

Malawi Social Cash Transfer Programme Impact Evaluation: Young Children and Adolescents at Baseline

Introduction

The Government of Malawi's (GoM's) Social Cash Transfer Programme (SCTP) is an unconditional cash transfer programme targeted to ultra-poor, labour-constrained households. The transfer amount varies based on household size and the number of children enrolled in primary and secondary school. The impact evaluation for Malawi's SCTP is government led, and is being implemented by The University of North Carolina at Chapel Hill and the Centre for Social Research at University of Malawi. The impact evaluation uses a mixed methods, longitudinal, experimental study design, combining quantitative surveys, qualitative in-depth interviews, and focus group discussions. The evaluation consists of a baseline survey with two follow-up surveys in two Traditional Authorities each in Salima and Mangochi districts. Children comprise 52 per cent of household members and over one-third of these children are orphans.

The purpose of this brief is to describe the anthropometric, health, and care-seeking behaviour for children under five and educational experiences of children, adolescents, and young adults at baseline. We also review the sexual behaviour and mental health of adolescents. Where possible we compare SCTP-eligible households in the baseline evaluation sample with rural ultra-poor households from the 2010-2011 Third Malawi Integrated Household Survey (IHS3) and rural household in the lowest wealth asset quintile from the 2010 Malawi Demographic and Health Survey (MDHS). In general, SCTP-eligible children are more likely to be underweight, stunted, or wasted than IHS3 comparison children, are more likely to have been sick in the past two weeks and less likely to have sought any type of care, and less likely to be enrolled in school than rural ultra-poor IHS3 children.

Children Under Five

The 2013 SCTP impact evaluation baseline survey included 1,868 children under-five (ages 6-59 months, inclusive), representing 11 per cent of all household members. Approximately half of children under five are female.



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Anthropometrics

Table 1 presents anthropometric indicators for underweight (weight-for-age), stunting (length/height-for-age), and wasting (weight-for-length/height) among children ages 6 to 59 months using the World Health Organization (WHO) 2006 growth standards.¹ Children with weight-for-age, length/height-for-age, or weight-for-length/height z-scores less than two standard deviations below the median of the WHO reference population are classified as underweight, stunted, or wasted, respectively. Boys fare somewhat worse than girls for all anthropometric indicators, except for wasting in the IHS3 comparison sample.

¹ For moderate underweight, wasting and stunting indicators, the results reported in the IHS3 report have been recently updated and are reported in a brief issued by the World Bank, "Child Anthropometrics and Malnutrition in Malawi". Our calculations are consistent with those reported in this brief, which also show that malnutrition rates among rural ultra-poor are not consistently worse off than the national rates. Brief available at: http://siteresources.worldbank.org/INTSURAGRI/Resources/7420178-1294259038276/MW_Anthro_Brief.pdf.

Table 1. Nutritional Status of Children, Ages 6-59 Months						
	Weight-for-Age		Length/Height-for-Age		Weight-for-Length/Height	
	(Underweight ¹)		(Stunting ¹)		(Wasting ¹)	
	SCTP-Eligible	IHS3 Rural Ultra-Poor	SCTP-Eligible	IHS3 Rural Ultra-Poor	SCTP-Eligible	IHS3 Rural Ultra-Poor
	% underweight	% underweight	% stunted	% stunted	% wasted	% wasted
Total	17.6	7	47.6	29.3	3.9	4.2
Boys	18.5	7.8	49.1	31.5	4.4	4.1
Girls	16.8	6.2	46.3	26.9	3.4	4.4

¹%<-2SD includes both moderate and severe levels

Weight-for-age is a composite measure of both stunting and wasting, reflecting current and chronic malnutrition. Approximately 18 per cent of SCTP-eligible children ages 6 to 59 months are underweight, compared to seven per cent of rural ultra-poor children under five from the IHS3 sample.

Length/height-for-age is an indicator of cumulative growth retardation and is a measure of long-run growth deficits. SCTP-eligible children are much more likely to be stunted than children from the IHS3 comparison sample (48 per cent compared to 29 per cent).

Weight-for-length/height is an indicator of current nutritional status and acute malnutrition. The prevalence of wasting in the SCTP sample and the IHS3 sample are both about four per cent.

Feeding Practices

The SCTP baseline survey also collected information about the number of times children were given solid foods in a day and the types of food children had eaten in the last day. Half of all SCTP-eligible children under five consume two meals per day; one-third consume three or more meals per day and 17 percent consume one meal a day or less; over half of IHS3 rural ultra-poor households reported that children under five years typically consume three meals per day. The percentage of children consuming Vitamin A-rich fruits and vegetables (including pumpkin, red or yellow yams or squash, carrots, red sweet potato, dark green leafy vegetables, mango, papaya, and guava) in the past day is 67 per cent among SCTP children; this figure is not reported for the IHS3 comparison sample.

Morbidity and Use of Curative Care Services

Mothers or guardians were asked to report whether the child had diarrhoea, fever, or an illness with a cough at any time in the last two weeks and, if so, whether the child received

treatment for the condition (Table 2). A little less than half (44 per cent) of SCTP-eligible children had at least one illness in the past two weeks, compared to 17 per cent of children under five in the IHS3 comparison sample. In general, SCTP-eligible children were more likely to report an illness in the past week than IHS3 rural ultra-poor children, but less likely to seek care for the illness.

The incidence of diarrhoea in the past two weeks was much higher among SCTP-eligible children (17 per cent) than IHS3 rural ultra-poor children (2 per cent). Three-fourths of the SCTP-eligible children reporting incidence of diarrhoea sought care, compared to 89 per cent of IHS3 children. It was reported that over a quarter of SCTP-eligible children had a fever in the previous two weeks (compared to 14 per cent of IHS3 children), and nearly three-fourths of those children

Table 2. Morbidity and Use of Curative Care Services in past 2 Weeks for Children 6-59 Months				
	SCTP-Eligible			IHS3 ¹
	Total	Male	Female	Total
% With diarrhoea, fever, or cough in the past 2 weeks	43.6	43.7	43.5	16.8
% With diarrhoea in the past 2 weeks	16.6	17.1	16.0	2.0
% Seeking any care	74.9	73.5	76.2	88.7
% With fever in the past 2 weeks	26.1	26.3	25.9	13.8
% Seeking any care	74.1	77.0	71.4	91.4
% With cough in the past 2 weeks	26.0	24.5	27.3	1.0
% Seeking any care	73.1	73.2	73.0	82.1

¹IHS3 rural ultra-poor; figures are for the first reported illness or injury only.

Table 3. Preventive Care Practices Among SCTP-Eligible Children Ages 6-59 Months				
	Participation in Nutrition Program	Participation in Under-five Clinic	Check-up at Well-baby or Under-five Clinic (last 6 months)	Possession of a Child Health Passport
Characteristic	Mean (%)	Mean (%)	Mean (%)	Mean (%)
Total	4.0	73.0	49.8	87.1
Child Sex				
Male	3.8	72.6	48.6	85.6
Female	4.2	73.4	51.0	88.4
IHS3 ¹	20.1	74.1	-	-

¹ IHS3 rural ultra-poor; information not collected for well-baby/under-five clinic check-up or Child Health Passport.

received any type of care for the fever (compared to 91 per cent of IHS3 children). Lastly, 26 per cent of SCTP-eligible children were reported as having had a cough in the past two weeks (compared to 1 per cent of IHS3 comparison children), and of these, 73 per cent sought care.

Preventive Care Practices

Table 3 shows the percentage of children ages 6 to 59 months participating in four preventive care practices: nutrition programs, well-baby check-up, under-five clinic, and whether the child has a health passport (to keep track of clinic visits, immunizations, etc.). Very few SCTP-eligible children (4 per cent) were reported to be participating in a nutrition program, compared to 20 per cent of rural ultra-poor children from the IHS3 sample. About three-fourths of children were reported to be participating in an under-five clinic (close to

the 71 per cent reported among IHS3 children), half were reported to have had a check-up at a well-baby or under-five clinic in the past six months, and 87 per cent had a health passport.

Delivery Location and Assistance

The baseline survey also asked the mothers or guardians where each child under five was born and who assisted with the delivery of the child. Nearly 80 per cent of SCTP-eligible children were delivered in a health facility, compared to 76 per cent of IHS3 rural ultra-poor children. Approximately 80 per cent of SCTP children were delivered by a skilled attendant, compared to 77 per cent of IHS3 children.

Education

Enrolment

In addition to anthropometric and health data for children under five, the SCTP baseline survey also collected education information from all household members age three and above. Approximately 79 per cent of the SCTP-eligible sample ages 3 to 24 years old were attending school during the 2012-2013 academic year, compared to 83 per cent in the IHS3 rural ultra-poor sample (Table 4). The per cent of children currently attending school decreases with age. Among all SCTP-eligible children currently attending school, 6 per cent were in pre-school, 91 per cent were in primary school, and 3 per cent were in secondary school.

Grade-for-Age

The official entry age for primary school in Malawi is six years old; primary school runs from grades 1-8 and secondary school consists of grades 9-12. Among SCTP-eligible children, the primary school net attendance rate is 87 per cent,

Table 4. SCTP-Eligible Sample Currently Attending School (2012-2013 Academic Year) (per cent)				
Characteristic	Total	Among Those Currently Attending		
		Pre-School	Primary (Grades 1-8)	Secondary (Grades 9-12)
Total	78.7	6.4	90.7	2.9
Child Sex				
Male	79.5	5.6	91.1	3.3
Female	77.9	7.3	90.3	2.4
Age (years)				
3 - 5	95.7	82.1	17.9	0.0
6 - 9	93.7	7.3	92.7	0.0
10 - 13	87.4	0.0	100.0	0.0
14 - 15	74.8	0.0	98.5	1.5
16 - 17	63.6	0.0	90.8	9.2
18 - 24	33.6	0.0	62.6	37.4
IHS3 ¹	82.6	0.5	96.3	3.3

¹ IHS3 rural ultra-poor

indicating that nearly 90 per cent of children ages 6-13 are currently attending primary school; this is lower than the net primary school attendance rate of the IHS3 comparison sample (97 per cent). Only three per cent of secondary-school-age SCTP-eligible adolescents (ages 14 to 17) were actually attending secondary school. As a result virtually all children age 14 to 17 are below grade-for-age. However, even among children age 6-13, a full 89 per cent are below grade-for-age compared to 79 per cent in IHS3.

School Dropout

Among the SCTP-eligible sample, 14 per cent of children ages 6-17 reported temporarily withdrawing from school during the 2012-2013 academic year, compared to only four per cent of the IHS3 comparison sample. Of those SCTP-eligible children who withdrew, over half did so because they did not have the money necessary for school-related expenses, and a quarter did so because of illness. These findings emphasize the toll financial hardship takes on the educational opportunities for children in SCTP-eligible households.

Adolescents

To assess the impact of the SCTP on the safe transition to adulthood, we administered a separate questionnaire to adolescents of the household between ages 13 to 19, covering topics such as sexual activity, mental health, alcohol and cigarette consumption, and expectations about the future. Up to three adolescents were interviewed for each household. We interviewed 2,109 out of 2,737 eligible youth for a response rate of 77 per cent. Additionally, qualitative in-depth interviews were administered to respondents to the Young Person's Module from 16 households. IHS3 does not have a comparable section for youth so the Malawi Demographic and Health Survey (MDHS) results are used when applicable to compare results on youth sexual activity. The average age of the youth sample is a little over 15 and there are even proportions of males and females.

Sexual Experience and Behaviour

For youth age 13 to 19, about a third have made their sexual debut and males are more likely than females to have debuted (38 and 27 per cent respectively). The MDHS reports that 33 per cent of 15 to 19 year olds have made their sexual debut; to make direct comparisons, we restricted the SCTP sample to this age group. This older SCTP youth group is more likely to have had sex, as 44 per cent of the full sample has debuted including 50 per cent of males and 37 per cent of females. However, restricting the MDHS to the bottom wealth quintile to more closely resemble the SCTP sample,

Table 5. Age at First Sex for SCTP-Eligible and MDHS Youth¹

	SCTP-Eligible Ages 13-19	SCTP-Eligible Ages 15-19	MDHS Ages 15-19	MDHS Bottom Wealth Quintile
All	14.0	14.5	14.3	15.0
Females	13.7	14.9	14.8	15.1
Males	14.5	14.2	13.9	14.8

¹MDHS samples are for unmarried young people age 15-19 from South/Central region only, calculated by authors from MDHS micro data. Figures are based on those who reported having ever had sex. SCTP-eligible samples are of unmarried youth age 13-19.

38 per cent had debuted (61 per cent of males and 27 per cent of females). Therefore, the typical concern of under-reporting with self-reported sexual debut in face-to-face interviews does not seem to be a problem in the SCTP-eligible sample.

For those that have debuted, age at first sex is an important indicator because young people who debut at an early age are considered to be at a higher risk of contracting HIV and other Sexually Transmitted Infections (STIs) than those who delay debut. Table 5 shows, among adolescents who report ever having sex, the average age of sexual debut in our sample is 14 years old and there is no significant difference between males and females. Focusing on the older 15 to 19 year old group, the mean age of debut is 14.5 in the SCTP-eligible sample, which falls directly between the debut age in the general MDHS 15 to 19 year old sample and the MDHS bottom wealth quintile.

Another important measure of the risk of HIV and other STIs are rates of condom usage among sexually active youth. At first sex, about a third of SCTP youth report using a condom, however this increases for respondents' last reported sex. About 41 per cent of the SCTP sample reported using a condom during their last sexual encounter, which is comparable to the 45 per cent from the MDHS non-married females and males age 15 to 19.

Alcohol and Cigarette Use

Both alcohol and cigarette use are very rare in our sample. Only three per cent have ever tried alcohol and one per cent has ever tried cigarettes. Males are more likely to have tried both alcohol and tobacco than females, although only the difference in smoking occurrence is significant.

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www.cpc.unc.edu/projects/transfer/countries/malawi

Mental Health

The youth questionnaire also measured mental health using the short form of the Center for Epidemiological Studies Depression (CES-D) scale². Results indicate that 47 per cent of adolescents in the SCTP sample have depressive symptoms and that more females (49 per cent) are depressed than males (45 per cent). The CES-D scale was also administered to similar populations as part of the evaluations of the Zambia Multiple Category Cash Transfer Programme (MCP) and the Zimbabwe Harmonised Social Cash Transfer (HSCT) Programme. Although we cannot offer direct comparisons across these samples, the percentage of adolescents with scores indicating depressive symptoms in Malawi is considerably greater than in Zambia (25 per cent) and Zimbabwe (37 per cent).

Peer Networks

Youth from 16 households were interviewed about their social networks. In general, the qualitative interviews showed that youth had fairly small social networks, with mostly “strong” family and friend ties with fewer “bridging” ties, or peers who extend beyond the immediate network of the person and who may provide linkages to other resources, ideas, and opportunities. Only one respondent, a male, described having a network that included both strong and bridging ties.

All peer networks were unisex. Youth that attended school had mostly peers who were also in school, while those out of school generally had peers who were also out of school. Males generally reported having larger peer networks (three or four on average) compared to females (two on average). Males also seemed more socially connected, describing doing school work, playing soccer, and doing *ganyu*, or informal day labour, and chores as the main ways they spent time with their peers. Two young men mentioned going to watch movies with their friends.

²This is a ten item scale with responses ranging from 1 (rarely) to 4 (always) so the overall scale ranges from 10 to 40. The cut-off point used for depressive symptoms is 20 or above. See Andresen, E. M., Malmgren, J. A., Carter, W. B., & Patrick, D. L. (1994). Screening for depression in well older adults: Evaluation of a short form of the CES-D. *American Journal of Preventive Medicine*.

Female participants emphasized more time spent doing chores and *ganyu* with their friends, with less discussion of doing schoolwork or general social activities together. Young women who had babies were especially isolated. The most socially isolated participant was a young woman who was out of school and had an infant. She indicated she had no peer network, describing herself as “secretive”.

Summary

SCTP households represent some of the most vulnerable in Malawi, with clear consequences for children. In almost all child dimensions reported on, children in SCTP households perform worse than their ultra-poor counterparts in the rest of the country. This is due to the unique demographic targeting criterion of the SCTP which captures labour-constrained and high dependency families. One implication of this targeting strategy is that the programme reaches households with many older children, particularly those who are orphaned, and relatively few children of pre-school age. Given the importance of intervening early in a child’s life to mitigate the adverse effects of poverty and deprivation, alternative approaches are necessary to adequately address the needs of very young children living in poverty.



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