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CASH TRANSFERS IN AFRICA

Impacts on Health Care Utilisation and Physical and Mental Health: Evidence Summary

September 2025

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1. INTRODUCTION

Social protection is prominently featured in the 2030 development agenda, and 52.4 per cent of the global population are covered by at least one social protection benefit (ILO 2024). Social protection programmes can contribute to reducing poverty and inequality and can also enhance social cohesion. They are vital to national development strategies. Nevertheless, social protection coverage rates among children and adolescents are among the lowest of all groups, at 28.2 per cent globally (ranging from 14.2 per cent in the Arab states and 15.2 per cent in Africa to 76.6 per cent in Europe and Central Asia) (ILO 2024).

Regional comparisons indicate that Africa has the lowest social protection coverage globally, with 19.1 per cent of people covered by at least one social protection benefit (12.6 per cent of vulnerable persons are covered by social assistance in Africa), yet coverage in many countries is substantially lower (ILO 2024). At the same time, social protection programming in the region has expanded dramatically over the past two decades. Many countries in Africa have invested in and expanded their social protection systems (ILO 2021, 2024). In fact, between 2000 and 2015, the number of non-contributory social protection programmes in the region tripled (Cirillo and Tebaldi 2016), and almost every African country now has at least one social safety net programme (Beegle, Coudouel, and Monsalve 2018). In response to the COVID-19 pandemic, countries paid increased attention to social programmes around the world.

Social protection programming can be divided into contributory and non-contributory programming. In contributory programming, participants must pay into programming to receive benefits when eligible (for example, in the event of injury, maternity/paternity, unemployment, or retirement). In contrast, non-contributory programming is available to individuals even if they have not paid into programmes and includes both social assistance programmes and social care. Social assistance includes social transfers (cash transfers), food vouchers or consumable in-kind transfers including school feeding programmes, productive asset transfers, public works programmes, fee waivers, targeted subsidies, and social care services (e.g., childcare benefits, family support services, childcare provision). In Africa, governments have introduced flagship social safety net programmes and increased social protection coverage (World Bank 2018). For instance, between 2010 and 2016, the number of countries in sub-Saharan Africa with an unconditional cash transfer programme doubled from 20 to 40 out of 48 countries (Hagen-Zanker et al. 2016). Nevertheless, countries have struggled to significantly expand coverage of their cash transfer programmes, with some notable exceptions.

Much of the expansion of social protection in Africa is in the form of social cash transfers and is informed by a growing body of global evidence that demonstrates that cash transfer programmes can improve key outcomes that can help break the intergenerational persistence of poverty, improve human capital outcomes, and address gender inequities in the burden of poverty. In the current overview, we focus on cash transfers, which are a core element of social protection strategies in low- and middle-income countries. They are generally designed to provide regular and predictable cash support to poor and vulnerable households or individuals. The direct provision of cash empowers these households and individuals to address their vulnerability and helps them alleviate the worst effects of poverty (Agrawal et al. 2020; Garcia, Moore, and Moore 2012). Many cash transfer programmes have objectives related to reducing poverty and food security, in combination with improving human capital development (including health and education). Poverty reduction objectives can be framed from the perspective of both monetary poverty and multidimensional poverty. These measures are complementary, and multidimensional poverty aims to capture individuals' access to goods and services and measures deprivations across various domains (including health, education, infrastructure, among others). Evidence shows cash transfers reduce poverty and food insecurity and increase asset ownership, school attendance, and other aspects of well-being (Baird et al. 2014; Bastagli et al. 2019; Davis et al. 2016; Owusu-Addo, Renzaho, and Smith 2018; Pega et al. 2022).

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At the same time, country-level expansion of social protection programming is often constrained by incomplete awareness and understanding among different stakeholders of social protection impacts. This includes commonly held misperceptions around the nature and impacts of cash transfer programmes. The problem is further compounded by the inaccessibility and underutilisation of existing evidence which has the potential to inform policy and programmatic reform. In the wake of not only the COVID-19 pandemic, but also with increasing challenges associated with the effects of climate change, local and global socio-economic crises, and an increasing number of people living in fragile and conflict contexts, it is imperative that available evidence is made accessible to inform decisions on the use of scarce resources to extend coverage, improve adequacy, and optimise the delivery of social protection programmes in Africa.

While numerous impact evaluations and systematic reviews have examined cash transfer programme impacts, including in Africa, these are often in academic publications (which may require payment to access) or lengthy technical reports that are not easily accessible to a broader audience. In addition, summaries of evidence across countries or outcomes are also lacking, as many systematic reviews focus on narrow outcomes by design. In this series of papers, we aim to synthesise this evidence on the impacts of social cash transfer programmes or social safety net programmes as it applies to the sub-Saharan African context in brief and in language accessible to policymakers, practitioners, civil society actors, and other stakeholders. The series covers topics such as: poverty, food security, and resilience; health; education; gender equality; adolescents; and nutrition.

This is the second paper in the series, examining impacts of social cash transfer programmes on health outcomes (physical and mental) and health services utilisation in language accessible to policymakers, practitioners, and other stakeholders. The paper provides an overview of the evidence with a focus on Africa, focusing on where notable impacts are evident, where they are not, where evidence is scarce, and a discussion of the factors determining programme effectiveness or its absence, as the evidence allows. Where possible, we focus on evidence from national cash transfer programmes and not emergency settings. In particular, we highlight evidence from evaluations conducted in Africa under the Transfer Project[1].

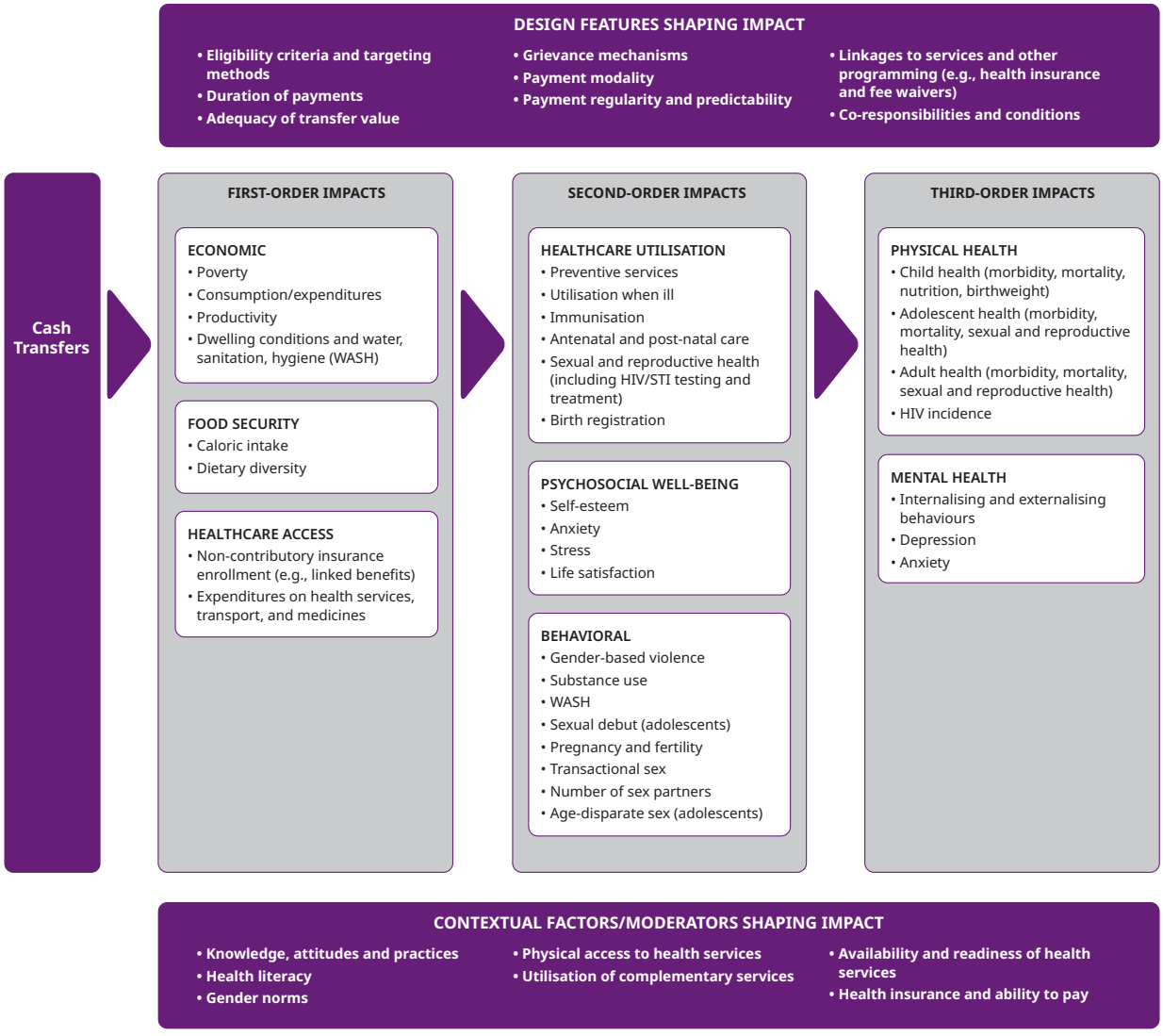
Box 1. Key concepts and terminology

- The Social Protection Inter-Agency Cooperative Board (SPIAC-B) defines social protection as the "set of policies and programmes aimed at preventing or protecting all people against poverty, vulnerability and social exclusion, throughout their life cycles, with a particular emphasis towards vulnerable groups" (SPIAC-B). Social protection programming can be divided into **contributory** and **non-contributory programming**. In contributory programming, participants must pay into programming to receive benefits when eligible (for example, in the event of injury, maternity, unemployment, or retirement). In contrast, non-contributory programming is available to individuals even if they have not paid into programmes and includes both social assistance programmes and social care (family support services). Social assistance includes social transfers (cash transfers, vouchers, in-kind transfers), public works programmes, fee waivers, and subsidies.
- This review focuses on evidence from **social cash transfers**, including both unconditional and conditional cash transfers. **Unconditional** cash transfers are provided to individuals or households without conditions around compliance with certain behaviours. **Conditional** cash transfers, on the other hand, are provided subject to households or individuals complying with certain behavioural requirements (conditions), such as household members' school attendance or health check-ups. In some settings, an unconditional base transfer may be provided and then additional top-up amounts may be subject to conditions. Conditions are increasingly referred to as "co-responsibilities."
- **Social cash transfers** are regular, predictable cash transfers delivered to households, generally with objectives related to poverty reduction, consumption smoothing, and human capital development. They are typically delivered over a longer period of time as compared to cash transfers in humanitarian or emergency settings. The latter may be short-term transfers intended to meet basic needs for food, shelter, etc.
- When cash transfers are linked with other programming or services, this is referred to as "cash plus". These services might include health care, vocational training, social and behaviour change communication, or other programming. The motivation for designing programmes with intentional linkages is that evidence shows that cash alone may not be sufficient to overcome many barriers that poor and marginalised households face. Thus, additional, often intersectoral linkages, can help address some of these barriers to health, education, livelihoods' access, and ultimately contribute to the sustainable poverty reduction.

2. CONCEPTUALISING HOW CASH TRANSFERS AFFECT HEALTHCARE UTILISATION AND PHYSICAL AND MENTAL HEALTH AND WELL-BEING

The conceptual framework in Figure 1 shows how cash transfer programmes may influence different outcomes of interest. These outcomes include physical health and well-being, including mortality, morbidity, and sexual and reproductive health. At the child level, outcomes include morbidity and mortality. Mental health outcomes include clinically relevant measures (for example, depression and anxiety disorders) as well as symptoms of poor psychosocial well-being, such as internalising (for example, social withdrawal, depressed mood) and externalising (aggression, hyperactivity) problems. Cash transfer programmes may influence these outcomes across the short, medium, and long term. Global evidence on the impact of cash transfers on health is extensive and potential pathways of impact are well defined. In the evidence review section, we highlight which pathways have strong supporting evidence and where gaps exist. The framework serves as the point of departure for the remainder of this paper.

FIGURE 1. CONCEPTUAL FRAMEWORK LINKING CASH TO HEALTHCARE UTILISATION AND PHYSICAL AND MENTAL HEALTH AND WELL-BEING



First-Order Impacts

ECONOMIC: As can be seen in Figure 1, cash transfers increase economic security (reduce poverty and increase consumption, income, and productivity) in first-order impacts and allow households to make decisions that impact their health directly or indirectly. Cash transfer programmes can also increase household income by enabling households to engage in more productive activities and/or employment because they allow households to save or invest in productive assets for agriculture or non-farm enterprises (Covarrubias, Davis, and Winters 2012; Asfaw et al. 2014). These activities reinforce increased income and investments in dwellings related to water, sanitation, and hygiene (WASH), all of which can have subsequent effects on health or modify impacts of cash transfer on health (for example, the role of WASH in children's nutrition outcomes).

FOOD SECURITY: In first-order impacts, cash transfers lead to increased food security, through both increased caloric intake as well as dietary diversity, including higher quality food or more diverse food groups, which, in turn, can positively affect nutrition and reduce morbidity, especially among children (Owusu-Addo, Renzaho, and Smith 2018).

HEALTHCARE ACCESS: Cash transfers can also increase enrolment in health insurance, either through increased ability to pay for premiums, or sometimes due to linked benefits, whereby cash transfer participants are eligible for fee waivers for premiums (for example, fee waivers for premiums in the National Health Insurance Scheme among participants of Ghana's Livelihood Empowerment Against Poverty (LEAP) program). Increased health insurance coverage and increased income together can improve household's ability to pay for (and subsequently, make expenditures on) health services, transportation, and medications. Uptake of health insurance may depend on contextual factors, such as perceived benefits, which are correlated with service availability and readiness.

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Second-Order Impacts

HEALTHCARE UTILISATION: Through reducing financial barriers, in the medium-term cash transfers programmes can improve use of preventative or treatment health care services (when ill), including well-child check-ups, care related to illness, antenatal and postnatal care, and birth registration (which allows individuals to access benefits to which they are entitled, like health insurance, throughout the life course through legal recognition). Cash transfers may also increase testing for HIV/STIs and access to sexual and reproductive health care services (including access to modern contraceptives). In addition to increased utilisation of services, cash transfers can improve adherence to treatments through both ability to pay for medications, but also through improved food security, which has been linked to adherence to antiretroviral treatment (ARTs) for HIV (Weiser et al. 2012). Subsequently, increased utilisation can lead to improved health outcomes through better prevention and treatment.

PSYCHOSOCIAL WELL-BEING: Cash transfers can also improve mental health and psychosocial well-being. Poverty and mental health are closely linked, and there are two explanations for this. The first explanation is the social causation hypothesis, which suggests that conditions related to poverty increase the risk of poor mental health (Lund et al. 2011). The second explanation is the social drift hypothesis, which suggests that poor mental health adversely affects income and economic security through increased out-of-pocket health expenditures, job loss, and illness (Saraceno, Levav, and Kohn 2005; Johnstone and Baylin 2010; Dohrenwend et al. 1992; Fox 1990). Improved economic and food security can reduce chronic stress, which in turn is linked to mental health (anxiety and depression), as well as physical health. Chronic stress can cause molecular changes which initiate or accelerate the development of disease. It can also cause poor immune system function and elevated inflammation (McEwen 1998; Aiello and Dowd 2013). Thus, by alleviating the financial and social burdens associated with poverty, including those related to food insecurity, social exclusion, and exposure to violence, cash transfers may lead to reductions in stress with subsequent effects on mental and physical health. Similarly, because cash transfer programmes increase participants' ability to pay for community activities such as weddings and funerals, as well as increase their ability to pay for soap and new clothes, cash transfers can also increase social inclusion for households who may have previously been excluded from community activities and networks. These social networks may also be reinforced in contexts where payments are manual (and thus participants spend time waiting for payments together), or where there is complementary programming (for example, information sessions) where people meet in groups. This can subsequently improve their mental health.

BEHAVIOURAL OUTCOMES: In terms of behavioural health outcomes, cash transfers can reduce various forms of violence, including gender-based violence and intimate partner violence, as well as other forms of violence against children (for example, violent discipline) and adolescents (for example, sexual violence). Simultaneously, improved economic security can improve material well-being and reduce adolescents' (especially girls') incentives to engage in some sexual behaviours that pose health risks. Examining effects on these outcomes is important in Africa, where approximately one in five people are adolescents. These risky behaviours include early sexual debut, early pregnancy, and age-disparate sexual relationships. Among both adolescents and adult women, cash transfers may reduce number of partners and engagement in transactional sex. This in turn further reduces risk of gender-based violence and HIV/STI infection, all of which have important impacts on health. Among both adolescents and adults, cash transfers' protective effects on mental health may subsequently reduce alcohol and drug use. The various effects in the medium term can be mutually reinforcing and amplify overall effects of cash transfers. Cash transfers may also have impacts on childbearing and fertility. However, the direction of impacts is not always clear. It is theoretically possible that increased economic security resulting from cash transfers may increase couples' desire to have more children. In contrast, increased economic security may allow women and couples to space births, or may allow adolescent girls to delay childbearing.

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Third-Order Impacts

PHYSICAL HEALTH: In the third-order effects, these first- and second-order effects can lead to reduced morbidity and mortality, improved sexual and reproductive health, and improved nutrition, including among children, adolescents, and adults. Nutrition outcomes can include underweight, wasting, stunting , and overweight/obesity. Cash transfers may also lead to increases in birthweight, which is important because low birthweight is associated with stunting and wasting, infant mortality, and health throughout the life course, including noncommunicable diseases such as cardiovascular disease and diabetes.

MENTAL HEALTH: Also in third-order effects, impacts of cash transfers on first- and second-order effects highlighted above can improve mental health outcomes.

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Programme Design Features

Programme design features that can moderate impacts of cash transfers include the following:

- Targeting criteria and processes (effectiveness of targeting)
- Modality of transfer (e-payment v. Manual)
- Frequency and predictability of transfer
- Adequacy of the cash transfer value (including whether these keep pace with inflation)
- Duration of transfer receipt
- Existence of conditions or co-responsibilities
- Integrated linkages to social services (in case of integrated cash transfer programmes often referred to as 'cash plus,' including health fee waivers or non-contributory health insurance).

Transparent and effective cash transfer targeting processes help ensure the most vulnerable households and individuals are included and improve community understanding, trust, and acceptance of the programme. Meanwhile, 'adequate', regular, and predictable transfers may empower households to meet their immediate consumption needs. It is important that transfer values keep pace with inflation.

Contextual Factors

As shown in Figure 1, a wide range of programme design features of cash transfers and factors resulting from the operating contexts in which these programmes are implemented can influence the effects of cash transfers. These factors can influence cash transfer impacts independently and jointly. Their effects can be positive or negative. Nevertheless, a review focusing on moderating factors concluded that moderating characteristics were often underreported or not frequently analysed in cash transfer evaluations (Cooper et al. 2020).

Contextual factors also influence the size of impacts. While not an exhaustive list, such factors include:

- Knowledge, attitudes, and practices
- Health literacy
- Gender norms
- Physical access to health services
- Utilisation of complementary services
- Availability and readiness of health services
- Health insurance and ability to pay

Cash transfer programmes' inclusion of complementary services or linkages to health services (such as through health insurance premium waivers, free services, or related initiatives) will further reduce financial barriers to health and improve health-seeking behaviour in the household (Onwuchekwa, Verdonck, and Marchal 2021; Ranganathan and Lagarde 2012; Roelen et al. 2017). Pathways can also be reinforced where integrated linkages or referrals to complementary health and social services exist, including through case management or behaviour change communication on various health and nutrition[2] topics. Meanwhile, when cash transfer programmes implement conditions (or co-responsibilities), pressure to meet these conditions may increase stress and worsen mental health. These adverse effects may be worse for women than for men, as conditions often fall to women to comply with, increasing their responsibilities and exacerbating women's workload (sometimes referred to as "time poverty"). Time poverty may counteract effects on impacts like women's empowerment (Peterman et al. 2024). As such, these design characteristics can moderate the level of impact on the outcomes described above. In addition, inability to meet the conditions for whatever unforeseen reasons can also have consequences for a household who is both in need of and has planned on additional resources.

In addition to programme design and implementation features, **contextual factors** also influence whether and to what extent cash transfers translate to desired impacts. While not an exhaustive list, such factors include prevailing knowledge, attitudes and practices with relevance to health, health literacy, existing financial access to health services (e.g., health insurance coverage), physical access to health services (particularly in fragile contexts), utilisation of complementary services (service uptake), quality (service availability and readiness), and inclusiveness of health services (e.g., the extent to which health services are adolescent-friendly). Income shocks at the household level are also common in the African context of ongoing economic, climate, and conflict poly-crises, and can affect a household's financial reserves, and in turn, financial access to services.

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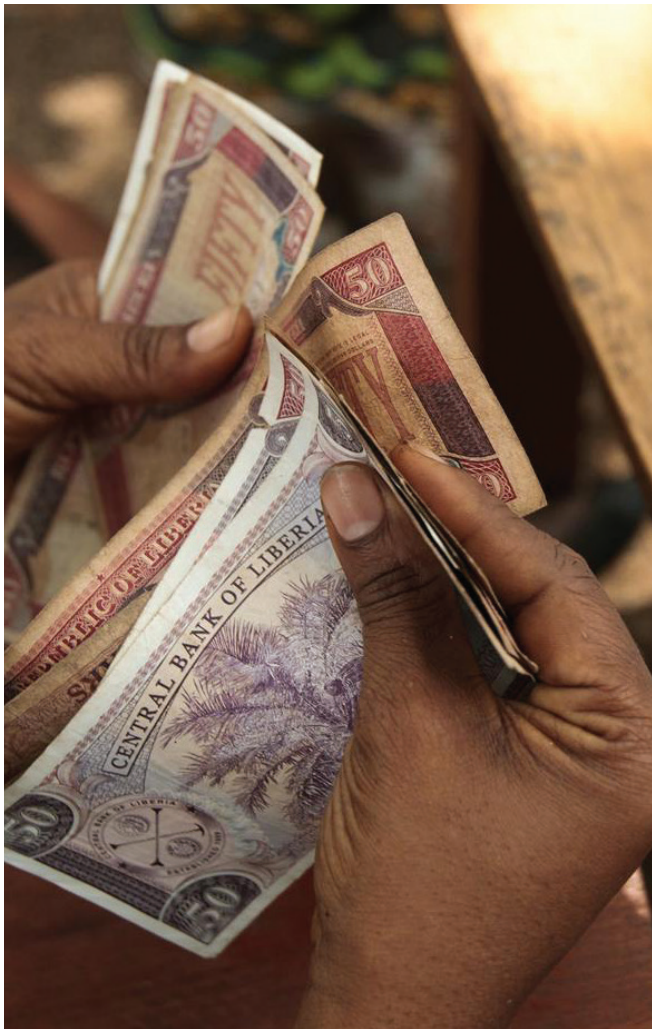
3. METHODOLOGY

The section outlines the approach we followed to review the available evidence. Guided by the logic model (see Figure 1), this synthesis summarises the existing evidence on the short-, medium-, and long-term impacts of cash transfer programmes on health, including mental health. Geographically, evidence from Africa was prioritised, unless this evidence was limited or showed mixed conclusions, in which case we complemented summaries with global evidence. In the latter case, we drew evidence from global reviews to fill in the gaps and flagged these as areas for more research to strengthen the African evidence base.

We prioritise evidence from systematic reviews, narrative reviews, and meta-analyses of impact evaluations of cash transfer programmes, with a focus on evidence from Africa as well as individual studies (published reports and peer-reviewed articles) from the Transfer Project. For outcomes where there exist reviews but there are gaps in the evidence from Africa, we draw on global reviews and evidence. For outcomes where systematic reviews and meta-analyses were not available, we draw on evidence from individual studies identified through searches in PubMed and Google Scholar. We have flagged these as areas for more research to strengthen the African evidence base. This, for example, holds for areas where evidence is emerging but not yet solidified (e.g., cash plus programmes without accompanying rigorous impact evaluations) or evaluations that consider the moderating effects of programme design features and implementation fidelity.

Regarding the key indicators to measure impact across areas of interest (Table 1), we adopted indicators most widely reported in past key systematic reviews (e.g., (Bastagli et al. 2019)) and Transfer Project evaluation studies. Table 1 presents an overview of these indicators which are then explained in more detail in upcoming sections that present the evidence on each.



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Definitions:

- **NARRATIVE REVIEW** – examines many studies on a single topic and narratively synthesises the findings to draw more generalisable conclusions. Narrative reviews may be traditional narrative reviews or systematic reviews.
- **SYSTEMATIC REVIEW** - comprises a systematic search of the literature, involving a detailed and comprehensive search strategy. Systematic reviews synthesise findings on a single topic to draw generalisable conclusions.
- **META-ANALYSIS** – uses statistical methods to combine estimates from multiple studies to synthesise data and develop a single quantitative estimate or summary effect size. Meta-analyses are often performed as part of systematic reviews but require a large enough number of studies examining similar interventions and outcomes.
- **IMPACT EVALUATION** – an evaluation which uses rigorous methods to determine whether changes in outcomes can be attributed to an intervention (such as a cash transfer). Impact evaluations may use experimental (where treatment and control conditions are randomised at the individual or community level) or quasi-experimental methods to identify a counterfactual (what would have happened to the treatment group had they not received the treatment.

Table 1: Outcomes of interest and list of corresponding indicators

OUTCOMES OF INTEREST	DOMAINS	INDICATORS
Access	Health care access	Insurance uptake
		Expenditures
Healthcare utilisation	General health care utilisation	Sought health care services (preventive or for illness)
	Reproductive health	Antenatal care seeking
		Skilled birth delivery
		Contraceptive use
	Preventive health care	Check-ups
		Vaccination
	HIV/STI testing and treatment	HIV/STI testing and treatment
		HIV treatment adherence
Behavioural outcomes	Gender-based violence	Sexual, emotional, physical violence
		Intimate partner violence
	Substance use	Alcohol and tobacco expenditures
	Sexual behaviours	Sexual debut
		Transactional sex
		Age-disparate relationships
		Pregnancy
		Fertility
		Birth spacing
		Number of sexual partners
Physical health	Mortality	Mortality
	Morbidity	Illness incidence
	Child health outcomes	Diarrhoea
		Fever or fever/malaria
		Acute respiratory illness
		Birth registration
	Malnutrition	Stunting
		Underweight
		Wasting
		Overweight/Obesity
	HIV	HIV incidence (and prevalence)
		Perception of HIV risk

Table 1: Outcomes of interest and list of corresponding indicators (CONT.)

OUTCOMES OF INTEREST	DOMAINS	INDICATORS
Mental health	Mental health	Internalising and externalising behaviours
		Self-perceived stress
		Life satisfaction
		Depression

Summaries from several reviews are included in the results below, and the aims of these reviews are summarised in Table 2.

Table 2: Summary of reviews covered

AUTHORS & YEAR	TYPES OF CASH TRANSFERS EXAMINED	AIMS
Cirillo, Palermo, Viola, 2021	Governmental non-contributory social protection programmes including cash and in-kind transfers; educational fee waivers; and school feeding programmes	Narrative review of 85 studies examining impacts of non-contributory social protection programmes on adolescent well-being and safe and productive transitions to adulthood in lower- and middle-income countries.
Cooper et al. (2020)	Conditional and unconditional	Conducted a narrative review of 56 studies (11 in Africa) from lower- and middle-income countries to examine whether effects of cash transfers on health outcomes differ across study subgroups.
Evans and Popova (2017)	Unconditional and conditional	Conducted a review and meta-analysis 19 studies from 10 countries globally reporting on expenditures on alcohol and tobacco.
Hidrobo et al., 2018	Cash transfers, public works, food vouchers, and in-kind food transfers	Systematic review and meta-analysis examining impacts of social assistance programmes on food security and assets.
Khan et al. (2016)	Unconditional and conditional	Narrative review of 11 studies covering 10 programmes (five from Africa) to understand impacts on contraceptive use.
Kneale et al., 2023	Cash transfers	Systematic review and meta-analysis of 15 studies examining the impact of cash transfers on adolescent contraception and fertility.
Lagarde et al. (2007)	Conditional cash transfers	Examined impacts from 10 studies covering six conditional cash transfers (one in Africa).
McGuire et al., 2022	Unconditional and conditional cash transfers	Review and meta-analysis of 45 studies (30 in Africa) examining impacts of conditional and unconditional cash transfers on mental health and subjective well-being.
Onwuchekwa et al. (2021)	Conditional cash transfers	Systematic review (narrative synthesis) of 9 studies examining health services utilisation and child health in Africa.
Owusu-Addo et al. (2018)	Conditional and unconditional cash transfers	Conducted a narrative review of 53 studies covering 24 unconditional and conditional cash transfer programmes in Africa.
Owusu-Addo and Cross (2014)	Conditional	Narrative systematic review of 17 studies (16 from Latin America, one from Zimbabwe) on child health.
Pega et al. (2022)	Unconditional cash transfers	Systematic review of 34 studies (covering 24 unconditional cash transfers) in Africa, the Americas, and South-East Asia and meta-analysis of sub-groups of studies on outcomes where feasible.

Table 2: Summary of reviews covered (CONT.)

AUTHORS & YEAR	TYPES OF CASH TRANSFERS EXAMINED	AIMS
Ranganathan and Lagarde (2012)	Conditional cash transfers	Authors reviewed 13 CCTs (three in Africa) and impacts on health outcomes.
Semba et al., 2022	Cash transfers	Systematic review of 20 studies examining impacts of cash transfers on overweight and obesity in children and adults.
Stoner et al., 2021	Cash transfers	Systematic review of 45 studies examining impacts of cash transfers on HIV infection, STIs, or sexual behaviours.
Sun et al. (2021)	Cash transfers	Narrative review of cash transfers and pathways to affecting health
Wollburg et al., 2023;	Unconditional and conditional	Conducted a review and meta-analysis of 17 studies (13 in Africa) in lower- and middle-income countries examining impacts of conditional and unconditional cash transfers on adult mental health (anxiety and depressive disorders).
Zaneva et al., 2022;	Unconditional and conditional	Conducted a review and meta-analysis of 14 studies (10 in Africa) examining impacts of conditional and unconditional cash transfers on mental health of children aged 0-19 years in lower- and middle-income countries as evaluated by randomised controlled trials.
Zimmerman et al., 2021	Cash transfers (conditional and unconditional)	Systematic review (of 14 studies) and meta-analysis (of eight studies) examining impacts of cash transfers on mental health of children and young people aged 0-24 years in LMICs.

Source: ©UNICEF/UNI702938/Dicko

4. EVIDENCE ON THE IMPACTS OF CASH TRANSFERS ON HEALTH-RELATED OUTCOMES IN AFRICA

The below sections have been organised to show where impacts have been seen, what factors explain differences in impact, and what gaps still exist in the African evidence base to inform future research. When possible, we discuss differences in impacts on outcomes across age groups and gender.

Before delving into a detailed description of findings in the remainder of Section 4, we provide a short summary of impacts of cash transfers on health-related outcomes, following pathways outlined in the conceptual framework. First, there is strong evidence that cash transfers improve outcomes related to important **determinants of health**, including poverty and food insecurity (both quantity and quality of diets). Through this increased income, cash transfers allow households to spend more on health care, including for preventative and sick visits. Expenditures may include direct fees, related transportation, or medications. Very few studies have examined impacts of cash transfers on health insurance enrolment, which also affects access to care, but among those examining this outcome, they find that cash transfers increase health insurance enrolment.

Next, we examined impacts on **healthcare utilisation** and find that cash transfers increase general utilisation (including for sick visits). However, in Africa, cash transfers generally do not increase immunisation rates, despite their impacts on this outcome in other regions. Turning to more specialised healthcare utilisation, there is evidence that cash transfers increase antenatal care visits in Africa, but not skilled attendance at delivery (birth). Nevertheless, one exception was found where cash transfers increased skilled attendance at delivery in communities with higher quality health services, suggesting the importance of contextual factors and supply-side characteristics. Two other areas where cash transfers have not had impacts are modern contraceptive use and HIV treatment adherence. Nevertheless, cash transfers do appear to increase HIV testing in Africa. Relatedly, cash transfers also increase birth registration, but the number of studies examining this outcome is small.

Cash transfers can also influence other **behaviours** which can have direct and indirect impacts on health. Thus, we examined impacts on gender-based violence, alcohol and tobacco use, sexual behaviours, and fertility. There is strong evidence that cash transfers reduce intimate partner violence, and there is also evidence to suggest that they can reduce violence against children and adolescents. There is also strong evidence that cash transfers do not increase the purchase and use of alcohol and tobacco. The evidence on sexual behaviours (which is typically more studied among adolescents) is more mixed. For example, governmental unconditional cash transfer programmes can delay sexual debut among adolescents and may reduce age-disparate relationships and risk of transactional sex in some contexts. However, they have limited effects on other sexual behaviours posing health risks, particularly among adolescents. Nevertheless, cash transfers can reduce adolescent pregnancy and increase birth spacing (among adult women) in Africa. Cash transfers do not increase fertility.

Through these pathways, cash transfers can ultimately affect **physical and mental health**. Physical health outcomes can be categorised broadly as child malnutrition, birthweight, mortality, morbidity, and within morbidity, HIV incidence. Global evidence on malnutrition suggests that cash transfers have modest effects on increasing height-for-age and reducing stunting and wasting, but they generally do not have impacts on weight-for-age. The small number of studies examining impacts of cash transfers on birthweight have found that cash transfers can increase birthweight, and these effects may be influenced by season of birth. Cash transfers reduce occurrence of illness, particularly among children, but effects are not found in all contexts. There is some evidence to suggest that cash transfers implemented as part of research trials can reduce HIV incidence, and an observational study comparing national cash transfer coverage rates with population data on HIV incidence found that cash transfers are associated with fewer HIV infections. Turning to mental health, cash transfers can improve mental health, but impacts vary according to program design and recipient characteristics. Further, unconditional cash transfers have larger protective effects on mental health than conditional cash transfers.

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Program design and contextual factors can influence the extent to which cash transfers improve these outcomes. For example, impacts may be larger in contexts with higher quality health services, as was seen with cash transfer impacts on health insurance enrolment and skilled delivery at birth. Other contextual factors are environmental, and cash transfer impacts on birthweight were found to be larger in the dry season compared to the rainy season when risk factors such as food insecurity and malaria risk are greater. Programme design can also influence the size of impacts. For example, unconditional cash transfers were found to have larger impacts on improving mental health than conditional cash transfers.

In summary, cash transfers improve determinants of health, healthcare utilisation, mitigate some behaviours that increase risk factors for poor health outcomes, and improve different aspects of physical and mental health. Contrary to existing myths, however, cash transfers do not increase fertility or the purchase and use of alcohol and tobacco.

4.1 Evidence of Impacts of Cash Transfers on Consumption, Productivity, and Food Security

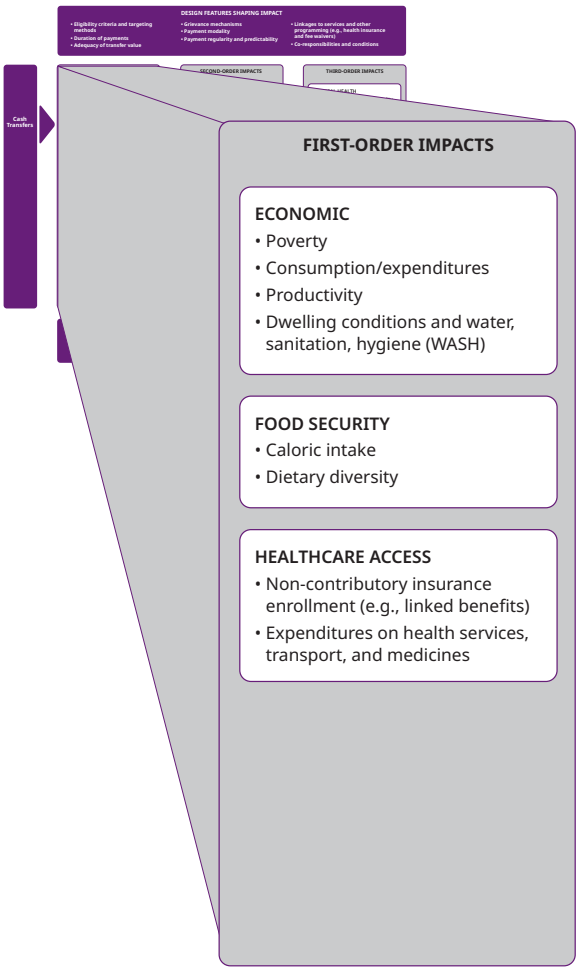
Poverty

Evidence from various systematic reviews and evaluations of large-scale and government-led cash transfer programmes demonstrates that cash transfers have reduced poverty including in Africa.

The effects of cash transfers on poverty, consumption, productivity, and food security have been extensively reviewed in the accompanying summary document. We briefly describe that evidence here, as they are pathways through which cash transfers can improve health-related outcomes.

Bastagli et al. (2019) conducted a comprehensive review of cash transfer programmes globally. Six out of nine studies that considered impacts of cash transfers on poverty found that cash transfers were associated with reductions in poverty headcount (with reductions ranging from 4.1 percentage points in Zambia to 21.9 percentage points in Pakistan) and seven out of nine studies found reductions in the poverty gap (with reductions ranging from 4.5 percentage points in Mexico to about 8.4 percentage points in Zambia). Among five studies (out of nine) in Africa, cash transfers led to reductions in headcount poverty (two studies) and poverty gap (two studies).

FIGURE 1A. CONCEPTUAL FRAMEWORK LINKING CASH TO HEALTHCARE UTILISATION AND PHYSICAL AND MENTAL HEALTH AND WELL-BEING - FIRST-ORDER IMPACTS



Similarly, several impact evaluations of cash transfer programmes in Africa, all implemented as part of the Transfer Project, have found impacts of cash transfers on poverty (e.g., (SCTP Evaluation Team 2016; The Transfer Project 2017; LEAP 1000 Evaluation Team 2018; AIR 2015b, a). Seven out of ten Transfer Project evaluations found protective impacts of cash transfers on headcount poverty, ranging from 2.1 percentage points in Ghana to 15.3 percentage points in Burkina Faso. Six out of eight studies reported significant reductions in the poverty gap, with impacts ranging from 2.6 to 12.6 percentage points across programmes evaluated.

Consumption (expenditures)

Evidence from systematic reviews and evaluations of large-scale and government-led cash transfer programmes on impacts on household expenditure has consistently demonstrated positive effects, including in sub-Saharan Africa.

In the Bastagli et al. (2019) review, 9 out of 13 studies conducted in sub-Saharan Africa that examined cash transfer impacts on expenditures found that cash transfers increased total household expenditures. Transfer Project evaluations confirm these findings. Handa et al. (2018) reviewed Transfer Project evaluations and found that total per capita expenditure increased significantly in six out of seven evaluations examined, including in Zambia (AIR 2015a), Malawi (SCTP Evaluation Team 2016), and Ghana (LEAP 1000 Evaluation Team 2018). There are a few limited exceptions to these findings where cash transfers did not increase expenditures.

Material well-being

There is substantial evidence that cash transfer programmes in Africa help participating households meet the material needs of household members.

Cash transfer programmes can increase household assets, improve dwelling characteristics, and improve the material well-being of individuals (including children). However, to date, reviews have tended to only cover productive assets and not other types of household assets or material well-being (Bastagli et al. 2019; Hidrobo et al. 2018). In national cash transfer programmes, positive impacts on material well-being, including ownership of durable goods, housing quality, housing assets, shoes, clothing, and blankets have been found in various countries, including Senegal, Burkina Faso, and Angola.

All Transfer Project evaluations (eight total) which have examined impacts of cash transfers on material well-being found positive impacts (for example, SCTP Evaluation Team 2016; LEAP 1000 Evaluation Team 2018; HSCT evaluation team 2018; The Tanzania Cash Plus Evaluation Team 2018; Child Grant Evaluation Team 2022; AIR 2015b, a, 2014). Material well-being in this case was defined as household member ownership of specific items (for children, this is often measured as clothes, a pair of shoes, and a blanket). Overall, the evidence indicates that cash transfer programmes in Africa help participating households meet the material needs of their children. In terms of pathways to improving educational outcomes, this pathway is important because children are often required to have clean clothes (often specific uniforms) and shoes to attend school. Thus, increasing material well-being of poor households can facilitate school attendance among their children.

Productivity

The evidence demonstrates strong productive impacts of cash transfer programmes in sub-Saharan Africa, including on the purchase or ownership of farm assets, livestock ownership, the use of improved agricultural inputs, and the operation of microenterprises/non-farm enterprises.

Reviews by Alderman and Yemtsov (2012), Arnold et al. (2011), Bastagli et al. (2019), and Hidrobo et al. (2018) all demonstrate that cash transfers increase productive capacity and related activities, including the purchase of livestock, farm tools, and nonfarm productive assets, the use of improved or modern agricultural inputs, and the operation of micro- or non-farm enterprises. Transfer Project studies confirm these positive impacts (Child Grant Evaluation Team 2022; LEAP Evaluation Team 2017; AIR 2014; LEAP 1000 Evaluation Team 2018; Berhane et al. 2015; AIR 2015b, a). These positive productive impacts can have implications for adults' and children's engagement in economic activities, as described below.

Food security (dietary diversity and caloric intake)

Cash transfer programmes increase both the quantity and quality of food consumed by participating households.

Bastagli et al. (2019) included 12 studies on the impacts of cash transfers on dietary diversity and found that just over half of these studies (7 out of 12) showed significant improvements in this area. Among these, in Africa, positive impacts were found in Malawi (Baird et al. 2013) and Zambia (AIR 2014; Daidone et al. 2014). Hidrobo et al. (2018) conducted a meta-analysis of 58 studies covering 46 programmes in 25 countries in Latin America and the Caribbean, East Asia and the Pacific, South Asia and sub-Saharan Africa. In this meta-analysis, they found that cash transfer programmes improved both the quantity and quality of food consumed by participants. Caloric intake increased by 8 per cent across 21 programmes (6 per cent in sub-Saharan Africa). As explained by the authors, food expenditure tends to rise faster than calorie intake as a result of cash, at least at the start

of programme exposure, because households typically use the transfers to improve the quality of their diet first by increasing their consumption of more expensive animal source foods. In terms of dietary diversity, Hidrobo et al. (2018) find that across studies, consumption of fruits and vegetables increased by 7 per cent on average, globally. Turning to animal source foods, Hidrobo and colleagues (2018) examined impacts across 17 programmes and found that cash transfers increased animal source food consumption by 19 per cent on average, globally. In sub-Saharan Africa, this effect was much larger and amounted to a 32 per cent increase.

Transfer Project evaluations support these positive impacts on dietary diversity, including in Ghana (LEAP 1000 Evaluation Team 2018), Malawi (SCTP Evaluation Team 2016), Mozambique (Child Grant Evaluation Team 2022), Zambia (American Institutes for Research 2015), and Zimbabwe (HSCT evaluation team 2018). Transfer Project studies have not specifically examined caloric intake.

There are not many examples from the region where cash transfers did not increase dietary diversity.

4.2 Evidence of Impacts of Cash Transfers on Health Insurance Uptake

A limited number of studies suggest that cash transfers can increase enrolment in health insurance in Africa.

Health insurance enrolment is not a commonly measured outcome in cash transfer evaluations. However, at least two government cash transfer programmes in Africa have increased levels of enrolment in health insurance. First, Ghana's Livelihood Empowerment Against Poverty 1000 pilot programme increased health insurance enrolment among adults by 14.1 percentage points and among children 5-17 years by 12.7 percentage points (Ghana LEAP 1000 Evaluation Team 2018), as measured by a Transfer Project Evaluation (Table 3). An in-depth study found that LEAP 1000 increased health insurance enrolment at a higher rate in communities with higher quality health services as compared to communities with lower quality health services (among adults, 18 percentage point increase v. 9 percentage point increase; among children, 20 percentage point increase v. 0 percentage point increase) (Otieno et al. 2022). It is important to note that the programme was designed to combine cash transfers with a premium fee waiver to enrol in the health insurance scheme, but households still had to apply for health insurance and renew their cards annually. Second, a non-Transfer Project evaluation of Tanzania's pilot conditional cash transfer programme (a pre-cursor to the Productive Social Safety Net, also implemented by the Tanzania Social Action Fund) increased the probability that households enrolled in the government-run health insurance programme, the Community Health Fund (CHF), by 36 percentage points (Evans, Holtemeyer, and Kosec 2019). In the Tanzanian context, fee waivers for CHF enrolment were not provided to cash transfer participants at the time of the evaluation; however, participants were encouraged by programme implementers to enrol using cash transfer funds.[3] Theoretically, health insurance may also influence the direct impacts of cash transfers on other health outcomes; however, evaluations have not measured these effects.

Source: ©UNICEF/UNI469427/Onafuwa

Table 3. Summary of Transfer Project impacts on health insurance enrolment

UPTAKE OF HEALTH INSURANCE ENROLMENT							
COUNTRY	**PROGRAMME**	**ACRONYM**	**EVALUATION TIME POINT**	**AGE RANGE**	**INDICATOR**	**REFERENCE PERIOD**	**EFFECT SIZE**
Ethiopia	Social Cash Transfer Pilot Programme (Tigray Region)	SCTPP	36 months	N/A	At least one member in HH enroled	*Not measured*	*Not measured*
Ghana	Livelihood Empowerment Against Poverty 1000	LEAP 1000	72 months	Adults 18+	Individual enroled in National Health Insurance scheme	Last 12 months	0.141***
				Children 5-17 years	Individual enroled in National Health Insurance scheme	Last 12 months	0.127**
Kenya	Cash Transfers for Orphans and Vulnerable Children	CT-OVC	24 months	N/A	At least one member in HH enroled	*Not measured*	*Not measured*
Malawi	Social Cash Transfer Programme	SCTP	24 months	N/A	At least one member in HH enroled	*Not measured*	*Not measured*
Mozambique	Child Grant 0-2	CG-02	24 months	N/A	At least one member in HH enroled	*Not measured*	*Not measured*
South Africa	South African Child Support Grant	CSG	N/A (dose-response effect)	N/A	At least one member in HH enroled	*Not measured*	*Not measured*
Tanzania	Productive Social Safety Net	PSSN	24 months	N/A	At least one member in HH enroled	*Not measured*	*Not measured*
Zambia	Child Grant Programme	CGP	48 months	N/A	At least one member in HH enroled	*Not measured*	*Not measured*
	Multiple Category Targeting Programme	MCTP	36 months	N/A	At least one member in HH enroled	*Not measured*	*Not measured*
Zimbabwe	Harmonised Social Cash Transfer Programme	HSCT	48 months	N/A	At least one member in HH enroled	*Not measured*	*Not measured*

N/A = not applicable
**p<0.05, **p<0.01, ***p<0.001*

4.3 Evidence of Impacts of Cash Transfers on Health Care Expenditures

Cash transfers increase amount spent on health care.

H

Key concepts:

- **HEALTH EXPENDITURE** – amount spent on costs related to health care (transport, services, medicines, and related costs)

No reviews focusing exclusively on Africa have examined household expenditures on health. Globally, in the Pega et al. (2022) review, eight studies examined impacts of unconditional cash transfers on health care expenditures. While meta-analysis was not possible, a narrative summary of these studies indicates that cash transfers increased the amount of money spent on health care 7 to 36 months after cash transfers began (Pega et al. 2022).

Within the Transfer Project, studies have also examined the impacts of cash transfers on health expenditures. Novignon and colleagues (2022) found that cash transfers increased health expenditures in Zimbabwe's Harmonised Social Cash Transfer Programme among elderly household members who reported an illness, and in Zambia's Multiple Categorical Targeting Programme among all ages. There were no impacts on health expenditures in Ghana's LEAP 1000, Malawi's Social Cash Transfer, or Zambia's Multiple Categorical Targeting Programme. In Transfer Project studies not included in Novignon and colleagues (2022), health expenditures were found to increase as a result of Kenya's Cash Transfer for Orphans and Vulnerable Children (CT-OVC) and were found to decrease as a result of Mozambique's Child Grant (Bonilla et al. 2022) (Table 4).

Table 4: Summary of Transfer Project impacts on health care expenditures

HEALTHCARE EXPENDITURES							
COUNTRY	**PROGRAMME**	**ACRONYM**	**EVALUATION TIME POINT**	**AGE RANGE**	**INDICATOR**	**REFERENCE PERIOD**	**EFFECT SIZE**
Ethiopia	Social Cash Transfer Pilot Programme (Tigray Region)	SCTPP	36 months	N/A	Expenditures	*Not measured*	*Not measured*
Ghana	Livelihood Empowerment Against Poverty	LEAP	72 months	N/A	Expenditures	*Not measured*	*Not measured*
	Livelihood Empowerment Against Poverty 1000	LEAP 1000	48 months	Children ages 5-17	Real health expenditures	Last 2 weeks	N.S.
				Adults 18+	Real health expenditures	Last 2 weeks	N.S.
Kenya	Cash Transfer for Orphans and Vulnerable Children	CT-OVC	24 months	All participants	Monthly health expenditure (*excluding AIDS drugs) HH =<6	Monthly	75.44**
				All participants	Monthly health expenditure (*excluding AIDS drugs) HH >6	Monthly	N.S.
Malawi	Social Cash Transfer Programme	SCTP	24 months	Entire households with baseline poverty lower than 50%	Any expenditure for illness or injury	Last 4 weeks	N.S.

Table 4: Summary of Transfer Project impacts on health care expenditures (CONT.)

HEALTHCARE EXPENDITURES							
COUNTRY	**PROGRAMME**	**ACRONYM**	**EVALUATION TIME POINT**	**AGE RANGE**	**INDICATOR**	**REFERENCE PERIOD**	**EFFECT SIZE**
Mozambique	Child Grant 0-2	CG-02	24 months	Adults 18+	Health Expenditures	Monthly	-0.25***
South Africa	South African Child Support Grant	CSG	N/A (dose-response effect)	Children ages 0-17	Illness-related expenditures	Last 15 days	N.S.
Tanzania	Productive Social Safety Net	PSSN	24 months	N/A	Expenditures	*Not measured*	*Not measured*
Zambia[1]	Child Grant Programme	CGP	48 months	Adults 18+	Health expenditures	Monthly, per capita	0.95*
	Multiple Category Targeting Programme	MCTP	36 months	Adults 18+	Health expenditures (small HH)	Monthly, per capita	0.864"
Zimbabwe	Harmonised Social Cash Transfer Programme	HSCT	48 months	Adults 18+	Health expenditures (small HH)	Monthly, per capita	N.S.
				Adults 18+	Health expenditures (large HH)	Monthly, per capita	N.S.

N/A = not applicable
N.S. = not significant
*"p<0.10, *p<0.05, **p<0.01, ***p<0.001*

[1]Estimates come from Novignon, J., et al. (2022). "The impact of unconditional cash transfers on morbidity and health-seeking behaviour in Africa: evidence from Ghana, Malawi, Zambia and Zimbabwe." Health policy and planning 37(5): 607-623.

Source: ©UNICEF/UN0841707/Dejongh

4.4 Evidence of Impacts of Cash Transfers on Health Care Utilisation

Health care utilisation is a common outcome examined in cash transfer impact evaluations. This outcome is most often operationalised as whether individuals sought (utilised) healthcare services at facilities (either across all types of services or categorised by type of services).

General healthcare utilisation

In Africa, cash transfer programmes have increased use of health services.

Key concepts:

- **HEALTHCARE UTILISATION** – visits to healthcare providers (public, private, traditional), including for preventative services, sick visits, and treatment of chronic conditions

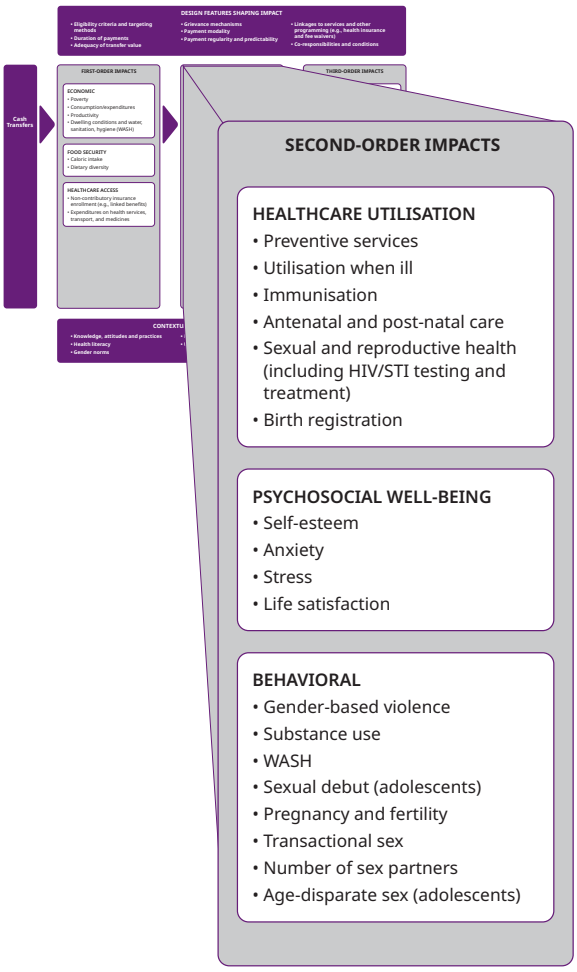
Healthcare utilisation (general preventive services and care when ill)

Cash transfers generally increase use of health services, including in Africa, but effects are not seen in all contexts.

Several reviews have examined the impacts of cash transfers on use of health services. Two reviews have focused exclusively on Africa. Owusu-Addo and colleagues (2018) examined both conditional and unconditional cash transfers in Africa and found that among programmes examining impacts on healthcare utilisation (preventative, curative, and immunisation services), 9 out of 11 studies found positive impacts, including in Malawi's Social Cash Transfer Programme, Malawi's Sexual Health Incentive Study, Ghana's Livelihood Empowerment Against Poverty, Zimbabwe's Community-led Cash Transfer Programme, and Tanzania's Community-Based Conditional Cash Transfer. In a second review by Onwuchekwa et al. (2021) of conditional cash transfers, two out of three studies (in Burkina Faso and Tanzania) examining health care utilisation found positive impacts.

Turning to the global evidence base, Pega et al. (2022) examined impacts of five unconditional cash transfers (with a majority of studies from Africa) on use of health services and found that estimates were positive but not statistically significant in a meta-analysis (RR 1.04, CI 1.00-1.09), suggesting that unconditional

FIGURE 1B. CONCEPTUAL FRAMEWORK LINKING CASH TO HEALTHCARE UTILISATION AND PHYSICAL AND MENTAL HEALTH AND WELL-BEING - SECOND-ORDER IMPACTS



cash transfers did not impact use of health services in these five studies. In another global review (including conditional and unconditional cash transfers), Bastagli and colleagues (2019) found that nine out of 15 studies found positive impacts of cash transfers on utilisation of health services; in this review, only one study (in Tanzania) found a negative impact, while five studies found no impacts. In one of the earliest reviews on this topic, Lagarde et al. (2007) examined impacts from ten studies covering six conditional cash transfers (one in Africa – Malawi), and found positive impacts on use of health services in five out of the six programmes. Ranganathan and Lagarde (2012) reviewed 13 conditional cash transfer programmes (one in Africa) and found that 10 out of 13 found positive impacts on use of health care services.

Studies within the Transfer Project have also examined impacts on health services utilisation (Table 5). Novignon and colleagues (2022) analysed Transfer Project data from five unconditional cash transfer programmes in four African Countries (Malawi, Ghana, Zambia, Zimbabwe). The authors found that government cash transfer programmes had strong, positive impacts across age groups on health services use when ill in Malawi (approximately 8 percentage points), among some age groups in Zambia (12.9 percentage points among those 20-59 years), and in Ghana (11 percentage points among adults 20-59 years). No impacts on health services use were found in Zimbabwe. In the same study, positive impacts were also found in preventative care among children under five years in Zambia's Child Grant Programme.

Taken together, this body of evidence suggests that unconditional and conditional cash transfers can increase use of health services in Africa.

Table 5: Summary of Transfer Project impacts on use of preventive health services

USE OF PREVENTIVE HEALTH SERVICES							
COUNTRY	**PROGRAMME**	**ACRONYM**	**EVALUATION TIME POINT**	**AGE RANGE**	**INDICATOR**	**REFERENCE PERIOD**	**EFFECT SIZE**
Ethiopia	Social Cash Transfer Pilot Programme (Tigray Region)	SCTPP	36 months	N/A	Vaccinations	*Not measured*	*Not measured*
				N/A	Check-ups	*Not measured*	*Not measured*
Ghana	Livelihood Empowerment Against Poverty	LEAP	72 months	Children 0-17 years	Preventive care (check-ups)	Last 12 months	N.S.
				N/A	Vaccinations	*Not measured*	*Not measured*
	Livelihood Empowerment Against Poverty 1000	LEAP 1000	48 months	Children 12-23 months	Basic Vaccinations	Lifetime	N.S.
				Children 0-59 months	Postnatal care Check-ups	Last 12 months	N.S.
Kenya	Cash Transfers for Orphans and Vulnerable Children	CT-OVC	24 months	Children ages 1-3	Vaccinations (HH size ≤6)	Lifetime	24.2pp**
				Children ages 1-3	Vaccinations (HH size >6)	Lifetime	N.S.
				N/A	Check-ups	*Not measured*	*Not measured*
Malawi	Social Cash Transfer Programme	SCTP	24 months	N/A	Vaccinations	*Not measured*	*Not measured*
				Children ages 0-5	Check-ups (well-baby/U5 clinic)	Last 6 months	N.S.
Mozambique	Child Grant 0-2	CG-02	24 months	Children ages 0-6	Has vaccination card	Lifetime	11pp***
				N/A	Check-ups	*Not measured*	*Not measured*
South Africa	South African Child Support Grant	CSG	N/A (dose-response effect)	Children ages 0-24 months	Vaccinations	Lifetime	N.S.
				N/A	Check-ups	*Not measured*	*Not measured*
Tanzania	Productive Social Safety Net	PSSN	24 months	N/A	Vaccinations	*Not measured*	*Not measured*
				N/A	Check-ups	*Not measured*	*Not measured*

Table 5: Summary of Transfer Project impacts on use of preventive health services (CONT.)

USE OF PREVENTIVE HEALTH SERVICES							
COUNTRY	**PROGRAMME**	**ACRONYM**	**EVALUATION TIME POINT**	**AGE RANGE**	**INDICATOR**	**REFERENCE PERIOD**	**EFFECT SIZE**
Zambia	Child Grant Programme	CGP	48 months	Children 0-15 months	Tetanus vaccination during pregnancy	Duration of pregnancy	N.S.
				Children 0-15 months	Malaria prevention during pregnancy	Duration of pregnancy	N.S.
				N/A	Child Vaccinations	*Not measured*	*Not measured*
				N/A	Check-ups	*Not measured*	*Not measured*
				N/A	Child Vaccinations	*Not measured*	*Not measured*
	Multiple Category Targeting Programme	MCTP	36 months	N/A	Check-ups	*Not measured*	*Not measured*
				N/A	Vaccinations	*Not measured*	*Not measured*
Zimbabwe	Harmonised Social Cash Transfer Programme	HSCT	48 months	N/A	Check-ups	*Not measured*	*Not measured*
				N/A	Vaccinations	*Not measured*	*Not measured*

N/A = not applicable
N.S. = not significant
pp=percentage points
**p<0.05, **p<0.01, ***p<0.001*

Immunisation

While cash transfers positively affect vaccination coverage in other regions, these impacts have largely not been realised in Africa.

In reviews focused on Africa, Onwuchekwa et al. (2021) found that among three studies examining vaccination among children, none found any significant effects. Owusu-Addo and colleagues (2018) reported on one study examining vaccination coverage, Zimbabwe's Community-led Cash Transfer Programme, which found increases in vaccination resulting from both conditional and unconditional cash transfers. In Pega et al. (2022), a meta-analysis of three studies (from Lesotho, Kenya, Zimbabwe) showed no significant impacts on the probability of children being up to date on the vaccination calendar. In another African study not covered in these reviews, there were no effects of Tanzania's Productive Social Safety Net (PSSN) on vaccinations among children 0-2 years (Rosas et al. 2019).

Global evidence on the topic of immunisation is provided by additional reviews. Ranganathan and Lagarde (2012) found positive effects of conditional cash transfers in four out of four countries (all in Latin America), however findings varied by age group; for some groups there were no impacts in three countries. A review by Cooper et al. (2020) examined differential impacts of cash transfers by sub-groups and found that in India, impacts on full immunisation coverage were higher among children in the wealthiest households as compared to the poorest, while in Nicaragua, impacts on vaccination were largest among children living furthest from health facilities and among those whose mothers had low levels of education. Another review of conditional cash transfers identified 17 studies (only one in Africa, a non-governmental experimental study in Zimbabwe). The review reported generally positive impacts on immunisation rates, including in Zimbabwe where impacts of an unconditional cash transfer were larger than a conditional cash transfer on vaccination among children 0-4 years (Cruz, Moura, and Soares Neto 2017; Robertson et al. 2013).

Studies within the Transfer Project have also examined impacts on childhood immunisation. Ghana's Livelihood Empowerment Against Poverty 1000 programme did not have impacts on

vaccinations, at least in part because rates of vaccination were already high at baseline (Ghana LEAP 1000 Evaluation Team 2018). The Child Support Grant in South Africa and Zambia's Child Grant Programme did not have any effects on vaccinations either (Unicef 2012; American Institutes for Research 2016). In Mozambique, the Child Grant 0-2 years cash transfer alone did not increase the likelihood of having a vaccination card, but a case management component (added to the cash transfer) increased the probability of having a vaccination card by 11 percentage points (Bonilla et al. 2022). However, the Mozambique cash transfer had no impact on the probability of having received the complete series of polio, pentavalent, pneumococcal, rotavirus, and measles vaccines.

Utilisation of antenatal care and skilled attendance at delivery

Cash transfers in Africa have positive effects on antenatal care seeking but generally do not have effects on skilled attendance at delivery (except in circumstances with high-quality health services).

Key concepts:

- **ANTENATAL CARE** – care provided by qualified health care professionals during pregnancy
- **SKILLED BIRTH DELIVERY** – birth attended by a skilled birth attendant, including midwife, doctor, or nurse, trained in skills needed to manage normal pregnancies, childbirth, and the immediate postnatal period

Antenatal care utilisation and skilled birth delivery are important pathways through which cash transfer programmes can impact child health and maternal and infant mortality.

In terms of antenatal care (ANC), two out of three studies reviewed in Owusu-Addo et al. (2018) found positive impacts (Nigeria's Cash Transfer Pilot Programme and Uganda's Antenatal Care Utilisation Study), however Zambia's Child Grant Programme did not have effects on ANC. In another African study not covered in this review, Tanzania's Productive Social Safety Net (PSSN) also increased use of ANC (Rosas et al. 2019). Another study conducted as part of the Transfer Project was not covered in these reviews (Table 6). Ghana's Livelihood Empowerment Against Poverty (LEAP) 1000 increased the probability of seeking antenatal care by 11.4 percentage points (Ghana LEAP 1000 Evaluation Team 2018).

Turning to use of skilled delivery attendants, none of the three studies covered by in Owusu-Addo et al. (2018) found effects on skilled care at delivery (Nigeria's Cash Transfer, Uganda's Antenatal Care Utilisation Study, or Zambia's Child Grant Programme). Tanzania's Productive Social Safety Net also had no effects on skilled delivery (Rosas et al. 2019). However, a more in-depth study of Zambia's Child Grant Programme (a Transfer Project study), while confirming a lack of overall impacts on skilled delivery, did find that there were differential impacts on this outcome based on quality of health services in the community. That is, researchers found that women in communities with better health services were more likely to access skilled delivery as a result of Zambia's CGP (Handa et al. 2016). This is an important finding in the context of Africa, where health infrastructure is often limited, and suggests that to maximize cash transfer impacts, supply-side investments are simultaneously needed.

Source: ©UNICEF/UN0361588/Naftalin

Table 6. Summary of Transfer Project impacts on antenatal care and skilled attendance at birth

ANTENATAL CARE AND SKILLED ATTENDANCE AT BIRTH							
COUNTRY	**PROGRAMME**	**ACRONYM**	**EVALUATION TIME POINT**	**AGE RANGE**	**INDICATOR**	**REFERENCE PERIOD**	**EFFECT SIZE**
Ethiopia	Social Cash Transfer Pilot Programme (Tigray Region)	SCTPP	36 months	N/A	Antenatal Care	*Not measured*	*Not measured*
				N/A	Skilled Delivery	*Not measured*	*Not measured*
				N/A	Modern contraceptive use	*Not measured*	*Not measured*
Ghana	Livelihood Empowerment Against Poverty	LEAP	72 months	N/A	Antenatal Care	*Not measured*	*Not measured*
				N/A	Skilled Delivery	*Not measured*	*Not measured*
				N/A	Contraception Services	*Not measured*	*Not measured*
	Livelihood Empowerment Against Poverty 1000	LEAP 1000	48 months	Women ages 12-49	Antenatal Care	Current pregnancy	11.4pp*
				Children ages 0-35 months	Skilled Delivery	Current pregnancy	N.S.
				LEAP eligible women	Modern contraceptive use	Currently using	N.S.
Kenya	Cash Transfers for Orphans and Vulnerable Children	CT-OVC	24 months	N/A	Antenatal Care	*Not measured*	*Not measured*
				N/A	Skilled Delivery	*Not measured*	*Not measured*
				N/A	Contraception Services	*Not measured*	*Not measured*
Malawi	Social Cash Transfer Programme	SCTP	24 months	N/A	Antenatal Care	*Not measured*	*Not measured*
				Women ages 12-49	Skilled Delivery	Last 24 months	N.S.
				N/A	Contraception Services	*Not measured*	*Not measured*
Mozambique	Child Grant 0-2	CG-02	24 months	N/A	Antenatal Care	*Not measured*	*Not measured*
				N/A	Skilled Delivery	*Not measured*	*Not measured*
				Caregiver	Modern contraceptive use	Currently using	N.S.
South Africa	South African Child Support Grant	CSG	N/A (dose-response effect)	N/A	Antenatal Care	*Not measured*	*Not measured*
				N/A	Skilled Delivery	*Not measured*	*Not measured*
				N/A	Modern contraceptive use	*Not measured*	*Not measured*

Table 6. Summary of Transfer Project impacts on antenatal care and skilled attendance at birth (CONT.)

ANTENATAL CARE AND SKILLED ATTENDANCE AT BIRTH							
COUNTRY	**PROGRAMME**	**ACRONYM**	**EVALUATION TIME POINT**	**AGE RANGE**	**INDICATOR**	**REFERENCE PERIOD**	**EFFECT SIZE**
Tanzania	Productive Social Safety Net	PSSN	24 months	N/A	Antenatal Care	*Not measured*	*Not measured*
				N/A	Skilled Delivery	*Not measured*	*Not measured*
				Youth ages 14-28	Modern contraceptive use	Currently using	N.S.
Zambia	Child Grant Programme	CGP	48 months	Children 0-15 months	Antenatal Care	Duration of pregnancy	N.S.
				Children 0-15 months	Skilled Delivery	At birth	N.S.
				N/A	Modern contraceptive use	*Not measured*	*Not measured*
	Multiple Category Targeting Programme	MCTP	36 months	N/A	Antenatal Care	*Not measured*	*Not measured*
				N/A	Skilled Delivery	*Not measured*	*Not measured*
				N/A	Modern contraceptive use	*Not measured*	*Not measured*
Zimbabwe	Harmonised Social Cash Transfer Programme	HSCT	48 months	N/A	Antenatal Care	*Not measured*	*Not measured*
				N/A	Skilled Delivery	*Not measured*	*Not measured*
				N/A	Modern contraceptive use	*Not measured*	*Not measured*

N/A = not applicable
N.S. = not significant
pp=percentage points
**p<0.05, **p<0.01, ***p<0.001*

Use of sexual and reproductive health care services

There is no evidence to date that cash transfers increase contraceptive uptake in Africa. The evidence on cash transfers and HIV testing in Africa is mixed, but they generally do not increase treatment adherence.

In this section, we summarise impacts on three reproductive health care seeking behaviours: contraceptive uptake, HIV/STI testing, and adherence to HIV treatment. The impacts of cash transfers on modern contraceptive uptake have been less frequently studied, but there is no evidence to date that cash transfers increase contraceptive uptake in Africa.

Khan et al. (2016) narratively reviewed this topic among 11 studies (five from Africa) covering 10 programmes. Among these, two out of three showed a positive effect on contraceptive use (both positive impacts were from Mexico's Oportunidades programme), while the remaining studies did not examine contraceptive use. However, there were some differences by age. In Mexico, positive impacts on contraceptive use were seen among women 20-24 years of age, but no impacts were seen among adolescents aged 15-19 years (Lamadrid-Figueroa et al. 2008). In the one African study covered in this review (a Transfer Project study) which examined contraceptive use (Zambia's Child Grant Programme), no impacts were found (Palermo et al. 2016). Another review focused on adolescents found that cash transfers (the review also included several cash plus or bundled interventions targeted to adolescents) were not effective at increasing contraceptive use (Kneale et al. 2023).

Other Transfer Project studies have also investigated whether cash transfers increase uptake of modern contraceptives. No impacts were found in Ghana's LEAP 1000, Zambia's Child Grant Programme (as covered in the above review), Tanzania's Productive Social Safety Net (among adolescents and youth up to 29 years old), or Mozambique's Child Grant 0-2 years. Despite a lack of impacts on contraceptive use, Tanzania's Productive Social Safety Net was found to increase women's knowledge of modern contraceptive methods (Tanzania PSSN Youth Study Evaluation Team 2018). While part of this cash transfer payment was conditional on taking young children to health check-ups, and that increased interaction with health providers may have increased knowledge, evaluators were not able to conclusively say through which pathway knowledge was increased.

One study used population-level data from Demographic and Health Surveys and AIDS Indicator Surveys from 42 countries (36 in Africa) combined with coverage levels of national government cash transfer programmes to examine the association between cash transfer coverage and HIV testing rates. The authors found that cash transfer programmes were associated with an increased probability of having had an HIV test within the past 12 months (OR=0.61, CI 1.15, 5.88) (Richterman and Thirumurthy 2022). These findings should be interpreted with caution because the study design lacks a causal identification strategy. Thus, they are suggestive at best. In contrast, one systematic review included 16 studies (including 13 conditional cash transfer programmes) and found no impacts on HIV testing (Guimarães et al. 2023). Differences in these findings may reflect the type of cash transfers examined (the study finding positive impacts on testing examines government cash transfer coverage, while the study finding no impacts examined research studies only – none of the included programmes were government-run). Differences may also be driven by study design.

In terms of adherence to HIV treatment, the aforementioned systematic review of 16 studies found no impacts on antiretroviral therapy adherence (Guimarães et al. 2023). However, the review by Owusu-Addo (2018) reported that a cash transfer targeted to HIV-infected pregnant women, conditional on attending Prevention of Mother-to-Child Transmission (PMTC) services, increased the probability that they remained in care (Yotebieng et al. 2016). This was also a research study and not a governmental cash transfer programme.

Transfer Project studies, on the other hand, largely do not directly test or ask about HIV status and thus have not investigated treatment adherence. However, within the Transfer Project, a few studies have examined adolescents' HIV-risk perceptions and HIV testing behaviours (Table 7). Studies from Malawi, Tanzania, and Zimbabwe examined the effects of adolescents' and youths' perception of HIV risk and found no impacts (Table 7). Evaluations of government cash transfers in Tanzania and Zimbabwe also examined impacts on HIV testing; in Tanzania there were no impacts of cash transfers on HIV testing for adolescents, while in Zimbabwe, the cash transfer reduced the probability of adolescents' having been tested for HIV by 8.9 percentage points. The programme also reduced sexual debut and transactional sex, so it is plausible that overall risk was lowered (Angeles et al. 2018).

Table 7: Summary of Transfer Project impacts on HIV testing and risk perception

HIV TESTING & RISK PERCEPTION							
COUNTRY	**PROGRAMME**	**ACRONYM**	**EVALUATION TIME POINT**	**AGE RANGE**	**INDICATOR**	**REFERENCE PERIOD**	**EFFECT SIZE**
Ethiopia	Social Cash Transfer Pilot Programme (Tigray Region)	SCTPP	36 months	N/A	HIV Testing	*Not measured*	*Not measured*
Ghana	Livelihood Empowerment Against Poverty	LEAP	72 months	N/A	HIV Testing	*Not measured*	*Not measured*
	Livelihood Empowerment Against Poverty 1000	LEAP 1000	48 months	N/A	HIV Testing	*Not measured*	*Not measured*

Table 7: Summary of Transfer Project impacts on HIV testing and risk perception (CONT.)

HIV TESTING & RISK PERCEPTION							
COUNTRY	**PROGRAMME**	**ACRONYM**	**EVALUATION TIME POINT**	**AGE RANGE**	**INDICATOR**	**REFERENCE PERIOD**	**EFFECT SIZE**
Kenya	Cash Transfers for Orphans and Vulnerable Children	CT-OVC	24 months	N/A	HIV Testing	*Not measured*	*Not measured*
Malawi	Social Cash Transfer Programme	SCTP	24 months	Youth ages 13-19	Perceived HIV risk (moderate or high)	Last 12 months	N.S.
	Social Cash Transfer Programme	SCTP	24 months	N/A	HIV Testing	*Not measured*	*Not measured*
Mozambique	Child Grant 0-2	CG-02	24 months	N/A	HIV Testing	*Not measured*	*Not measured*
South Africa	South African Child Support Grant	CSG	N/A	N/A	HIV Testing	*Not measured*	*Not measured*
Tanzania	Productive Social Safety Net	PSSN	24 months	Youth ages 14-28	HIV Testing	Last 12 months	N.S.
	Productive Social Safety Net	PSSN	24 months	Youth ages 14-28	Perceived HIV risk (moderate or high)	Last 12 months	N.S.
Zambia	Child Grant Programme	CGP	48 months	Pregnant women	Voluntary counseling & testing for HIV	Last 12 months	N.S.
	Multiple Category Targeting Programme	MCTP	36 months	N/A	HIV Testing	*Not measured*	*Not measured*
Zimbabwe	Harmonised Social Cash Transfer Programme	HSCT	48 months	Youth ages 13-24	HIV Testing	Last 12 months	-8.9pp***
	Harmonised Social Cash Transfer Programme	HSCT	48 months	Youth ages 13-24	Perceived HIV risk (moderate or high)	Last 12 months	N.S.

N/A = not applicable
N.S. = not significant
pp=percentage points
**p<0.05, **p<0.01, ***p<0.001*

Birth registration

There is some evidence supporting cash transfers' ability to increase birth registration.

Key concepts:

- **BIRTH REGISTRATION** – process of recording a child's birth; permanent and official record of child's existence and provides legal proof of identity

There is some limited evidence that cash transfer programmes encourage birth registration (Pega et al. 2022). In their review, three studies found no effects of cash transfers on birth registration (in Kenya, Zambia, and Zimbabwe), while a fourth (in Lesotho) found positive impacts on birth registration. In contrast, a review of conditional and unconditional cash transfers by Owusu-Addo et al. (2018) found that four programmes (in Kenya, Lesotho, Malawi, and Zimbabwe) led to positive impacts on birth registration (effects ranged from 1.5 to 37 percentage point increases).

4.5 Evidence of Impacts of Cash Transfers on Psychosocial Well-Being

Impacts of cash transfers on psychosocial well-being, including mental health, can work in both the second- and third-order effects. While the conceptual framework reflects both of these timelines of impact, in the text we summarise impacts in Section 4.8.

Source: ©UNICEF/U.S. CDC/UN0641102/Daylin Paul

4.6 Evidence of Impacts of Cash Transfers on Behavioural Health Outcomes

Physical, emotional, and sexual violence

There is strong evidence that cash transfers reduce intimate partner violence, and there is also evidence to suggest that they can reduce violence against children and adolescents.

Key concepts:

- **EMOTIONAL VIOLENCE** – psychological aggression (yelling and insults) and threats, including threats of harm, belittling, and humiliation.
- **SEXUAL VIOLENCE** – forced or coerced intercourse or other sexual acts.
- **PHYSICAL VIOLENCE** – acts that physically hurt an individual, including but not limited to being slapped, pushed, shoved; hit with a fist; being kicked, dragged, or beaten up; being choked or burnt; being threatened with a gun, knife, or weapon.
- **CONTROLLING BEHAVIOURS** – isolation from friends and family; restricting access to financial resources; monitoring and restricting movement, employment, education, or access to medical care.

In their global review of social assistance programmes, Cirillo and colleagues (2021) reported on six studies across five programmes examining impacts on violence among adolescents. One study from Malawi's Social Cash Transfer Programme examined impacts specifically among adolescents and found that the programme reduced adolescents' aged 13 to 19 years' experiences of forced sex. Five other studies covered in the review examined impacts among adolescents and older youth (below age 30) combined. In Zimbabwe, protective effects against emotional and physical violence among youth (age 13 to 24 years) were found three years post cash transfer rollout (despite increased physical violence impacts at an earlier follow-up around 12 months post cash transfer rollout) (American Institutes for Research 2014; Angeles et al. 2018; Chakrabarti et al. 2020). Adverse effects were found resulting from government cash transfers in Zambia (increased experiences of forced sex, driven by females). Finally, there were no impacts of Tanzania's Productive Social Safety Net on violence outcomes among adolescents and youth aged 15 to 29 years. The remaining study was outside of Africa and found no impacts.

Another review of social safety nets in lower- and middle-income countries globally (including governmental and non-governmental programmes) covering 57 violence outcomes among children and adolescents across 11 studies found that 19 per cent of impacts were protective (Peterman et al. 2017). The remaining 81 per cent of impacts estimated were not significant; no adverse effects were found. There was a higher proportion of significant protective impacts for sexual violence (40 per cent), including sexual abuse and exploitation (20 per cent), as compared to physical violence (20 per cent) (Peterman et al. 2017). However, studies published since that review have found that government cash transfers can reduce violence experienced by children (in the form of violent discipline), including in African countries such as Mali and Mozambique (Heath, Hidrobo, and Roy 2020; Bonilla et al. 2022).

Intimate partner violence

There is strong evidence that cash transfers reduce intimate partner violence, especially physical intimate partner violence, globally. Evidence among adolescents and youth is lacking, but protective impacts were found in two out of three settings examined.

Key concepts:

- **PHYSICAL INTIMATE PARTNER VIOLENCE** – acts perpetrated by an intimate partner that physically hurt the victim, including but not limited to being slapped, pushed, shoved; hit with a fist; being kicked, dragged, or beaten up; being choked or burnt; being threatened with a gun, knife, or weapon.
- **EMOTIONAL INTIMATE PARTNER VIOLENCE** – psychological aggression (yelling and insults) and threats, including threats of harm, belittling, humiliation, and threats to take away children, perpetrated by an intimate partner
- **CONTROLLING BEHAVIOURS** – Acts perpetrated by an intimate partner including isolation from friends and family; restricting access to financial resources; monitoring and restricting movement, employment, education, or access to medical care.

A subset of violence outcomes includes acts (including physical, sexual, and emotional violence or controlling behaviours) perpetrated by an individuals' intimate partner (husband, wife, girlfriend, boyfriend, or other romantic or sexual partner), referred to as intimate partner violence. There is a strong global evidence base (including studies from Africa) demonstrating that cash transfers reduce intimate partner violence experienced by adult women.

Two global systematic reviews on this topic largely focused on adult women (Baranov et al. 2021; Buller et al. 2018). Buller et al. (2018) reviewed studies (quantitative and qualitative) examining 22 cash transfer interventions (six in Africa) and found that 11 out of 14 quantitative studies showed that cash transfers reduced intimate partner violence (with reductions ranging from 11 to 66 per cent), while only one showed mixed findings (Haushofer and Shapiro 2016). Reductions were more consistently found for physical and/or sexual violence, followed by controlling behaviours, and then emotional intimate partner violence. Pathways through which cash transfers reduce intimate partner violence suggested by these studies include: 1) economic security and emotional well-being; 2) intra-household conflict; and 3) women's empowerment. The second global systematic review and meta-analysis found strong evidence that cash transfers reduce physical and emotional intimate partner violence and controlling behaviours (Baranov et al. 2021). A meta-analysis of all the reviewed studies in combination found that cash transfers reduced physical intimate partner violence (by 4 percentage points), emotional intimate partner violence (by 2 percentage points), and controlling behaviours (by 4 percentage points).

In Africa specifically, a regional systematic review examined impacts of social safety nets (broader than just cash transfers) on women's experiences of intimate partner violence in five countries in Africa (in Ghana, Kenya, Malawi, South Africa, and Tanzania) (Peterman et al. December 2019). Four out of these five studies found that social safety nets reduced intimate partner violence. Decreases were more consistent for **physical intimate partner violence**, followed by **controlling behaviours** and **emotional intimate partner violence**. In contrast, in Zambia there were no impacts of the Child Grant Programme on women's experience of intimate partner violence (Peterman et al. 2018). One of the studies reviewed, from Mali, found that cash transfers not only reduced intimate partner violence among women, but also reduced violent discipline experienced by young children (Heath, Hidrobo, and Roy 2020).

Only five studies have examined impacts of cash transfer on **adolescents' and youths' exposure to intimate partner violence** (all in Africa). Mozambique's Child Grant Programme, which was not targeted to adolescents specifically but included

many adolescent and young mothers as primary beneficiaries, led to strong reductions in emotional intimate partner violence (by 38 per cent), particularly among younger female caregivers (those aged 24 years or younger), and physical intimate partner violence (by 45 per cent), driven by older caregivers in the sample (Bonilla et al. 2022). A study examining impacts of Malawi's government cash transfer on experiences of intimate partner violence among youth (aged 19 to 30 years) found that longer duration of cash transfer receipt (targeted to households, not directly to adolescents/youth) was not associated with intimate partner violence experiences among females or males; however among females (but not males), cash was associated with increased trust in their relationship (Pereira et al. 2025). Three studies (all examining the same non-governmental cash transfer programme in South Africa (HIV Prevention Trials Network (HPTN) 068), found that the conditional cash transfer reduced experiences of intimate partner violence among females aged 13 to 20 years, and possible pathways were through delays in sexual debut and reductions in the number of sexual partners (Kilburn et al. 2018; Pettifor et al. 2016). However, impacts dissipated one to two years post-intervention (effects were in the same direction but were only marginally statistically significant) (Groves et al. 2024).

Alcohol and tobacco use

There is strong evidence that cash transfers do not increase the purchase and use of alcohol and tobacco.

A review by Evans and Popova (2017) reviewed 19 studies from 10 countries globally reporting on expenditures on alcohol and tobacco. The authors performed a meta-analysis and found cash transfers had a negative impact on expenditures on temptation goods (effect size -0.176 standard deviations; CI -0.350, -.002). In other words, cash transfers reduced purchase of tobacco and alcohol. In fact, among all the studies examined, 17 either had no impact or negative impacts on temptation good expenditures; only two studies found positive effects (in Indonesia and Peru), and neither of these were in Africa.

Another study examining evidence from eight Transfer Project studies (in Ethiopia, Ghana, Lesotho, Malawi, Zambia (two studies), and Zimbabwe; Table 8) found no impacts of cash transfers on expenditures on alcohol and tobacco, with the exception of Lesotho, where the cash transfer reduced the amount of money spent on alcohol and tobacco (Handa, Daidone, et al. 2018). A separate Transfer Project evaluation report from Zimbabwe showed that cash transfers reduced spending on alcohol and tobacco.

Source: ©TransferProject/Michelle Mills/Ghana 2015

Table 8. Summary of Transfer Project impacts alcohol and tobacco expenditures

ALCOHOL & TOBACCO SPENDING							
COUNTRY	**PROGRAMME**	**ACRONYM**	**EVALUATION TIME POINT**	**AGE RANGE**	**INDICATORS**	**REFERENCE PERIOD**	**EFFECT SIZE**
Ethiopia	Social Cash Transfer Pilot Programme (Tigray Region)	SCTPP	36 months	N/A	Alcohol spending	*Not measured*	*Not measured*
				N/A	Tobacco spending	*Not measured*	*Not measured*
Ghana	Livelihood Empowerment Against Poverty	LEAP	72 months	N/A	Alcohol spending	*Not measured*	*Not measured*
				N/A	Tobacco spending	*Not measured*	*Not measured*
	Livelihood Empowerment Against Poverty 1000	LEAP 1000	48 months	Entire household	Combined alcohol & tobacco expenditure	Monthly per capita	N.S.
Kenya	Cash Transfers for Orphans and Vulnerable Children1	CT-OVC	24 months	N/A	Alcohol spending	*Not measured*	*Not measured*
				N/A	Tobacco spending	*Not measured*	*Not measured*
Malawi	Social Cash Transfer Programme	SCTP	24 months	Entire household	Combined alcohol & tobacco expenditure	24 months (pre/post programme consumption)	N.S.
Mozambique	Child Grant 0-2	CG-02	24 months	Entire household	Combined alcohol & tobacco expenditure	Monthly per capita	N.S.
South Africa	South African Child Support Grant	CSG	N/A (dose-response effect)	N/A	Alcohol spending	*Not measured*	*Not measured*
				N/A	Tobacco spending	*Not measured*	*Not measured*
Tanzania	Productive Social Safety Net	PSSN	24 months	N/A	Alcohol spending	*Not measured*	*Not measured*
				N/A	Tobacco spending	*Not measured*	*Not measured*

Table 8. Summary of Transfer Project impacts alcohol and tobacco expenditures (CONT.)

ALCOHOL & TOBACCO SPENDING							
COUNTRY	**PROGRAMME**	**ACRONYM**	**EVALUATION TIME POINT**	**AGE RANGE**	**INDICATORS**	**REFERENCE PERIOD**	**EFFECT SIZE**
Zambia	Child Grant Programme	CGP	48 months	Entire household	Alcohol spending	Monthly per capita	N.S.
				Entire household	Tobacco spending	Monthly per capita	N.S.
	Multiple Category Targeting Programme	MCTP	36 months		Combined alcohol & tobacco expenditure	Monthly per capita	N.S.
Zimbabwe	Harmonised Social Cash Transfer Programme	HSCT	48 months	Entire household	Combined alcohol & tobacco expenditure	Monthly	-0.271**

N/A = not applicable
N.S. = not significant
**p<0.05, **p<0.01, ***p<0.001*

Sexual behaviour

Governmental unconditional cash transfer programmes can delay sexual debut among adolescents and may reduce age-disparate relationships and risk of transactional sex in some contexts. However, they have limited effects on other sexual behaviours posing health risks, particularly among adolescents.

Key concepts:

- **SEXUAL DEBUT** – typically measured as (1) ever had sexual intercourse; (2) age at sexual debut.
- **CONCURRENT SEXUAL PARTNERS** – having more than one sexual partner within the same time period
- **AGE-DISPARATE SEXUAL RELATIONSHIPS** – having a sexual partner five (or ten) or more years older than the individual
- **TRANSACTIONAL SEX** – non-marital, non-commercial sexual relationships, with the implicit understanding that sex will be exchanged for money, material goods, or both (Wamoyi et al. 2019)
- **CONDOM USE AT LAST SEX** – whether a condom was used at last sexual intercourse

Evaluations of cash transfers have focused on a number of sexual behaviours that can pose health risks among adolescents, including age of sexual debut, number of sexual partners, age-disparate sexual relationships, use of condom at last sex, and transactional sex.

In their global review of government **social assistance programmes**, Cirillo and colleagues (2021) reviewed eight studies that included **sexual debut** as an outcome – three of those examined adolescents specifically while the rest grouped adolescents and young adults below age 30 (the majority were focused on African countries). Half of the studies found that cash transfers were associated with significant reduced likelihood of adolescent sexual debut. Where studies disaggregated by gender, the results were primarily significant among females but not males. In contrast, Malawi's Social Cash Transfer Programme was found to delay sexual debut among male adolescents (but not females) living in targeted households 12 months after the unconditional cash transfer began, but the effect was no longer significant after 24 months (Abdoulayi et al. 2016). In their global systematic review of **cash transfers** (not limited to governmental programmes), Stoner et al. (2021) reported that the majority of studies (10 out of 18) found that cash transfers delayed **sexual debut**. However, in roughly a third of these programmes, the effect only held for girls and not boys.

In a global review (including governmental and non-governmental cash transfers), Bastagli and colleagues (2016) reported that in three out of four studies in Africa, cash transfers reduced the likelihood of multiple sexual partners among women and girls.

Stoner and colleagues (2021) reviewed 45 studies (primarily in Africa, but included governmental and non-governmental cash transfers) to examine the effect of cash transfers on HIV incidence and risk factors, including risky sexual behaviours. The majority of studies that examined the impact of cash transfers on risky sexual behaviour found no effects on reductions in sex without a condom (14 out of 19 studies), number of sexual partners (11 out of 15 studies), participation in transactional sex (six out of eight studies), and age-disparate partnerships (four out of eight studies). Most of the cash transfers that had protective impacts on these outcomes were small-scale research studies (including cash transfers conditional on HIV/STI testing or school attendance) and were not government-implemented cash transfers. In two examples where cash transfers did reduce transactional sex, South Africa's Child Support Grant reduced engagement in transactional sex among adolescent girls (Cluver et al. 2013) and Kenya's Cash Transfer for Orphans and Vulnerable Children reduced transactional sex among girls enrolled in school (but not in the overall sample) (Rosenberg et al. 2014).

Transfer Project studies have examined adolescent sexual risk behaviours in Kenya, South Africa, Tanzania, Zambia, and Zimbabwe (Table 9). Unconditional cash transfers delayed sexual debut in Kenya (OR=0.689), Malawi (delay of .223 years), and South Africa (17 percentage point reduction in the probability of debut). Protective effects on other outcomes related to risky sexual behaviours were not found in Kenya and Malawi. There were no protective effects on sexual risk behaviours in Tanzania's Productive Social Safety Net or Zambia's Multiple Categorical Targeting Programming; in fact, in the Zambian programme there was an adverse effect, whereby the cash transfer increased the risk of age-disparate relationships at first sex. However, cash transfers reduced the probability of engaging in transactional sex by 2.8 percentage points in Zimbabwe, as well as among a sub-sample of adolescent girls attending school in Kenya (as reported above, but not among the full sample described in Table 11).

Source: ©UNICEF/UNI665103/Dejongh

Table 9. Summary of Transfer Project impacts on adolescent sexual risk behaviours

ADOLESCENT SEXUAL RISK BEHAVIOURS							
COUNTRY	**PROGRAMME**	**ACRONYM**	**EVALUATION TIME POINT**	**AGE RANGE**	**INDICATORS**	**REFERENCE PERIOD**	**EFFECT SIZE**
Ethiopia	Social Cash Transfer Pilot Programme (Tigray Region)	SCTPP	36 months	N/A	Sexual Debut	*Not measured*	*Not measured*
				N/A	Number of Sexual Partners	*Not measured*	*Not measured*
				N/A	Concurrency	*Not measured*	*Not measured*
				N/A	Age-disparate sex	*Not measured*	*Not measured*
				N/A	Transactional sex	*Not measured*	*Not measured*
				N/A	Condom use at last sex	*Not measured*	*Not measured*
Ghana	Livelihood Empowerment Against Poverty	LEAP	72 months	N/A	Sexual Debut	*Not measured*	*Not measured*
				N/A	Number of Sexual Partners	*Not measured*	*Not measured*
				N/A	Concurrency	*Not measured*	*Not measured*
				N/A	Age-disparate sex	*Not measured*	*Not measured*
				N/A	Transactional sex	*Not measured*	*Not measured*
				N/A	Condom use at last sex	*Not measured*	*Not measured*
	Livelihood Empowerment Against Poverty 1000	LEAP 1000	48 months	N/A	Sexual Debut	*Not measured*	*Not measured*
				N/A	Number of Sexual Partners	*Not measured*	*Not measured*
				N/A	Concurrency	*Not measured*	*Not measured*
				N/A	Age-disparate sex	*Not measured*	*Not measured*
				N/A	Transactional sex	*Not measured*	*Not measured*
				N/A	Condom use at last sex	*Not measured*	*Not measured*
Kenya	Cash Transfers for Orphans and Vulnerable Children1	CT-OVC	24 months	Youth ages 15-25	Sexual Debut	Ever had sex	OR = 0.689**
				Sexually debuted youth ages 15-25	Number of Sexual Partners	Last 12 months	N.S.
				N/A	Concurrency	*Not measured*	*Not measured*
				N/A	Age-disparate sex	*Not measured*	*Not measured*
				Sexually debuted youth ages 15-25	Transactional sex	Lifetime	N.S.
				Sexually debuted youth ages 15-25	Condom use at last sex	Last sex	N.S.

Table 9. Summary of Transfer Project impacts on adolescent sexual risk behaviours (CONT.)

ADOLESCENT SEXUAL RISK BEHAVIOURS							
COUNTRY	**PROGRAMME**	**ACRONYM**	**EVALUATION TIME POINT**	**AGE RANGE**	**INDICATORS**	**REFERENCE PERIOD**	**EFFECT SIZE**
Malawi	Social Cash Transfer Programme	SCTP	24 months	Youth ages 13-19	Sexual Debut	Ever had sex	N.S.
				Youth ages 13-19	Age at debut	Ever had sex	-0.223*
				Youth ages 13-19	Number of Sexual Partners	Last 12 months	N.S.
				Youth ages 13-19	Concurrency	Last 12 months	N.S.
				Youth ages 13-19	Age-disparate sex	Last 12 months	-9.1 pp***
				Youth ages 13-19	Transactional sex	Last 12 months	N.S.
				Youth ages 13-19	Condom use at last sex	Last 12 months	N.S.
Mozambique	Child Grant 0-2	CG-02	24 months	N/A	Sexual Debut	*Not measured*	*Not measured*
				N/A	Number of Sexual Partners	*Not measured*	*Not measured*
				N/A	Concurrency	*Not measured*	*Not measured*
				N/A	Age-disparate sex	*Not measured*	*Not measured*
				N/A	Transactional sex	*Not measured*	*Not measured*
				N/A	Condom use at last sex	*Not measured*	*Not measured*
South Africa	South African Child Support Grant	CSG	N/A (dose-response effect)	Adolescents	Sexual Debut	Ever had sex	-17 pp*
				N/A	Number of Sexual Partners	*Not measured*	*Not measured*
				N/A	Concurrency	*Not measured*	*Not measured*
				N/A	Age-disparate sex	*Not measured*	*Not measured*
				N/A	Transactional sex	*Not measured*	*Not measured*
				N/A	Condom use at last sex	*Not measured*	*Not measured*

Table 9. Summary of Transfer Project impacts on adolescent sexual risk behaviours (CONT.)

ADOLESCENT SEXUAL RISK BEHAVIOURS							
COUNTRY	**PROGRAMME**	**ACRONYM**	**EVALUATION TIME POINT**	**AGE RANGE**	**INDICATORS**	**REFERENCE PERIOD**	**EFFECT SIZE**
Tanzania	Productive Social Safety Net	PSSN	24 months	Youth ages 14-28	Sexual Debut	Ever had sex	N.S.
				Youth ages 14-28	Number of Sexual Partners	Last 12 months	N.S.
				Youth ages 14-28	Concurrency	Last 12 months	N.S.
				Youth ages 14-28	Age-disparate sex	Last 12 months	N.S.
				Youth ages 14-28	Transactional sex	Last 12 months	N.S.
				Youth ages 14-28	Condom use at last sex	Last 12 months	N.S.
Zambia	Child Grant Programme	CGP	48 months	N/A	Sexual Debut	*Not measured*	*Not measured*
				N/A	Number of Sexual Partners	*Not measured*	*Not measured*
				N/A	Concurrency	*Not measured*	*Not measured*
				N/A	Age-disparate sex	*Not measured*	*Not measured*
				N/A	Transactional sex	*Not measured*	*Not measured*
				N/A	Condom use at last sex	*Not measured*	*Not measured*
	Multiple Category Targeting Programme	MCTP	36 months	Youth ages 13-24	Sexual Debut	Ever had sex	N.S.
				Youth ages 13-24	Number of Sexual Partners	Last 12 months	N.S.
				N/A	Concurrency	*Not measured*	*Not measured*
				Youth ages 13-24	Age-disparate sex (>10 years older) at first sex	At first sex	3.9 pp*
				Youth ages 13-24	Transactional sex	Lifetime	N.S.
				Youth ages 13-24	Condom not used at last sex	Last 12 months	N.S.

Table 9. Summary of Transfer Project impacts on adolescent sexual risk behaviours (CONT.)

ADOLESCENT SEXUAL RISK BEHAVIOURS							
COUNTRY	**PROGRAMME**	**ACRONYM**	**EVALUATION TIME POINT**	**AGE RANGE**	**INDICATORS**	**REFERENCE PERIOD**	**EFFECT SIZE**
Zimbabwe	Harmonised Social Cash Transfer Programme	HSCT	48 months	Youth ages 13-24	Sexual Debut	Ever had sex	-0.079***
				Youth ages 13-24	Number of Sexual Partners	Last 12 months	N.S.
				N/A	Concurrency	*Not measured*	*Not measured*
				Youth ages 13-24	Most recent sex partner's age	Last 12 months	N.S.
				Youth ages 13-24	Transactional sex	Lifetime	-0.028***
				Youth ages 13-24	Condom not used at last sex	Last 3 months	N.S.

N/A = not applicable
N.S. = not significant
pp = percentage points
OR = odds ratio
**p<0.05, **p<0.01, ***p<0.001*

[1]Findings not reported in any overall report; estimates come from journal articles as follows: Handa et al. (2014); Rosenberg et al. (2014); Handa et al. (2015).

Source: ©TransferProject/Michelle Mills/Ghana 2015

Fertility

Cash transfers reduce adolescent pregnancy and increase birth spacing in Africa. Cash transfers do not increase fertility.

Evaluations have also examined impacts of cash transfers on fertility. Examining a broad range of reproductive ages, a global systematic review by Bastagli et al. (2016) found that seven out of ten studies showed that cash transfers decreased the likelihood of **pregnancy or giving birth** among women and girls. Other studies have examined pregnancy more specifically among adolescents. In a review of **non-contributory social protection programming** (largely cash transfers) in lower- and middle-income countries, two out of five studies found that cash transfers reduced the probability of **adolescent pregnancy** (Cirillo, Palermo, and Viola 2021). These included the Child Support Grant in South Africa and Bolsa Família in Brazil, while the remaining studies found no effects. Six additional studies (all Transfer Project studies in Africa) examined pregnancy among adolescent girls and young women combined (no disaggregated findings among adolescents), and among these, three found that cash transfers reduced the probability of pregnancy (in Kenya, Malawi, and Zimbabwe). A systematic review and meta-analysis of eight studies (and 17 study arms[4]) examining impacts of cash transfers (not restricted to governmental programmes) on pregnancy among adolescents found that cash transfers reduced adolescent pregnancy (OR=0.90, CI 0.81, 1.0) (Kneale et al. 2023).

Birth spacing is generally not covered in reviews, but the unconditional, government-implemented Child Support Grant in South Africa increased **birth spacing** (cash transfers delayed adult women's second pregnancy) (Rosenberg et al. 2015). Increases in birth spacing are linked to healthier pregnancies and increased birthweight.

Transfer Project evaluations found that government-led cash transfer programmes delayed pregnancy among adolescents and young women in Kenya, Zimbabwe, and South Africa, but had no impacts in Malawi, Tanzania, or Zambia. In Kenya, girls in households receiving the Cash Transfer for Orphans and Vulnerable Children were 34 per cent (or 5 percentage points) less likely to have ever been pregnant compared to girls in non-cash transfer households (Handa et al. 2015). The Harmonised Social Cash Transfer programme in Zimbabwe reduced the probability of lifetime pregnancy among girls aged 13 to 20 at baseline by 11.8 percentage points (Angeles et al. 2018). Adolescent girls in households receiving South Africa's Child Support Grant since early childhood were less likely to have ever been pregnant (reported above in review by Cirillo et al., 2021) (DSD, SASSA, and UNICEF 2012). Malawi's Social Cash Transfer reduced the probability of ever having been pregnant (by 1.5 percentage points) at midline among females aged 15 to 24; however, these results were no longer significant one year later at endline (Abdoulayi et al. 2016). Among younger females (adolescents 13 to 19 years), however, there were no impacts on pregnancy at either wave (Abdoulayi et al. 2016). Finally, in Tanzania there were no impacts of the Productive Social Safety Net on girls' and young women's (ages 15 to 28 years at baseline) pregnancy rates (Tanzania PSSN Youth Study Evaluation Team 2018).

Among adult women, Transfer Project evaluations in Ghana, Mozambique, and Zambia did not find any adverse effects of cash transfers on **fertility** (Ghana LEAP 1000 Evaluation Team 2018; Palermo et al. 2016; Bonilla et al. 2022). That is, cash transfers did not increase childbearing. In fact, in Ghana, the Livelihood Empowerment Against Poverty (LEAP) 1000 programme reduced fertility, and in Mozambique, cash transfers reduced the probability of current or recent pregnancies.

Source: ©TransferProject/Michelle Mills/Ghana 2015

4.7 Evidence of Impacts of Cash Transfers on Physical Health

Evaluations of cash transfer programmes generally consider morbidity and child nutrition to assess impact on physical health, and some studies have recently started to examine impacts on mortality.

Child malnutrition

Global evidence suggests that cash transfers have modest effects on increasing height-for-age and reducing stunting and wasting, but they generally do not have impacts on weight-for-age. However, when examining Africa specifically, only protective impacts on wasting emerged.

Key concepts:

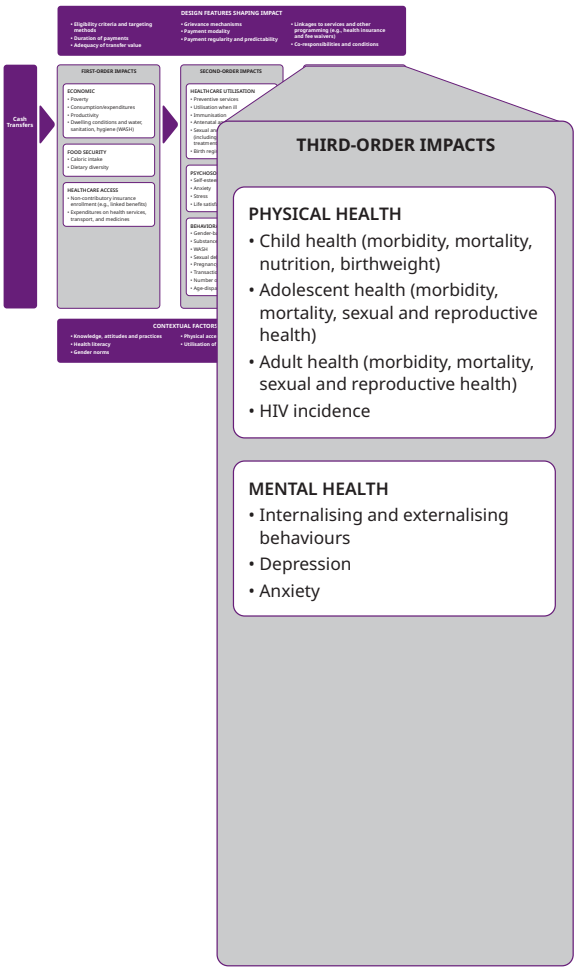
- **STUNTED** – low height-for-age; often the result of chronic or recurrent undernutrition
- **WASTED** – low weight-for-height; often indicates recent and severe weight loss

Studies on the impact of cash transfer programmes have often measured malnutrition (measured by stunting, underweight, and wasting) among children.

The effects of cash transfers on nutrition-related outcomes, including **stunting, underweight, wasting, and overweight/obesity**, are covered in a separate summary document. We summarise the evidence briefly here. In the most recent global meta-analysis of cash transfer impacts on stunting and wasting, published in 2022 (covering a total of 129 articles), Manley and colleagues (2022) found that cash transfers improved linear growth and reduced stunting and wasting, but effects were small. In a previous study by Manley and Slavchevska (2019) reviewing 20 studies (including 12 in Africa), the authors found that only two cash transfers in Africa reported positive impacts on child nutrition outcomes (one each in Malawi and South Africa). Meanwhile, two other studies in the region (in Zambia and Mozambique) found no impacts on anthropometric outcomes (Manley and Slavchevska 2019).

A global review of 20 studies evaluating impacts of government cash transfers on **overweight and obesity status** identified one study examining impacts on adolescents specifically, while four studies examined impacts on adolescents combined with other ages (ranging from 5 to 21 years); programmes reduced the probability of being overweight or obese in Brazil, Japan, South Africa, and Mexico (Semba et al. 2022)

FIGURE 1C. CONCEPTUAL FRAMEWORK LINKING CASH TO HEALTHCARE UTILISATION AND PHYSICAL AND MENTAL HEALTH AND WELL-BEING - THIRD-ORDER IMPACTS



In the Transfer Project, only one out of seven impact evaluations that measured **stunting, wasting, or underweight** found protective impacts (Table 10). In Malawi, children were 2.7 percentage points less likely to be wasted as a result of the Social Cash Transfer (Abdoulayi et al. 2016). The other six evaluations found no impacts on these outcomes. One of the reasons for this lack of impact may be the fact that prevalence of stunting can generally be expected to decline as a result of an intervention (such as cash transfers) by approximately one percentage point per year. The number of children needed in an impact evaluation to detect such a small change over 12 months is approximately 10,000 children (researchers refer to this as minimum sample size, which is related to statistical power). However, most Transfer

Project evaluations have a sample size of approximately 2,000 to 4,000 households and thus are more likely to detect impacts in the range of 3 to 5 percentage point decreases annually. This may explain why meta-analyses (which pool samples and estimates from multiple studies) have found small impacts, but individual evaluations tend not to find significant impacts on stunting.

Table 10. Summary of Transfer Project impacts on child malnutrition

COUNTRY	PROGRAMME	ACRONYM	EVALUATION TIME POINT	AGE RANGE	INDICATORS	EFFECT SIZE
Ethiopia[1]	Social Cash Transfer Pilot Programme (Tigray Region)	SCTPP	36 months	Children < 48 months	Stunting	N.S.
				Children < 48 months	Wasting	N.S.
				Children < 48 months	Height for age	N.S.
				Children < 48 months	Weight for height	N.S.
Ghana[2]	Livelihood Empowerment Against Poverty	LEAP	72 months	N/A	Stunting	*Not measured*
				N/A	Wasting	*Not measured*
				N/A	Height for age	*Not measured*
				N/A	Weight for height	*Not measured*
	Livelihood Empowerment Against Poverty 1000	LEAP 1000	48 months	Children 0-83 month	Stunting	N.S.
				Children 0-83 month	Wasting	N.S.
				Children 0-83 month	Height for age	N.S.
				Children 0-83 month	Weight for height	N.S.
Kenya[3]	Cash Transfers for Orphans and Vulnerable Children1	CT-OVC	24 months	Children < 60 months	Stunting	N.S.
				Children < 60 months	Wasting	N.S.
				Children < 60 months	Height for age	N.S.
				Children < 60 months	Weight for height	N.S.
Malawi	Social Cash Transfer Programme	SCTP	24 months	Children 6-59 months	Stunting	N.S.
				Children 6-59 months	Wasting	-2.7pp***
				Children 6-59 months	Height for age	N.S.
				Children 6-59 months	Weight for height	N.S.
Mozambique	Child Grant 0-2	CG-02	24 months	Children 0-24 months	Stunting	N.S.
				Children 0-24 months	Wasting	N.S.
				Children 0-24 months	Height for age	N.S.
				Children 0-24 months	Weight for height	N.S.

Table 10. Summary of Transfer Project impacts on child malnutrition (CONT.)

COUNTRY	PROGRAMME	ACRONYM	EVALUATION TIME POINT	AGE RANGE	INDICATORS	EFFECT SIZE
South Africa	South African Child Support Grant	CSG	N/A (dose-response effect)	N/A	Stunting	*Not measured*
				N/A	Wasting	*Not measured*
				N/A	Height for age	*Not measured*
				N/A	Weight for height	*Not measured*
Tanzania	Productive Social Safety Net	PSSN	24 months	N/A	Stunting	*Not measured*
				N/A	Wasting	*Not measured*
				N/A	Height for age	*Not measured*
				N/A	Weight for height	*Not measured*
Zambia	Child Grant Programme	CGP	48 months	Children ages 0-9 years	Stunting	N.S.
				Children ages 0-9 years	Wasting	N.S.
				Children ages 0-9 years	Height for age	N.S.
				Children ages 0-9 years	Weight for height	N.S.
	Multiple Category Targeting Programme	MCTP	36 months	N/A	Stunting	*Not measured*
				N/A	Wasting	*Not measured*
				N/A	Height for age	*Not measured*
				N/A	Weight for height	*Not measured*
Zimbabwe	Harmonised Social Cash Transfer Programme	HSCT	48 months	N/A	Stunting	*Not measured*
				N/A	Wasting	*Not measured*
				N/A	Height for age	*Not measured*
				N/A	Weight for height	*Not measured*

N/A = not applicable
N.S. = not significant
pp=percentage points

Birthweight

The small number of studies examining impacts of cash transfers on birthweight have found that cash transfers can increase birthweight, and these effects may be influenced by season of birth.

Key concepts:

- **BIRTHWEIGHT** – child's weight at birth
- **LOW BIRTHWEIGHT** – baby born with absolute weight less than 2,500 grams

A global systematic review identified four studies examining impacts of cash transfers on birthweight, all of which found positive effects, ranging from 31 to 578 grams (Leroy et al. 2021). However, none of the studies covered in the review were conducted in Africa (three were in Latin America and one was in Nepal). Since that review, three additional studies have been published examining impacts of Ghana's LEAP 1000 on birthweight. The studies found that LEAP 1000 reduced low birthweight prevalence by 3.5 percentage points overall, and even more (4.1 percentage points) in the dry season (but not in the rainy season). In terms of absolute birthweight, LEAP 1000 had larger impacts on increasing weight among babies born in the dry season compared to in the rainy season (109 v. 79 grams) (Quinones et al. 2023). Because the rainy season is generally a time of increased food insecurity (when food stocks are low) and increased risk of malaria (which is associated with increased risk of low birthweight), babies born in this period may be particularly vulnerable, and thus cash transfers may not be sufficient to overcome all these barriers to healthy birthweight. Next, the research team examined whether LEAP 1000 could mitigate the adverse effects of high temperatures on low birthweight. They found that high temperatures were associated with increased likelihood of low birthweight among babies born in households not receiving cash transfers, but there was no association between high temperatures and low birthweight in households receiving cash transfers (LaPointe et al. 2024). These findings suggest that LEAP 1000 mitigated the adverse effects of high temperatures on low birthweight risk.

Mortality

Increasing national cash transfer coverage is associated with reduced mortality risk, including AIDS-related death, in Africa.

Key concepts:

- **MORTALITY RISK** – risk of death

A review of unconditional cash transfers (a mix of government and non-governmental) programmes, found that none directly examined the impacts of cash transfers on mortality (Pega et al. 2022). In Latin America, two conditional cash transfers led to reductions in mortality. The Oportunidades cash transfer in Mexico and the Bolsa Família programme in Brazil led to declines in maternal mortality of 11 per cent and 10 to 20 per cent, respectively (Hernández et al. 2003; Rasella et al. 2021). In terms of overall mortality, the Oportunidades programme in Mexico led to a 4 per cent decline in overall mortality (Barham and Rowberry 2013), while Bolsa Família was associated with reductions in all-cause mortality (Hazards Ratio=0.96, CI = 0.94–0.98) (Pescarini et al. 2022).

Source: ©UNICEF/UN0613189/Dejongh

Another study published in 2023 extrapolated information from cash transfer programme coverage and national mortality statistics (however impact evaluations of these programmes were not designed to examine impacts on mortality). The study compared 16 countries in Africa, Asia, Latin America, and the Caribbean that implemented 29 government-led cash transfer programmes first initiated between 2000 and 2019 to 21 countries without such programmes in the same period (Richterman et al. 2023). Out of the total 37 countries examined, 29 were from sub-Saharan Africa. While there were no evaluations of these cash transfer programmes set up to examine impacts on mortality, Richterman and colleagues (2023) extrapolated data from the cash transfer coverage onto external mortality data and concluded that cash transfers were associated with a 20 per cent reduction in mortality risk among adult women. In sub-Saharan Africa specifically, cash transfers reduced the risk of mortality among women by 23 per cent. Examining sex- and age-specific impacts, effects were found to be driven by women, men aged 18 to 40 years, and children younger than 5 years. Impacts did not differ between conditional and unconditional cash transfer programmes. Countries with higher cash transfer coverage and larger transfer values saw larger reductions in mortality, as did countries with lower per capita health expenditures and lower life expectancy. Nevertheless, given the study design, internal validity is questionable and these findings should be interpreted with caution.

Another study used population-level data from Demographic and Health Surveys and AIDS Indicator Surveys from 42 countries (36 in Africa), combined with coverage levels of national government cash transfer programmes, to examine the association between cash transfer coverage and AIDS-related mortality. The study found that cash transfer programmes were associated with a reduction in AIDS-related deaths (incidence rate ratio = 0.91, CI 0.83, 0.99) (Richterman and Thirumurthy 2022). These findings should be interpreted with caution because the study design lacks a causal identification strategy. Thus, they are suggestive at best.

Source: ©UNICEF/UN0376751/Esiebo

Morbidity

Cash transfers reduce occurrence of illness, particularly among children.

H

Key concepts:

- **ILLNESS INCIDENCE** – occurrence of disease
- **MORBIDITY** – condition of suffering from disease or medical condition
- **PREVALENCE** – number of individuals in a population who have a disease in a specific period of time, usually reported as a percentage

Most evaluations of government-led cash transfer programmes assess impacts on health outcomes such as illness/injury incidence (for example, fever, diarrhoea, and cough/acute respiratory illness). In general, the evidence suggests that cash transfer programmes can reduce morbidity (Sun et al. 2020), but evidence is mixed and depends on the context and age groups considered.

Owusu-Addo and colleagues (2018) reviewed 53 studies covering 24 unconditional and conditional cash transfer programmes in Africa, where seven out of the nine studies examining child health found significant reductions in illness, ranging from 4.9 percentage points in Zambia to 17.1 percentage points in Lesotho.

In global evidence, Pega et al. (2022) reviewed unconditional cash transfers and conducted a meta-analysis of six studies (including three countries in Africa: Kenya, Malawi, Lesotho). They found that unconditional cash transfers reduced the risk of illness (RR 0.79, CI 0.67, 0.92). In two additional RCT studies not included in the meta-analysis, unconditional cash transfers were also found to reduce the risk of illness. Then, in two quasi-experimental studies, findings were mixed: one study found the risk of illness to be reduced among children but increased among adults, while the second study found no impacts.

In another systematic review focusing exclusively on children that included conditional cash transfer programmes in 16 countries (15 in Latin America and one in Zimbabwe), Owusu-Addo and Cross (2014) found that three out of four studies (two in Mexico, one in Colombia, and one in Nicaragua) reporting on prevalence of disease found reductions in illness resulting from cash transfers, though findings varied by children's age group. Cash transfers in Mexico and Colombia reduced reported illness in Mexico and diarrhoea in both Mexico and Colombia; these

protective effects were only found among younger children under 5 and 4 years in Mexico and Colombia, respectively, but not among older children. In Nicaragua, a study examined impacts on anaemia and haemoglobin deficiency, but no impacts were found. The review did not include any studies covering these outcomes in Africa.

Several impact evaluations under the Transfer Project have also considered the impact of cash transfers on morbidity (Tables 11 and 12). Novignon et al. (2022) analysed data from five Transfer Project studies in four countries and found considerably mixed results. Overall, the authors found protective effects in Malawi, a mix of adverse and null impacts in Zambia, and no impacts in Ghana and Zimbabwe. In Malawi, cash transfers reduced morbidity as measured by fever and malaria (at 24 months of follow-up) across all age groups (children and adults) and also reduced reports of illness at the 17-month follow-up but not at 24 months, and these impacts appeared to be driven by individuals aged 60 years and above. There were no impacts on illness among children below 5 years. In Zambia, Novignon and colleagues (2022) reported mixed results from Zambia's Multiple Categorical Targeting Programme. At 24 months' follow-up, the cash transfer increased illness for children under 5 and adults 60 and above. Similarly, the programme increased reports of fever/malaria among children under 5 years, chronic illness among adults 20-59 years, and respiratory illness among adults 60 years and above. Nevertheless, these adverse impacts disappeared at 36 months' follow-up, and at that wave, there were protective effects of the cash transfer on chronic illness and fever/malaria among children and adolescents aged 5-19 years. In a second cash transfer in Zambia (the Child Grant Programme), respiratory illness increased among those 5-19 years at 24 months and among the full sample at 48 months' follow-up as a result of the cash transfer. In Ghana and Zimbabwe, no impacts were found on morbidity/illness.

Turning to an additional Transfer Project study not covered under the Novignon et al. (2022) study, in Kenya, the Cash Transfer for Orphans and Vulnerable children showed no impact on children ill with fever, cough, or diarrhoea in the month preceding the survey. However, there were differential impacts, whereby among the poorest households the cash transfer reduced the probability of children under 5 years having a fever by 15.9 percentage points and a cough by 22.3 percentage points (Ward et al. 2010).

Table 11. Summary of Transfer Project Impacts on children's morbidity

CHILD MORBIDITY							
COUNTRY	**PROGRAMME**	**ACRONYM**	**EVALUATION TIME POINT**	**AGE RANGE**	**INDICATOR**	**REFERENCE PERIOD**	**EFFECT SIZE**
Ethiopia	Social Cash Transfer Pilot Programme (Tigray Region)	SCTPP	36 months	N/A	Diarrhoea	*Not measured*	*Not measured*
				N/A	Acute Respiratory Infection	*Not measured*	*Not measured*
				N/A	Fever	*Not measured*	*Not measured*
Ghana	Livelihood Empowerment Against Poverty	LEAP	72 months	N/A	Diarrhoea	*Not measured*	*Not measured*
				N/A	Acute Respiratory Infection	*Not measured*	*Not measured*
				N/A	Fever	*Not measured*	*Not measured*
	Livelihood Empowerment Against Poverty 1000	LEAP 1000	24 months	Children 0-59 months	Diarrhoea	Last 2 weeks	N.S.
				Children 0-59 months	Acute Respiratory Infection	Last 2 weeks	N.S.
				Children 0-59 months	Fever	Last 2 weeks	N.S.
Kenya	Cash Transfers for Orphans and Vulnerable Children	CT-OVC	24 months	Children 0-59 months	Combined Diarrhoea/Acute Respiratory Infection/Fever	Last month	N.S.

Table 11. Summary of Transfer Project Impacts on children's morbidity (CONT.)

CHILD MORBIDITY							
COUNTRY	**PROGRAMME**	**ACRONYM**	**EVALUATION TIME POINT**	**AGE RANGE**	**INDICATOR**	**REFERENCE PERIOD**	**EFFECT SIZE**
Malawi	Social Cash Transfer Programme	SCTP	24 months	Children 0-5 years	Diarrhoea	Last 2 weeks	N.S.
				Children 0-5 years	Acute Respiratory Infection	Last 2 weeks	N.S.
				Children 0-5 years	Fever	Last 2 weeks	N.S.
Mozambique	Child Grant 0-2	CG-02	24 months	Children 0-23 months	Diarrhoea	Last 2 weeks	N.S.
				N/A	Acute Respiratory Infection	*Not measured*	*Not measured*
				N/A	Fever	*Not measured*	*Not measured*
South Africa	South African Child Support Grant	CSG	N/A (dose-response effect)	N/A	Diarrhoea	*Not measured*	*Not measured*
				N/A	Acute Respiratory Infection	*Not measured*	*Not measured*
				N/A	Fever	*Not measured*	*Not measured*
Tanzania	Productive Social Safety Net	PSSN	24 months	N/A	Diarrhoea	*Not measured*	*Not measured*
				N/A	Acute Respiratory Infection	*Not measured*	*Not measured*
				N/A	Fever	*Not measured*	*Not measured*
Zambia	Child Grant Programme	CGP	48 months	Children 0-5 years	Diarrhoea	Last 2 weeks	N.S.
				Children 0-5 years	Acute Respiratory Infection	Last 2 weeks	N.S.
				Children 0-5 years	Fever	Last 2 weeks	N.S.
	Multiple Category Targeting Programme	MCTP	36 months	N/A	Diarrhoea	*Not measured*	*Not measured*
				N/A	Acute Respiratory Infection	*Not measured*	*Not measured*
				N/A	Fever	*Not measured*	*Not measured*
Zimbabwe	Harmonised Social Cash Transfer Programme	HSCT	48 months	Children 0-5 years	Combined Diarrhoea/cough/ fever	Last 2 weeks	NS in full sample; -12.6pp** in poorest 50%

N/A = not applicable
N.S. = not significant
pp = percentage points
**p<0.05, **p<0.01, ***p<0.001*

Table 12. Summary of Transfer Project impacts on adult morbidity

ADULT MORBIDITY							
COUNTRY	**PROGRAMME**	**ACRONYM**	**EVALUATION TIME POINT**	**AGE RANGE**	**INDICATOR**	**REFERENCE PERIOD**	**EFFECT SIZE**
Ethiopia	Social Cash Transfer Pilot Programme (Tigray Region)	SCTPP	36 months	N/A	Illness	*Not measured*	*Not measured*
Ghana	Livelihood Empowerment Against Poverty	LEAP	72 months	Adults 18+	Illness/injury	Last 4 weeks	N.S.
	Livelihood Empowerment Against Poverty 1000	LEAP 1000	48 months	Adults 18+	Illness	Last 2 weeks	N.S.
Kenya	Cash Transfers for Orphans and Vulnerable Children	CT-OVC	24 months	N/A	Illness	*Not measured*	*Not measured*
Malawi	Social Cash Transfer Programme	SCTP	24 months	Adults 18+	Illness	Last 2 weeks	-5.9pp**
Mozambique	Child Grant 0-2	CG-02	24 months	N/A	Illness	*Not measured*	*Not measured*
South Africa	South African Child Support Grant	CSG	N/A (dose-response effect)	N/A	Illness	*Not measured*	*Not measured*
Tanzania	Productive Social Safety Net	PSSN	24 months	N/A	Illness	*Not measured*	*Not measured*
Zambia	Child Grant Programme	CGP	48 months	Women 18+	Illness/injury	Last 2 weeks	N.S.
				Women 18+	Chronic illness	Last 6 months	N.S.
	Multiple Category Targeting Programme	MCTP	36 months	Women 18+	Illness/injury	Last 24 months	N.S.
				Women 18+	Self-reported morbidity	Last 24 months	N.S.
Zimbabwe	Harmonised Social Cash Transfer Programme	HSCT	48 months	Adults 18+	Illness/injury	Last 30 days	N.S.

N/A = not applicable
N.S. = not significant
pp=percentage points
**p<0.05, **p<0.01, ***p<0.001*

HIV incidence

Higher national cash transfer coverage rates are associated with fewer HIV infections. There is some evidence to suggest that cash transfers implemented as part of research trials can reduce HIV incidence, but impact evaluations of national cash transfer programmes have not directly examined this outcome.

Key concepts:

- **HIV INCIDENCE** – estimated number of persons newly infected with HIV during a specified time period
- **HIV PREVALENCE** – proportion of a population living with HIV at a given time regardless of the time of infection

Two recent systematic reviews have examined the impacts of cash transfer programmes on HIV incidence/prevalence. Stoner and colleagues (2021) reviewed 27 studies (across 45 articles) in 12 countries on the impact of cash transfers on HIV outcomes and risk factors. Out of the 27 studies reviewed, 23 studies were conducted in sub-Saharan Africa including in Eswatini (one study), Kenya (five studies), Lesotho (one study), Malawi (three studies), South Africa (six studies), Tanzania (two studies), Uganda (one study), Zambia (one study), and Zimbabwe (three studies). Among the eight studies that examined HIV biomarkers as an outcome, three found reductions in HIV incidence or prevalence. It is important to note that all eight studies testing HIV incidence were interventions implemented by researchers; none were national government cash transfers. The second review and meta-analysis on the impacts of cash transfer programmes on HIV was restricted to programmes evaluated as part of randomised controlled trials only (Guimarães et al. 2023). The review included 16 studies (including 13 conditional cash transfer programmes) and found that cash transfers lowered the relative risk of HIV incidence among cash transfer beneficiaries who had to meet programme health care or schooling conditionalities, suggesting that conditional cash transfers lower the risk of HIV infection (RR 0·74, 95% CI 0·56–0·98). An important caveat to the Guimaraes et al. review is that all studies included evaluated NGO-implemented cash transfer programmes or programmes implemented as part of research trials, with most including conditions related to attending health care centres. There was no single government-led cash transfer programme in the review, even though the summary table in the article erroneously concludes that it included several, for example in Tanzania (Guimarães et al. 2023). Moreover, most studies drew on clinic-based samples, which means that samples consisted of individuals who were already accessing health clinics before

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the start of the intervention. Such populations are likely very different from the types of households and individuals reached by government-led cash transfer programmes. We are therefore unable to conclude that cash transfer programmes should implement conditions to achieve HIV-related objectives. In fact, imposing conditions in large-scale government programmes would likely impose further hardship on marginalised households and those with lower access to care in the first place.

Another study used population-level data from Demographic and Health Surveys and AIDS Indicator Surveys from 42 countries (36 in Africa), combined with coverage levels of national government cash transfer programmes, to examine the association between cash transfer coverage and HIV incidence. The authors found that cash transfer programmes were associated with a reduction in new HIV infections (incidence rate ratio=0.94, CI 0.89, 0.99) and AIDS-related deaths (incidence rate ratio = 0.91, CI 0.83, 0.99) (Richterman and Thirumurthy 2022). These findings should be interpreted with caution because the study design lacks a causal identification strategy. Thus, they are suggestive at best.

Within the Transfer Project, studies have not examined HIV incidence.

4.8 Evidence of Impacts of Cash Transfers on Mental Health

Cash transfers can improve mental health, and unconditional cash transfers have larger protective effects on mental health than conditional cash transfers.

Key concepts:

- **DEPRESSION** – mood disorder causing feelings of sadness and loss of interest; may interfere with daily activities
- **INTERNALISING PROBLEMS** - emotional or psychological problems manifested in inwardly-focused symptoms, such as depressed mood, feelings of anxiety, somatic complaints, social withdrawal, and suicidal thoughts
- **EXTERNALISING PROBLEMS** – emotional or psychological problems manifested in outward behaviour, including aggression, risky sexual behaviour, delinquency, and hyperactivity
- **SELF-PERCEIVED STRESS** – extent to which individuals perceive their demands to exceed their ability to cope

Four recent systematic reviews have examined the impacts of cash transfer programmes on mental health, and three of these concluded that cash transfers have protective benefits on mental health. Zimmerman et al. (2021) identified 12 articles (seven in Africa) estimating the impacts of cash transfers on mental health or mental well-being among youth aged below 25 years. The authors conducted a meta-analysis, reporting no significant overall effects on depression outcomes among youth, although individual studies showed promising results. Zaneva et al. (2022) identified 14 papers reporting mental health outcomes among youth under 20 years. Their review found a small protective effect on internalising (e.g., mood-related) and externalising (e.g., behavioural-related) symptoms. Among all ages, McGuire et al. (2022) identified 45 studies, most of which were conducted in Africa (30 out of 45), evaluating mental health as well as subjective well-being (e.g., happiness and life satisfaction). The authors found small positive effects of cash transfers on mental health. Finally, Wollburg and colleagues (2023) identified 17 studies (13 in Africa) that examined mental health outcomes including anxiety and depressive disorders among adults. The meta-analysis overall reported small protective effects on mental health, and found larger effects on mental health among evaluations of unconditional cash transfers compared to conditional cash transfers.

In more recent evidence not covered in these reviews, Mali's government cash transfer program Filets Sociaux (Jigisemejiri) was found to reduce worry (including about money and food) and self-perceived stress (Hidrobo, Karachiwalla, and Roy 2023). Relatedly, the cash transfer was found to increase participants' self-esteem and patience.

Meanwhile, several Transfer Project evaluations of government-led cash transfer programmes in Africa have also considered impacts of cash transfers on mental health (Table 13). Positive effects were found on subjective well-being in Malawi's Social Cash Transfer Programme (Natali et al. 2018) and on happiness in Zambia's Child Grant Programme (Molotsky and Handa 2021). Furthermore, a systematic qualitative analysis of cash transfer programmes in Ghana (Livelihood Empowerment Against Poverty), Malawi (Social Cash Transfer Programme), and Zimbabwe (Harmonised Social Cash Transfer) reported evidence of increased hopefulness, decreased feelings of shame, and greater autonomy (Attah et al. 2016). An in-depth Transfer Project study examining impacts on self-perceived stress found that Malawi's Social Cash Transfer reduced self-perceived stress, while there were no impacts of Tanzania's Productive Social Safety Net or Ghana's LEAP 1000 (Maara et al. 2023). Turning to depressive symptoms, cash transfers in Malawi and Kenya were found to reduce depressive symptoms among adolescents and youth (Angeles et al. 2019; Kilburn et al. 2016). However, in Tanzania while there were no overall effects on mental health when examining male and female adolescents and youth together (Table 12), an in-depth study found that when examining separately, Tanzania's Productive Social Safety Net reduced depressive symptoms among males and increased depressive symptoms among females (Prencipe et al. 2021). The authors posited that responsibility for fulfilling conditions to remain eligible for the programme largely falls to females and this may have increased their care responsibilities, contributing to time poverty and reduced mental health.

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Table 13. Summary of Transfer Project impacts on mental health

IMPACTS ON MENTAL HEALTH							
COUNTRY	**PROGRAMME**	**ACRONYM**	**EVALUATION TIME POINT**	**AGE RANGE**	**INDICATOR**	**REFERENCE PERIOD**	**EFFECT SIZE**
Ethiopia	Social Cash Transfer Pilot Programme (Tigray Region)	SCTPP	36 months	Adult women	Self-Reported Questionnaire Score	Last 30 days	N.S.
				N/A	Life satisfaction	*Not measured*	*Not measured*
				N/A	Depressive symptoms	*Not measured*	*Not measured*
				N/A	Stress Scale	*Not measured*	*Not measured*
Ghana	Livelihood Empowerment Against Poverty	LEAP	72 months	Adult women	Life Satisfaction (happy with life)	Lifetime	11.8pp*
				N/A	Depressive symptoms	*Not measured*	*Not measured*
				N/A	Stress Scale	*Not measured*	*Not measured*
	Livelihood Empowerment Against Poverty 1000	LEAP 1000	48 months	Adult women	Enhanced Life Distress Index2	Last 7 days	N.S.
				Adult women	Stress (Cohen Scale)	Last 4 weeks	N.S.
				N/A	Life satisfaction	*Not measured*	*Not measured*
				N/A	Depressive symptoms	*Not measured*	*Not measured*
Kenya	Cash Transfers for Orphans and Vulnerable Children	CT-OVC	24 months	Youth ages 15-22	CES-D (>=10)1	Last 7 days	OR=0.79
				N/A	Life satisfaction	*Not measured*	*Not measured*
				N/A	Stress Scale	*Not measured*	*Not measured*
Malawi	Social Cash Transfer Programme	SCTP	24 months	Adult Caregivers	CES-D (>=10)	Last 7 days	-1.05***
				Adult Caregivers	Depressive Symptoms	Last 7 days	-7pp**
				Adult Caregivers	Stress (Cohen Scale)	Last 4 weeks	-0.84***
				N/A	Life satisfaction	*Not measured*	*Not measured*
Mozambique	Child Grant 0-2	CG-02	24 months	Caregiver of Children ages 0-6	Depressive Symptoms (CES-D (>=10)	Last 7 days	-0.07**
				Caregiver of Children ages 0-6	Stress (Cohen Scale)	Last 4 weeks	-0.84***
				N/A	Life satisfaction	*Not measured*	*Not measured*

Table 13. Summary of Transfer Project impacts on mental health (CONT.)

IMPACTS ON MENTAL HEALTH							
COUNTRY	**PROGRAMME**	**ACRONYM**	**EVALUATION TIME POINT**	**AGE RANGE**	**INDICATOR**	**REFERENCE PERIOD**	**EFFECT SIZE**
South Africa	South African Child Support Grant	CSG	N/A (dose-response effect)	N/A	Depressive Symptoms/Stress/ Life satisfaction	*Not measured*	*Not measured*
Tanzania	Productive Social Safety Net	PSSN	18 months	Youth ages 14-28	Life Satisfaction (Cantril self-anchoring scale)	N/A	N/A
				Youth ages 14-28	Depressive Symptoms (CES-D (>=10)	Last 7 days	N.S.
				Youth ages 14-28	Enhanced Life Distress Index	Last 7 days	N.S.
				Youth ages 14-28	Stress (Cohen scale)	Last 4 weeks	N.S.
Zambia	Child Grant Programme	CGP	48 months	Main respondents	Stress (Cohen scale)	Last 4 weeks	N.S.
				N/A	Life satisfaction	*Not measured*	*Not measured*
				N/A	Depressive symptoms	*Not measured*	*Not measured*
	Multiple Category Targeting Programme	MCTP	36 months	Youth ages 13-17	CES-D	Last 7 days	N.S.
				Youth ages 13-17	CES-D (>=20)	Last 7 days	N.S.
				N/A	Life satisfaction	*Not measured*	*Not measured*
				N/A	Stress Scale	*Not measured*	*Not measured*
Zimbabwe	Harmonised Social Cash Transfer Programme	HSCT	48 months	Youth ages 13-24	CES-D	Last 7 days	0.561*
				N/A	Life satisfaction	*Not measured*	*Not measured*
				N/A	Stress Scale	*Not measured*	*Not measured*

N/A = not applicable
N.S. = not significant
pp=percentage points
**p<0.05, **p<0.01, ***p<0.001*

CES-D = Center for Epidemiological Studies-Depression: 10-question scale with score ranging from 10 to 40; higher score indicates increased depressive symptoms. Cut-offs of >10 or >20 are used to create binary indicators of depressive symptoms in these studies.
[1]Estimates reported come from Kilburn et al. (2016).
[2]Estimates come from Maara et al. (2023).

Box 2. Considerations for interpreting impact of cash transfers on health in Africa to global evidence

There are several points that should be taken into account when interpreting impacts of cash transfers on health-related outcomes in Africa:

- **CONDITIONAL V. UNCONDITIONAL:** Large-scale government-led cash transfer programmes in Africa are more likely to be unconditional than conditional, or to implement soft conditionalities (or co-responsibilities), which are communicated but not monitored. In contrast, many cash transfer programmes in Latin America are often designed with strict and enforced conditions. At the same time, generalised levels of poverty in Africa are higher and health infrastructure is more limited. Thus, it is impossible to conclude that differences in health outcomes across regions are attributable to the presence or absence of conditions.
- **SUSTAINED AND/OR LONG-TERM IMPACTS:** Long-term impacts of cash transfers are not frequently studied. This is sometimes due to limited funds for research (to do additional rounds of follow-up data collection) or programme design; for example, control groups are often rolled into the programme and thus it is more challenging to study impacts. Alternatively, programmes may have been more recently implemented and the ability to study long-term impacts is limited due to shorter elapsed time. Another challenge is that Africa generally rolled out cash transfer programmes later than regions such as Latin America, where some of the cash transfer programmes have been operational for decades, and, as such, allow for longer-term follow-up studies (Barham, Macours, and Maluccio 2017). Not only have these programmes achieved greater maturity at the operational level, but they are also more likely to show impact on more distal outcomes, such as health outcomes, that require longer periods of programme exposure (see conceptual framework in Figure 1). Thus, absence of impact on health outcomes in some of these evaluation studies should thus not automatically be interpreted as programme ineffectiveness.
- **QUALITY OF SERVICES:** Differences in contextual factors across regions may influence cash transfer programme impacts. The few studies that have evaluated the role of contextual factors suggest that supply-side factors (e.g., quality of health services) influence programme impacts on health outcomes in cash transfer programmes. For instance, there is evidence that cash transfer impacts are greater (in terms of health insurance uptake and skilled delivery at birth) for households living in communities with relatively better health infrastructure. This is particularly relevant in Africa where cash transfers may remove financial barriers to healthcare, but where poor physical access or low-quality services due to understaffing, medicine stockouts, etc. can still limit service utilisation.
- **WEAK INSTITUTIONS:** The fact that cash transfer programmes in Africa are implemented in a context where there are often sometimes weak institutions may also limit effects on health. Several evaluations in the region have pointed out widespread implementation challenges that constrain programme effectiveness. These challenges include, among others, the transfer size, the timing and frequency of payments, and, at a broader level, economic instability, challenges that are interrelated. Meanwhile, widespread economic instability has affected programme effectiveness, with inflationary pressures eroding real transfer values, limiting their purchasing power and ability for programmes to achieve substantial coverage.

Source: ©UNICEF/UNI731758/Benekire

5. LESSONS LEARNED FROM REVIEWING THE EVIDENCE

In general, evidence on the impact of cash transfer programmes on health has received reasonable attention in Africa. However, our review suggests that the amount of evidence is not equally distributed over different types of health outcomes. In this section, we highlight where the evidence is strongest and where we observed gaps and make recommendations about priorities for future research.

5.1 Summary of impacts

Evidence of impacts of cash transfers on health care access

- A limited number of studies suggest that cash transfers can increase enrolment in health insurance in Africa, especially when cash transfers are linked to eligibility for subsidised enrolment into national health insurance programmes.
- Cash transfers increase amount spent on health care.

Source: ©UNICEF/UNI587862/Ramasomanana

Evidence of impacts of cash transfers on health care utilisation

General health care utilisation

- In Africa, cash transfer programmes have increased use of health services.

Health care utilisation (general preventive services and care when ill)

- Cash transfers generally increase use of health services, including in Africa, but effects are not seen in all contexts.

Immunisation

- Generally, the evidence suggests that, while cash transfers positively affect vaccination coverage in other regions, these impacts have largely not been realised in Africa except in two cases.

Utilisation of antenatal care and skilled attendance at delivery

- Cash transfers in Africa have positive effects on antenatal care seeking but generally do not have effects on skilled attendance at delivery (apart from in circumstances with high-quality health services).

Use of sexual and reproductive health care services

- There is no evidence to date that cash transfers increase contraceptive uptake in Africa. The evidence on cash transfers and HIV testing in Africa is mixed, but they generally do not increase treatment adherence.

Birth registration

- There is evidence supporting cash transfers' ability to increase birth registration.

Evidence of impacts of cash transfers on behaviours

Physical, emotional, and sexual violence

- There is strong evidence that cash transfers reduce intimate partner violence, and there is also evidence to suggest that they can reduce violence against children and adolescents.

Alcohol and tobacco use

- There is strong evidence that cash transfers do not increase the purchase and use of alcohol and tobacco.

Sexual behaviour

- Governmental unconditional cash transfer programmes can delay sexual debut among adolescents and may reduce age-disparate relationships and risk of transactional sex in some contexts. However, they have limited effects on other sexual behaviours posing health risks, particularly among adolescents.

Fertility

- Cash transfers reduce adolescent pregnancy and increase birth spacing in Africa. Cash transfers do not increase fertility.

Source: ©UNICEF/UNI610163/Dejongh

Evidence of impacts of cash transfers on physical health

Child malnutrition

- Global evidence suggests that cash transfers have modest effects on increasing height-for-age and reducing stunting and wasting, but they generally do not have impacts on weight-for-age. However, when examining Africa specifically, only protective impacts on wasting emerged.

Birthweight

- The small number of studies examining impacts of cash transfers on birthweight have found that cash transfers can increase birthweight, and these effects may be influenced by season of birth.

Morbidity

- Cash transfers reduce occurrence of illness, particularly among children.

HIV incidence

- There is some evidence to suggest that cash transfers implemented as part of research trials can reduce HIV incidence, and an observational study comparing national cash transfer coverage rates with population data on HIV incidence found that cash transfers reduce HIV infections.

Evidence of impacts of cash transfers on mental health

- Cash transfers can improve mental health, but impacts vary according to program design and recipient characteristics. Further, unconditional cash transfers have larger protective effects on mental health than conditional cash transfers.

5.2 Where Do We Need More Research?

Reviewing the evidence on the impact of cash transfers on health-related outcomes in Africa, we identified some gaps:

1. **DESIGN AND IMPLEMENTATION**: More information is needed about programme design features and implementation and their moderating effect on programme impact. However, large-scale government programmes generally do not vary design and implementation features to experiment with how design features can affect outcomes. Thus, information on programme design can be learned from non-governmental programmes, including research trials which are more flexible and pilot different design features (for example, to study sex of transfer recipient, transfer amount and frequency, and other characteristics). More process evaluations of government-led cash transfer programmes can also contribute to learning around implementation and its influence on cash transfer impacts.
2. **CONTEXTUAL INFLUENCES**: More research is needed to understand how contextual factors, such as quality of surrounding health services and other environmental factors (water, sanitation, and hygiene), social and gender norms, and other characteristics influence the effects of cash transfers on health outcomes.
3. **HIV AND SEXUAL AND REPRODUCTIVE HEALTH**: More research is needed examining impacts of government cash transfers on HIV incidence/prevalence, treatment, and modern contraceptive use.
4. **PATHWAYS OF IMPACT:** More research is needed to understand pathways of impact on some health outcomes, for example mental health effects, including why unconditional cash transfers have larger protective impacts than conditional cash transfers.
5. **LINKAGES BETWEEN CASH TRANSFERS AND COMPLEMENTARY HEALTH AND SOCIAL SERVICES**: Multi-sector interventions may be needed to influence several health outcomes. For instance, interventions in infrastructure (e.g., health facilities or roads) can have an important impact on health outcomes. Improving health does not only require the removal of household-level financial barriers, but also the tackling of other demand- and supply-side barriers to health care utilisation, including supply-side factors (quality of health services) and information gaps. As such, more studies are needed that evaluate the linkages between cash transfer programmes' and complementary health and social services' impacts on health outcomes.

Source: ©UNICEF/UNI528406/Cisse

ENDNOTES

1 Established in 2008, the Transfer Project is a collaborative network between the United Nations Children's Fund (UNICEF), the Food and Agriculture Organization of the UN (FAO), University of North Carolina, national governments, and local research partners. Its goals are to provide rigorous evidence on the effectiveness of large-scale national cash transfer programmes in sub-Saharan Africa and the Middle East and to use this evidence to inform the development of cash transfer and social protection policies and programmes via dialogue and learning.

2 Then nutrition brief in this series provides a more comprehensive summary of pathways through which cash transfers influence children's nutrition.

3 In 2023, new legislation in Tanzania was passed regarding Universal Health Coverage, with plans to cover enrolment premiums for the most vulnerable groups (including cash transfer participants). Details of implementation are still being developed.

4 Some studies included multiple sites or multiple interventions, each representing a different "arm."

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