending classes”.

Another out of school male in Mulanje blamed his bad grades. “I was failing in class, hence I stay away from school”, adding he followed the path of other friends who left school.

Whether in or out of school, youth in the focus groups also reflected the tension between economic pressure to stay in school and also to drop out. Several youths said they left school to

alleviate the economic burden of school fees on their households. An out of school student in Mulanje shared, “Most parents are poor, and they depend on their children to help them by doing *ganyu*.”

The adolescents that were enrolled in educational institutes felt pressured to work in the morning before leaving for school. Some even felt that their caregivers prioritized completing morning chores over attending school on time. An in-school male in Salima described the process of how heavy morning work could result in youth missing school,

“It happens that parents wake you up early in the morning to go first to the field and cultivate. After cultivation, you go to school. You always go to school late because you first go to the farm to cultivate. Teachers always send you back [home] and you miss a lot of stuff. You know not what your friends have learned that day.”

Adolescents in SCTP households were often forced to choose between their personal well-being and the household’s well-being. Their caregivers expected them to help shoulder the burden of living with limited resources.

4.1.3 Social Cash Transfer Programme Response to Education Needs

There was large overlap in the ways the caregivers spent their cash transfers. Though many mentioned using the cash transfers to cover school fees and other school-related costs, they often felt that it was still difficult to meet all the needs of their school-going children. For example, an in-school youth focus group in Mulanje shared that the SCTP made the cost of school more manageable for his family.

“My parents pay school fees for me even though the [SCTP] money is not enough for the fees... [my parents] top up the amount using their own means. They do casual work; my mother draws water for those moulding bricks and they cultivate in someone’s field. At the end, they make money to pay my school fees.”

Caregivers from an in-school caregiver focus group in Mulanje, echoed this sentiment, “I thank Mtukula Pakhomo as it pushed me through, when the children have no books, I buy”. In-school youth expressed reduced pressure to work in response to the vignette of a secondary school student receiving SCTP cash that was presented to the group. One in-school female youth in Mulanje said, “Without SCTP, he couldn’t afford to go to school”. SCTP cash enabled youth to spend more time in school and less time on *ganyu*. Students still did *ganyu* to earn money but did so outside of school hours, rather than miss school to work.

Households invested SCTP cash to generate money to pay school fees, most notably by purchasing livestock to raise and sell. “They [caregivers] buy goats and after they multiply, they sell the small ones and use the money for school needs, like uniforms, books and fees”, said an in-school female in Salima. Therefore, in addition to using SCTP cash to pay fees, households used the multiplier effect of investing funds to send and keep their children in school.

4.1.4 Social Cash Transfer Programme Response to Other Needs

In addition to school fees, caregivers of adolescents used SCTP money to purchase maize and other food stuffs; household items like soap, housing repair/renovation, and livestock. SCTP money was also used to invest in the village banks or as capital to start small businesses selling firewood, dried fish, and doughnuts. In addition to covering household expenses, the additional money from SCTP allowed some adolescent caregivers in Mulanje to do less *ganyu*. One said:

“My life has changed because before I was relying on casual works but now after receiving money it’s like I am relieved a little bit because I am able to do business four, five days but when the business fails I go back to casual works.”

While all caregivers of adolescents could cite direct benefits from SCTP money, they continued to have chronic and substantial unmet needs to address their vulnerabilities and provide for their households. Many participants hesitated to complain about the amount of money they received since it was viewed as a gift. A caregiver in Mulanje, whose transfer had recently been reduced from MK17000 to MK14400, said,

“I cannot say that it is not enough, but it is enough because I have just received for free. No work done to deserve the payment.”

Nevertheless, with additional probing, it was clear that respondents were not satisfied with the SCTP cash amount. Later in the discussion the same caregiver admitted that her transfer was not enough to cover all of her expenses after the reduction. Participants’ hesitance to critique the SCTP gives insight to the many uncertainties they face on a daily basis. The cash transfers are a dependable source of income for beneficiary households. Given their extreme poverty, however, it was difficult for participants to critique the SCTP when the alternative would be no money at all.

4.1.5 Social Cash Transfer Response to Social Context

Amidst the lingering challenges, most of the caregivers of adolescents indicated that the SCTP had a positive impact on their social relationships. They felt more engaged with their

community after becoming SCTP beneficiaries. This engagement included being able to contribute to the funerals, for example. It also meant that they were able to borrow money from friends or family who trusted them to repay because they received the transfer. Additionally, receiving the transfer money helped alleviate some of the shame and exclusion associated with poverty. A caregiver from Salima shared,

“It has changed me in the sense that it has managed to hide my poverty. Yes, I am poor but now I at least look at par with my fellow villagers but am still lacking some things. However, some people respect me because I’m able to contribute when there is need to do so.”

The transfers helped many participants feel like a contributing member of their community worthy of respect.

Not all respondents, however, shared positive reactions to the SCTP. A caregiver in Mulanje mentioned that the cash transfers complicated some of her relationships, as illustrated in the exchange below,

“Participant: I do not feel good living in my home village. I am saying so because of the money I receive from the program. It’s like I am in conflict with people. I feel bad... As I have received today. They will talk negative things... I think this is a great challenge I have in my village seeing that I am surrounded by relations.

Interviewer: This happens because of the transfers or it was there to begin with?

Participant: It’s because of the social cash transfer money. It has created enmity. To run away from this, I share the money. Had it been that I was alone without these relations, I think I would have enjoyed fully.”

She also reported that the village chief was resentful towards the SCTP recipients in the community because they don’t share their money with him. The chief had even gone so far as to exclude SCTP recipients from the subsidized fertilizer programme as a form of punishment.

“[The chief] wants us to share him the money once we receive. At a meeting he also says this. One time he said it during one meeting saying ‘you do not share me your social cash transfer programme money, why?... because of this, most of the beneficiaries we do not attend his meetings if he calls one.”

These narratives suggest recipient stress and strained social and community relationships may be unintended consequences for SCTP recipients, as some may feel socially pressured or obligated to share their benefits with others in the community.

4.2 Quantitative findings on vulnerabilities within households with adolescents

The above qualitative findings point out various vulnerabilities experienced by caregivers. These range from chronic conditions to household shocks such as floods, poor harvest yield and loss of livestock. Most importantly, caregivers of adolescents mentioned education and food as their two main worries as a result of the shocks and vulnerabilities. Therefore, we studied the impact of household shocks and the condition of the household head on effective enrolment of adolescents aged between 15 – 24 years and the household annual food consumption. In order to facilitate comparison, we restricted our analyses to households with adolescents.

To empirically assess this relationship, the following regression equation was used, where Y_i was the outcome variable for adolescent i expressed in effective enrolment and annual food consumption expenditure:

$$Y_i = \alpha + \sum_h \beta_h Shocks + \sum_j \gamma_j Head + \mu_{ijh}, \quad (1)$$

Effective enrolment was derived by a combination of both enrolment and regular attendance information. An adolescent was effectively enrolled in an academic year, if (s)he was enrolled and regularly attends school in all three trimesters. The set of coefficients β captured shocks faced by household h . The shocks are classified into two broad categories: idiosyncratic shocks which are household specific (such as death of the bread winner or household destruction) and covariate shocks which are community level shocks (such as floods or draught). The set of coefficients γ include a set of household head j characteristics such as gender, health conditions and education attainment status. Finally, μ was a clustered error term for individual i , living with household j in a household h . The standard errors of all estimation were obtained by bootstrapping. Given that effective enrolment was expressed as a dummy variable, its estimation was performed using a probit model; whereas annual food consumption was a linear estimation.

Column (1) of Table 5 reflects the probability of effective enrolment by an adolescent given household shocks and household head characteristics. Results indicate that, neither idiosyncratic shocks nor covariates shock were determinants of effective school enrolment of adolescents. Regarding household head characteristics, while chronic health conditions of the household head

had a negative effect on effective enrolment, the coefficient was not statistically significant. However, disability condition of the household head reduced effective enrolment by 11 per cent on average. Hence, disability conditions of the household head thus impact adolescents schooling.

Table 5: Effect of Household shocks, HH head conditions on adolescents

VARIABLES	(1) Effective Enrolment Adolescents (15 -24yrs)	(2) Annual Food Consumption (MWK)
Household had any idiosyncratic shock	0.0195 (0.0729)	-204,406*** (24,916)
Household had at least one covariate shock	0.0514 (0.0649)	-131,510*** (17,000)
HH Head Female	-0.0873 (0.0725)	-95,505*** (18,622)
HH Head Has a chronic condition	-0.00181 (0.0682)	30,824* (16,148)
HH Head Has a disability	-0.284*** (0.103)	23,430 (26,265)
HH Head Ever attended school	0.0657 (0.0715)	36,567** (17,359)
Constant	-0.291*** (0.101)	789,744*** (32,640)
Observations	2,100	2,100
R-squared	0.07	0.095

Bootstrapped standard errors in parentheses; *** p<0.01, ** p<0.05, * p<0.1

In column (2) of Table 5, we estimated the relationship between shocks and household head conditions on annual food consumption. When the household experienced any idiosyncratic shock, annual food consumption reduced by MWK 204,400. Similarly, any community-level covariate shocks such as floods reduced annual food consumption by MWK 131,500. The quantitative results thus confirm the qualitative findings that household shocks greatly reduce food consumption in household with adolescents. Likewise, the table shows that female headed households had lower annual food consumption with respect to male headed households. In households where the head had ever attended school, their annual food consumption increased by approximately MWK 36,500 with respect to households where the head has never attended school.

Household shocks and vulnerabilities of household heads place a burden on adolescents either by taking up additional household chores or undertaking a short-term labour. Excessive labour is defined according to International Labour Organisation standards, whereby an

adolescent is performing excessive household chores if he/she has performed more than 28 hours of household chores in a week (International Labour Organisation, 2008). To empirically assess the burden of caregivers' vulnerabilities on adolescents, the following regression equation was used:

$$Y_i = \alpha + \sum_h \beta_h Shocks + \sum_j \gamma_j Head + \mu_{ijh}, \quad (2)$$

where Y_i was the outcome variable for adolescent i expressed as the probability of an adolescent engaging in excessive household chores and *ganyu* labour. All remaining variables and set of coefficients had the same interpretations as that of Equation (1) described above.

Column (1) of Table 6 analyses the probability of an adolescent to do excessive household chores on household shocks and household head conditions. The results show that household shocks were not statistical determinants of excessive household chores. However, certain household head conditions did correlate with excessive household chores of adolescents. Adolescents in female headed households were less likely to do excessive household chores compared to male headed households. On the other hand, if the household head was widowed, excessive household chores of adolescents increased by 6 per cent on average. Likewise, disability condition of the household increased excessive household chores by 5 per cent on average.

Table 6: Probability of adolescent HH excessive chores and *ganyu* labour

VARIABLES	(1) HH Excessive Chores	(2) Ganyu Labour
Household had any idiosyncratic shock	-0.0181 (0.0806)	0.0646 (0.0862)
Household had at least one covariate shock	-0.113 (0.0709)	0.232*** (0.0750)
HH Head Female	-0.229** (0.0940)	0.278*** (0.0960)
HH Head Widowed	0.256*** (0.0913)	-0.185** (0.0864)
HH Head Has a chronic condition	0.0106 (0.0703)	-0.00577 (0.0762)
HH Head Has a disability	0.214** (0.103)	0.253** (0.105)
HH Head Ever attended school	-0.102 (0.0799)	0.00845 (0.0798)
Constant	-0.817*** (0.116)	-1.175*** (0.122)

Observations	2,178	2,178
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Bootstrapped Standard errors in parentheses; *** p<0.01, ** p<0.05, * p<0.1

Column 2 of Table 6 analyses the probability of engaging in ganyu labour. Adolescents in female headed households had an 8 per cent higher probability of engaging in ganyu labour than adolescents in male headed households. Likewise, if the household head had a disability condition, it increased adolescents' probability of engaging in ganyu labour by 7 per cent. These estimates confirm the qualitative findings that when households experience shocks or when the household head is specially abled, the burden was placed on adolescents to perform excessive household chores and/or engage in ganyu labour to raise additional resources to supplement the household income.

Furthermore, results indicate that adolescents in female headed households are less likely to perform excessive household chores while concurrently more likely to engage in *ganyu* labour (see Table 6). This result can be attributed to rural labour market conditions and the nature of *ganyu*. SCTP households are labour constrained with an average age of households of 57 years compared to 45 years of other rural ultra-poor households (see Figure 2 and Table 4). Older female heads of household with physical disability and chronic disease may not be able to undertake heavy physical labour required by *ganyu*; this work may be left to adolescents to bring in additional income to the household.

4.3 Qualitative findings on vulnerabilities in households with elderly caregivers

The average age of the elderly caregiver participants (n=11) was 71 years (range 61-79 years). They were the least educated group in the Life Cycle study; six participants had no formal education and the highest level of education attained was Standard 4. With an average of five members, households with elderly caregivers tended to be smaller than the households with young mothers and caregivers of adolescents.

Four elderly participants identified themselves as the main breadwinners of their households as well as the sole caregivers for children and adolescents. Their dependents were often orphaned grandchildren or other relatives. The elderly participants' vulnerabilities were mostly related to their health status, limited capacity to work and limited social networks.

4.3.1 Diminished health status and labour capacity

Echoing the quantitative findings in Table 6 above, when asked about challenges in their households, elderly participants mentioned their age, chronic illness, and disability (their own and

their partner's). Their advanced age was often accompanied by both acute and chronic morbidities, which required more frequent medical attention. As a consequence, when compared to younger households, elderly households had to dedicate a larger portion of their budget to medical costs. An elderly participant in Mulanje had problems with his legs, which made it difficult for him to walk long distances. To make money, he bought and dried trees which his wife, who also suffered from medical issues, sold at the market. The small amount of profit yielded from the firewood was usually just enough to cover the costs of pain killers for his legs, thus neutralizing some of the medical costs but not providing additional income for the household. The pills only gave him enough relief to keep the firewood business going.

In addition to their medical expenditures, chronic illness and disabilities also made it difficult for some of the elderly participants to perform household chores and the casual work they had relied on in the past. An elderly caregiver in Salima shared that recently both she and her husband fell ill and were not able to cultivate their land or fulfil household duties such as cooking. When discussing the impact of her illness, she said "if you are sickly you cannot develop. You need a healthy person... You cannot do anything if you are sickly." During her illness, the SCTP became the only source of money for the household. While this participant was eventually able to start earning money again, three other participants mentioned that the SCTP money was their only source of income. Reflecting this reliance on the SCTP funds, an elderly caregiver from Mulanje said,

"Oh no, I do not source money on my own... the only channel that I make or receive money is through this social cash transfer program."

As the SCTP money was not designed to replace income, households that were completely dependent on the money were in an extremely precarious situation.

Beyond limiting work productivity and income, disability and prolonged illness also took an emotional toll on some of the elderly participants. Another elderly participant from Mulanje who sold firewood discussed his frustrations with his disability,

"The challenge on [a] daily basis is the illness I have. I wish I was okay to do what I want to do. Sometimes when I sit down and think about it, ah I feel sorry for myself. Had it been that I am okay, I would have done more for the betterment of my household."

This participant felt shame for not being able to contribute more to his household. Other participants echoed his sentiments of guilt for being less productive.

4.3.2 Limited social networks

In other Life Cycle study households, there were multiple generations of family members living together who might contribute small amounts to the family finances. Four of the elderly participants mentioned receiving financial support from their adult children. However, five of the elderly participants identified as the sole breadwinners for their household and mentioned that they did not have other relatives or friends who could help support them. After the death of her father, an elderly participant in Mulanje realised she had no social network beyond her two orphaned grandchildren that lived with her,

“Elders are dying, and I am alone remaining now. I have no relations. I am alone now without anyone to hold my hand.”

Beyond lacking financial support, she felt stress due to her social isolation. The combination of social isolation, health issues, and limited labour capacity put a seemingly insurmountable amount of pressure on these elderly participants.

After the death of her father, an elderly participant in Mulanje realised she had no social network beyond her two orphaned grandchildren that live with her.

“What I can complain about them it’s when they are sick. I go to hospital with them alone. No one else helps me...I am raising these children alone. I have no relations who can help me on this note.”

Beyond a lack of financial support, she felt socially isolated and disconnected from the rest of the world.

“My health was much affected because of stress...I am alone now. I am the one remaining. What should I do then? I am much affected.”

Relatedly, four of the five elderly participants that reported having no support system were also caregivers to orphaned grandchildren. A female participant in Mulanje shared that her stress as a caregiver had negatively impacted her own health.

“I was given these grandchildren while they were young. It has not been easy to raise them. I think of them how to make them live and survive. This is the reason why I developed [high] BP.”

She later went on to mention that she felt guilty for not being able to provide them more nutritional food. She worried that other people in the community might think she mistreats the children because they are often hungry.

Beyond food, she also worried about being able to cover their school fees. She wanted the children to pursue an education, but she doubted her ability to sustain them in secondary school due to her constrained financial situation.

“If they make it to secondary school, what am I going to do for them to pursue the education? This is what I think of them.”

Due to their age, elderly caregivers of adolescents had to consider the consequences of their passing on their dependent children. Often, they were the only living relative for these children, or at least the only one willing to care for them. Another caregiver from Salima wondered, “how [will I] support them if they move to other levels in their studies. If I die, what will they do?” The combination of current struggles and fear for the future put a seemingly insurmountable amount of pressure on these elderly caregivers.

4.3.3 SCTP Response to vulnerabilities in elderly households

The elderly participants used the SCTP money for a variety of needs including food, school fees, livestock, capital for small business, and housing repair. As mentioned previously, the SCTP was the main source of income for four of the elderly participants. Though the money was not enough to cover all the needs of these households, it was a more reliable source than the unpredictable casual labour or small businesses that the participants had previously engaged in. As one participant explained,

“I am not worried now. I know that I will soon have money after two months. This is helpful for me. I thank the project.”

In lean times, the elderly participants were able to borrow money from neighbours with the added assurance that within 1-2 months they would be able to repay. The transfer money also allowed them to purchase livestock, which could be sold off during financial emergencies. An elderly caregiver in Mulanje was happy to have bought chickens because “in times of needs you will be able to withstand. You can sell the chicken and buy what you want to buy.” As mentioned in the adolescent caregiver section, the SCTP recipients often use the SCTP money for investments such as livestock or village bank membership. When inevitably hit with a shock, these

investments are able to reduce the impact. However, this long-term financial planning is not possible for all recipient households.

As beneficiaries of the SCTP program, some elderly participants felt less insecure about their living situations. The participants were able to contribute to funeral funds and pay their church membership fees, actions which reduced the shame and guilt of many elderly members of society and instead made them feel like contributing members of the community. As recipients of the SCTP, they were no longer people to be pitied. A participant in Salima felt she was able to interact with her neighbours in a new way,

“Some people are happy that I have changed. They think I was after them in asking and begging for assistance. ‘I need this’ they give me. Since I started receiving the money then I am not begging anymore. I am able to keep MWK 2000. It’s like I am not a poor person. We pass one another along the road and we greet one another. ‘how are you’ ‘I am fine and you’ life goes on.”

While all of the elderly participants felt that the SCTP had positively impacted their lives, the majority still felt like there was room for improvement. Some participants were hesitant to be critical about the size of their transfers as exemplified by the following exchange between an elderly participant and the interviewer in Salima,

“Interviewer: How do you feel the amount of money you receive?”

Participant: Ah I cannot say a word on this. All is well because I am able to eat

[...]

Interviewer: In your words I want you to be free

Participant: It is not enough. The only thing I did not want to say a word on this question is that; I cannot demand to have more transfers. I just receive the transfers I am thankful.

Interviewer: In your opinion, what has kept your household from experiencing greater impact from the program?

Participant: The money is not enough. Priority goes to the food so that my grandchildren should eat enough. There is no where they can go and eat. I am a breadwinner to them.”

The money provided some relief but did not cover the many needs of the elderly participants. However, depending on the number of shocks a household experienced, the cash

transfer may be available for basic needs at all. When discussing her household's challenges, an elderly participant from Mulanje shared:

"Each time I go to collect the transfers, a shock comes in. 'your mother is dead'... then the other time I receive the transfer I hear 'so and so is hospitalized in town' I use the same money for transport and other needs. It's like that all the times."

As soon as she received the money, there was always an emergency requiring attention before she could think about her day-to-day needs. This made it difficult for SCTP households to make any progress as they were in perpetual catch up with their basic needs. An elderly participant in Mulanje talked about the amount of work that he and his household had to do in addition to the SCTP in order to "move forward",

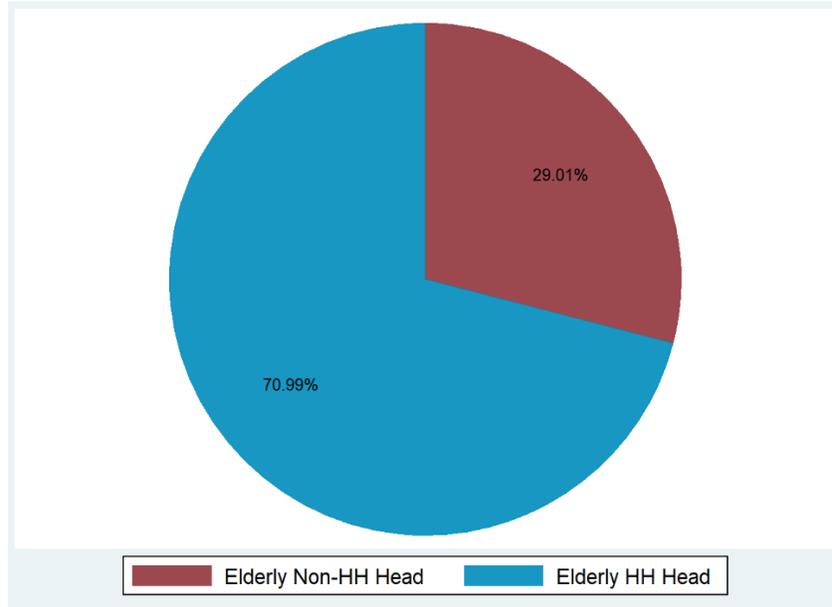
"Others they say that 'they do receive the money, but nothing is changing or developing' people do talk, you know. It's not that we just use the money from the social cash program. We do have our own businesses that we do. When developing, others they think that it is because of social cash transfer programme not knowing that we also sweat to develop. Whatever we do they relate it with social cash transfer programme and yet we sweat. It's not all that we do it's because of social cash transfer program. If you only depend on social cash transfer program, you cannot move forward. Nothing you can achieve."

4.4 Quantitative Findings on Vulnerabilities in Elderly Households

The study interviewed 1,505 households (see Table 3). In all of the households visited, there were 810 elderly individuals aged 65 and above. Of the 810 elderly in the study sample, 71 per cent of these were household heads (see Figure 3).³ The majority of the elderly were females (approximately with 7 out of 10).

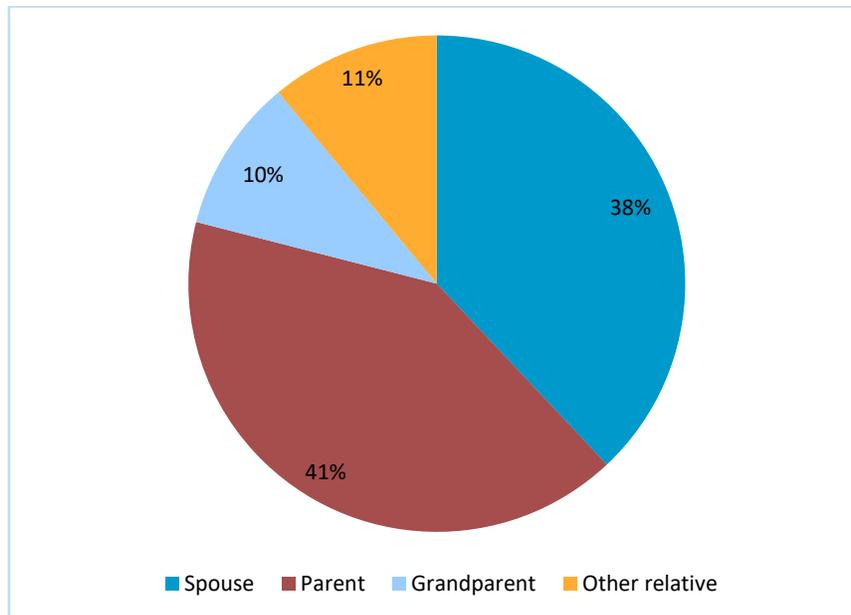
³ This shows that out of the 1505 households interviewed for this study, more than one third of the households are headed by an elderly.

Figure 3: Distribution of elderly in study sample by household head status



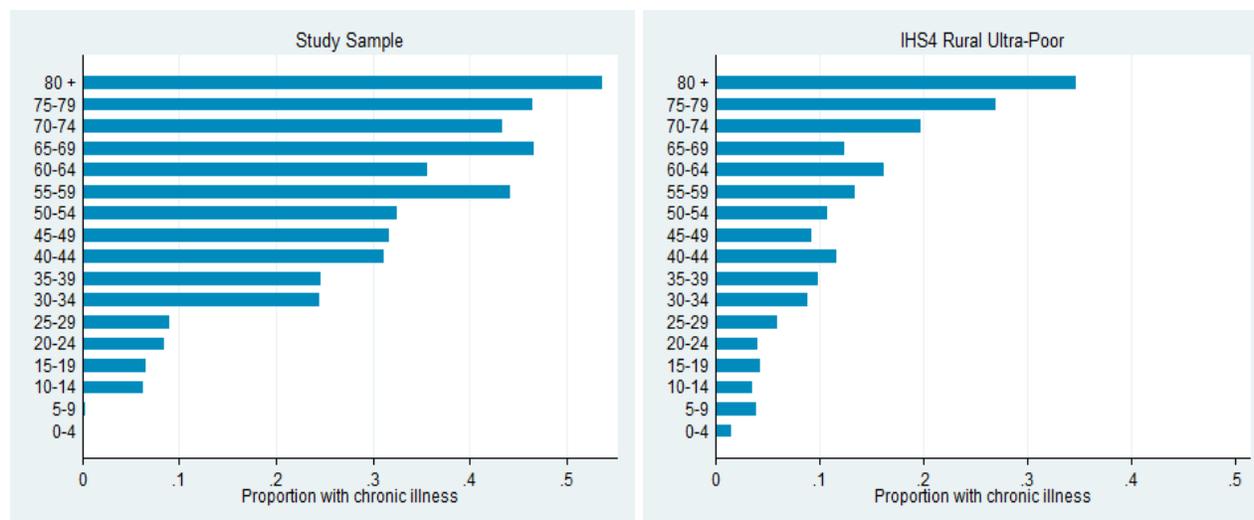
Of the 235 elderlies who were not household heads, 38 per cent of them were the spouse of the household head. 41 per cent were the parents (either mother or father) of the household head. 10 per cent were grandparents to the household head, and the remaining 11 per cent were in another category such as sibling, in-law or other relative (see figure 4).

Figure 4: Relationship of elderly non-HH head to household head



The qualitative findings identified chronic illness conditions among the elderly as one of their main vulnerabilities. The prevalence of chronic conditions is compared among different age groups within the study population. To provide a benchmark of comparison to verify if indeed the target beneficiaries of the Social Cash Transfer Programme (SCTP) are different from rural population, the report also compares the prevalence of chronic illness among other rural ultra-poor population who are of the social cash transfer (see figure 5). It can be noted that, chronic illness was higher in the social cash transfer beneficiaries group compared to other rural ultra-poor households. This generally reflects the targeting strategy of the social cash transfer aimed at reaching ultra-poor who are labour constraint.

Figure 5: Prevalence of Chronic Conditions by Age Group



Furthermore, the prevalence of chronic conditions was further disaggregated at gender level (see figure 6). There is a higher prevalence of chronic conditions among females than males (see figure 6). The elderly aged 65+ had the overall highest prevalence of chronic conditions. The general proportion of elderly with chronic conditions did not differ much among those who were households' heads and non-household heads. However, a sub-group of the elderly aged 80 years and above presented some differences. Within this sub-group, more than 60 per cent of the elderly 80+ who were not heads of households had chronic conditions compared to 48 per cent among those who were heads of households.

Figure 6: Prevalence of Chronic Conditions by Gender

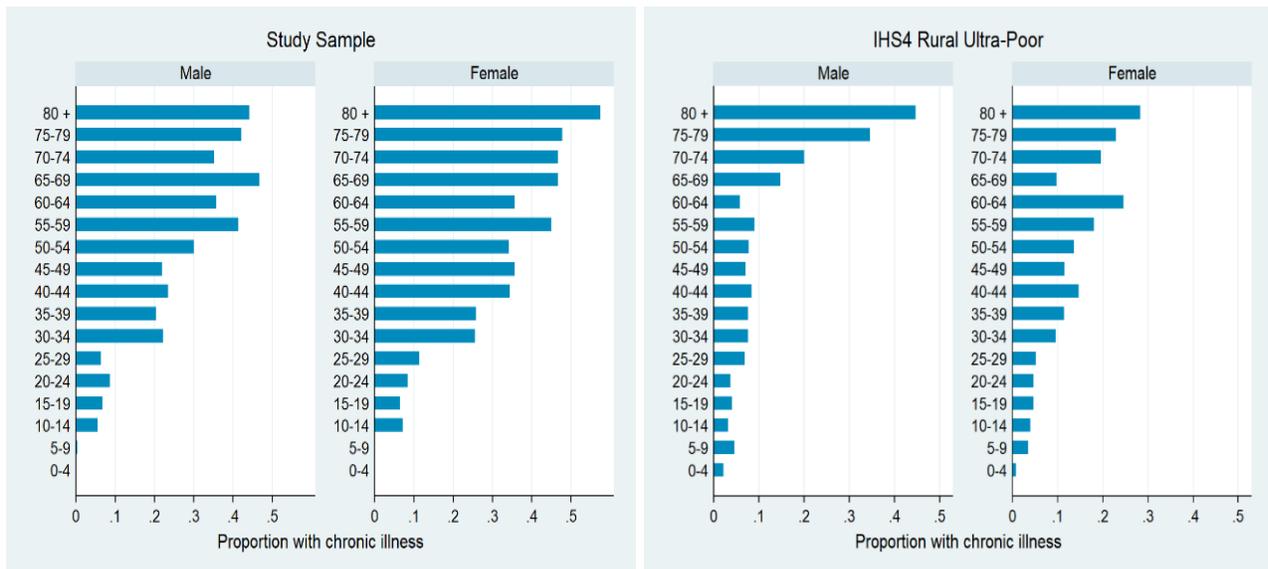
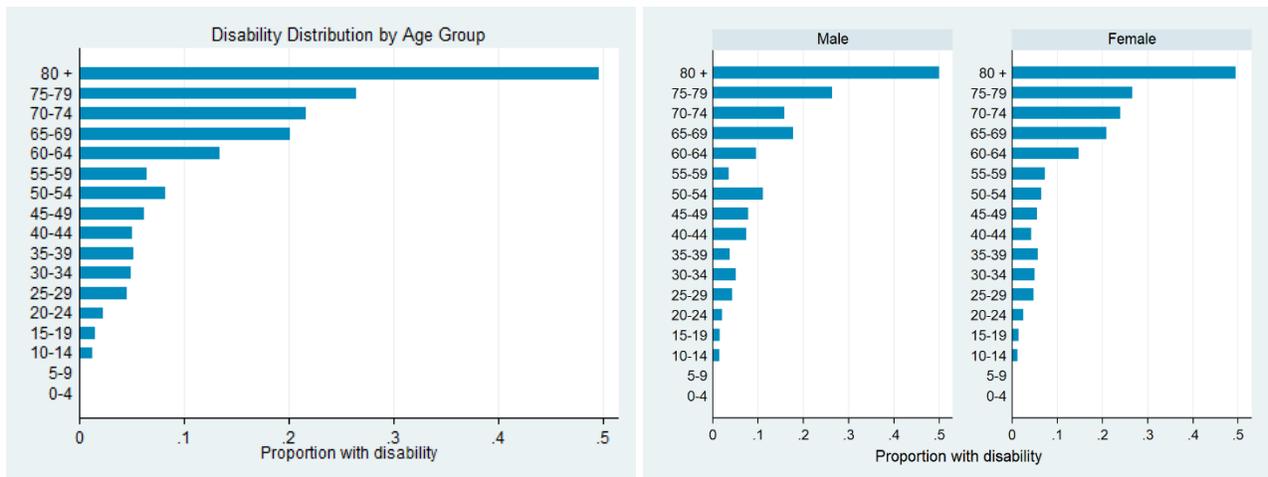


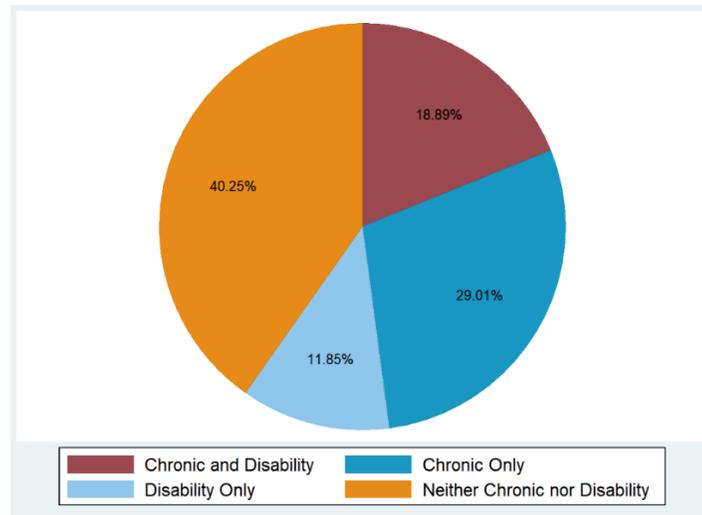
Figure 7: Prevalence of Disability by Age Group and Gender



Likewise, the percentage of the study sample living with a disability by age group and by gender is depicted in the left and right panels respectively (see figure 7). Recurrently, the elderly aged 65 and above had the highest rate of disability compared to the other age groups. Approximately half of the most elderly 80+ group live with some kind of disability. Overall, the proportion of the population with a disability was lower than the proportion with chronic illness. The incidence of disability among the elderly differed between elderly household heads and non-household heads elderly. Approximately 28 per cent of elderly household heads had a disability while this proportion increased to 37 per cent among non-household heads

Fig 8 depicts the joint incidence of chronic illness and disability among the elderly in our sample. Roughly 60 per cent of the elderly had some sort of chronic illness or disability (see figure 8). Specifically, 19 per cent of the elderly had both a chronic illness and a disability, 29 per cent had a chronic illness only; 12 per cent had a disability only, whereas the remaining 40 per cent had neither a disability nor a chronic condition.

Figure 8: Chronic Illness and Disability Among the Elderly



When we split the elderly by household head status, non-household heads (23 per cent v 17 per cent) had the highest proportion of those with both chronic and disability conditions. However, 58 per cent of elderly household heads had some condition, whether disability, chronic illness or both (see figure 9). Given that headship implies either decision-making or financial responsibility or both, this is a very grave concern among SCTP households.

Fig. 10 plots the types of disability among the elderly. Difficulty in walking or climbing steps was the most common type of disability among the elderly. This was followed by sight related problems, difficulty in remembering, communicating, and hearing.

Figure 9: Chronic Illness and Disability Among the Elderly by Status

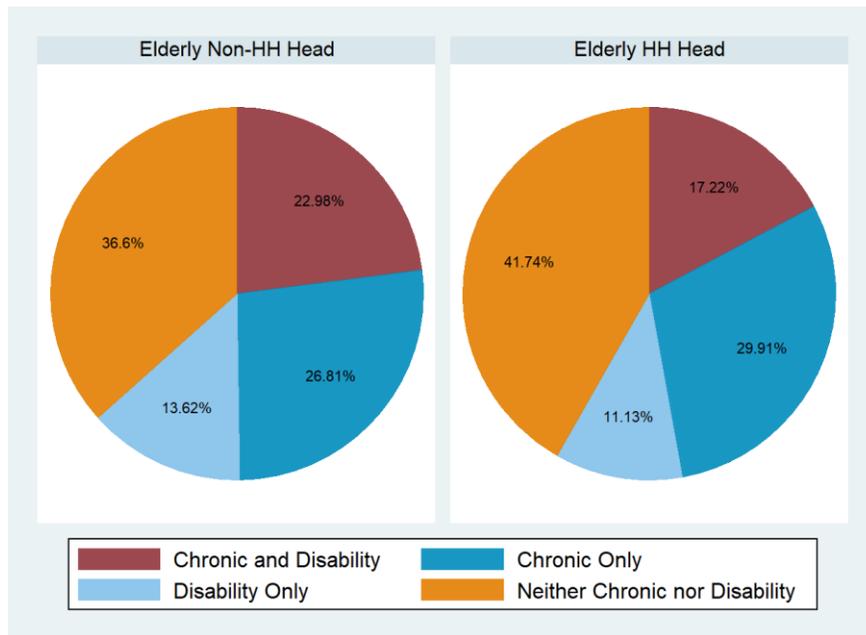
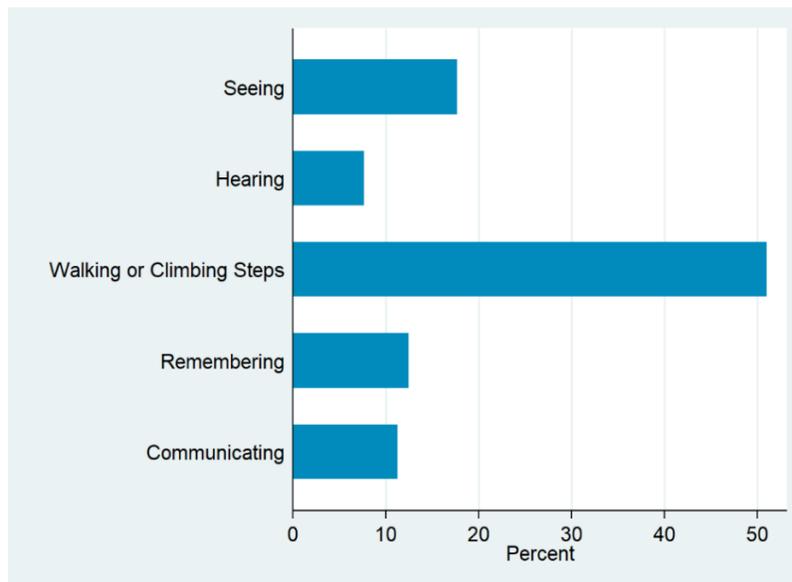


Figure 10: Distribution of Types of Disability Among Elderly



4.5. Qualitative findings on vulnerabilities of young mothers and children under 5

Young mothers tended to have larger households than caregiver or elderly participants. They reported an average household size of 7 members (range: 6-11). Six of the respondents were married at the time of the interview, and four were married at the birth of their first child. These participants tended to be less educated than the caregivers of adolescents. Seven of the young mothers had an education level of standard 5 or below. The average age of the young

mother participants at the time of their first pregnancy was approximately 15 years. Of the ten young mothers interviewed, seven had children under the age of five. In most cases it seemed that these children were treated as another dependent in the household and their experiences and wellbeing did not appear to differ much from the other children in the household. The main vulnerabilities that were identified included limited education, barriers to re-entry, and social isolation.

4.5.1 Limited education due to dropping out of school

Many of the respondents' experiences with motherhood had a significant impact on their education. Four respondents cited pregnancy as the main reason that they dropped out of school, the other six dropped out due to financial reasons and lack of support. Four participants reported getting pregnant or married soon after leaving school. One young mother said, "There were a lot of problems, getting married at a young age and having more children at young age, that's due to dropping out." She saw her pregnancy as a direct result of leaving school.

Limited education due to dropping out of school was closely linked to a variety of health and economic issues affecting this population. The average education level of the young mother participants was standard 4. Multiple participants felt that if they had stayed in-school they would have been able to find more reliable work with a salary and would have a better quality of life. If they were working at all, the young mother participants did casual work such as farming or selling doughnuts. One young mother participant summarized the main vulnerabilities faced by this group as ultimately connected to the issue of dropping out of school,

"There were a lot of problems, getting married at a young age and having more children at young age, that's due to dropping out."

A young mother from Salima discussed her limited opportunities due to her lack of education,

"I do regret most of the time...Education is good, there is a lot of programmes that comes in our communities that requires someone who knows how to write."

Two young mothers in Salima said the more stable, waged positions at community organisations were only given to people who could read and write.

In addition to better employment, education also meant freedom from the many challenges of raising children and running a household. A young mother from Mulanje, who dropped out of school because of fees, felt her pregnancy worsened an already difficult situation. As she continued to have kids, she felt like she "added more problems on [her] plate." When asked to

give advice to young girls currently in school, the young mothers viewed their own experiences as cautionary tales encouraging young girls to stay in school and avoid boys. A young mother from Salima said,

“I can tell them to work hard on their education, they should not get involved in the things that will put them in trouble like getting pregnant, they should work hard at school so that they will not be like me because education is the only future they have.”

Another from Mulanje shared:

“I can tell them to focus on their future and not do like I did, I would tell them that I admire their position as they go to school, and tell them not to do like me, as I am facing a lot of challenges.”

From their advice, it was clear that the young mothers associated education with having a better life than what they had been able to achieve. Though most of the young mothers expressed willingness to return to school, the following qualitative findings summarized main issues mentioned as barriers to school re-entry.

4.5.2 Barriers to school re-entry

As mentioned earlier, six of the young mothers had already dropped out due to school fees before they got pregnant. With the added responsibility of a child, the barrier to returning to school often felt insurmountable. Despite casual work, many had little to no income to put towards their education. The addition of another child meant that the household finances had to be stretched even further, leaving no extra money for school fees. A young mother from Salima shared her feelings of guilt about asking her parents to help her go back to school,

“When I look at our household, I feel that my parents can’t manage to send me back to school because I would also be imposing on them another responsibility when the household is already lacking.”

She left school because of fees and ended up getting married to escape poverty.

“Like my first child, it just happened because of poverty at home, as my parents had died a long time, and I was left at a very young age, so due to poverty and having no place to stay, I found a man to marry me and we indeed got married and that’s for my first child.”

Now with her own household, she had many more responsibilities that filled her time. The idea of going back to school seemed less and less attainable. Additionally, some participants

described having difficulty finding someone to look after their child while they attended classes. A young mother in Mulanje said that her husband would no longer allow her to go because “He says who will take care of him?”, reflecting how becoming a wife was a barrier to education given the context of gender roles and norms in this setting. As one young mother said, “Marriage is a river of problems and my being out of school meant I have added the problems.”

For those young mothers still living with their caregivers, lack of support from caregivers was another barrier to returning to school. Many youths from the education focus groups believed caregivers tended to enrol girls in school less, suggesting some caregivers perceived money spent on girls’ education as a loss rather than an investment. An in-school female in Salima described her mother’s reactions to her request for books,

“For me, sometimes when I ask for money for books, my mother tells me to get [it] from my boyfriend, and she even says, ‘Just quit [school]’. [Group laughs] You don’t want me to say the truth.”

A participant in the same focus group agreed adding,

“They [parents] tell you to get a boyfriend, they say, ‘If you are finding life hard, then find a boyfriend to support you’”.

Caregivers repeated similar narratives, as illustrated below in exchange between two caregivers in Salima,

“Male participant: ...so parents just say, ‘Just get married, then! Since you have a boyfriend!’ This does happen.

Female participant: Better to marry than to get pregnant”

Young men, such as an in-school male in Salima, also shared their observations on caregivers’ lack of support for female students,

“Some parents see that their daughter, one day, will be pregnant like the [others] in the community, [so] they prefer not to support a girl knowing that they will lose money for nothing, in terms of school fees.”

Interestingly, youth and caregivers referenced young women’s relationships with males as both a suggestion of what girls should do to seek financial support and to justify their lack of support for education expenses. An out of school caregiver in Mulanje, said some caregivers do not support girls in school despite receiving SCTP money, suggesting that reluctance to support

girls in school is rooted in gendered norms and expectations rather than limited financial resources,

“Each and every girl go through this. She was not cared for though they were receiving the social cash transfer money. The parents were not providing the necessities to her. ...Since the child was not care for, hence she resolves by getting married. Some parents they want their daughter to get married at tender age. They never take care of their daughter education. They are in this category of not supporting girl child.”

These narratives suggest that generally, caregivers illustrate less willingness, financial or otherwise, to support girls in school. This affects school access and retention and may discourage some young mothers from completing school.

Another barrier that the young mothers mentioned was feeling too old to return to school or that too much time had elapsed. These two barriers were connected to feelings of shame for having dropped out in the first place and for getting pregnant at a young age. Two out of school females in focus groups shared their resistance to continuing their education.

“I have no dreams. I feel like I failed already. I may say I should go back to school, and when there, I will be thinking of what my child will have, the home, so I may have the dream and maybe be supported by NGOs and still fail in class, so that’s not good.”

“Yes, I get the money and I would indeed demarcate it to cover the education needs, but I would never go back as I left school a long time ago.”

4.5.3 Social Isolation

When asked how they felt when they learned about their pregnancies, four of the young mothers discussed feeling like their lives were over. A young mother from Mulanje said she “didn’t feel good as [her] future [had] ended.” Another in Salima said there was nothing for her to do except be idle in the home.

“Instead of going to school or doing something that can bring money in your life you just stay at home, all your dreams dies, so I wasn’t happy.”

At home all day, the young mothers were no longer able to spend time with their peers. Another young mother reminisced about all the social moments with friends she missed after getting pregnant, like playing sports or going to the market. As time went on, the social distance between young mothers and their friends who stayed in school increased. In contrast to their

peers who were still able to be young, the young mothers had to take on new responsibilities as caregivers and wives. Beyond increasing distance from peers, in a few extreme cases, young mothers said that they were intentionally excluded or shamed for getting pregnant at an early age. A young mother from Salima shared her experience of bullying after getting pregnant.

“Participant: The challenge I face, people laugh at me, they say that I gave birth when I was too young. [...]

Interviewer: So how do you deal with that problem?

Participant: I just stay at home; I don't even answer them.”

This quote reflects the social isolation that resulted from public shaming of young mothers. This judgement didn't just come from random community members. Another young mother from Salima shared that even some of her close friends began gossiping about her behind her back. This rejection from their peers led some young mothers to further isolate themselves. Soon, the young mothers' social network would only consist of their family, in some cases the father of their child, and whatever friends they managed to keep.

4.5.4 Social Cash Transfer Programme Response

The impact of the SCTP on young mothers was limited because they were often not the head of the household and thus not in charge of household finances, including management of SCTP funds. Generally, the young mothers felt that the SCTP positively impacted their households. More often than not, the money was used for livestock, fees and supplies for school-going children, food, clothing, housing repairs and hygiene products. According to a young mother in Salima,

“When [the household] started receiving social cash transfer money, there have been improvements but not entirely, the money is not enough according to the number of people in our family.”

This quote reflects the potential added burden of having children or dependents in the same household without any increase to the transfer amount.

Often still living in their family homes, young mothers occupied a unique place in the household. While they were parents themselves, they were still dependent on their caregivers to provide their basic necessities. When asked how they personally benefitted from the SCTP program, some participants had trouble coming up with an answer beyond the household benefits. Two young mothers mentioned receiving a small amount of money from the SCTP cash their

household received that they were able to use how they pleased. More often than not, that money was no more than 2000 Kwacha, and they used it for necessities like soap, lotion, or clothing. However, the majority of the young mother participants felt that they mainly benefitted from food, soap, and other items that were purchased for the household.

When asked how their children were benefitting from the SCTP money, the young mothers had similar answers as they did for themselves in terms of food security and access to small amounts for material needs.

“[The SCTP] helps him because when my parents receive the money, they go and buy him clothes.”

When asked about their children’s well-being, the young mothers shared concerns and hopes similar to those of the caregivers of adolescents. Education was still the main concern. A young mother from Salima said of her child,

“I don’t want her to suffer in [the] future. I want to be able to send her to school. When she need[s] anything, I will be able to provide her.”

When discussing the challenges of raising children, the worries of the young mothers were similar to the older caregivers that were interviewed, potentially reflecting that the same patterns of poverty and stress were being passed on to the next generation.

4.6 Quantitative findings on vulnerabilities of Young Mothers and children under 5

The analysis begins with a description of the characteristics of the mothers/caregivers since the well-being of the child is closely tied to the characteristics and well-being of his/her caregiver. Moreover, programmatic responses to support preschool children will ultimately flow through their caregivers, and some appropriate responses would be directly targeted to improving the well-being of the caregiver herself, as these improvements would also indirectly benefit the child and could be more practical to implement.

The unique profile of SCTP households, which stems from the targeting criteria, results in disproportionately more adolescents and young adult beneficiaries than preschool children. Nevertheless, children under age 5 comprised 12 per cent of all household members and represented a vulnerable group because of their strict dependence on others, and the fact that this is a period of tremendous development and growth. Developmental deficits in this stage of life had far reaching consequences throughout the life-course. If the SCTP is to address the inter-generational transmission of poverty and vulnerability, it seems obvious that it needs to be

sensitive to and respond to the specific needs of children under 5 years in recipient households. Of particular concern, given the typical SCTP household profile, is that a significant proportion of preschool children were the child of a non-household head. This further exacerbates the vulnerability of the child, as they may not have direct access, through their primary caregiver, to the cash transfer. For this reason, the study focused on preschool children of younger mothers, those unlikely to be the recipient of the SCTP.

The average age at the time of their first pregnancy was approximately 15 years. Identification information of all children under 5 in the survey with their respective mothers was combined to create a matched child-mother database. There were 495 children under 5 matched with 412 mothers meaning some mothers had multiple children under the age of 5. Furthermore, taking the difference between a mother's current age and the age of first child under age 5, a mother was defined as "young mother" if the age at first birth was below or equal to 20 years.

Figure 11 presents the distribution of children under 5 based on their mother's status. Out of the 495 preschool children, approximately one out of three children in the study sample) had young mothers while the remaining others were above the young mother cut-off age.

Figure 11: Distribution of Children Under 5

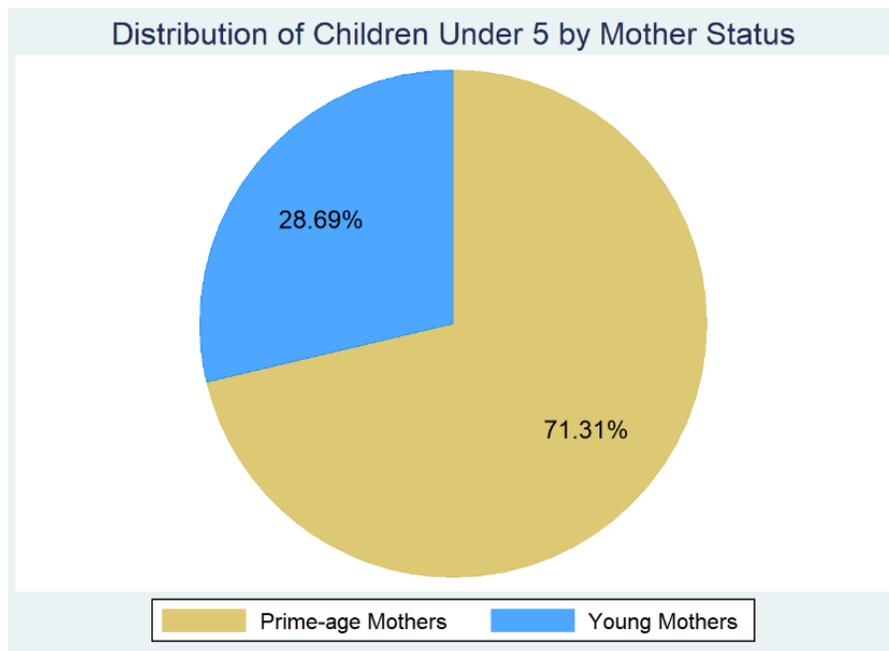


Figure 12: Comparisons of Mother's Relationship to Household Head

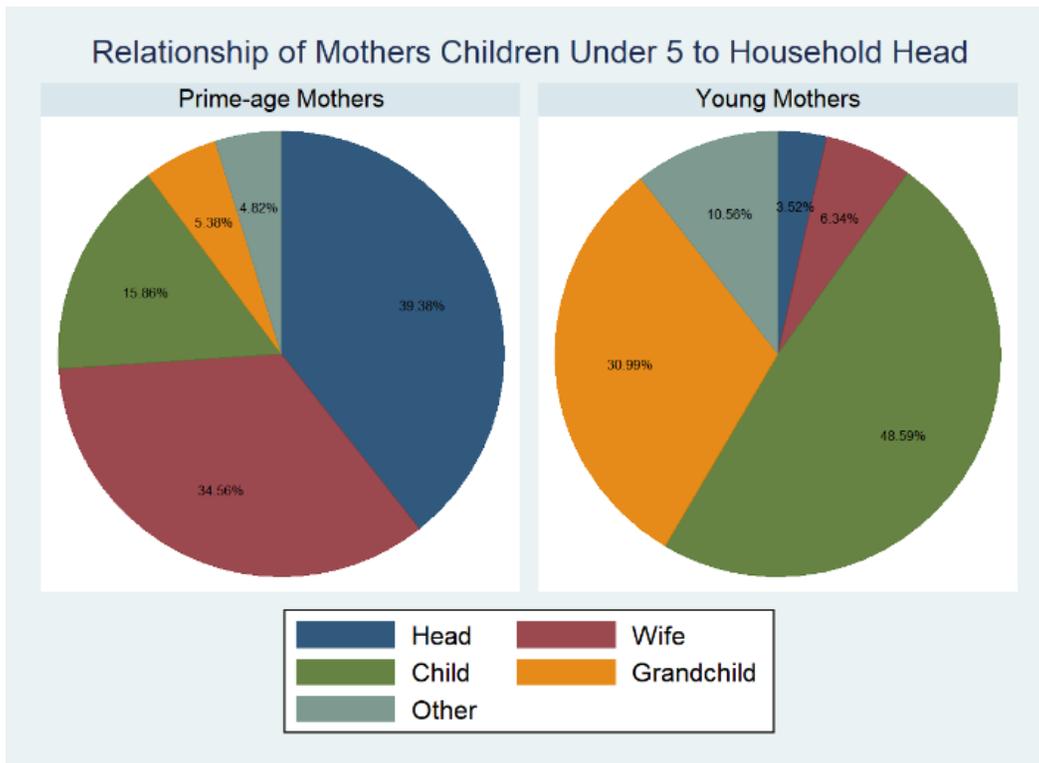


Figure 12 compares the two categories of mothers in their relation to the household head. A little over one-third (31 per cent) of these young mothers were grandchildren to the household head. Their children were therefore great-grandchild to the household head meaning the household spanned four generations. Moving up on the generation ladder, approximately half of these young mothers (representing 49 per cent) were children of the household head. This means that around 80 per cent of these young mothers were either children or grandchildren of the household head. In comparison, only one-fifth of prime-age mothers were either grandchildren or children to the household head. The vast majority of the prime-age mothers (74 per cent) were either married to the household head or they were heads of households themselves.

About one-tenth of the young mothers were either married to the household head or heads of households themselves. This is quite striking considering that these young mothers were mostly adolescents. The qualitative research component presented the following additional findings on early marriages faced by young mothers in the study.

Table 7: Comparisons of prime-age and young mothers

	Prime-age Mothers	Young Mothers
Average Age (years)	33.92	19.62
Proportion Currently Married	0.51	0.23
Proportion Previously Married	0.45	0.28
Proportion Never Married	0.04	0.49
Average Number of Children (All)	4.06	1.46
Average Number of Children Under 5	1.25	1.19
Proportion able to read and write in Chichewa	0.54	0.81
Proportion able to read and write in English	0.21	0.50
Proportion ever attended school	0.81	100.00
Highest Grade Completed (Median)	Standard 5	Standard 6
N	283	129

Table 7 further compares key characteristics among prime-age and young mothers. The average age of prime-age mothers was almost 34 years, while that of young mothers was a little below 20 years. The issue of early marriage presented above is further evidenced in the quantitative findings. At an average age of 19.62, 51 per cent of young mothers are either currently married or previously married (i.e. separated, divorced, or widowed). With regards to prime-age mothers, 96 per cent of them were either currently or previously married. On the other hand, 49 per cent of young mothers were never married while only 4 per cent of prime-age mothers were never married.

One key characteristic worth mentioning regards the education attainment of these two categories of mothers. All young mothers in the study had attended some school while only 81 per cent of prime-age mothers had. This difference is reflected in the proportion of young mothers who could read and write in either Chichewa or English compared to prime-age mothers. Despite all young mothers having attended school, the highest grade completed was Standard 6 indicating a high prevalence of drop outs. The two events of adolescent' pregnancy and school dropout do not occur in a prescribed, ordered sequence. For instance, in the qualitative study, four respondents cited pregnancy as the main reason that they dropped out of school, the other six dropped out due to financial reasons and lack of support. Four of the girls said that they were either pregnant or married soon after leaving school. While the qualitative components provide the following additional findings on young mothers' school dropouts.

4.7 Specific Vulnerable Condition of Children Under 5

Having presented vulnerabilities of young mothers compared to prime-age mothers, this section focuses on the vulnerabilities pertaining exclusively to the children. Table 8 compares health, nutrition status, general care, and early childhood development indicators for children within the range of 36-59 months. For all indicators, the research team first calculated the average by mother status then computed the differences between these two averages. The last column indicates whether the differences were statistically significant. The objective is to see whether children of young mothers have systematically different (possibly worse) outcomes.

Children of young mothers were more likely to participate in under 5 clinics than children of prime-age mothers. This difference was statistically significant. In addition, 84 per cent of children of young mothers had been taken for health check-up in the last 6 months compared to 66 per cent of children of prime-age mothers. While children of young mothers appeared to have regularly general health check-ups and participate in under 5 clinics, their performance on specific health status appeared mixed. Children of young mothers were more likely to suffer from diarrhoea compared to those of prime-age mothers (15 per cent and 11 per cent respectively). However, the difference between the two groups of children was not statistically significant. In addition, children of young mothers were also more likely to suffer from fever related symptoms sickness than children of prime-age mothers. The proportion of children with coughing related sickness did not statistically differ among children of prime-age and young mothers. Lastly, nutrition indicators in terms of variety of fruits and vegetables intake per day as well as the number of solid food intake per day did not statistically differ among children under 5 of young mothers and those of prime-age mothers.

Table 8: Comparisons of children under 5 by mother status

	Prime-age Mothers	Young Mothers	Diff (Prime-age - Young)	P-Value
HEALTH & NUTRITION				
Participation in Under 5 Clinic	0.75	0.89	-0.14	0.001
Last 6 months Under 5 Check-up	0.66	0.84	-0.18	0.000
Child had Diarrhea (last 2 weeks)	0.11	0.15	-0.04	0.174
Child had Fever (last 2 weeks)	0.18	0.32	-0.14	0.001
Child had illness with Coughing (last 2 weeks)	0.18	0.23	-0.04	0.262
Variety of Fruits and Vegetables	0.71	0.66	0.04	0.344
Number of solid foods per day	2.49	2.45	0.14	0.185
GENERAL CHILD CARE & ECD				
Child has toys (Homemade or Manufactured)	0.16	0.12	0.04	0.239
Number of days child left alone (past 7 days)	0.06	0.07	-0.01	0.650
Child can identify at least 10 alphabets	0.09	0.09	0.00	0.975
Child can recognise numbers 1 - 10	0.08	0.08	0.00	0.945
HOUSEHOLD CHARACTERISTICS				
Average Household Size	7.63	7.33	0.30	0.294
Average Food Expenditure	568,741	575,955	-7,214	0.860
Average Total Consumption	702,973	747,104	-44,131	0.467
Average Per Capita Consumption	7,878	8,561	-683	0.222
<i>N</i>	353	142		

Likewise, comparing general child care and early childhood development indicators, under 5's of both prime-age and young mothers were very similar to each other. Furthermore, we compared household annual average expenditures on food, total consumption, and per capita consumption to test whether households with children under the age of 5 having young mothers were worse-off than those with prime-age mothers. Again, results show that households with children under 5 of young mothers were not statistically different from those of prime-age mothers.

Figure 12 shows that approximately 80 per cent of young mothers lived in either their parents or grandparents' households. As such, the needs of their children (under 5 of young mothers) were being taken care of by the main caregiver of the household. This explains why the

children under 5 of young mothers were not statistically worse-off compared to children under 5' of prime-age mothers.⁴ The qualitative findings add further evidence in this regard.

⁴ A sub-group of under 5's whose young mothers who are households' heads are compared to under 5's whose prime-age mothers to examine whether this particular sub-group are more vulnerable. The result (not reported here) showed that under 5's of young headed mothers is not statistically different from those of prime-age mothers.

5 Effect of Vulnerabilities on Household Welfare

Although specific individuals or category, such as caregivers, young mothers, and elderly were likely to face certain vulnerabilities as evidenced above, the overall impact of the vulnerabilities may be shared by other household members. This is because, when the household acts as one economic unit, the resource generation and utilization mechanism may be shared by all “capable” household members. For instance, Table 5: *Effect of Household shocks, HH head conditions on adolescents* showed that vulnerabilities of the caregivers had an impact on adolescents and youths. In view of the above considerations, this section examines the effect of vulnerabilities on household welfare.

Table 9: Household welfare indicators in the presence of a vulnerable group

PANEL A: Per capita monthly food expenditure					
Vulnerable group	None present	At least one present	Difference	t-value	p-value
Children under 5	8,089.38	8,521.10	431.72	-1.30	0.904
Young Mother	9,014.12	6,664.74	-2,349.38	7.44	0.000
Elderly with chronic/disability	8,362.01	6,660.35	-1,701.66	3.10	0.001
One or more of the above	9,072.08	7,570.94	-1,501.15	4.93	0.000

PANEL B: Per capita monthly total expenditure					
Vulnerable group	None present	At least one present	Difference	t-value	p-value
Children under 5	9,927.51	10,545.84	618.33	-1.59	0.943
Young Mother	11,000.74	8,379.00	-2,621.74	7.03	0.000
Elderly with chronic/disability	10,264.20	8,470.98	-1,793.23	2.77	0.003
One or more of the above	11,054.29	9,398.73	-1,655.56	4.61	0.000

PANEL C: Household effective school enrolment rate of children					
Vulnerable group	None present	At least one present	Difference	t-value	p-value
Children under 5	0.47	0.43	-0.04	1.54	0.062
Young Mother	0.49	0.41	-0.08	3.58	0.000
Elderly with chronic/disability	0.48	0.28	-0.20	5.24	0.000
One or more of the above	0.49	0.43	-0.06	3.05	0.001

Table 9: *Household welfare indicators in the presence of a vulnerable group* reports household level indicators by comparing household with a vulnerable group and household without that vulnerable group. Panel A of the table compares monthly per capita food consumption by household. The average monthly food expenditure for households without any child under 5 is MWK 8,089 while households with child under 5 is MWK 8,521, indicating

households with children under 5 have a higher monthly per capita food consumption than those without. However, the difference between these groups is not statistically significant. On the other hand, household with young mothers consume per capita monthly food of MWK 2,349 less than households without young mothers. Similarly, households with an elderly having a chronic or disability condition consumes approximately MWK 1,700 less per capita food than those without. These two differences are statistically significant. Lastly, comparing households with any one or more of the vulnerable groups shows that they have a monthly per capita food consumption of MWK 1,500 less than households without any vulnerability.

Panel B extends on Panel A by considering the total per capita monthly expenditure not just focused on food. Results are very identical to food expenditure. Panels A & B confirms two messages that emerged in Section 4. The presence of a child under 5 in the household does not necessarily lead to lower household welfare indicators. However, if the mother of the child is a young mother then this is likely to affect the household per capita food consumption and monthly expenditure.

Lastly, panel C computes household effective enrolment rate by dividing the number of children of school going-age effectively enrolled over the total number of children of school going-age in the household. Households with children under 5, have an effective enrolment rate of 43 per cent compared to 47 per cent for households without any child under 5, statistically significant at 10 percentage level. Households with young mothers have an effective enrolment rate of 8 percentage points less than households without young mothers. Most astonishingly, the biggest difference is recorded by households with an elderly either with a chronic or disability condition. The effective enrolment rate difference is 20 percentage points less than households without elderly with chronic or disability conditions. This shows that while the elderly with chronic and disability conditions are undoubtedly a vulnerable group, their predicament mostly extends particularly to children of school going-age. Given that the elderly with chronic or disability conditions are often unable to perform any economic activities generating income, they may be unable to afford the education expenditure of children living under their care.

6 Discussion, Simulations and Policy Options

6.1. Brief Summary of Main Findings

6.1.1. Elderly caregivers

Fifty-eight per cent of recipients suffer from either a chronic health condition, disability or both, a much higher per cent than among all ultra-poor rural households. Female heads were more likely to suffer from a chronic illness relative to male headed households. IDIs indicate that elderly heads have weak social networks to depend on, and their physical capacity makes it hard to engage in *ganyu* and other income-generating activities. While the cash transfer alleviates some of the financial constraints, the near-constant health issues and associated financial costs of health care lead to difficult choices in terms of how to use the transfer and relying on other household members, often adolescents, for care and income- support.

6.1.2 Adolescents and young people

Ultra-poor labour-constrained households face a harsh trade-off when it comes to the long- term development of adolescents and young people. As the typical recipient is elderly with chronic health conditions, young people are often called upon for caregiving and income generation, which leads to school drop-out. Having a head with a disability is associated with a 20 percentage point increase in domestic chores and a 25 per cent increase in *ganyu* for young people, and a corresponding reduction in school enrolment of 28 percentage points. This is in spite of the school bonus. The school bonus itself represents just 10 per cent of the estimated out-of-pocket cost of attending school.

6.1.3. Children under five years

This group comprises 12 per cent of all household members and represents a vulnerable group because of their strict dependence on others, and the fact that this is a period of tremendous development and growth. Developmental deficits in this stage of life have far-reaching consequences throughout the life-course. Given the profile of the typical SCTP household, a significant portion of preschool children are not the child of the main recipient, but rather the grandchild or great grandchild of the main recipient. In other words, there is an important sub-family within the SCTP beneficiary household consisting of a young child and young mother, who do not receive any direct support from the programme.

6.1.4 Young mothers

As any intervention aimed at improving the well-being of young children would naturally need to account for the circumstances of the mother, the report also highlights the circumstances of this group. Most had their child at age 15, and subsequently dropped out of school. Although most would like to return to school, given their current age, they did not feel that formal schooling was an option. Social isolation was also an important concern, and not being able to meet or talk to other people that shared their life circumstances and experiences. This group do not have direct access to the cash transfer because they are not the main recipient of the programme.

6.1.5 The effect of vulnerability on household welfare

There are important, statistically significant associations between the vulnerabilities analysed in this report and overall household welfare as measured by consumption. The strongest (negative) association is having a young mother of a child under age five years, which is associated with a 26 per cent reduction in per capita food consumption and 24 per cent reduction in total consumption of the household. Having a head with a chronic illness or disability is also associated with lower consumption by 17 per cent and a 20 per cent reduction in food consumption. As mentioned earlier, adolescents and young people in these households also have significantly higher school drop-out and rates of *ganyu*.

6.2 Key implications from the data

The application of the theoretical concept of labour constraints leads to a unique profile of households in the SCTP. The combined data from the previous impact evaluation in 2013-16 and this study demonstrates clearly that SCTP recipient households are older, more likely to be female and have disproportionately more adolescent and young adults than the typical ultra-poor rural household. Due primarily to their age, 58 per cent of recipients suffer from either a chronic health condition, disability or both. These conditions, particularly disability, have an important negative association with key outcomes for adolescents. Households with a specially abled head show lower rates of effective school enrolment among young people (age 15-24), more *ganyu* and more excessive hours in overall work (paid and unpaid). Thus, disability of the household head particularly places the entire household at risk.

The analysis also highlights the special situation of children age five years and under, especially those with very young caregivers. In essence these mother-child dyads represent a

sub-family within the SCTP household, with the child typically either the great grandchild or the grandchild of the recipient of the SCTP transfer. While the data does not show significant differences in outcomes between the preschool children of the recipient households and non-recipient households, the outcomes are low for all children (e.g. only 72 per cent had a health check-up in the last 6 months, 22 per cent had a fever in the last 2 weeks). Moreover, these children rely on young mothers who have typically dropped out of school, and who express feelings of extreme isolation and lack of social or material support. The well-being of these caregivers will directly translate to the well-being of their young children. The quantitative analysis further shows that SCTP households with any of the specific life-cycle vulnerabilities studied here (having a preschool child, young mothers, and elderly and specially abled or sick heads), have significantly lower food and total consumption than other households without vulnerable groups. In other words, all SCTP households are not the same, and these specific characteristics lead to the programme being significantly less protective.

6.3 Discussion and Simulations of Alternative Targeting Approaches

The Malawi National Social Support Programme II (MNSSP II)⁵ explicitly recognises social, demographic and life-cycle vulnerabilities (page 7) in the population, and uses these vulnerabilities (and others) to develop a framework for action. Interestingly, the vulnerabilities explicitly highlighted in the MNSSP include female heads of household (social and demographic vulnerability), early childhood and old age (lifecycle vulnerability). High dependency among families is considered a demographic vulnerability in the MNSSP II, and of course the dependency ratio is a critical eligibility criterion of the SCTP. A key recommendation of the MNSSP II is to “*Develop a programme that maximises poverty and vulnerability alleviation by getting the basics of consumption support right and increasing the coverage of interventions (page 9).*”

In light of the stated policy framework of the Government of Malawi, the question arises to what extent the SCTP can be improved in order to respond to this recommendation. From the analysis in this report it is clear that the SCTP *indirectly* reaches many individuals who display social, demographic and life-cycle vulnerability as identified in the MNSSP II. These include the elderly, the specially abled, and female headed households. However, none of these are explicit eligibility criteria of the programme. And an important group as identified in the MNSSP II, young children, are neither indirectly nor directly reached through the SCTP—an important omission

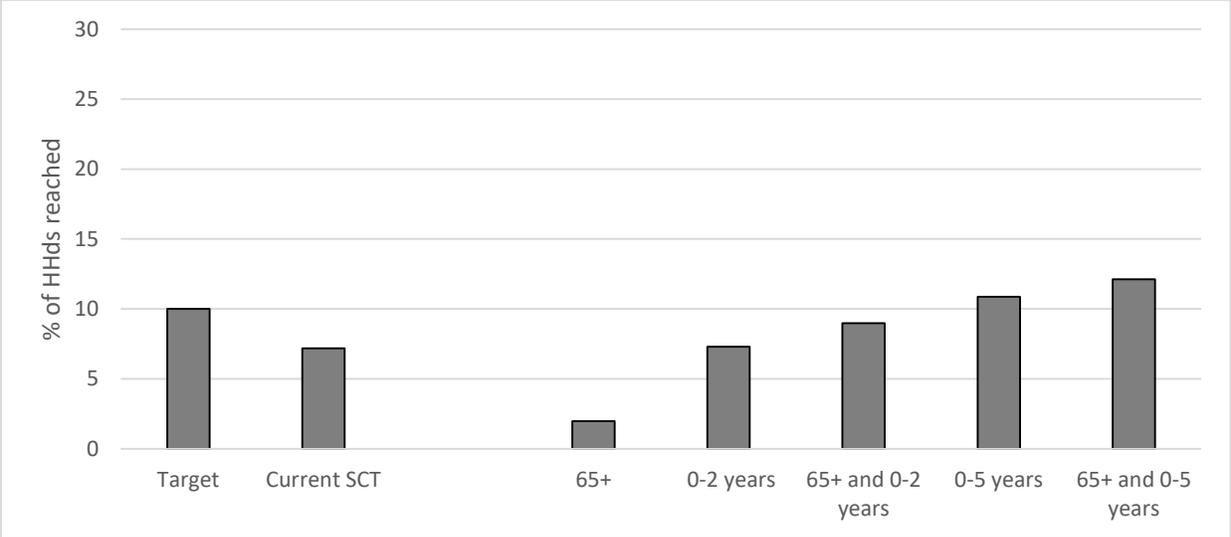
⁵ Republic of Malawi. 2018. Malawi National Social Support Programme II.

given the voluminous evidence base around the long-term benefits of early childhood development. Those that do end up in SCTP households are often the grandchild or great grandchild of the main recipient, with a very young caregiver. This vulnerable group often has very young caregivers, thereby bringing its own unique risks and challenges.

The SCTP can respond to the recommendation of the MNSSP II by identifying specific individuals and sub-groups within its existing target population (e.g. those with disability, young children, female heads) and providing additional benefits or support to them. This would maintain the SCTP as a narrow, sharply focused programme but potentially expand services within the group. An alternative is to adjust the eligibility criteria to explicitly target social, demographic and lifecycle vulnerabilities as identified in the policy document, which would lead to a broad-based, inclusive model of social protection. For both administrative and political reasons, this is the model that is adopted as countries expand and solidify their social protection system. Administratively, targeting based on categories (e.g. age 5 and under) is easier, and politically, life-cycle vulnerabilities are easily understood by the general population.

The current SCTP model aims to target 10 per cent of the population under the assumption that 10 per cent of rural households are both ultra-poor and labour-constrained; the current coverage is just over 7 per cent of the population. Figure 13 shows simulations of coverage rates under alternative targeting approaches that are more inclusive and that directly target lifecycle vulnerabilities. Simulations are based on the National Integrated Household Survey (IHS4). Eligibility is restricted to rural ultra-poor households only with the characteristic indicated in the figure. The first two bars show the target coverage rate (10 per cent) and actual coverage rate of the SCTP. The next bar show for example that if targeting was directed only at households with an elderly person (defined as a person age 65 years or older), coverage would be just 2 per cent. The next four bars show estimated coverage for alternative categorical targeting approaches, households with children age 2 years or younger, households with either an elderly person or a child age 2 or under, households with a child age 5 and under, and finally households with both a child age 5 and under and an elderly person. This last approach would reach 12 percent of rural ultra-poor, similar to the current objective of the SCT to reach 10 percent of this same group.

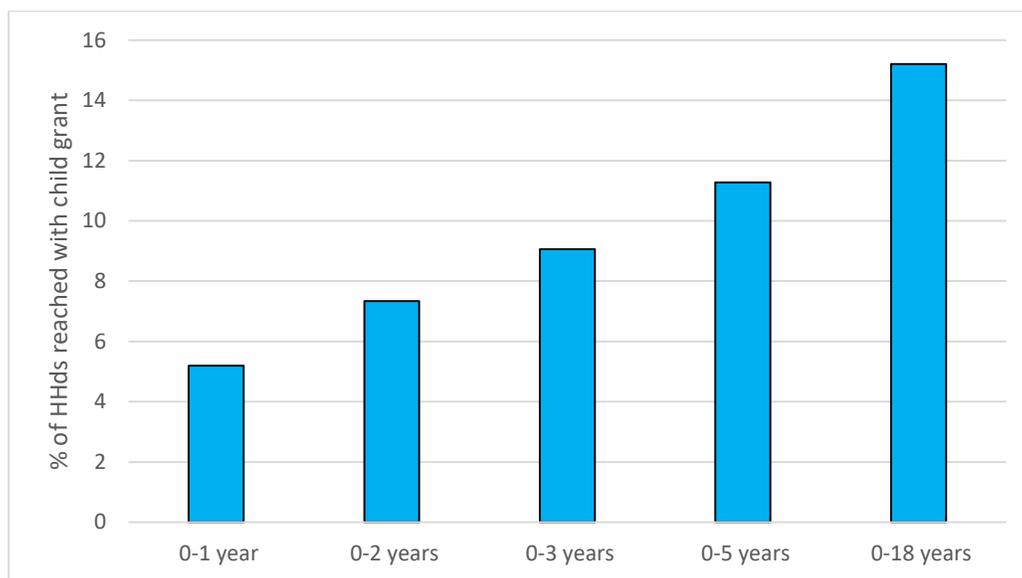
Figure 13: Coverage (per cent) Under Alternative Targeting Approaches



In this last approach, two important lifecycle vulnerabilities mentioned in the MNSSP II would be directly reached by the SCTP, leading to an inclusive, easily understood programme. Overall coverage would be very slightly higher than the current target coverage rate.

Zambia and Malawi have had a shared history in the evolution of their cash transfer programmes. The Kalomo pilot in Zambia started in 2004 and also employed the labour-constrained ultra-poor model, and this was subsequently exported across the border to Mchinji in 2006. While Malawi has stuck with and scaled-up this model, Zambia experimented with several different targeting models for 10+ years, and in 2014 consolidated these pilots into one harmonized programme that targets poor (not ultra-poor) households with an elderly or specially abled /sick member. This programme now reaches 12 per cent of the Zambian population and is still expanding. If Malawi were to adopt the Zambian model, targeting poor (not ultra-poor) households with an elderly member or a member with a severe health problem—coverage would be 14 per cent.

Figure 14: Coverage (per cent) of a Child-focused Programme



As mentioned earlier, the demographic profile of SCTP households is such that there are few children under age 5. Several countries in the region either have or are beginning to experiment with a child focused cash transfer programme. Of course, the most famous example is the South African Child Support Grant, which covers children age 0-18 years and reaches close to 9 million recipients. Importantly, this programme began by targeting children under age 5, and then slowly expanded to children age 8, then age 10, and only recently began to cover all children. Mozambique and Angola are both currently piloting child focused programmes targeting children age 2 and below, and the Kenyan government is in the planning stages of a programme targeted to pregnant women and children under age 2. Figure 14 illustrates coverage rates in Malawi for a child grant (for rural ultra-poor households only) targeting children of different ages. As the figure illustrates, if the grant covers children aged 0-2 years it will reach 7 per cent of the target population. While a less extensive programme targeting children 12 months and younger will cover only 5 per cent of the target population (all of whom would be rural ultra-poor).

The research team has also provided some estimates of the cost of the transfers for each of the programmes. These costs are based on the current average transfer to an SCTP household of MK 6,400 per month, and so essentially assumes the transfer structure and beneficiary profile will be such that the average transfer size will be the same. Nevertheless, in the first instance it is good to hold the average transfer size constant to understand the effect of the change in coverage on total costs. More refined cost simulations would impose more realistic transfer or appropriate transfer levels. For example, a child focused programme might provide MK 3000 per

child for up to a maximum of three children, which could lead to a smaller average transfer for a programme targeting children 0-5 years.

Figure 15: Simulated Annual Transfer Costs, in MK millions

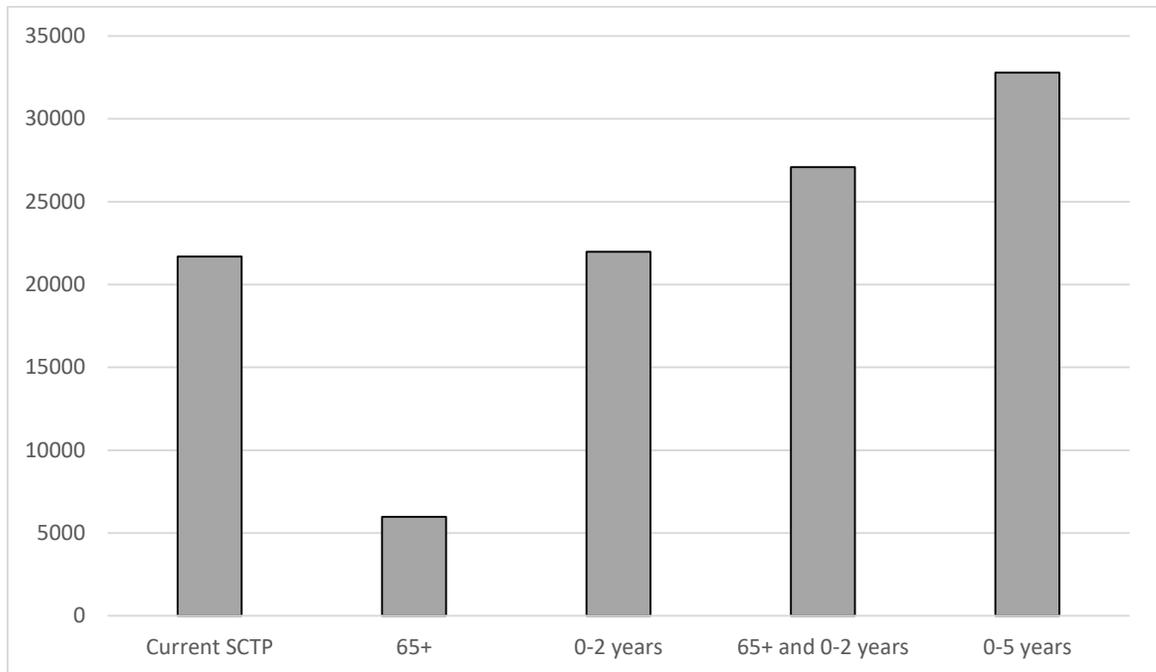
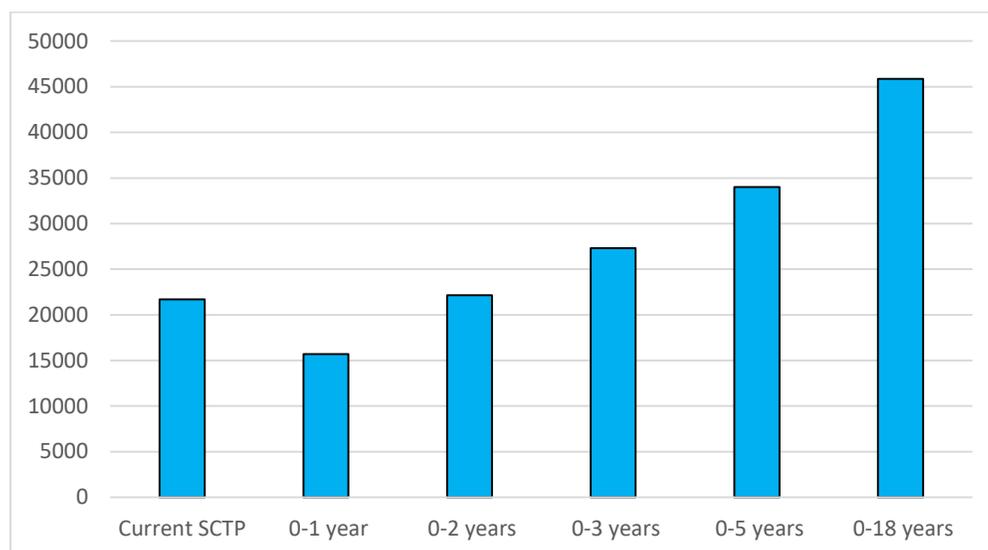


Figure 15 shows that the current programme, reaching 283,000 households and delivering an average transfer of MK 6,400 costs MK 21,684 million in transfers alone (US\$29m). A programme reaching the elderly or households with a child age 2 or under would cost MK 27,000m (US\$37m).

Figure 16 provides similar types of estimates for child-focused programmes. Again, these maintain the same average transfer as the current programme, which may not be appropriate. A child grant that reached all households with a child age 5 years and under would cost MK 34019 million (US\$46 million) in annual transfers.

Figure 16: Simulated annual transfer costs for child-focused Programmes, in MK millions



The main conclusion from these illustrative simulations is that with a few exceptions (such as reaching all children age 0-18 or the Zambian model), alternative targeting using inclusive, categorical criteria deliver roughly the same or slightly higher coverage rates (and costs) than the current programme, but these differences are not large. This speaks to feasibility of the options.

6.4 Policy Options

The following policy options are provided for consideration based on the evidence in this report and the discussions held with the reference group in early September.

- **Directly target lifecycle vulnerability:** The current SCTP targeting uses a very narrow approach, focused on the concept of labour-constraints. The application of this theoretical idea leads to households with high dependency ratios, and with individuals with specific lifecycle and social vulnerabilities. Instead of reaching these vulnerable individuals indirectly (and thus excluding many others), the MoGCDSW could consider directly targeting lifecycle vulnerabilities, using a categorical approach such as age, and/or health status. Such an approach is likely to significantly reduce targeting costs. The decision in part depends on the overall strategic vision of the MoGCDSW for the SCTP, whether it will remain a narrowly targeted, relatively small programme, or whether it will become a more inclusive, broad-based and much larger programme that reaches a range of constituents. There are important political economy considerations involved in this decision as well. Typically, as countries build their social protection systems, they move

from narrowly targeted programmes to broad, inclusive programmes. The MoGCDSW needs to determine whether the country is ready to begin that transition.

- Support specific vulnerabilities within the current targeting approach: If the MoGCDSW is not ready to make a significant change in the eligibility criteria as described above, the alternative is to ensure that individuals and households within the current programme with particular vulnerabilities receive adequate support. Of particular concern is the situation of households with heads who are either specially abled or chronically sick—these households, and young people within them, are significantly worse off than other SCTP households. One approach, currently used in Zambia, is to provide an additional top-up if the recipient (or any member) is specially abled or has a chronic illness. Linkages and referrals would also be appropriate, but these may be outside the influence of the Ministry. Another important group are young mothers, for whom traditional schooling is no longer a viable option.
- Nutrition bonus for children age 5 years and under: The current SCTP targeting approach tends to exclude families with preschool children. In addition, while families with school-age children are provided a ‘school bonus’, no similar support is contemplated for families with preschool children, who also have unique needs related to nutrition and preventive health care. A ‘nutrition bonus’, which would be analogous to the ‘school bonus’, could be considered for all children age 5 and under. This would recognise the vulnerability and developmental needs of all children in SCTP households, not just children age six years and above. The nutrition bonus would automatically convert to the current school bonus once the child turns 6 years old.

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Annex A: Sampling of TAs for the study

In each district, two TAs are to be selected randomly to represent the district. The TAs in Salima had already been sampled randomly during the 2013-16 impact evaluation. For Mulanje and Nkhata Bay, we took advantage of the availability of enrolment rate in the TAs to stratify the TAs as high and low. TAs with enrolment rate below 50 per cent are classified as low and those with enrolment rate above 50 per cent are classified as high, for the purposes of the study. One TA was then randomly selected from the low and one from the high performing TAs. Below are the enrolment rates and how the TAs were categorized.

Nkhata Bay		Mulanje	
TA name	Enrolment Rate	TA name	Enrolment Rate
Mkondowe	67	Chikumbu	59
Bogogho	61	Mthiramanja	56
Malanda	59	Nkanda	48
Fukamapiri	59	Mabuka	46
Malenganzoma	55	Juma	43
Timbiri	53	Laston Njema	40
Mbwana	52		
Zilikoma	46		
Fukamalaza	45		
Kabunduli	42		
Mankhambera	42		
Nyalubanga	40		
Mkumbula	40		

Using piece of papers where each of TA was written, the papers were presented to some person who was not involved in the analysis of the TAs to pick one from each stratum in each district. In Nkhata Bay TAs Bogogho and Fukamapiri were selected. However, considering that the TA Bogogho is not easily accessible, it was dropped and one of the remaining TAs in the stratum was again randomly selected. This time TA Mankhambera was picked. Thus, in Nkhata Bay the study will cover TA **Fukamapiri** for the high enrolment stratum while TA **Mankhambera** will represent the low enrolment stratum. In Mulanje, TA **Mthiramanja** was randomly selected to

represent the high enrolment TAs while TA **Mkanda** was selected to represent the low enrolment TAs. The sampled TAs by district are therefore as follows:

Sampled TAs in the three districts

District	First TA	Second TA
Nkhata Bay	Fukamapiri	Mankhambera
Salima	Maganga	Ndindi
Mulanje	Mthiramanja	Nkanda

Annex B: Sample size calculation for quantitative sample

The minimum sample size required for the survey was determined by:

$$n = \frac{4(r)(1-r)(1+t)}{(0.05r)^2(p)(\bar{n})} (Deff), \text{ where}$$

- n is the required sample size, expressed as number of households
- 4 is a factor to achieve the required 95 per cent level of confidence
- r is the predicted or anticipated enrolment rate of children of school going age in SCTP households (0.5 is chosen to give the largest sample size)
- t is the anticipated non-response rate at the household (assumed to be 10 per cent)
- $Deff$ is the design effect to account for clustering effect (taken to be 1.175 based on Malawi DHS data)
- 0.05 is the margin of error to be tolerated at the 95 per cent level of confidence
- p is the proportion of children of school going age in the population upon which the indicator, r , is based (taken to be 0.40)
- \bar{n} is the average household size (number of persons per household) taken to be 4.0

Thus, the minimum required sample size is given by

$$n = \frac{4(0.5)(1-0.5)(1+0.1)}{(0.05(0.5))^2(0.4)(4)} (1.175) = 1293.$$

Annex C: Fieldnote Template for Elderly and Caregiver Interviews

Programme Participant Interview Details

Participant Code No.: _____

Interviewer: _____

Date: _____

1. General interview Summary (Description of participant, place of interview, family and household structure, etc.)
2. Describe the participant's perceptions and opinions of being a young mother. (challenges, changes, support)
3. What was the participant's experience with school?
4. What are the participant's opinions and perceptions of the Mtukula Pakhomo?
5. How has Mtukula Pakhomo impacted the challenges and vulnerability of this household?
6. What questions do we want to ask in future interviews?
7. Reflect on the interview and any interview dynamics from your perspective.

Annex D: Fieldnote Template for Young Mother Interviews

Programme Participant Interview Details

Participant Code No.: _____

Interviewer: _____

Date: _____

1. General interview Summary (Description of participant, place of interview, family and household structure, etc.)
2. Describe the participant's perceptions and opinions of being a young mother. (challenges, changes, support)
3. What was the participant's experience with school?
4. What are the participant's opinions and perceptions of the Mtukula Pakhomo?
5. How has Mtukula Pakhomo impacted the challenges and vulnerability of the participant and their household?
6. Reflect on the interview and any interview dynamics from your perspective and any potential questions.

