Cash transfers and human capital development: Evidence, gaps and potential

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UNICEF Office of Research-Innocenti and UNC

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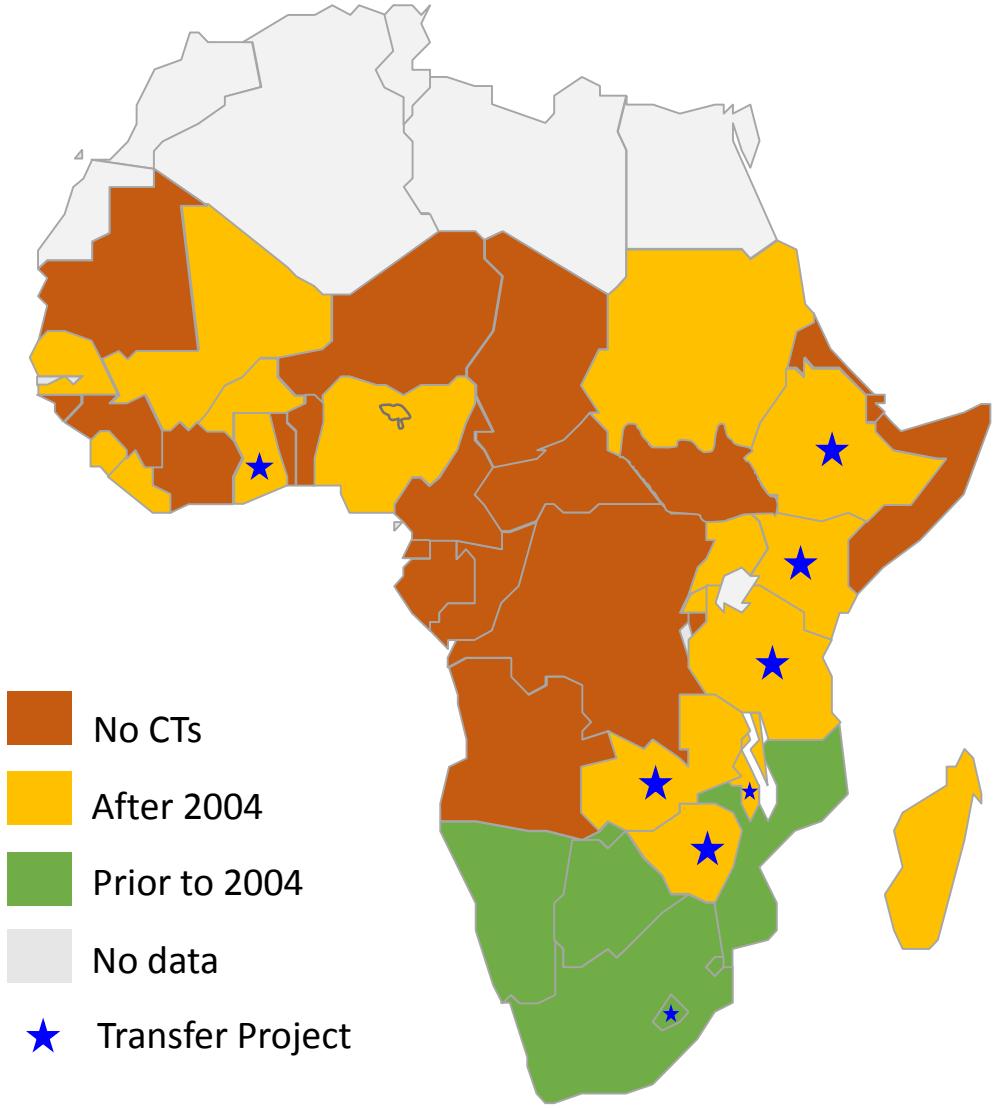
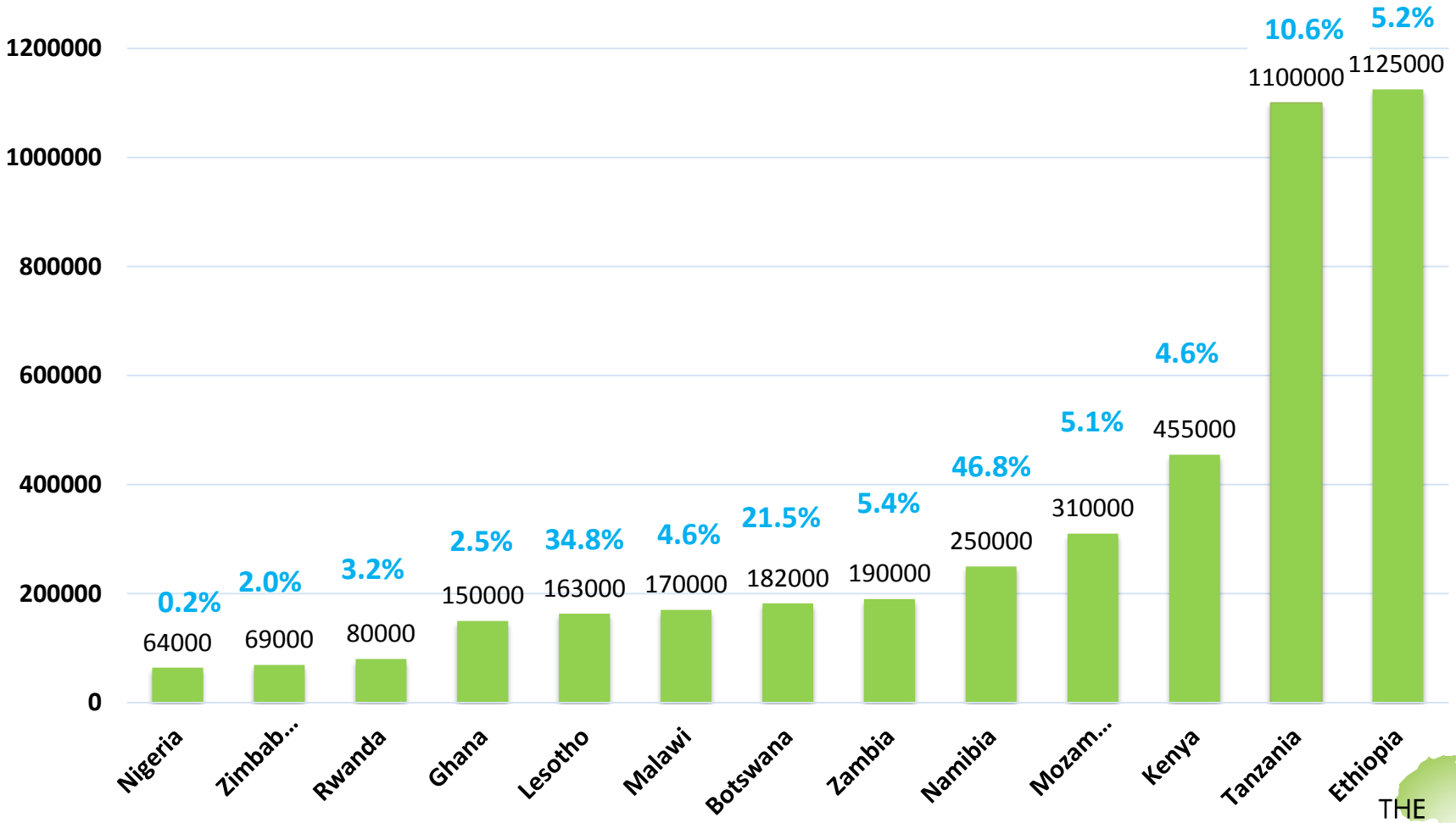
Cash Transfer programs in sub-Saharan Africa: The ‘quiet’ revolution



Households covered andpercent of population: Government programs

- Not included (due to scale): CSG in South Africa (>11 million recipients)



Percent of population are estimates assuming average household size and one beneficiary per household (child grant and pension designs)

Key features of the African 'Model'

- Programs tend to be unconditional (or with 'soft' conditions), with exception of Tanzania (conditional on schooling, health)
- Targeting is based on poverty and vulnerability (OVC, labor-constraints, elderly)
- Important community involvement in targeting process
- Payments tend to be manual ('pulling' beneficiaries to pay-points)
  - Opportunity to deliver complementary services

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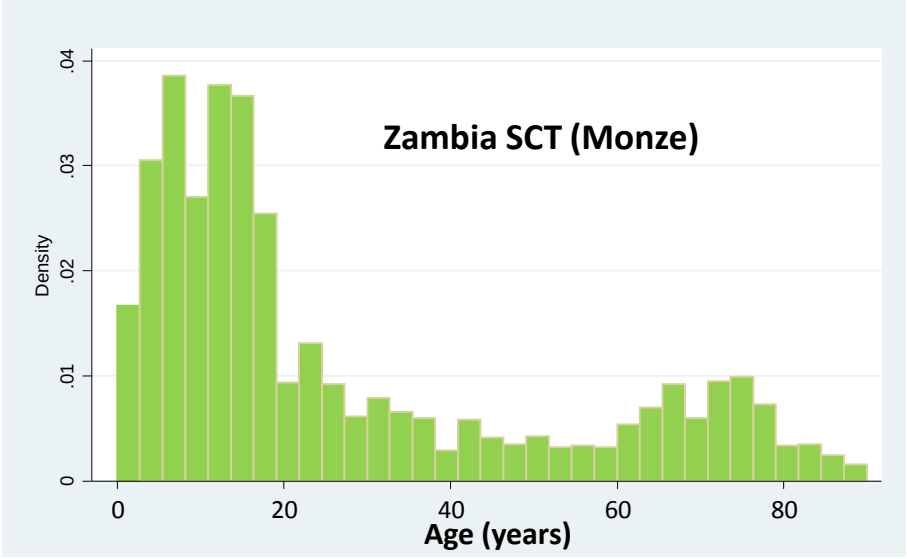
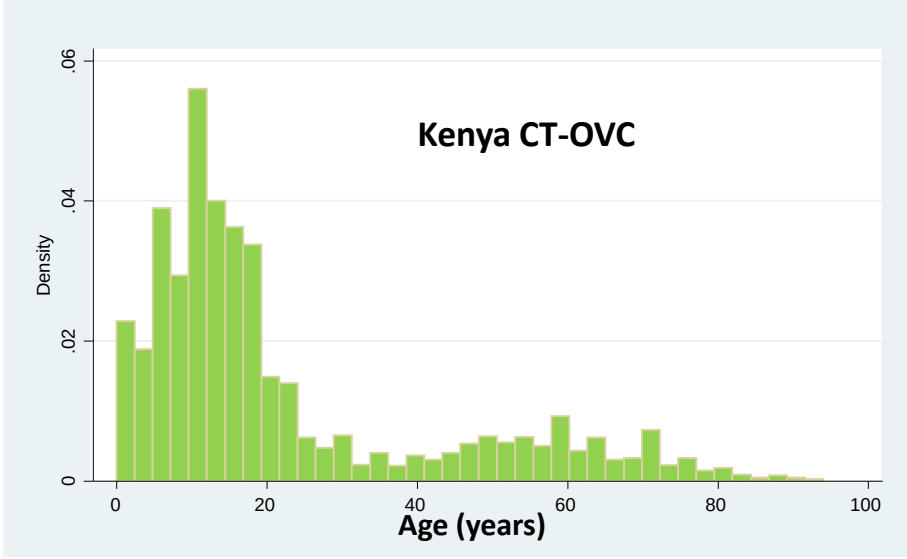
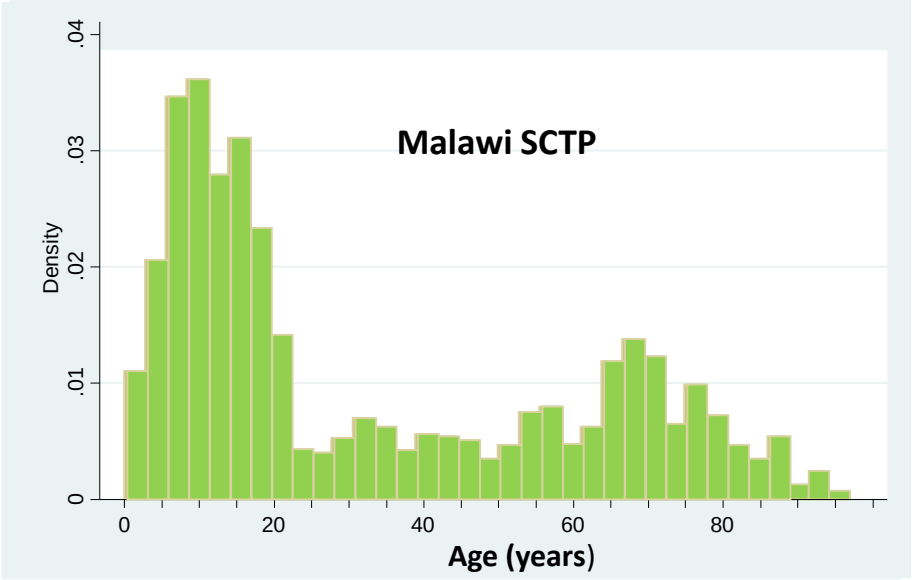
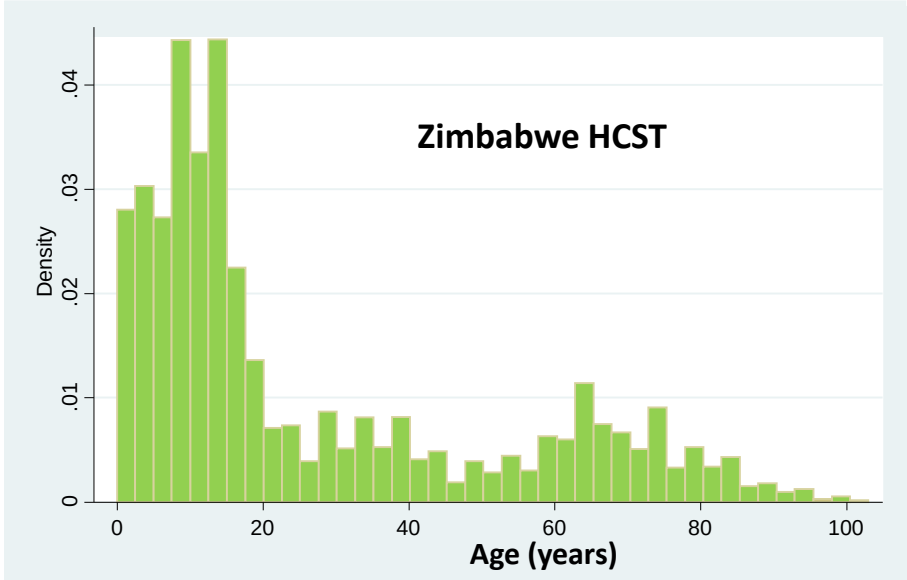
Unique demographic structure of recipient households: Missing prime-ages

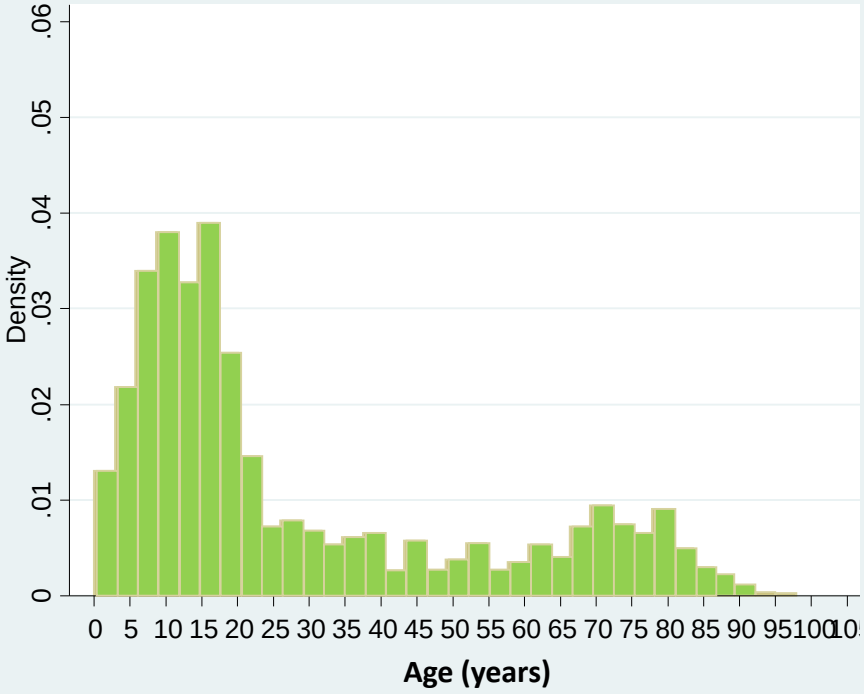




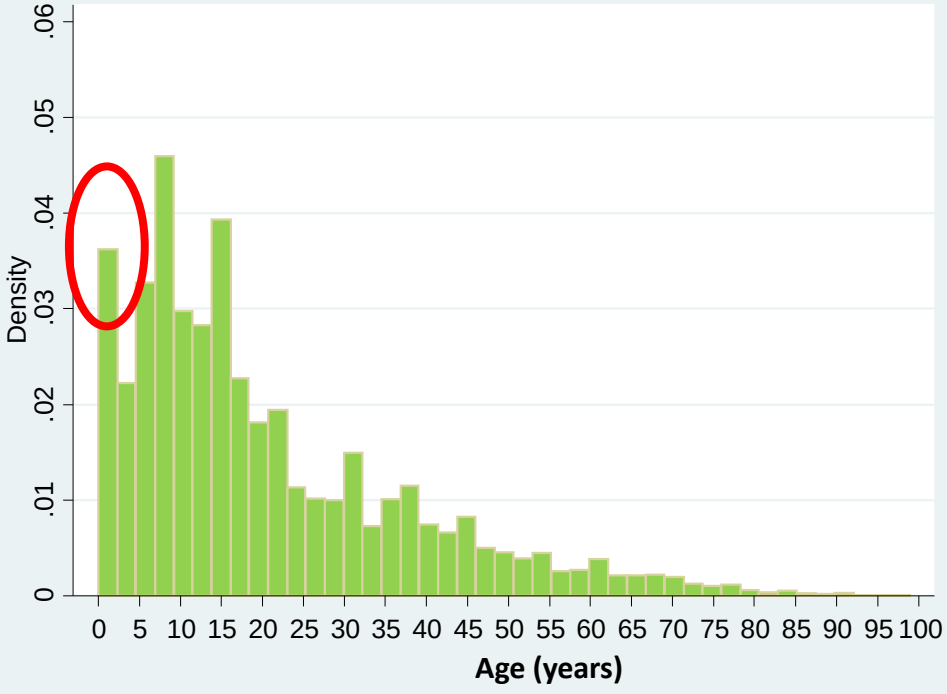




Labor-constrained criterion selects unique households: Example from Zambia



Zambia SCT Households



Rural Ultra-Poor LCMS 2010

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Who gets the cash?

Approximately two-thirds of beneficiaries are female

And three of five beneficiary HH are female-headed

Program	Female beneficiaries (%)	Female-headed households (%)
Ghana LEAP	44	60
Ghana LEAP 1000	100	11
Kenya CT-OVC	85	85
Malawi SCTP	84	84
Zambia CGP	99	-
Zambia MCTG	75	-
Zimbabwe HSCT	68	68

Figures for female-headed households may reflect evaluation sample, rather than beneficiary sample. Zambia studies did not collect information on headship.

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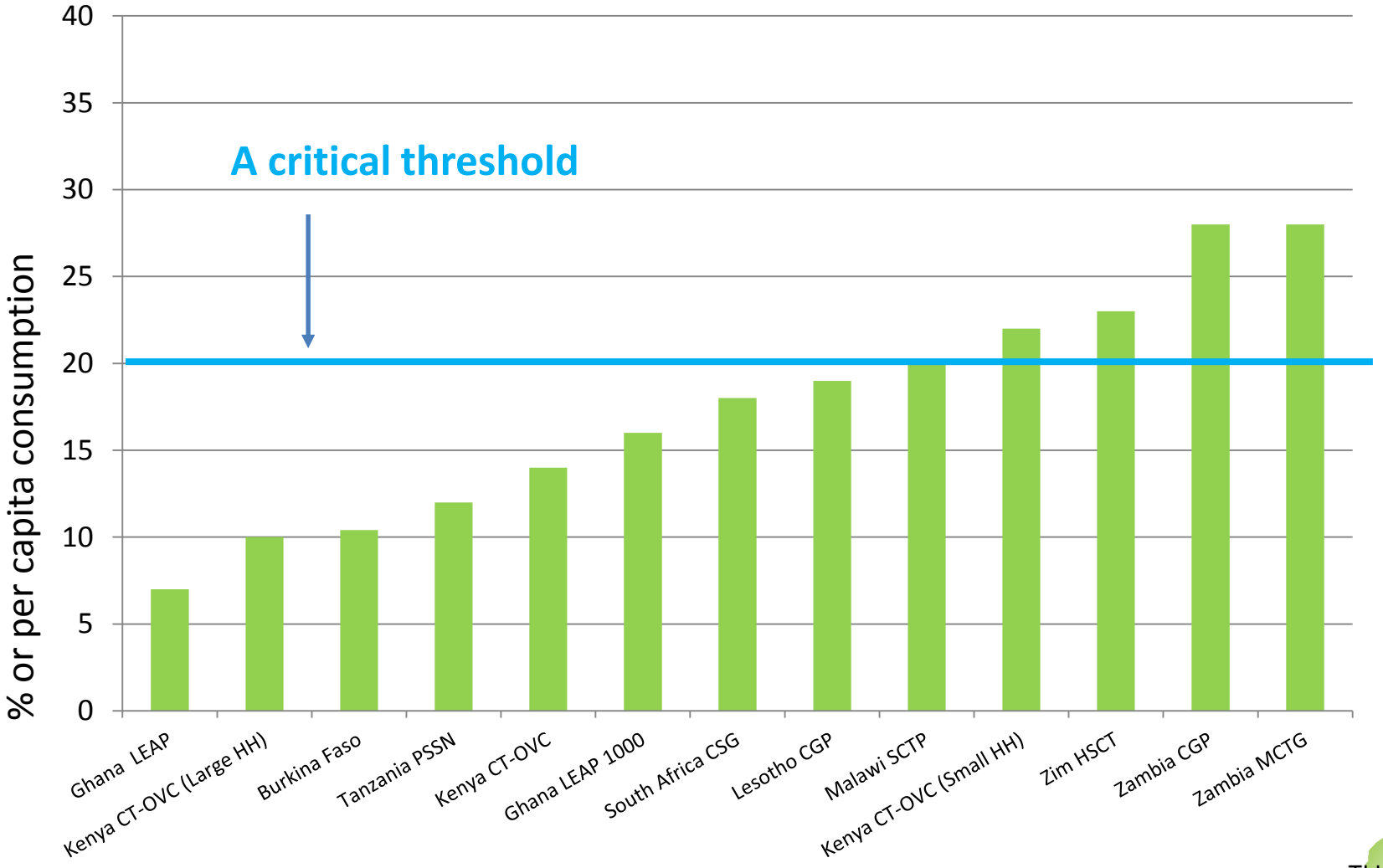
How much do programs pay? Transfer as share of beneficiary pre-program consumption



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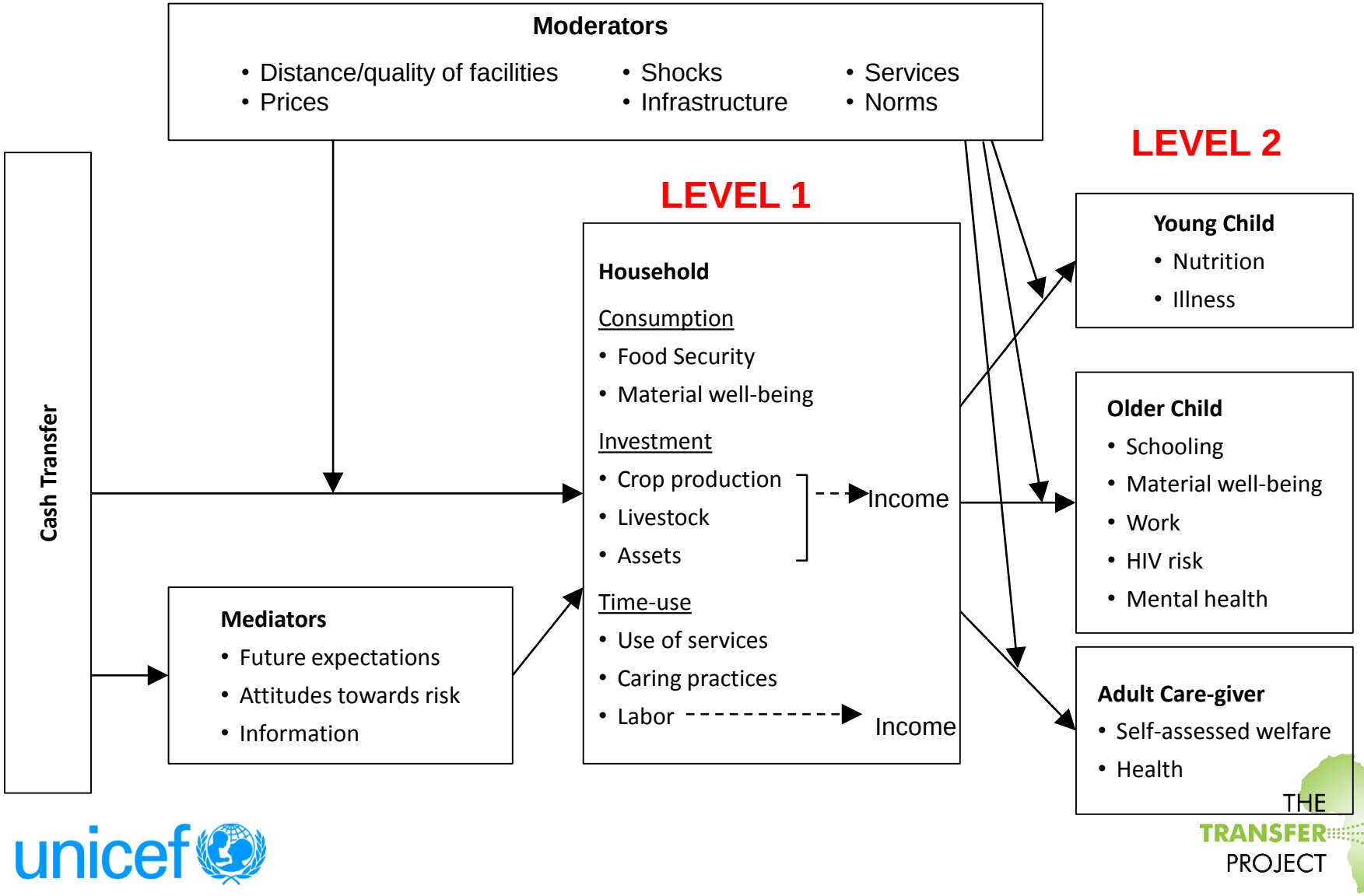
Overview of programs & evaluations connected with Transfer Project

Country (program)	Targeting (in addition to poverty)	Sample size (HH)	Methodology	LEWIE	Youth	Years of data collection
Ghana (LEAP)	Elderly, disabled or OVC	1,614	Longitudinal PSM	X		2010, 2012, 2016
Ghana (LEAP 1000)	Pregnant women, child<2	2,500	RDD			2015, 2017
Ethiopia (SCTP)	Labour-constrained	3,351	Longitudinal PSM	X		2012, 2013, 2014
Kenya (CT-OVC)	OVC	1,913	RCT	X	X	2007, 2009, 2011
Lesotho (CGP)	OVC	1,486	RCT	X		2011, 2013
Malawi (SCTP)	Labour-constrained	3,500	RCT	X	X	2011, 2013, 2015
South Africa (CSG)	Child <18	2,964	Longitudinal PSM		X	2010, 2011
Tanzania (PSSN)	Food poor	801	RCT		X	2015, 2017
Zambia (CGP)	Child 0-5	2,519	RCT	X		2010, 2012, 2013, 2014
Zambia (MCTG)	Female, elderly, disabled, OVC	3,078	RCT		X	2011, 2013, 2014
Zimbabwe (HSCT)	Food poor, labour-constrained	3,063	Longitudinal matched case-control	X	X	2013, 2014, 2016

How does cash affect the household and its members?



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Summary of results based on 7 rigorous impact evaluations

Domain of impact	Evidence
Food security, extreme poverty	
Alcohol & Tobacco	
Subjective well-being	
Secondary school enrollment	
Spending on school inputs (uniforms, shoes, clothes)	
Health	
Spending on health	
Nutritional status	
Increased fertility	

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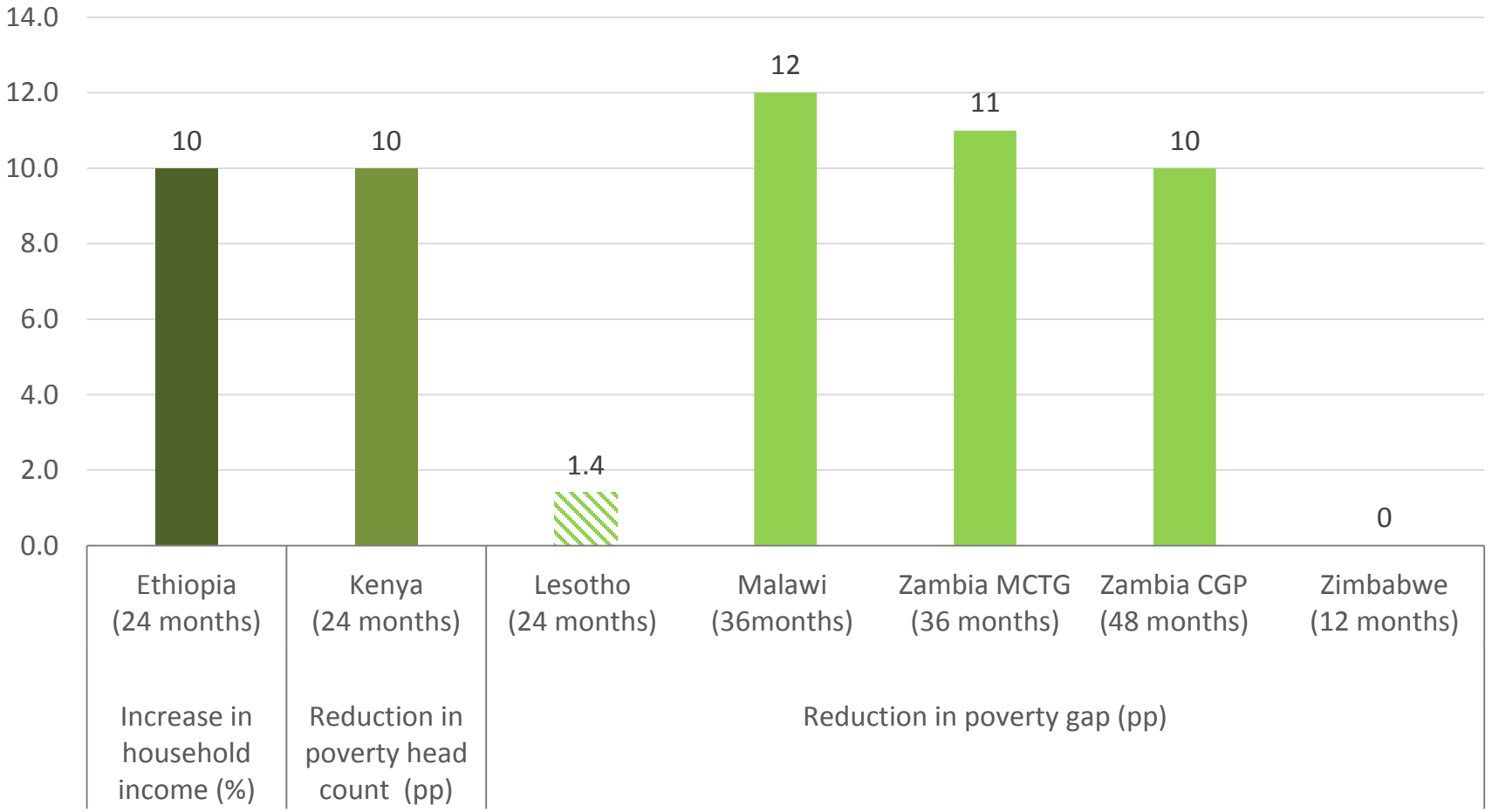
Reductions on poverty measures



Solid bars represent significant impact, shaded insignificant.
Impacts are measured in percentage points, unless otherwise specified

Across-the-board impacts on food security

	Ethiopia SCTP	Ghana LEAP	Kenya CT-OVC	Lesotho CGP	Malawi SCTP	Zambia MCTG	Zambia CGP	Zim HSCT
Spending on food & quantities consumed								
Per capita food expenditures	✓	✓	✓	✓	✓	✓	✓	✓
Per capita expenditure, food items	✓	✓			✓	✓	✓	✓
Kilocalories per capita	✓				✓			
Frequency & diversity of food consumption								
Number of meals per day					✓	✓	✓	
Dietary diversity/Nutrient rich food	✓		✓	✓		✓	✓	✓
Food consumption behaviours								
Coping strategies adults/children	✓	✓		✓	✓			
Food insecurity access scale						✓	✓	✓

Green check marks represent significant impact, black are insignificant and empty is indicator not collected

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No evidence cash is 'wasted' on alcohol & tobacco

- Alcohol/tobacco represent 1% of budget share
- Across 7 countries, no positive impacts found on alcohol/tobacco:
  - Data comes from detailed consumption modules covering over 250 individual items
  - In Lesotho negative impacts on alcohol consumption (possible decrease through decrease in poverty-related stress?)
- Alternative measurement approaches yield same result:
  - "Has alcohol consumption increased in this community over the last year?"
  - "Is alcohol consumption a problem in your community?"

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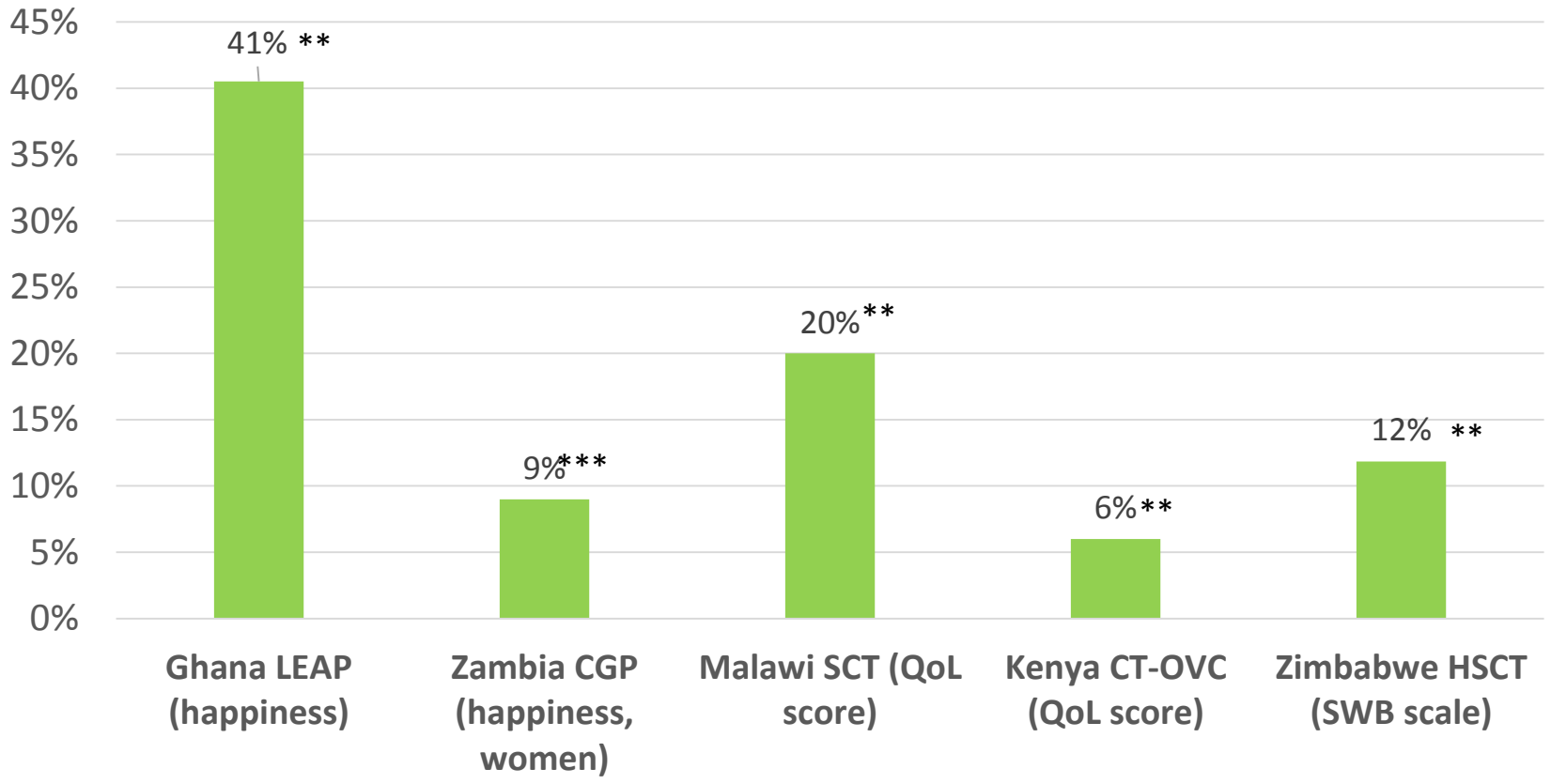
Beneficiaries are happier too: Consistent impacts on subjective well-being



Impacts are percentage changes, countries not shown did not collect data on subjective well-being

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What about the kids?

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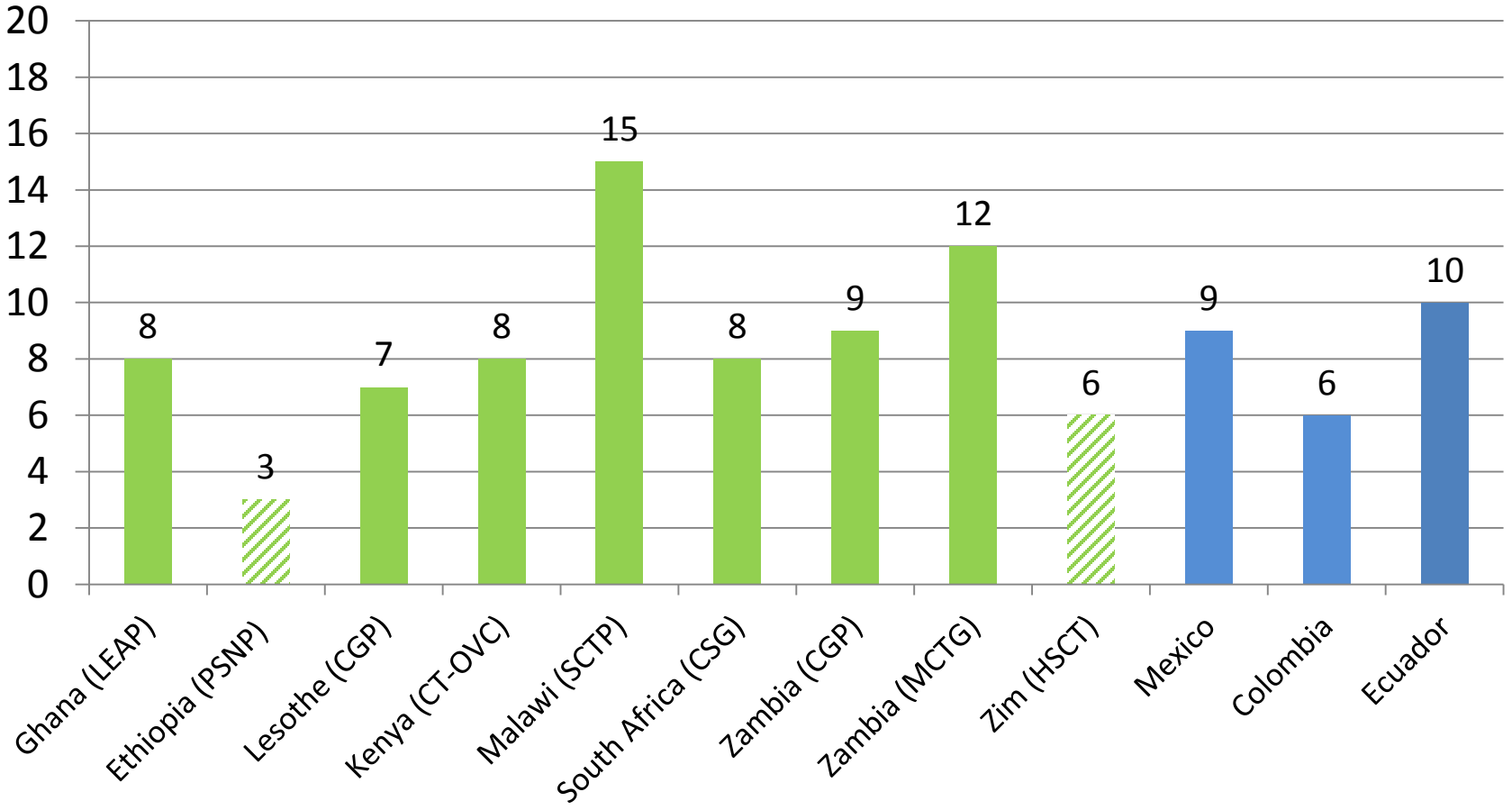
School enrollment impacts (secondary age children): Equal to those from CCTs in Latin America



Primary enrollment already high, impacts at secondary level. Ethiopia is all children age 6-16.
Bars represent percentage point impacts; all impact are significant.

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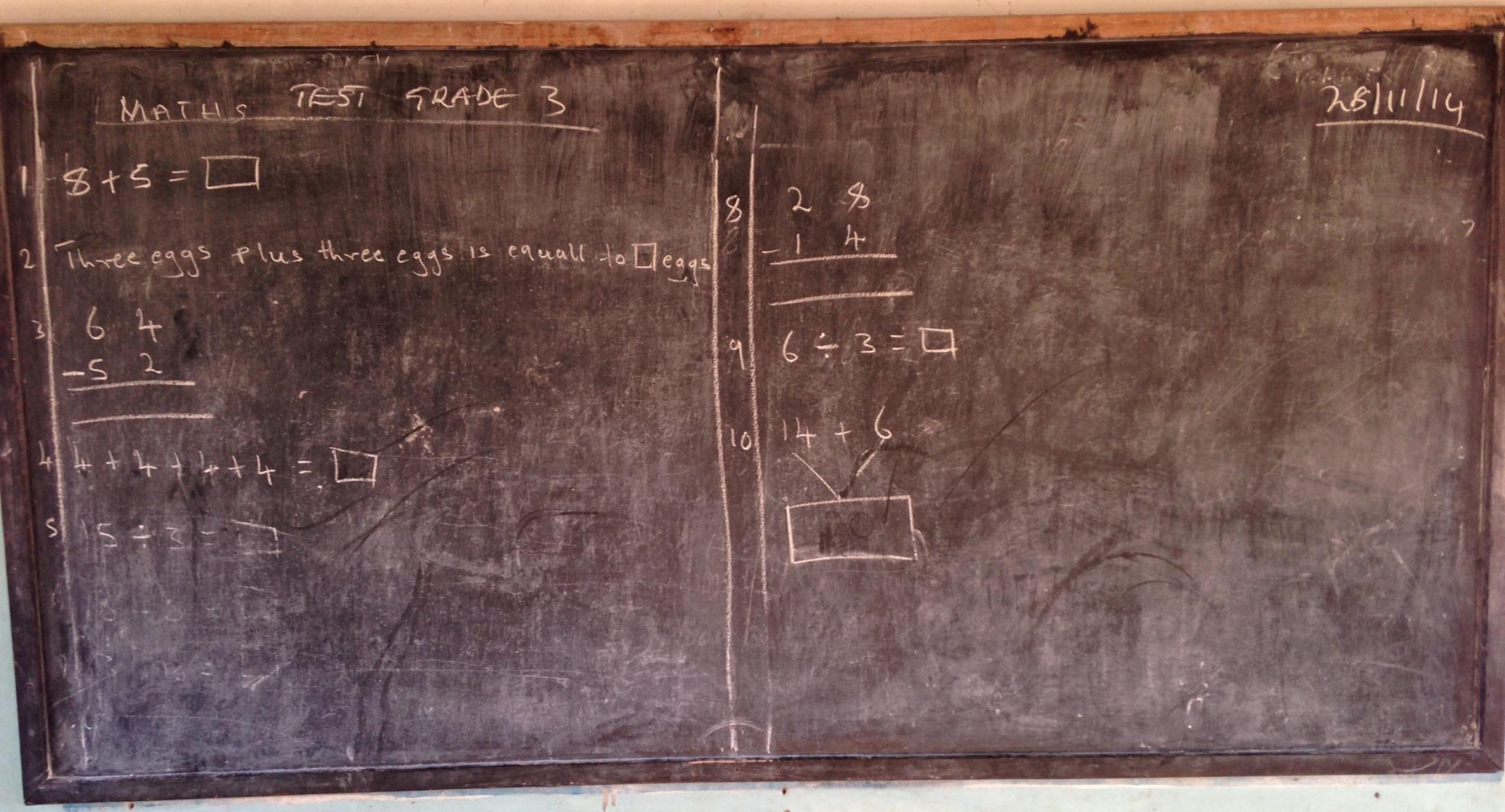
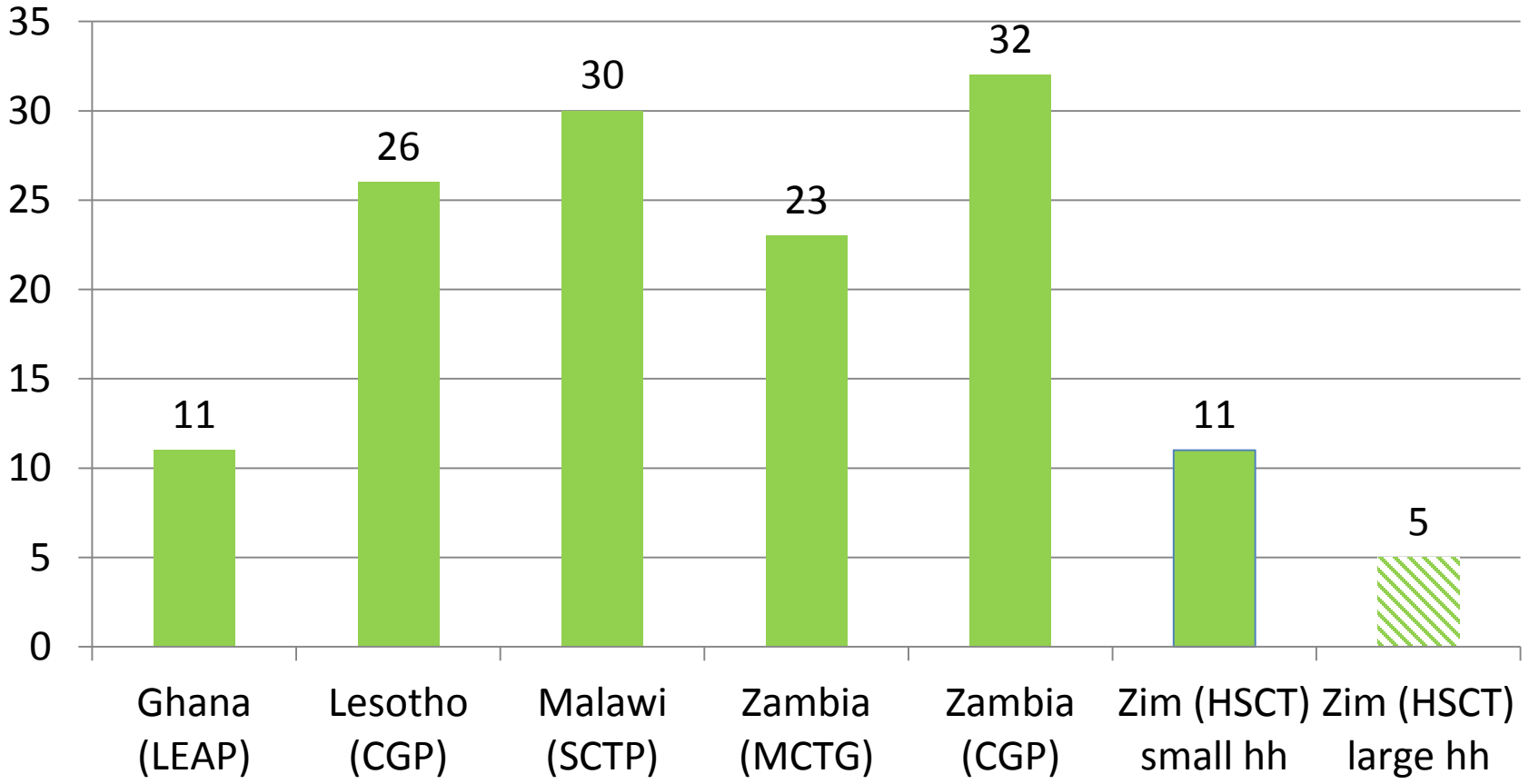


Grade 3 math test – Serenje District, Zambia

More kids in school but school quality still a challenge

Significant impacts on spending on school-age children (uniforms, children's shoes and clothing)



Solid bars represent significant impact, shaded insignificant.
Impacts are measured in percentage points; Lesotho includes shoes and school uniforms only, Ghana is schooling expenditures for ages 13-17. Other countries are shoes, change of clothes, blanket ages 5-17.

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Young child health and morbidity

Regular impacts on morbidity, but less consistency on care seeking

	Ghana LEAP	Kenya CT-OVC	Lesotho CGP	Malawi SCTP	Zambia CGP	Zimbabwe HSCT
Proportion of children who suffered from an illness/Frequency of illnesses	✓	✓	✓	✓	✓	✓
Preventive care	✓				✓	✓
Curative care	✓		✓	✓	✓	
Enrollment into the National Health Insurance Scheme	✓					
Vitamin A supplementation		✓				

Supply of services typically much lower than for education sector.
More consistent impacts on health expenditure (increases)

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Green check marks represent positive protective impacts, black are insignificant and red is risk factor impact. Empty is indicator not collected

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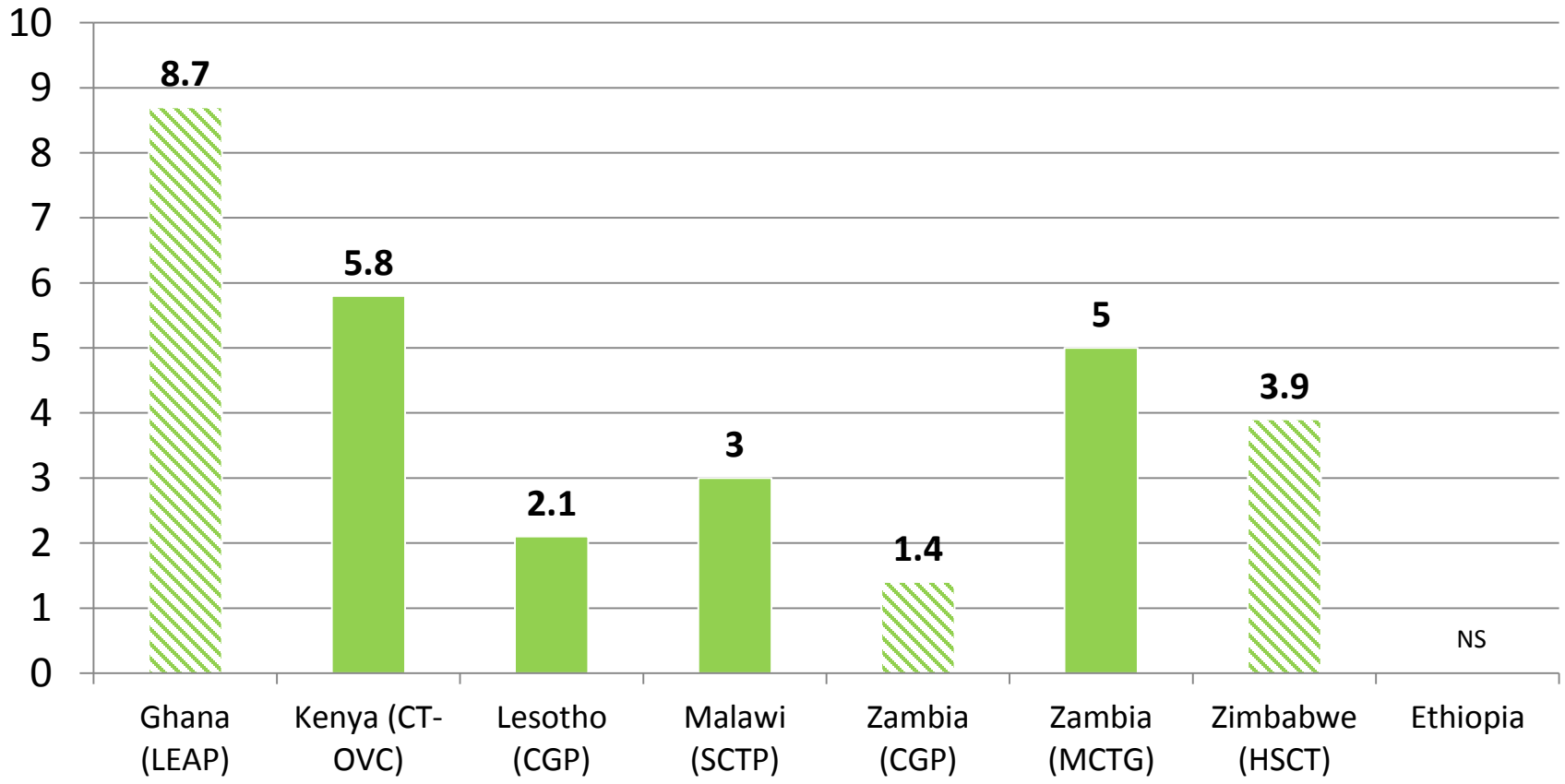
Budget shares and expenditure impacts on health



Solid bars represent significant impact, shaded insignificant.
Impacts are measured in percentage points (top figure). Bars represent % of budget share at baseline - Malawi figures represent treatment means.

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No impacts on young child nutritional status (anthropometry)

- Evidence based on Kenya CT-OVC, South Africa CSG, Zambia CGP, Malawi SCTP, Zimbabwe HSCT
  - However, Zambia CGP 13pp increase in IYCF 6-24 months
- Some heterogeneous impacts
  - If mother has higher education (Zambia CGP and South Africa CSG) or if protected water source in home (Zambia CGP)
- Possible explanations…
  - Determinants of nutrition complex, involve care, sanitation, water, disease environment and food
  - Weak health infrastructure in deep rural areas
  - Few children 0-59 months in typical OVC or labor-constrained household

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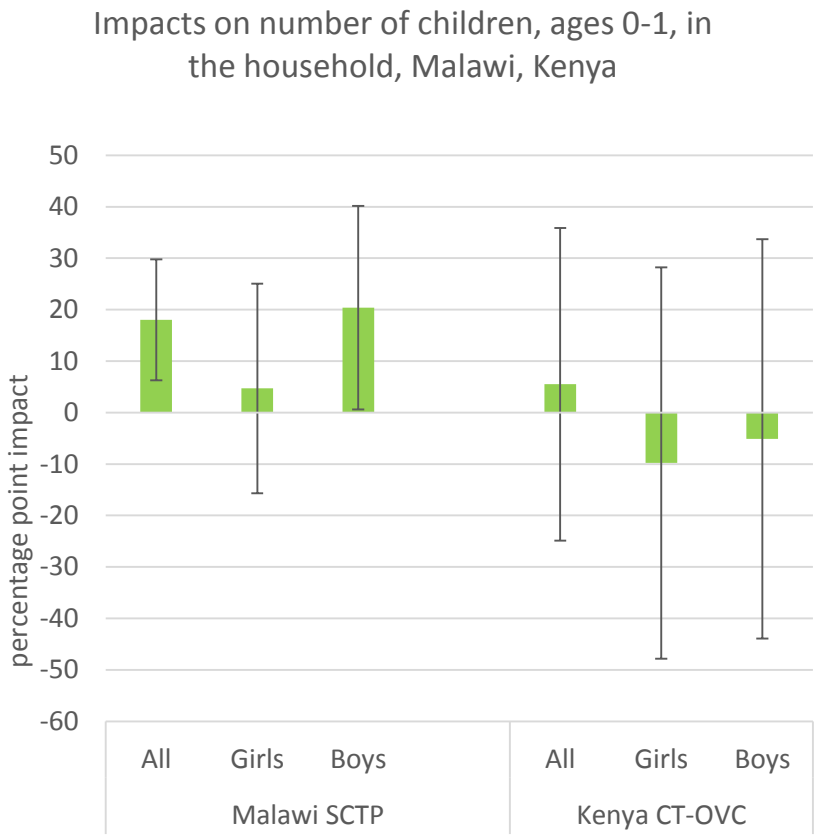
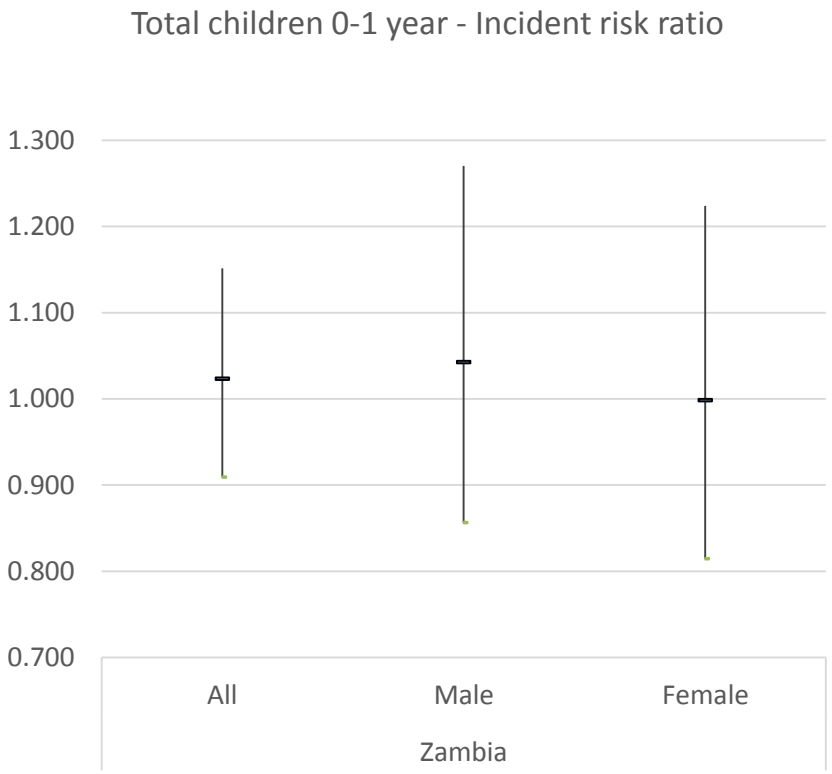
No fertility incentives!





- Malawi & Kenya: DD Probit models predicting Pr(child aged 0-1 in household)
- Zambia: DD Poisson models estimating number of children 0-1 years in household

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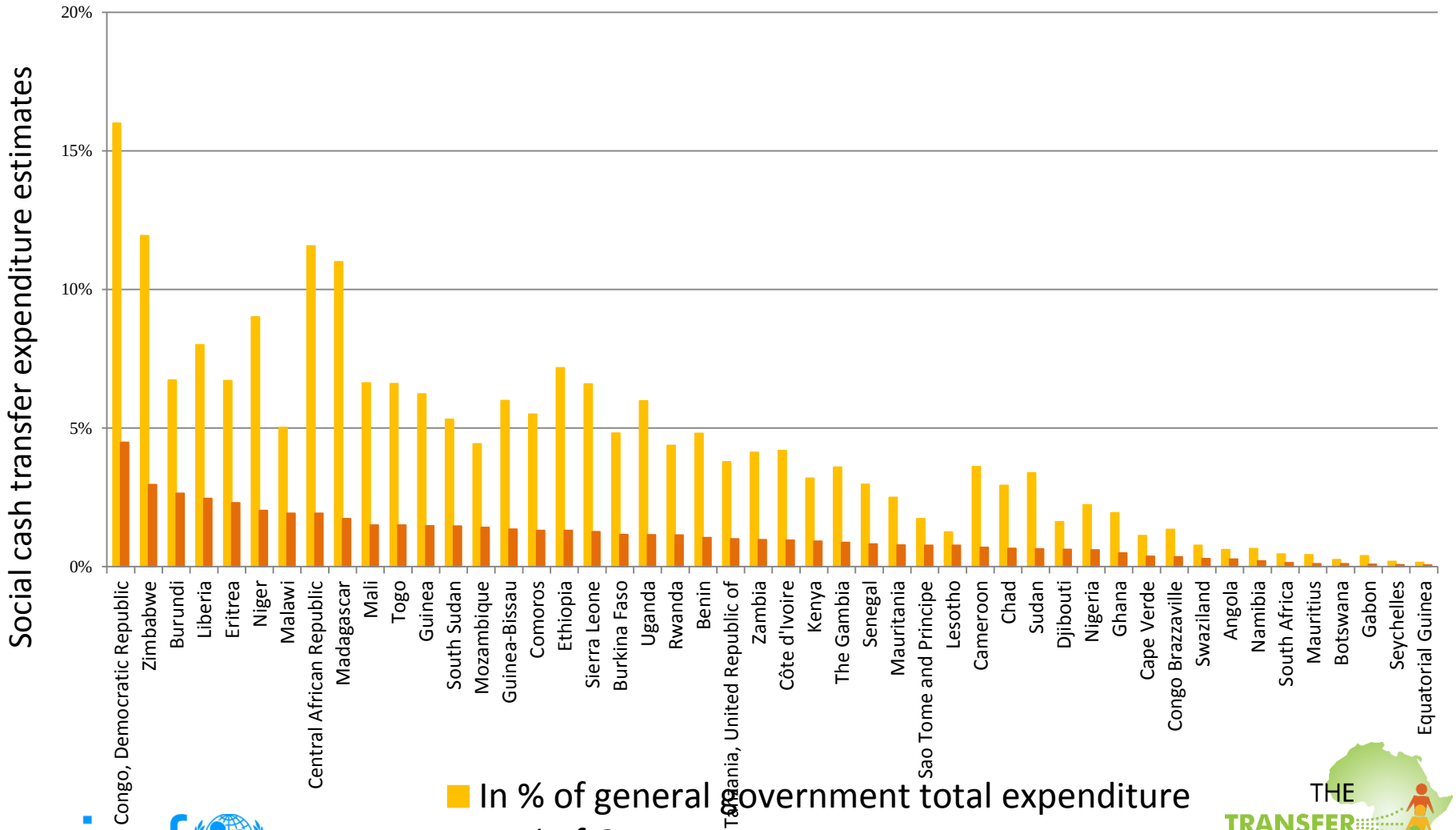
Scaled up cash transfers are affordable in SSA

Plausible simulations show average cost 1.1% of GDP or 4.4% of spending



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Emerging evidence that effect of cash larger depend on supply side factors

- Example 1: Skilled attendance at birth improved in Zambia CGP, only among women with access to quality maternal health services
- Example 2: Anthropometry in Zambia CGP improved among households with access to safe water source
- Example 3: Impacts on schooling enrollment in Kenya CT-OVC are largest among households which face higher out of pocket costs (uniform/shoes requirement, greater distance to school) [program offsets supply side barrier]

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What determines type and size of impacts?

- Predictability of transfers (Allows planning, consumption smoothing)
- Size of transfer and protection from inflation (Rule of thumb of 20% of mean consumption of target population)
- Context (Supply of health and education, user fees)
- Who you target (Labor-constrained; households with more adolescents/OVC and fewer pre-school children)

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Evidence, potential, gaps

- **Evidence**: Cash transfers are protective—they work
- **Potential**: Programs are affordable, can contribute to inclusive growth strategy
- **Gaps**: Health and nutrition effects on 0-5 years inconsistent
  - Few households with young children targeted are reached under current approaches
  - Health infrastructure not as well developed as schooling, attitudes and other factors at play in demand for health

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- Briefs: http://www.cpc.unc.edu/projects/transfer/publications/briefs

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