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Addressing Food Insecurity in Sub-Saharan Africa: the Role of Cash Transfers

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Abstract

Food insecurity, a complex and multi-faceted phenomenon, is currently one of the international community's main priorities, especially in sub-Saharan Africa (SSA). As food insecurity in this region is most widespread in pockets of extreme poverty, particularly in rural areas, traditional agricultural or general economic interventions alone are unlikely to generate substantial improvements. Instead, there is ample scope for social protection schemes.

This paper investigates the role played by rapidly expanding cash transfers (CTs) in enhancing food security. First, it offers an innovative conceptual framework for explaining the channels through which CT programmes can affect the various aspects of food security. It also illustrates how specific design features of CT programmes may generate effects through little known pathways, such as women's empowerment and improved intra-household decision-making.

Second, based on this conceptual framework, the paper provides a systematic review of evidence of the effects of CT programmes on different aspects of food security in middle-income and low-income countries in SSA. A rigorous overview based on a comprehensive conceptual framework is missing from the literature, as most of the overview papers published to date have concentrated on the specific effects of CT programmes on monetary poverty, human capital accumulation or food expenditure.

The paper shows that CTs offer great potential for enhancing households' access to food, as long as they take full account of:

- 1) the targeting of beneficiaries;
- 2) the regularity of payments;
- 3) the size of monetary transfers;
- 4) the need to amass political support.

In order to enhance all the different aspects of food security in the medium to long-term, CTs should be integrated with other interventions such as public works programmes, nutritional education, nutritional supplements for vulnerable groups, and economic policies. This is the main rationale behind the planned new phase of the Productive Safety Net Programme (PSNP) in Ethiopia.

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Bonn, September 2016

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Abbreviations

BMI	Body mass index
BMZ	Federal Ministry for Economic Cooperation and Development (Bundesministerium für wirtschaftliche Zusammenarbeit und Entwicklung)
CBN	Community-Based Nutrition Programme (Ethiopia)
CCT	Conditional cash transfer
CGP	Child Grant Programme (Lesotho and Zambia)
CSG	Child Support Grant (South Africa)
CT	Cash transfer
DT	Direct transfer
FAO	Food and Agriculture Organisation
GNI	Gross national income
HAZ	Height-for-age Z-score
HABP	Household Asset Building Programme (Ethiopia)
HSNP	Hunger Safety Net Programme (Kenya)
IFAD	International Fund for Agricultural Development
IFPRI	International Food Policy Research Institute
LEAP	Livelihood Empowerment Advancement Programme (Ghana)
OECD	Organisation for Economic Co-operation and Development
OFSP	Other Food Security Programme (Ethiopia)
OVC	Orphans and vulnerable children
PSA	Food Subsidy Programme (Mozambique)
PSNP	Productive Safety Net Programme (Ethiopia)
PW	Public works
SDG	Sustainable Development Goal
SEWOH	“One World - No Hunger” initiative of the German Ministry for Economic Cooperation and Development
SSA	Sub-Saharan Africa
UNICEF	United Nations International Children’s Emergency Fund
WAZ	Weight-for-age Z-score
WFP	World Food Programme
WHZ	Weight-for-height Z-score

1 Introduction

Food security has been one of the highest priorities on the international development agenda at least since the hike in food prices in 2007-2008. This is borne out by the huge amount of interest that the international community took in the issue during the negotiations on the post-2015 agenda. In the final 2030 Agenda, Sustainable Development Goal 2 concentrates entirely on food security, recognising much of its complex, multi-faceted nature.¹

Based on the latest Food and Agriculture Organisation (FAO) estimates, about 800 million people in the world suffer from hunger, i.e. lack of necessary calorie intake. This corresponds to about 11% of the entire population (Food and Agriculture Organisation [FAO], International Fund for Agricultural Development [IFAD], & World Food Programme [WFP], 2015). Less than 15 million are affected in what the FAO defines as the “developed regions”; the vast majority of those affected live in low-income and middle income countries. The macro-region with by far the highest prevalence of hunger is SSA (23.2%), followed by Southern Asia (15.7%).

The numbers increase dramatically if we embrace the comprehensive concept of food insecurity, which includes malnutrition in addition to hunger. Micronutrient deficiency, in particular iron and vitamin A deficiency, are widespread around the world, and have severe consequences for nutritional balance and health. While it is not easy to find accurate data about these problems, some indirect measures indicate that about 50% of pregnant women and about 40% of pre-school children in developing countries are anaemic (a proxy for low iron intake), and nearly 250 million pre-school children are vitamin A-deficient.²

Despite increasing concerns about food insecurity in urban and peri-urban areas, it still affects predominantly rural areas, especially in SSA. Therefore, improving agriculture could potentially be an effective means of alleviating food insecurity in the region. Policies supporting small-holder farmers may boost agricultural productivity and, as a consequence, income from agriculture, which constitutes rural households’ main source of revenue (FAO, IFAD, & WFP, 2015). However, in most cases the effects are not felt until the medium to long-term. Most food-insecure households live in poverty and are highly vulnerable to external shocks. On the basis of the Organisation for Economic Co-operation and Development’s (OECD) 2006 classification of households living in rural areas in developing countries (OECD, 2006), these households form part of the lowest “rural worlds”:

- world 5: chronically poor rural households, many of which are no longer economically active;
- world 4: landless rural households and micro-enterprises, and to a lesser extent;
- world 3: subsistence agricultural households and micro-enterprises.

Most food-insecure households have few or no assets, no land or just a very small plot of land, and a high dependency ratio (i.e. many members are either too old or too sick to work). Most are also extremely vulnerable to external events such as droughts, floods and price fluctuations. When they experience such shocks, they often have to adopt “negative” coping

1 See Burchi and Holzapfel (2015), for example, for an in-depth discussion of the pros and cons of SDG 2.

2 Source: <http://www.who.int/nutrition/topics/vad/en/>

strategies, such as reducing food consumption, selling productive assets, shifting production to more stable, lower-productivity crops, or taking children out of school (FAO, 2015).

Raising the living standards of these households is likely to make the biggest contribution to alleviating hunger and, broadly speaking, food insecurity in general terms. This opens ample scope for social protection interventions. Social protection means “policies and actions which enhance the capacity of poor and vulnerable people to escape from poverty and enable them to better manage risks and shocks” (OECD, 2009). It can have both a “preventional function”, i.e. preventing households just above the poverty line from falling into the poverty trap by helping them to better manage risks and deal better with shocks, and a “protective function”, i.e. lifting households above the poverty line.

This paper focuses on one important type of social protection scheme, i.e. *cash transfers* (CTs), and their role in alleviating food insecurity in SSA. CT programmes are designed to provide vulnerable families with regular cash payments with the general aim of alleviating poverty. These programmes have a purely protective function as they usually target poor households and individuals, often the extreme poor or extremely vulnerable groups (such as people with HIV-AIDS, orphans and other vulnerable children). They can alleviate short-term deprivations, regularise consumption and reduce the adoption of negative coping strategies. Moreover, they also foster long-term improvements in human capital because most of the money is spent on child education, health and nutrition, thus reducing the intergenerational transmission of poverty (Hanlon, Barrientos, & Hulme, 2010; Devereux, 2016). In this way, CTs can facilitate the more systematic engagement of these households in productive activities, both on-farm and off-farm.

After a long history of implementation in Europe, CT programmes became popular throughout Latin America during the 1990s, where they took the form of monetary transfers to poor households that require the beneficiaries to meet certain behavioural requirements. These transfers are known as *conditional cash transfers* (CCTs; Adato & Hoddinott, 2010; de Braw & Hoddinott, 2011; Fiszbein, Schady, Ferreira, Grosh, Kelleher, Olinto, & Skoufias, 2009; Gaarder, Glassman, & Todd, 2010; Skoufias, 2005; World Bank, 2015a). CCTs are usually targeted at children and require parents, principally mothers, to meet certain conditions linked to improving children’s health, education and nutrition. For example, families must send their children to school and undertake regular health visits in order to qualify for cash transfers. The guiding principle is therefore that of shared responsibility between citizens and government, and the aim is to alleviate poverty by encouraging investments in human capital. The most widely known CCT programmes have been operated in Mexico since 1997 (*Progresá*), in Chile since 2002 (*Chile Solidario*) and in Brazil since 2003 (*Bolsa Família*). By 2013, CCT programmes had been adopted in 18 Latin American countries covering 129 million people (World Bank, 2013a).

CT programmes were subsequently launched in other emerging and developing countries, including in SSA. However, most of them did not seek to impose any particular conditionalities on beneficiaries (World Bank, 2015a). The main reasons for this different arrangement are the higher incidence of monetary poverty and the insufficiency of social services in SSA, which is a precondition for introducing demand incentives (Cecchini & Madariaga, 2011; Barrientos & Villa, 2013). While it remains debatable whether CCT schemes would be viable in low-income SSA countries given the lack of state capacity for implementing them (Kakwani, Veras Soares, & Son, 2005; Schubert & Slater, 2006; Schüring, 2010a; Schüring,

2010b), more recently, under the threat of food, financial and fuel crises, a number of low-income countries in SSA have launched new CT programmes and improved administrative systems to make their programmes more efficient (Fiszbein, Kanbur, & Yemtsov, 2014). Another factor driving the introduction of CTs in SSA countries has been the AIDS crisis, which led to an increase in the number of orphans and vulnerable children (OVC) in countries with major epidemics (Garcia & Moore, 2012).

This paper seeks to investigate in depth the relationship between CT programmes and food security. It starts by providing an innovative conceptual framework for explaining the channels through which CT programmes can affect the various dimensions and indicators of food security. It also illustrates how specific issues in the design of these policies may produce effects through pathways such as women's empowerment and improvements in intra-household decision-making. It also shows how CT programmes can be combined with other nutritional policies so as to have a bigger impact on food security, in particular on nutritional knowledge and practice.

Second, we provide a systematic, comprehensive review of evidence of the effects of a large number of CT programmes on various aspects and indicators of food security in SSA. A rigorous overview is missing from the literature, as most studies to date have concentrated on specific effects of these policies on monetary poverty, human capital accumulation and food consumption. The ultimate objective is to understand how effective CT programmes are in alleviating food insecurity, and on which dimensions and indicators they have a relatively big impact. Finally, we set out some initial findings regarding the main design and implementation features that are likely to be the drivers of success (and failure).

The paper is structured as follows. The next section introduces the concept of food security and explains the theoretical framework linking CT programmes to food security. Using this framework as our guide, we then review in section 3 the evidence in SSA, first in middle-income countries and subsequently in low-income countries. Section 4 sets out our main findings and policy recommendations.

2 Conceptual framework

In order to understand the potential pathways through which CT programmes can impact on food security, we first need to have a clear understanding of what we really mean by “food security”. Scholars, politicians and policy-makers often confuse the term with other terms such as “food self-sufficiency”, “food sovereignty” and “food safety”. Food security is a multi-dimensional, multi-faceted phenomenon. Its definition and conceptualisation have changed significantly in recent decades (see Burchi & De Muro, 2016a). During the 1970s and part of 1980s, it was a synonym for food availability. At the 1974 World Food Conference, food security was defined as the “availability at all times of adequate world food supplies of basic foodstuffs to sustain a steady expansion of food consumption and to offset fluctuations in production and prices” (United Nations, 1975). During the second half of the 1980s and 1990s, there was a radical shift in the perception of food security, as was reflected by the widely accepted definition given at the 1996 World Food Summit:

Food security exists when all people, at all times, have physical and economic access to sufficient, safe and nutritious food that meets their dietary needs and food preferences for an active and healthy life. (FAO, 1996)

This definition was revised, albeit only slightly, in 2001, when food security was defined as:

A situation that exists when all people, at all times, have physical, social and economic access to sufficient, safe and nutritious food that meets their dietary needs and food preferences for an active and healthy life. (FAO, 2001)

Based on this definition, most studies break down the concept of “food security” into four components:

1. *Food availability:* this refers to food production and, at a national level, to the trade in food commodities. Using the ‘food balance sheets’ it is possible to estimate how much food (and calories) are available in the country (i.e. production + imports + food aid received – exports – waste). The availability of a sufficient amount of food is a necessary condition, but not a sufficient condition, for household food security.

2. *Access:* most scholars have interpreted this dimension only in terms of food access. However, access to other items that are relevant to food security is just as important as access to food (Drèze & Sen, 1989; Burchi & De Muro, 2016a):

2.1 Food access: the economic means (entitlements) by which people and households are able to access food, i.e. by means of the market, by means of production or, finally, by means of transfers. Income, agricultural production and employment are the most important instruments for gaining access to food. It is also important to take account of the problem of physical access to food alongside the economic dimension. Physical access is all about distances, infrastructure and transportation.

2.2 Access to other (non-food) food security-related items: access to drinkable water, adequate sanitation, health services and medicines is also fundamental to food security (though underrated).

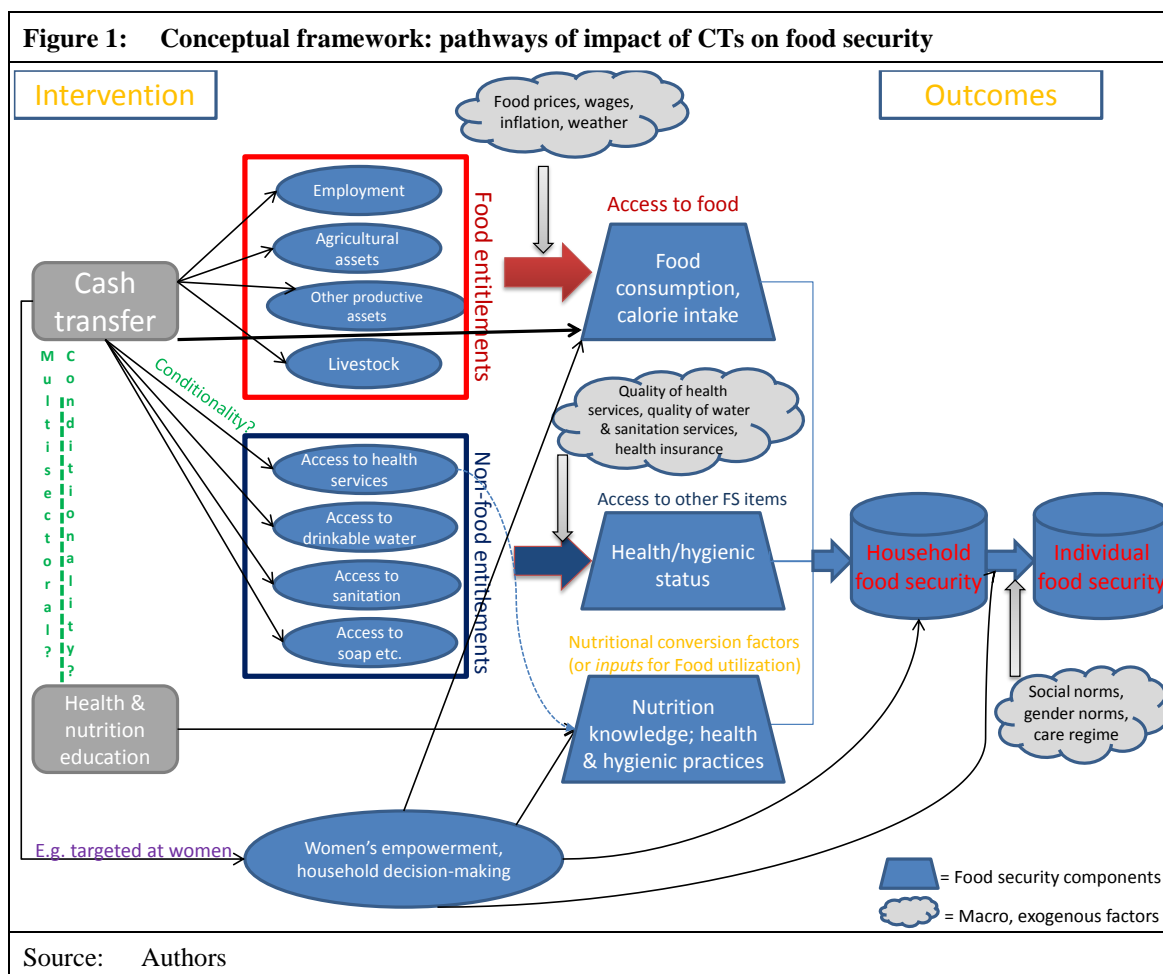
3. *Food utilisation:* this dimension is about dietary choices (a high-quality and varied diet is required), knowledge of nutritional issues and hygienic and healthy practices, cooking methods, and the cultural acceptability of certain types of food.

4. *Stability:* food security should be analysed in a dynamic framework in which food availability, access and utilisation need to be guaranteed “at all times” (see the FAO definitions above). This dimension is very close to the concept of vulnerability. If people have seasonal jobs, produce food only at certain times of the year and have difficulty storing their food stocks, and if the price of the commodity they offer fluctuates widely, they may encounter serious problems in accessing high-quality, varied foods throughout the year.

This characterisation of food security based on the four above dimensions is not especially helpful, however, when it comes measuring it and identifying the linkages with social protection schemes such as cash transfers. The four dimensions are in fact interdependent and not independent, and are analysed at different levels. For example, an individual or a household cannot have adequate food utilisation without having access to an adequate amount of food or calories. Like well-being, food security is best viewed as a process in which different factors come into play at different stages (De Muro, 2015).

In line with this view, the diagram in Figure 1 is a non-exhaustive illustration of the impact pathways of CT programmes on the dynamic concept of food security. This conceptual framework builds on the framework provided by Burchi and De Muro (2016a, p. 16) for the analysis of food security, but revises it slightly in order to identify the scope for public policies. This framework focuses on the household and individual-level effects of CTs, but does not examine the effects on food availability at national and local level (agricultural production, food demand, food prices) – an aspect neglected by the literature. Finally, while this is a theoretical framework that could be applied anywhere, we have rural SSA areas mainly in mind. These areas are characterised by a relatively high proportion of agricultural employment, poor market and social infrastructures and low local administrative capacities, among other things.

First of all, CTs can immediately boost economic access to food. They provide extra income to targeted individuals that could be used directly to increase food consumption, and in particular the calorie intake (see direct arrow connecting cash transfers to food consumption). This is a virtually automatic result of a well-planned CT programme, as poor individuals tend to allocate a very high proportion of their income to food (Alderman, 2015). Moreover, as has been discussed by Ibrahim, Kedir and Torres (2007) and Kedir and Girma (2007), given that food is a luxury for a large proportion of the population in poor countries, additional income at low levels of total consumption distribution will boost not just the amount of food consumed, but also the share of food consumption in total consumption. All the rest being the same, household food security will improve.



CTs can also boost food consumption indirectly, by impacting on other food entitlements, i.e. other means of gaining access to food (Sen, 1981). Having a regular, predictable income may influence decisions taken by household members about their participation in labour market, as well as their labour productivity. This effect may be negative if household members decide not to work in order to remain in the programme (see Woolard & Klasen, 2005, for example). This potential disincentive effect clearly calls for a careful appraisal of the transfer value during the CT design stage and of the provision of the right incentives in order to graduate out of the programme.

At the same time, CTs may have a positive effect on the quality of employment by relaxing liquidity constraints (Samson, 2009). With a regular cash inflow, workers can spend more time searching for a better job, and not feel obliged to accept any kind of low-quality work. A more stable and better remunerated job could be a valuable route to sustainable graduation out of food insecurity. Of course, this is possible only if CTs target households with at least one able-bodied person.

CTs also affect agricultural and other income-generating activities. They often represent a significant share of household income and most beneficiaries live in rural areas, where they depend on subsistence agriculture and where markets for financial services (such as loans and insurance), labour, goods and inputs are either non-existent or do not function well (Asfaw, Davis, Dewbre, Handa, & Winters, 2014). For these reasons, when CTs are made in a regular fashion, they may help households to overcome obstacles they encounter in accessing loans and thus improve the accumulation of productive, especially agricultural, assets (Asfaw et al., 2014). The presence of more and better agricultural assets helps in turn to raise productivity in the sector, and hence to give households access to more food, either directly (through production) or indirectly (through the market).³ This can also form the basis for a sustainable graduation out of poverty and food insecurity.

The lack of variety in crop production and, more broadly, in income-generating activities remains a big problem in SSA (Sen, 2013). CT recipients could engage in activities other than agriculture to diversify their incomes and hence reduce their vulnerability to external shocks, especially natural disasters. The resultant additional income could be used to purchase livestock and off-farm productive assets, thus enhancing food security by improving both the *access* and the *stability* dimensions. The feasibility of this type of strategy depends, however, on all sorts of socio-economic household characteristics and again on the design features of the CT programme.⁴

As we stressed at the beginning of this section, promoting food security requires an analysis of people's access to items other than food, such as health services, drinkable water and sanitation. Greater use of health facilities, better access to safe sources of potable water and improved sanitation significantly reduce the risk of disease, including water-borne diseases such as diarrhoea, which have a detrimental effect on metabolism and lower the body's

3 Amartya Sen (1981) refers to these as “direct food entitlements” and “exchange food entitlements” respectively.

4 CTs can have a big impact on education, as has been suggested by the experience in Latin America. Education, in turn, plays a crucial role in enhancing employability and productivity, in improving household allocation of resources, and in promoting women's empowerment and expanding nutritional knowledge. However, as the potential impact is on children's education, which could have only a long-term, intergenerational effect on food security, we did not include education in Figure 1.

capacity to absorb food. If parasitic diseases are prevalent, for example, access to sufficient amounts of high-quality food does not automatically mean that people are adequately nourished. As a core pillar of human capital, health is also an important driver of productivity and hence food consumption.

Households receiving CTs can decide to use the extra cash in order to increase their expenditure on health and – where needed – make more frequent use of health services, without waiting for the illness in question to become chronic. Similarly, the money could be used to access better hygienic or sanitation services and materials, including soaps. In countries such as Ghana and Tanzania, which operate public health insurance schemes, cash transfers may increase enrolment in these schemes. However, their ability to improve people's health status depends tremendously on their quality.⁵

Thus far, we have assumed that CTs can impact only on the quantity of food consumed and not on its quality. However, if people consume food with a low nutritional value for purely economic reasons, the availability of additional income may lead them to purchase food of a higher quality, thus improving their diet.⁶ However, monetary poverty is only one of the causes of poor diet. The problem is often due to low levels of “nutritional conversion factors.”⁷ In other words, a lack of nutritional knowledge and poor nutritional and hygienic practices can be the main drivers of food insecurity.

When not anchored to conditionalities, CTs have hardly any direct impact on the utilisation dimension of food security. However, they may have an indirect effect through access to health services: if people use health services more often thanks to the CTs they receive, they are exposed to more information on nutrition and health (see the dashed line in Figure 1).

In short, CTs alone cannot influence the multiple aspects of food security. There are two possible ways of ensuring they have a broader impact:

- 1) including conditionalities under which beneficiaries are required to attend courses in nutritional education;
- 2) integrating CTs with a broader set of policies.

The first possibility could also be an option for resource-constrained and institutionally weak countries, as providing basic nutrition information does not require a great deal of administrative capacity and is relatively cheap. One option could be to give this information to people every time – usually monthly or bi-monthly – they receive the cash from the

5 The experience with large CTs in Latin American countries shows that one means of producing significant health effects is by including conditionalities relating to visits to health clinics for vaccination, deworming and other pre-natal or post-natal services (Gaarder, Glassman & Todd, 2010). Given our focus on rural SSA, where CCTs are still rare and their use is often seriously undermined by poor institutional arrangements and the low quality of health infrastructures, this does not seem a very reliable hypothesis.

6 There is some empirical evidence of this direct effect on the quality of the diet. In particular, an evaluation of the *Oportunidades* programme in Mexico estimated that nearly 70% of cash transfers were spent on “higher quality” calories, in particular on meat, fruit and vegetables (Hoddinott & Skoufias, 2000).

7 The term “nutritional conversion factors” means all those factors that are fundamental in converting an adequate amount of food into adequate food security. They could also be conceived as crucial inputs for the utilisation of food.

programme.⁸ However, little experience has been gained to date with these two interventions, as most of the CCTs in Latin America specified nutritional education as only one, often marginal, condition.

The second option ties in with the idea that food insecurity is a multi-dimensional problem and should therefore be tackled with the aid of multi-sectoral interventions. Integrated approaches linking CT with nutritional education have been used principally in Asia and Latin America (Attanasio, Fernández, Fitzsimons, Grantham-McGregor, Meghir, & Rubio-Codina, 2014). Their use in SSA has been restricted to fragile states such as Niger (see Save the Children UK, 2010a, 2010b and 2010c). A rigorous impact evaluation conducted by the International Food Policy Research Institute (IFPRI) together with the World Food Programme (WFP) in Bangladesh revealed that CTs had a substantially bigger impact on child nutrition – as measured by stunting (or low height-for-age) – when combined with a nutritional education component (Ahmed, Hoddinott, Shalini, Sraboni, & Quabili, & Margolies, 2016). Another interesting integrated approach was adopted by the Zimbabwe Protracted Relief Programme, in which a CT scheme was accompanied by several other interventions in areas such as nutrition (behaviour change communication), water, health and hygiene, asset management, agricultural production (e.g. input distribution) and vocational training (FAO, 2015).

The final channel through which CTs can influence food security outcomes is women's empowerment and an improvement in household decision-making processes. Women's economic empowerment can impact on household income, particularly on the intra-household distribution of resources (Van den Bold, Quisumbing, & Gillespie, 2013). There is indeed substantial evidence in support of the hypothesis that women are more likely than men to spend money on resources for childcare, food, health and other basic needs (Bassett, 2008; Hoddinott & Bassett, 2008). This helps to improve not only household access to these commodities – and therefore food security – but also the food security and nutritional status of all household members. However, a CT cannot in itself directly affect women's empowerment: this happens only if it is targeted at mothers or possibly at children, in which case it is received and managed by their mothers.⁹

The above conceptual framework guides the review of the empirical evidence in the following section. We consider all studies analysing the effects of CTs on various aspects of food security in SSA. We examine the evidence of impacts on:

- 1) indicators of food entitlements (i.e. means of gaining access to food);
- 2) indicators of access to food (mainly related to calorie intake);
- 3) indicators of non-food entitlements (i.e. means of gaining access to other items);
- 4) indicators of access to other food security-related items (i.e. health and hygienic conditions);
- 5) the nutritional conversion factors (in other words, the input indicators of food utilisation);
- 6) outcome indicators of food security, such as children and women's anthropometric status.

8 Obviously, this intervention is possible only if the payments are not made through mobile phones or other forms of technology. However, these situations occur only rarely in SSA, given the high levels of poverty and poor access to electricity in many SSA countries.

9 Some scholars have criticised the rationale of CT schemes targeting women. The main reason often cited as a justification for this has been the greater propensity of women to spend money better (for both productive and social purposes). Only rarely has women's empowerment had any intrinsic relevance. See Holmes, Jones, Vargas, & Veras, (2010), among others, for a discussion of these controversies.

3 A systematic review of the empirical evidence of the impact of CTs on food security in SSA

At the beginning of the 21st century, many countries in SSA started moving gradually towards regular and reliable social protection instruments (Gentilini & Omamo, 2011; Niño-Zarazúa, Barrientos, Hickey, & Hulme, 2012). Donors and international organisations facilitated the gradual introduction of new anti-poverty policies by operating small pilot projects in many countries, although most of these did not include an evaluation component (Barrientos & Villa, 2013). Nowadays, CTs are the main form of social protection in the region. Unlike in Latin America, the eligibility criteria in the ‘African CT model’ generally focus on extreme poverty and demographic features such as labour constraints, orphanhood and vulnerability, and local communities help to compile eligibility lists (Handa, Natali, Seidenfeld, & Tembo, 2015).

Now, some 15 years since they first appeared in the region, the time is ripe to undertake a systematic review of the effects of CTs on the various components (and indicators) of food security. Given that we are looking at CTs exclusively through a food security lens, we are interested only in CTs that have one of the following features:

- a specific focus or objective relating to hunger, food security or nutrition (or possibly poverty);
- beneficiaries are targeted on the basis of nutritional indicators;
- evaluations are based on their effects on these indicators.

The first two points are, in fact, regarded as fundamental elements of a nutrition-sensitive social protection scheme (FAO, 2015). Where less attention is paid to food security and nutrition in the planning stage, this is likely to indicate that these issues are not central to the implementation of the CTs. For this reason, we cannot expect such CT schemes to have a big, direct impact on food security and nutrition.

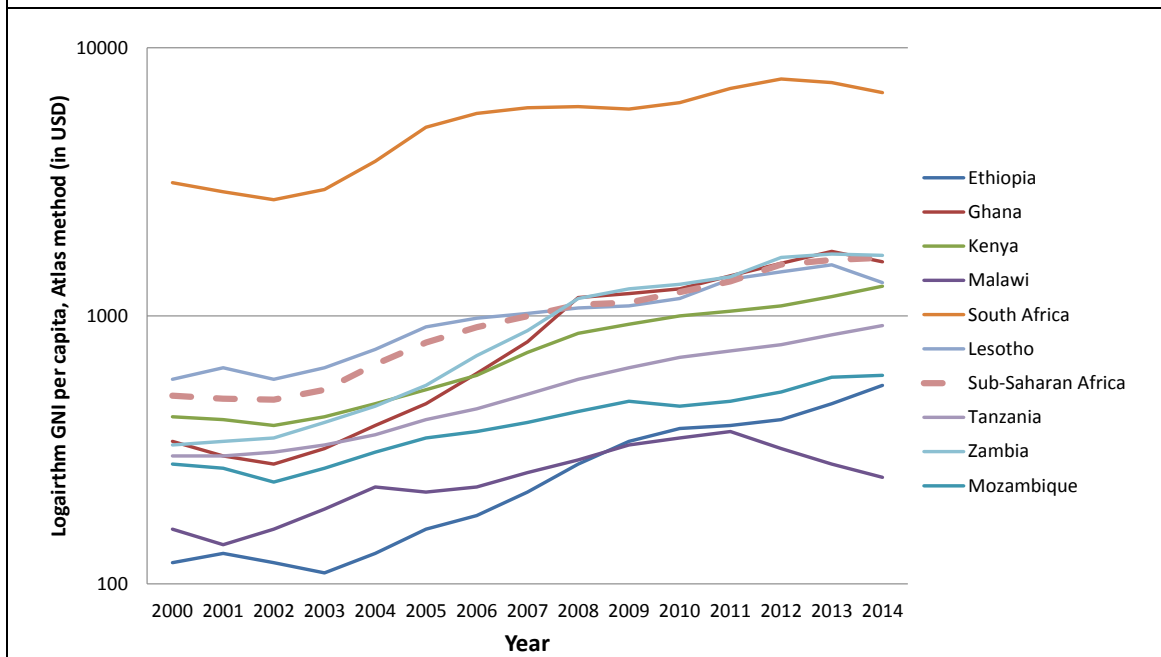
Our sample of countries does not include fragile states, countries only operating emergency CT schemes and countries that have performed only very small-scale pilot projects (such as the *Bourse Mamans* in Mali). Moreover, since the provision of social protection in SSA is highly diverse and since specifically grant-based policies aimed at poverty reduction vary widely from one country to another (Niño-Zarazúa et al., 2012; Garcia & Moore, 2012), we decided to categorise the countries in question according to income levels. As most of the CT schemes were launched around 2005, we used that year’s World Bank’s country classification as our starting point. Figure 2 shows that, in 2005, two of the countries in our study, i.e. South Africa and Lesotho, had a GNI per capita that was above the average value for SSA. The former was classified by the World Bank as an upper middle-income country, and the latter as a lower middle-income country. The other seven countries in the study were classified as low-income countries, with Malawi and Ethiopia being the poorest. For this reason, we decided to label the first group middle-income countries and the second group low-income countries.

Middle-income countries have adopted a system of *rights-based social protection* centred on non-contributory pension schemes and child support grants (Niño-Zarazúa et al., 2012). Their CT schemes often take the form of cash grant programmes planned with a long-term horizon. They are usually nationally owned, i.e. they are (largely) managed by government

institutions and are domestically funded. These CT schemes are stable by nature and are targeted at vulnerable groups such as the elderly and children, using various types of targeting mechanisms. The rationale for adopting elderly people and children as the target groups is the desire to support poor households without members of working age as a consequence of internal migration, family disruption and HIV/AIDS diffusion. Overall, these programmes have gradually emerged, backed by clear political support and embedded in legislation (Niño-Zarazúa et al., 2012).

Conversely, lower-income countries in SSA often lack the capacity to collect taxes and so have limited scope for extended redistributive policies. They can only afford basic social protection in the form of targeted CTs requiring, on average, less than 1 percent of GDP in terms of resources (Behrendt, 2008). As a consequence, the CT schemes they use are often designed to combat food insecurity and extreme poverty within a relatively short time frame. Such interventions are generally emergency responses to natural disasters or conflicts, and are not linked to other programmes but are an incoherent collection of measures (del Ninno & Mills, 2015). The CT schemes in question are typically non-government programmes that are partially or fully funded by donors, with a weak national political commitment and precarious long-term sustainability (Garcia & Moore, 2012; Niño-Zarazúa et al., 2012). As a final point, the effects of these programmes are often hampered by the difficulty of defining the target groups, since the majority of households are poor and, in practical terms, the safety nets cover only the poorest 10 to 20 percent of the population (del Ninno & Mills, 2015).

Figure 2: Trends in GNI per capita in selected SSA countries



Source: Authors' elaboration of data from World Development Indicators, World Bank.

Due to the fundamentally different natures of CT schemes in the two groups of countries, the next subsections focus first on middle-income countries and then on low-income countries. In Table 1 we report the main findings of the various studies we examined,¹⁰ by

10 In our search for relevant studies, we tried to select all those reports and journal articles that employed a rigorous quantitative methodology to assess the causal effect of CT programmes in the countries in

country, name of CT programme and direction and intensity of the effects on the different dimensions of food security. It is important to note that it is not always easy to include indicators for certain categories. For example, the household dietary score – measured as the proportion of food groups consumed by a household at least in a set minimum quantity – could be interpreted both as an indicator of food access and as an outcome indicator of food security (Hoddinott & Yohannes, 2002; Burchi & De Muro, 2016b). Having a varied diet depends both on access to a sufficient amount of food and on nutritional knowledge, but is not directly affected by access to other items that are relevant to food security. By contrast, anthropometric indicators are the outcome of access to food, other food security-related items and food utilisation. For this reason, anthropometric indicators are the preferred outcome indicators of food security (Frankenberger, 1992).

3.1 Middle-income countries

South Africa was the first country to introduce social pensions, which it did in the late 1920s in order to protect the white population. It gradually extended eligibility, reaching the whole population by the end of *apartheid* in 1994. Today, the South African social assistance programme, which represents 3.5-4% of GDP, is wider and more effective than those in other African countries (Niño-Zarazúa et al., 2012; Woolard & Leibbrandt, 2013). The programme revolves around a number of CT schemes aimed at reducing the intergenerational transmission of vulnerability and poverty by raising households' income and incentivising investments in human capital. CT programmes in South Africa are typically non-contributory social grants that do not require beneficiaries to meet specific conditions. The benefits are provided in the form of monthly income transfers to eligible beneficiaries, with eligibility typically defined by means testing: in order to qualify, beneficiaries' income must be below a given ceiling, that is adjusted each year for inflation.

South Africa has seven types of social grants targeted at children, elderly people and people with disabilities (Department of Social Development, 2010).¹¹ In March 2015, these programmes reached more than 16.5 million people representing over 25 percent of the population (South African Social Security Agency, 2015). One of the most important social grants is the Child Support Grant (CSG), launched in 1998 with the aim of supporting children in poverty and poor households, particularly in rural areas, who had been excluded from the social assistance programmes during *apartheid* (Pauw & Mncube, 2007). The ideas behind this programme are, first, that child protection can be mediated by the effectiveness of social transfer programmes in reducing poverty and, secondly, that poverty is due largely to deficits in income or consumption that transfers should be able to reduce (Barrientos, Byrne, Villa, & Peña, 2014). Between 1998 and 2014, the value of the grant grew from 100 to 320 Rands per month per child. It is currently awarded to a maximum of six children per household. Targeting is based on two criteria: household income and child age. The age limit was initially seven years, but has been gradually increased, first to nine years in 2003, then to 11 years in

question. A small number were incorporated as part of other, quantitative studies that did not assess causal relations, but provided information on aspects not explored by rigorous impact evaluations. The criteria for the selection of programmes and countries are explained earlier on in this section.

11 These social grants are the Older Persons Grant, Disability Grant, Child Support Grant, Care Dependency Grant, Foster Child Grant, War Veterans Grant and Grant-In-Aid.

2004, 14 years in 2005, and finally to 18 years in 2010 (Pauw & Mncube, 2007; Woolard, Harttgen, & Klasen, 2010).

The direct recipient is the main child carer. Although conditionalities were initially imposed – beneficiaries were supposed to take part in development programmes and provide proof of their children's immunisation – the CSG has operated in practice as an unconditional CT since 2010. Conditionalities are soft and compliance is not monitored (Budlender & Woolard, 2006, Woolard et al., 2010).

A number of studies have analysed the impact of the CSG on different dimensions or the main drivers of food security. Williams (2007) found that significantly more children in CSG recipient households attended school and that they tended to suffer less from hunger (as reported by the mother). The effect on another crucial food entitlement, employment – as measured by adult labour force participation was insignificant on the other hand.

Based on the findings of a new survey of households in low-income areas, Delany, Ismail, Graham, & Ramkissoo (2008) estimated that beneficiary households allocated a larger proportion of their expenditure to essential goods such as food. Although this study did not employ a rigorous method to assess the CSG's causal effects, it did show that the CSG was just one of many anti-poverty measures – albeit not a carefully planned part of a comprehensive strategy – taken in South Africa. Delany et al. examined whether participation in the CSG programme influenced the likelihood of participation in the school nutrition programme – consisting of a free, daily, balanced and varied cooked meal for primary schools pupils and a programme in nutritional education programme (Rendall-Mkosi, Morojele, London, Moodley, Singh, & Girdler-Brown, 2013), and also in accessing and being knowledgeable about the health services offered.

The study revealed new, potential pathways through which CTs can impact on food security: in both the cases, the relationship is mediated by schooling and access to other development programmes. First, CTs can boost school attendance (by reducing opportunity costs). Where free, high-quality cooked meals are provided in school (as is the case in South Africa, at least on paper), this can lead to a higher consumption of high-quality food. Second, by going to school, South African children are exposed to nutritional education, which can lead to a better utilisation of food (also outside school) and hence improve diet and food security.¹² Delany et al. (2008, p. 40) tentatively concluded that “CSG beneficiaries (74%) were more likely to report receiving free food at school than non-beneficiaries (62%)” and that all CSG recipient households were very much aware that basic medical services and preventive care were free in South Africa. Given the lack of a control group, the authors could not assess whether non-CSG households possessed more or less the same degree of knowledge. Finally, the study did not collect information on the quality of the food offered in school and did not assess changes in food security.

To the best of our knowledge, only two studies have tried to assess whether the CSG has enhanced children's anthropometric status. Agüero, Carter, and May (2007) and Coetzee (2013) reported a significant, though small, effect on the height-for-age (HAZ) score for 0-3

12 These links were not illustrated in the conceptual framework presented in Figure 1 given the necessary stylised nature of the relationships and the rarity of these situations in SSA.

year-old and 0-14 year-old children respectively. On the other hand, the impact on child weight-for-age (WHZ) was found to be insignificant (Coetzee, 2013). Given their limited set of dependent variables, these studies did not shed any light on the pathways of impact. In particular, it is not clear from the study by Agüero et al. (2007), which focused on a period in which the programme was still a CCT-based programme, what role was played by the conditionalities.¹³

Finally, a recent study by d'Agostino, Napolitano, and Scarlato (2015) provides further evidence of the positive impact of the CSG on food expenditure. Their research offers two additional insights:

- 1) the effect of the CSG on per adult equivalent food expenditure increases with the income level: food expenditure rises substantially for people living under the food poverty line;
- 2) the CSG is significantly more effective in urban areas. One possible explanation is that physical access to food is often seriously constrained in rural, marginalised areas in South Africa (Grobler, 2015; Kirsten, 2012). Given that food insecurity applies predominantly to rural areas, the CSG alone has limited capacity to tackle this problem in the countryside.

Like most Southern African middle-income countries, **Lesotho** adopted a *rights-based social protection system* in the early 2000s covering a wide range of vulnerable groups. The system consists of both a *Child Grant Programme* (CGP) and a universal *Old Age Pension*, which was introduced in 2004.¹⁴

Pellerano, Moratti, Jakobsen, Bajgar, and Barca (2014) recently conducted a rigorous impact evaluation of Lesotho's CGP. This study revealed large, positive effects on subjective or self-reported measures of food access, but only very small effects on food expenditure and consumption, and no effect on household poverty. CGP beneficiary households were found to invest more in education, but this did not translate (at least not in the short run) into higher school attendance and completion by their children. The relationship between CGP and health was unclear: although treated households did not report that their children made more frequent use of health facilities when needed, their health was significantly better than that of children in the control group. Interestingly, Pellerano et al. (2014) are among the few scholars to examine whether a CT influences hygienic practices: they reported a substantial improvement in the frequency of bathing and tooth-brushing. Finally, the food security outcome analysed in the study, i.e. the household dietary score, did not seem to be affected by participation in the CGP.

Overall, while the CGP was found to play an important protecting role by mitigating the effect of greater food insecurity in Lesotho, it did not form an adequate solution to long-term food insecurity.

13 Some scholars argue that the positive effects of the CSG on child nutrition are likely to be due mainly to factors others than the conditionalities (Glassman, Tod, & Gaarder, 2007; Manley, Gitter, & Slavchevska, 2013).

14 The rapid increase in food prices after 2005 resulted in reduced purchasing power for pensioners, and CTs became inadequate to meet the nutritional needs of this group (Croome, Nyanguru, & Molisana, 2007).

3.2 Low-income countries

Most low-income countries in SSA undertake fragmented social protection interventions, funded and managed almost entirely by donors. CTs were introduced as pilot interventions and eventually extended to other areas.

Ghana is the first member of this group that we analysed. Ghana launched a *Livelihood Empowerment Advancement Programme* (LEAP) in 2008. This programme is domestically financed from debt relief and combines transfers to households in extreme poverty with complementary services (Niño-Zarazúa et al., 2012). Moreover, some of the transfers are conditional on children's school attendance, basic health care utilisation and registration. According to Agbaam and Dinbabo (2014), this programme has had a significant and large positive impact on food consumption, frequency of utilisation of healthcare facilities and, though smaller in magnitude, on school enrolment. However, the findings of this study must be viewed with caution, given that the authors focused on just one district, used a very small sample size (i.e. 30 participating households and 30 households in the control group) and did not account for endogeneity problems in the estimates as they used simple means tests. Moreover, food consumption was measured by an imprecise, subjective indicator, defined as "satisfaction after meals".

A more rigorous study by Handa, Park, Darko, Osei-Akoto, Davis, & Daidone (2013) painted a very different picture, finding that the LEAP had not had any impact on food (and non-food) consumption, employment and the use of productive inputs. Nevertheless, the authors found a reduction in the use of extreme coping strategies due to food insecurity, such as eating less food and cutting the number of daily meals. However, although being a LEAP beneficiary was not found to increase healthcare utilisation in case of need, it did increase the likelihood of enrolment in the Ghanaian national health insurance scheme. This finding was confirmed by the qualitative work of Agbaam & Dinbabo (2014). It does not translate into better health conditions, however. Participating in the LEAP slightly reduces the likelihood of 6-17 year-old children experiencing illness, but actually increases the likelihood of disease among 0-5 year-old children.

In contrast with the experience in Ghana, several new pilot CT projects in other countries are based on pure income transfers with no conditionalities. In **Zambia**, five pilot social transfer schemes have been introduced since 2004. One of the flagship programmes, the *Child Grant Programme* (CGP), was launched in 2010 in three of the poorest districts and was targeted at households with a child under three years of age. This programme has been evaluated by both the American Institutes for Research (2013) and Daidone, Davis, Dewbre, Gonzales-Flores, Handa, Seidenfeld, & Tembo (2014). Their findings suggest that the programme has had a large impact on food consumption, the number of meals consumed, and the ownership of agricultural inputs and livestock. The CGP programme is thought to have reduced the severe poverty headcount rate, the poverty gap and squared poverty by 5.4, 10.9 and 10.8 percentage points respectively after 24 months (American Institutes for Research, 2013). There is also some evidence of a small effect on crop production, mostly driven by groundnut production. No effect was detected on curative or preventive health-seeking behaviour. Finally, the CGP programme was found to make a small contribution to diets, as measured by the household dietary score based on 12 food items. The impacts on child height-for-age, weight-for-age and weight-for-height are statistically insignificant.

In our view, there are two possible explanations for these seemingly contradictory findings, which are not mutually exclusive:

- 1) CTs alone do not influence key components like food utilisation (see section 2). They need to be integrated as part of a comprehensive food security and nutritional strategy in order to impact on final household food security outcomes ;
- 2) anthropometric indicators, especially the height-for-age indicator, change very slowly and only long-term impact evaluations would be able to identify highly significant effects on them.

Finally, a study by Handa et al. (2015) complements the study described directly above, by concentrating on education-related outcomes and child labour. In particular, their findings suggest the CGP programme leads to a reduction in child labour. In addition to being a valuable outcome in itself, from a food security perspective this a sign that less use is made of extreme coping strategies.

The introduction of a pilot programme and progressive scaling-up are also features of **Kenya's CT scheme for orphans and vulnerable children**, which is targeted at ultra-poor households. After starting life as a pre-pilot in 2004, it was extended in 2005. By the end of 2014, nearly 240,000 households were enrolled in the programme (World Bank, 2015b). Despite remaining an unconditional CT, it involves "social messaging" (Asfaw et al., 2014): the programme sends out a clear signal about the areas in which money should be invested, namely health and nutrition, especially in relation to children. The programme consists of both money transfers and services. To the best of our knowledge, this is one of a very small number of programmes in non-fragile countries in SSA that integrates CTs with nutrition-related services, such as the provision of micronutrient supplements (Bassett, 2008).

According to Asfaw et al. (2014), the programme has had a significant positive impact on food consumption. This has been due mainly to an increase in home production and the accumulation of productive assets. Moreover, the CT programme has enabled families to be more flexible in terms of their decisions on labour allocation. While the programme has not had an impact on total employment, it has lowered households' dependency on agriculture and fostered their engagement in other forms of business. The household dietary score has improved remarkably as a result (Asfaw et al., 2014). Although we have no information on the specific role played by the educational component of the project, i.e. social messaging, it is possible that this has played a role in improving access to nutrition-related services, nutrition knowledge and diet.

Another important unconditional CT scheme operated in Kenya is the *Hunger Safety Net Programme* (HSNP). This was launched in 2008 with the goal of reducing poverty and food insecurity, and increasing asset accumulation in the arid and semi-arid regions in the north of the country. Oxford Policy Management, financed by the UK Department for International Development, carried out an in-depth impact evaluation of the HSNP (Merttens, Hurrell, Manzi, Attah, Farhat, Kardan, & MacAuslan, 2013). As is the case with most other CT schemes, the programme has increased both total and food consumption, although it has not succeeded in significantly reducing income poverty and raising household accumulation of productive assets. There is basically no impact on education: as Merttens et al. (2013) explain, this is due to the fact that the barriers to education are related not so much to school fees and

other direct costs as to other factors such as cultural norms, parents' attitude to education and supply-side problems in the sector. Although HSNP beneficiaries were found to spend slightly more than non-beneficiaries on health, this did not translate into better health-seeking behaviour and health status. Finally, the project did not generate any benefits in terms of food security outcomes, i.e. household diet and child anthropometrics.

Despite being a low-income country and one of the poorest in our samples, **Ethiopia's** social protection system is very advanced. The *Productive Safety Net Programme* (PSNP) is characterised by strong domestic support and ownership, two factors that helped to focus the programme on both poverty reduction and development (Lavers & Hickey, 2015; Niño-Zarazúa et al., 2012). The PSNP was launched in January 2005 by the Ethiopian government, with the support of a group of development partners, as part of the wider Food Security Programme of Ethiopia. Its introduction reflected the increasing importance attached to comprehensive and predictable social protection and represented a major step in breaking a cycle of annual emergency appeals (World Bank, 2014). The PSNP targets food-insecure households in chronically food-insecure (rural) districts and seeks to bridge food gaps, prevent asset depletion at household level and create assets at community level (Government of Ethiopia, 2004).

In the first and second stages of the programme (2005-2009), the PSNP provided for transfers food or cash to chronically food-insecure households in four drought-prone districts (six months a year). In return, healthy and able-bodied adults were required to carry out public works (PW). Vulnerable beneficiaries with no other means of support, including disabled people and the elderly, received unconditional food and/or transfers, called direct transfer (DTs). The PW component, which applied to some 80% of programme participants, centred on soil and water conservation measures and the development of community assets such as roads, water, schools, and clinics. This was complemented by a third component: the Other Food Security Programme (OFSP), which gave households access to improved agricultural technologies including extension services, fertilisers, productive assets, credit and other services (Gilligan, Hoddinott, & Taffesse, 2008).

During the third phase (2010-2014), the programme was expanded to two new regions, Somali and Afar. The design and management of the two core components, i.e. DTs and PWs, were adjusted in order to improve the timeliness of transfers and the quality of public works, and to shift the focus more to cash transfers. The OFSP component was radically changed and renamed as the Household Asset Building Programme (HABP). The latter was designed to build household assets, but with improved financial institutional structures.

Excluding South Africa, Ethiopia's PSNP is currently the largest social transfer scheme in SSA, reaching around 7.6 million beneficiaries by 2012 (World Bank, 2013b). A number of impact evaluations have been conducted during the past decade. Gilligan, Hoddinott, and Taffesse (2009) and Berhane, Gilligan, Hoddinott, Kumar, & Taffesse (2014) found, for example, that participation in the PW component of the PSNP alone did not significantly improve access to food. Only if the PW component is accompanied by participation in the third component of the PSNP (i.e. OFSP in the first study and HABP in the second) is it found to have a significant effect on the accumulation of agricultural assets, agricultural productivity and food consumption. The study performed by Debela, Shively, and Holden (2015) generated preliminary evidence that the PSNP had a positive – though small – impact on child

anthropometrics. However, this study did not distinguish between the PW and the DT components of the PSNP. To the best of our knowledge, only the study by Berhane et al. (2011) examined the specific contribution of the DT component, even though it did not break them down into CTs (which would have been of direct interest to this paper) and food transfers. The authors reported that the value of the transfer received and the number of years of involvement – two measures of the duration of participation in the programme – had a positive impact on several indicators of food access and the accumulation of productive assets, as well as on a household's dietary diversity score.

Another development in Ethiopia was the launch of the *Social Cash Transfers Pilot Programme* in 2011 by the Regional Government of Tigray together with the Bureau of Labour and Social Affairs and with the support of UNICEF. This programme targets labour-constrained and ultra-poor households in the Tigray region. In particular, it aims to alleviate poverty and hunger among orphans and vulnerable children (OVC), elderly people and people with disabilities, by providing regular cash transfers and linking these with the provision of social welfare services (Berhane, Devereux, Hoddinott, Nega Tegebu, Roelen, & Schwab, 2012). A comprehensive evaluation of this CT was conducted by the IFPRI in 2015, in cooperation with the Institute of Development Studies (Berhane, Devereux, Hoddinott, Hoel, Roelen, Abay, Kimmel, Ledlie, & Woldu, 2015). This showed that the pilot had generated certain benefits in terms of access to food, slightly increasing the household calorie intake and reducing the food gap,¹⁵ and in terms of diet. However, it proved to be ineffective in improving the nutritional status of children and mothers.

A number of social protection schemes have also been in operation in **Malawi** for some years now, including PW, CT and input subsidy programmes. However, they are not as well integrated as the Ethiopian programmes are. In 2006, with funding from the Global Fund through the National AIDS Commission, Malawi launched a pilot 'Social CT' scheme in the district of Mchinji. Since 2009, as part of Malawi's National Social Welfare Policy, the Social CT scheme has gradually been extended to the country's other 17 districts, reaching nearly 56,000 households (UNICEF, 2014). Targeted at ultra-poor (i.e. the 10% lowest-income households in each district) and labour-constrained households, it is designed to alleviate poverty and hunger, and raise school enrolment rates among these households. Transfers are made to the head of the household: since female-headed households are more likely to meet the eligibility criteria, however, the beneficiaries are predominantly female.

The pilot project has been extensively studied by international scholars. The first evaluation study, conducted by Miller, Tsoka, and Reichert (2008; 2011), revealed positive effects on livestock ownership and, above all, very large positive effects on health-seeking behaviour and the health status of children and adults. Their qualitative research indicated that the additional money was used mostly to buy food, school uniforms and soap (also very important from a food security perspective). The introduction of social CTs resulted in a remarkable improvement in the beneficiaries' diet. As in many other countries and programmes, however, the programme was not found to have had any significant effects on children and adults' anthropometric status. Covarrubias, Davis and Winters (2012) concentrated on the CTs' economic effects. They found that the programme had both an important production function,

15 The food gap is a subjective measure of access to food. It involves asking households during how many of the past 12 months they have had difficulty meeting their food needs.

as it boosted investments in agricultural assets and household food consumption thanks to own production, and a protective function, as it significantly reduced the adoption of negative coping strategies, such as selling productive assets (especially for households with able-bodied members) and taking children out of school. The authors did not collect information on food security.

Thanks to its gradual extension to other districts, the Malawi Social CT scheme offers an ideal opportunity to investigate the causal effects of the programme. A recent, in-depth evaluation of the scheme following its extension to the districts of Salima and Mangochi found that it made a large, positive contribution to food entitlements in the short term (i.e. higher food consumption, more meals and lower poverty) and a probable contribution in the medium to long term, thanks to an increase in livestock, agricultural assets, crop production and paid work (Handa et al., 2015). Again, however, the programme did not help to improve children's nutritional status.

In 2010, **Tanzania** launched one of the very few CCT schemes in SSA, the *Tanzania Community-Based Conditional Cash Transfer* programme. Designed as a randomised control trial, the programme operates in three districts. It provides transfers to poor households, depending on the number of vulnerable children and elderly members. These households have to satisfy the following conditions:

- a) for pre-school children: visit a health clinic at least six times a year,
- b) for 7-15 year-old children: enrol in school and achieve at least 80% attendance;
- c) for the elderly: visit a health clinic at least once a year.

Locally elected community management committees are responsible for monitoring compliance with these conditions (Evans, Hausladen, Kosec, & Reese, 2014).

Evans et al. (2014) estimated the impact of this CCT scheme on a number of indicators. Surprisingly, they did not find any evidence of the programme's effects on food and overall expenditure, although they did find positive effects on livestock ownership. On the other hand, the programme was found to have had a remarkable impact on education and different measures of health-related behaviour and health status. As in the case of Ghana, the extra income from the CTs enabled many households to enrol in the health insurance scheme. In accordance with the programme conditions, there was a significant rise in the frequency of visits to health clinics among CCT recipients during the period until the mid-term review (2010-mid-2011). However, the frequency of visits declined again afterwards. This was probably due to the fact that the beneficiary households had already become aware of right health behaviours and reduced the number of their visits after the initial period, as monitoring of compliance became more lax (Evans et al., 2014). While further research is needed to confirm this, the fact that improvements were registered only in those areas where conditions applied suggests that the conditions themselves played an important role. Finally, no short-term effects were detected on any of the anthropometric indicators for 0-4 year-old children, i.e. height, weight and middle-upper-arm circumference.

Finally, **Mozambique** was actually one of the first countries in the region to implement a CT scheme, which it did in the early 1990s. The *Food Subsidy Programme* (PSA) targets poor households whose head is old, disabled or chronically ill. The programme has increased both

its coverage and transfer size significantly in the course of time. In 2008-2009, in particular, it was extended to new geographical areas with the aid of financial support from the UK Department for International Development and the Dutch embassy, thus creating a good opportunity to analyse its impact. Though only conducted on a quasi-experimental basis, an evaluation by Veras Soares and Teixeira (2010) indicated that the PSA had had a large, positive effect on food expenditure and the number of meals consumed. They found that, although it had not changed the adult labour supply, it had helped to reduce child labour. A similar finding emerged from a study performed by Kondratjeva (2010). Finally, the PSA has not had any effects on education and health, although it has significantly reduced wasting (or low weight-for-height), one of the three anthropometric indicators for 0-5 year-old children.

Table 1: Evidence of the impact of CTs on food security in SSA								
Author & year	Country	Programme	Effect on food entitlements	Effect on access to food	Effect on non-food entitlements	Effect on access to other FS items	Effect on nutritional conversion factors	Effects on food security outcomes
<i>Middle-income countries (2005 classification)</i>								
Agüero et al. 2007	South Africa	Child Support Grant						Children's (0-3) HAZ (+)
Williams 2007	South Africa	Child Support Grant	Adult participation in the labour force (0)	Child (7-8) hunger (reported by mother) (---)				
Delany 2008	South Africa	Child Support Grant	Access to school meals (+)					
Coetzee 2013	South Africa	Child Support Grant	Household food expenditure (++)					Children's (0-14) HAZ (+); children's WHZ (0)
D'Agostino et al. 2015	South Africa	Child Support Grant	Food expenditure (++); food poverty (---)					
Pellerano et al. 2014	Lesotho	Child Grant Programme	Food expenditure (+); poverty (0)	Food gap (---); self-reported food security (+++)	Children's use of healthcare (0); hygienic practices (+++)	Children's health status (++)		Household food consumption score (0); Household dietary diversity (0)
<i>Low-income countries (2005 classification)</i>								
Agbaam & Dinbabo 2014	Ghana (1 rural district)	LEAP	Satisfaction after meals (+++)		Frequency of utilisation of healthcare facilities (+++)			
Handa et al. 2013	Ghana	LEAP	Food expenditure (0); household coping strategies: cutting meals (--), less food (--); paid work (0); input use (0)		Use of curative health services (0); preventive care (0); enrolment in health insurance (++)	Child (0-5) illness (+); child (6-17) illness (-)		

Table 1 (cont.): Evidence of the impact of CTs on food security in SSA								
Author & year	Country	Programme	Effect on food entitlements	Effect on access to food	Effect on non-food entitlements	Effect on access to other FS items	Effect on nutritional conversion factors	Effects on food security outcomes
<i>Low-income countries (2005 classification) (cont.)</i>								
American Institutes for Research 2013	Zambia	Child Grant Programme	Food consumption (+++); poverty headcount (-); poverty gap (-); use of agricultural inputs (++); agricultural tools (+); livestock (+++); crop production (+)	Meals/day (++); FANTA food security scale (++)	Curative/preventative health-seeking behaviour (0)			Household dietary diversity (+); children's (0-5) HAZ (0), WAZ (0), WHZ (0)
Handa et al. 2015	Zambia	Child Grant Programme	Child labour (-)					
Asfaw et al. 2014	Kenya	Cash Transfers for OVC	Productive assets (+); food consumption (++); total household employment (0); agricultural employment (--); non-agricultural employment (++)					Household dietary diversity (++)
Merttens et al. 2013	Kenya (North)	Hunger Safety Net Programme	Mean consumption expenditure (++); food consumption (++); poverty (0); livestock (+); productive assets (0)		Seeking health care when needed (0); expenditure on health (+)	Illness (0)		Dietary diversity score (0); children's stunting (0); wasting (0); underweight (0)
Debela et al. 2015	Ethiopia	PSNP: Direct Transfers and Public Works						Children's (0-5) WHZ (++)
Berhane et al. 2011	Ethiopia	PSNP: Direct Transfers	Productive assets (+++)	Food gap (-); months of food security (++)				Household dietary diversity (+++)

Table 1 (cont.): Evidence of the impact of CTs on food security in SSA								
Author & year	Country	Programme	Effect on food entitlements	Effect on access to food	Effect on non-food entitlements	Effect on access to other FS items	Effect on nutritional conversion factors	Effects on food security outcomes
<i>Low-income countries (2005 classification) (cont.)</i>								
Berhane et al. 2015	Ethiopia (Tigray region)	Social Cash Transfer pilot programme in Tigray region		Food gap (--); household calories (+)				Household dietary diversity (++); children's height (0), stunting (0), weight (0), wasting (0); mother's BMI (0)
Covarrubias et al. 2012	Malawi (Mchinji District)	Social Cash Transfer pilot scheme	Agricultural tools and livestock (++); selling assets (---)					
Miller et al. 2008; Miller et al. 2011	Malawi (Mchinji District)	Social Cash Transfer pilot scheme	Household livestock (++)		Adults and children seeking health care (+++)	Adult and child illness (--)		Household dietary diversity (+++); underweight children (0); household heads' BMI (0)
Handa et al. 2015	Malawi (districts of Salima and Mangochi)	Social Cash Transfer programme (scaled up)	Food consumption (++); poverty (++); livestock (++); crop production (++); agricultural assets (++); paid work (++)	Meals/day (++)	Adult illness; curative care (++)	Child illness (--)		Children's WAZ (0); HAZ (0); WHZ (0)
Evans et al. 2014	Tanzania (two districts)	Community-based Conditional Cash Transfer	Food expenditure (0); total expenditure (0); livestock (++)		Health clinic visits (-); participation in public health insurance (+++)	Household member sick last month (--); child sick last month (---); no. of days the child was sick (0)		Children's (0-4) height (0), weight (0), middle-upper-arm circumference (0)
Veras Soares and Teixeira 2010	Mozambique	Food Subsidy Programme (PSA)	Food expenditure (+++); adult labour supply (0); child labour (--)	Meals/day (++)	Health (0)			Children's wasting (--), stunting (0), underweight (0)
Source: Authors								

4 Concluding remarks and policy recommendations

Alleviating food insecurity is one of the priority goals of the international development community, especially in rural SSA. The main problem in this region is not food availability but hunger, i.e. access to food. Agriculture is a basic source of income for rural people, but a strategy based only on the expansion of the agricultural sector is unlikely to be a very effective tool for alleviating food insecurity. Carefully calibrated social protection interventions are required in order to reach chronically poor and food-insecure households, many of which include a number of labour-constrained members and own either no land or very small plots of land. In this respect, we need to examine the potential of the rapidly expanding cash transfer programmes in the region and identify the evidence of their impact to date.

This paper first proposes a new conceptual framework that links cash transfers to the different components of food security in the short to medium term. This framework does not include channels such as children's education or effects on the local economy, as these affect household food security only in the long term. We used the framework to summarise the evidence in SSA, bearing in mind the differences between programmes in terms of stated objectives and target groups. Our analysis shows that CTs have a significant, positive impact on food entitlements – in particular on the accumulation of productive assets - and on direct measures of access to food. This is particularly true in countries like Zambia, Malawi, Ethiopia (but only for the PSNP) and Kenya (for the CT scheme for OVC). The only obvious exceptions are Ghana and Tanzania, where not even monetary indicators such as food expenditure were affected by the introduction of CTs.

The evidence on the effects of CTs on non-food entitlements and direct measures of health and hygienic status is more mixed. The programmes were found to affect output and outcome measures of health and/or sanitation and hygiene in Malawi and Lesotho and, to a lower extent, Tanzania. In contrast, no effect was found in Ghana, Zambia and in Kenya (in the shape of the Hunger Safety Net Programme).

As Figure 1 shows, there is no theoretical reason to expect CTs alone to have an impact on issues such as nutritional knowledge (defined here as “nutritional conversion factors”). None of the empirical studies we examined even made an attempt to focus on these dependent variables.

Finally, did the CTs affect food security outcomes? There is some evidence of a positive impact on household dietary variety in Ethiopia (i.e. both programmes), Malawi and Kenya (i.e. the programme for OVC). No effects were identified in Lesotho, Zambia and Kenya (i.e. the HSNP programme). CTs were not found to have an impact on children's and women's anthropometric status. The only exceptions are the CT programmes in South Africa and Mozambique, where scholars have found some minor positive effects on certain indicators.

Based on this extensive review, we can draw a number of conclusions that are of direct relevance to policy-makers:

- 1) CTs have great potential for alleviating hunger, i.e. lack of access to an adequate amount of food. Their actual success depends, however, on whether the programmes are properly implemented. We cross-checked our results on the effectiveness of CTs in

terms of food access against the available studies on the strengths and weaknesses of these programmes' design and operational features. This comparison revealed the importance of certain key features of these programmes:

- *Targeting*: Reaching the target population is a prerequisite for a CT scheme to affect poverty or food insecurity. CTs use very different targeting mechanisms, and there is no pre-determined ideal solution as all depends greatly on the local context. Whether community-level targeting works, for example, depends on local institutional arrangements, social cohesion and the incidence of corruption. While interventions seem to have reached the target population in Ghana (Tsimpo & Wodon, 2012) and Tanzania (Evans et al., 2014),¹⁶ certain problems were identified in the other two countries where results were not positive from a food security perspective, i.e. Kenya (HSNP) and Mozambique. A study by Cosgrove, Hannigan, Kidd, & McPherson (2011) revealed that the community targeting used for the HSNP in Kenya was effective in reaching the poorest, i.e. the group that registered the greatest improvements (Merttens et al., 2013), but often failed to properly identify the other poor. The dependency ratio criterion was problematic because it failed to reach the poor with a low dependency ratio (an exclusion error) and incorporated the non-poor with a high dependency ratio (an inclusion error). Despite generally acceptable targeting outcomes (Handa et al., 2015), the CCT programme in Mozambique did not include a sufficient number of vulnerable children, was biased towards smaller households, and featured a number of unclear implementation rules, resulting in more arbitrary interpretation (Cunha, Pellerano, Mueller, Lledo, Xiao, & Gitton, 2013).
- *Regularity of payments*: the basic assumption behind CT schemes is that payments are regular. Only if people feel confident that they will receive cash on a regular – usually monthly or bi-monthly – basis will they make long-term plans about consumption, saving and investment (Lagarde, Haines, & Palmer, 2009). Irregularity in payment is a big problem in Ghana, where it was reported that the next transfer after the cash disbursement in May 2011 was eight months later (Handa et al., 2013; UNICEF-ESARO, 2015). In Mozambique, a complicated disbursement system involving a number of different actors led to frequent delays in payment (World Bank, 2009). In Kenya, on the other hand, payments to HSNP beneficiaries have been fairly regular (Oxford Policy Management & Institute of Development Studies, 2012). CT programmes that have had a bigger impact on food security, primarily Zambia's Child Grant Programme (UNICEF-ESARO, 2015) and Kenya's CT programme for OVC (Ward, Hurrell, Visram, Riemenschneider, Pellerano, O'Brien, MacAuslan, & Willis, 2010), are characterised by timely payments to beneficiaries.
- *Transfer size*. The monetary value of the transfer should be big enough to change the life of the beneficiaries, but not so big as to generate negative incentives to work and cause inequality and conflicts between those just below the eligibility threshold and those just above it (Handa, Huang, Hypher, Teixeira, Soares, & Davis, 2012). There is now some evidence about the necessary minimum threshold: 20% of the

16 The targeting mechanism for the CCT programme in Tanzania is based on the combination of two methods: community targeting and proxy means-testing for verification purposes (i.e. to minimise exclusion and inclusion errors). Moreover, people can make an official appeal if they believe that they have erroneously been excluded from the programme.

consumption of the poor. The size of transfers in countries like Malawi, Zambia, Tanzania and Kenya (both programmes), is above this threshold (UNICEF-ESARO, 2015; African Development Bank & Bill and Melinda Gates Foundation, 2015). The threshold in the case of the LEAP in Ghana is only about 11% (Handa et al., 2013). The PSA in Mozambique was supposed to pay 30% of minimum wage. However, not only was the minimum wage not updated in the following years but, more importantly, there was a high rate of inflation, thus significantly reducing the transfer size, which became too low (Cunha et al., 2013). Moreover, many beneficiaries claimed to have received significantly less than the amount that was due to them (Garcia & Moore, 2012). The transfer size was raised substantially, first in 2011 and later in 2014. However, these increases were made after the impact evaluations examined in this paper.

- *Political support*: in order to have a long-lasting effect on food security, CT programmes and social protection schemes in general need to have strong political support. Ideally, CT schemes should be form part of a broader, nationally owned, anti-poverty strategy. The best examples are found in South Africa and Ethiopia, with the PSNP. The government also played a vital role in Ghana in developing the National Social Protection Strategy, including a range of interventions – including LEAP – in favour of people living in situations of extreme poverty and vulnerability. Similarly, government ownership of the PSA in Mozambique does not seem to be a problem. It is, in fact, in line with government’s commitment to ensure a basic minimum standard of living for the most marginalised groups in society (Overseas Development Institute, 2013). A lack of political support is a particularly important problem in Kenya, where the HSNP has been perceived to date as strongly donor-driven. The government did not play a prominent role in the first phase of the programme, i.e. 2009-2013 (Garcia & Moore, 2102). Interestingly, the great benefits generated by the CT programme in Zambia risk being undermined in the long term by the absence of strong political support from the national government and local elites, and the absence of a coherent anti-poverty and nutritional strategy (Niño-Zarazúa et al., 2012).
- 2) CTs alone cannot impact on nutritional knowledge and practices, or generally speaking, on the utilisation of food. In other words, they can directly affect food security outcomes only in specific cases, where the lack of an adequate, varied diet is due exclusively to economic hardship. An integrated approach and nutrition-sensitive social protection is required in order to enhance the multiple, dynamic components of food security. In short, CT schemes should form part of a broader package of interventions. The simple combination of CTs with nutritional education – often minor components of multi-sectoral interventions – has great potential for affecting nutritional outcomes, as was illustrated by the results of a recent experiment in Bangladesh (Ahmed et al., 2016).

This rationale is also evident in the success of the CT programme for OVC in Kenya and in the plan for the new stage of the PSNP in Ethiopia. Given the clear evidence of the positive effects on access to food, but the limited evidence of effects on nutrition, the PSNP is planned to be closely connected to the existing National Nutrition Programme, in particular the Community-Based Nutrition programme (CBN), with effect from 2016 (World Bank, 2014). The CBN provides mothers with nutritional education and children and mothers with supplementary food. Similarly, the Rapid

Response Child-Focused Social Cash Transfer and Nutrition Security Project in Senegal, funded by the World Bank and designed to better link emergency with development interventions aiming to improve child nutrition, combines a CCT element with nutritional education and a number of health and nutritional services (SUNRAY, 2012).

Given the poor institutional arrangements and limited administrative and monitoring capacities of many low-income countries in SSA, the use of conditionalities does not seem to be a practical option. Moreover, studies of conditional CT schemes in Latin America have not yet demonstrated their added value (Gaarder, 2012). However, the possibility of introducing conditions relating to the attendance of basic courses in nutritional education should not be rejected outright. This is because these are fairly simple interventions, requiring neither a large budget nor great implementation and monitoring capacities. In rural African contexts, this type of conditional cash transfer is likely to generate substantial added value. Conditions may be “soft”, as in the case of the CT scheme for OVC in Kenya, where implementers were required to send clear “messages” to the beneficiaries that part of the cash should be spent on specific food products (e.g. micronutrients).¹⁷

Finally, CT programmes, especially those subject to conditionalities, should be accompanied by supply-side interventions. As the rise in beneficiaries’ purchasing power may place further pressure on economic infrastructures, health clinics and schools, interventions aimed at improving services in these areas are required (Maluccio, Murphy, & Regalia, 2010; African Development Bank & Bill and Melinda Gates Foundation, 2015). These complementary investments are commonplace in Latin America (Behrman, Parker, & Todd, 2005; Saavedra & Garcia, 2012; Samson, Van Niekerk, & MacQuene, 2010), while they are usually absent in SSA.

The PSNP is again an interesting example. In addition to linking CTs with public works, and to nutritional services in its fourth phase, it has a productivity-enhancing component (see section 3.2). By facilitating access to credit, agricultural inputs and other services, it links beneficiaries to the economic system, thereby laying the foundations for a sustainable graduation from social protection, as well as from poverty and food insecurity. This increasing complexity in the design of comprehensive social protection systems requires considerable institutional capacity, however. Empirical studies showed that the implementation of this last component of the PSNP varied significantly across Ethiopia’s regions (Berhane, Hoddinott, Kumar, Taffesse, Diressie, Yohannes, Sabates-Wheeler, Handino, Lind, Tefera, & Sima, 2013), and graduation has generally been limited so far (Devereux, Sabates-Wheeler, Tefera Taye, Sabates, & Sima, 2014). In conclusion, in Ethiopia as well as in other countries in SSA, there is considerable scope for donors and international organisations to undertake capacity-building activities in order to improve the public sector’s ability to supply these services, as has occurred, for example, in Bangladesh, Cambodia and Mexico (Fiszbein et al., 2009).

17 Bastagli (2010) argues that, in Latin America, the communication of desired behaviours has often had a large impact on the use of educational and health-related services, irrespective of the imposition of conditions.

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