Understanding the linkages between social safety nets and childhood violence: A review of the evidence from low- and middle-income countries

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Abstract:

As many as one billion children experience violence every year, and household- and community-level poverty are among the risk factors for child protection violations. Social safety nets are a main policy tool to address poverty and vulnerability, and there is substantial evidence demonstrating positive effects on children’s health and human capital. This paper reviews evidence and develops a framework to understand linkages between non-contributory social safety nets and the experience of childhood emotional, physical and sexual violence in low- and middle-income countries. We catalogue 14 rigorous impact evaluations, 11 of which are completed, analyzing 57 unique impacts on diverse violence indicators. Among these impacts, approximately one in five represent statistically significant protective effects on childhood violence. Promising evidence relates to sexual violence among female adolescents in Africa, while there is less clear evidence of significant impacts in other parts of the developing world, and on young child measures, including violent discipline. Further, few studies are set up to meaningfully unpack mechanisms between social safety nets and childhood violence; however those most commonly hypothesized operate at the household level (through increases in economic security and reductions in poverty-related stress), the interpersonal level (improved parental behaviors, caregiving practices, improved psychosocial well-being) and at the child-level (protective education and decreases in problem or risky behaviors). It is important to emphasize that traditional social safety nets are never designed with violence prevention as primary objectives, and thus should not be considered as standalone interventions to reduce risks for childhood violence. However, social safety nets, particularly within integrated protection systems, appear to have potential to reduce violence risk. Linkages between social safety nets and childhood violence are understudied, and investments should be made to close this evidence gap.

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1. Introduction

Physical, emotional or sexual violence is experienced by as many as one billion children every year (Hillis et al. 2016; UNICEF 2014a), and has detrimental impacts on children’s development, their ability to learn, and their right to healthy and productive lives (Abramsky et al. 2011; Arseneault et al. 2010; Devries et al. 2014; Gershoff 2002; Gini and Pozzoli 2013; Jennings et al. 2015; Paolucci et al. 2001; Ports et al. 2016; Ogando Portela and Pells 2015). Violence experienced in childhood is also of concern because of its intergenerational nature, whereby violent behaviors are typically normalized in childhood, putting children who experience or witness violence at a higher risk of experience and perpetration in adulthood (Abramsky et al. 2011; Fleming et al. 2015; Fulu et al. 2013; Jennings et al. 2015). The United Nations Convention on the Rights of the Child (UNCRC), recognizes a child’s right to protection from all forms of violence. Adopted in 1989, it is the most widely ratified human rights treaty (UN Committee on the Rights of the Child (CRC) 2011; UNICEF 2014b).

Despite these recognized rights, childhood violence rates remain high globally. In 62 low- and middle-income countries (LMICs), 4 out of 5 children aged 2 to 14 experienced physical punishment or aggression from a parent or caregiver in the past month (UNICEF 2014a), and a global meta-analysis with prevalence rates from 331 samples and nearly ten million participants finds prevalence rates for child sexual abuse at 11.8% (18.0% for girls and 7.6% for boys) (Stoltenborgh et al. 2011). While risk and protective factors for childhood violence have been studied, effective prevention strategies, particularly in LMIC settings, remain elusive. Global policy attention to the prevention of childhood violence was renewed with the adoption of the UN Sustainable Development Goals in 2015, with the commitment to ending abuse, exploitation, trafficking and all forms of violence against and torture of children (Goal 16.2).

Household- and community-level poverty are among the risk factors for child protection violations (Akmatov 2011; Berger 2004; Butchart et al. 2006; Elgar et al. 2009; Gilbert et al. 2009; Meinck et al. 2015; OECD 2011; Pelton 2015; Shook Slack et al. 2011). There is however, little rigorous evidence demonstrating whether this relationship is causal, with some research suggesting that certain
child protection issues, including sexual exploitation, unnecessary family separation, child labor and early marriage have a more direct link to poverty, whereas other types of childhood violence, such as child sexual abuse and violent discipline, might be more indirectly related to poverty (Barrientos et al. 2014; Markus and Page 2014; Sheahan 2011). Regardless, economic pressures have been broadly shown to leave children at increased risk of violence (Butchart et al. 2006; Butchart and Hillis 2016; OECD 2011).

In recent years, social safety nets (SSNs) have emerged as a primary policy tool to address poverty and vulnerability. SSNs (also referred to as social assistance or transfers) are non-contributory programs, designed to provide regular and predictable support to poor and vulnerable populations, and are key components of larger social protection systems (Honorati et al. 2015). There is strong evidence that cash transfers have resulted in considerable reductions in poverty globally (Miller and Samson 2012). Further, a growing evidence base around the world is documenting the role that SSNs play in improving child well-being, regardless of whether these programs are explicitly child-focused. Child well-being outcomes commonly studied in relation to cash transfers include nutrition, illness, schooling, mental health and stress (Lagarde et al. 2007; Owusu-Addo and Cross 2014). Relatedly, the relationship between SSNs and intimate partner violence (IPV) among adults has increasingly been studied (Bobonis et al. 2013; Hidrobo et al. 2016).

Despite the hypothesized potential of SSNs to reduce childhood violence, little attention has been paid to these linkages by researchers, and hence few studies empirically or theoretically document the pathways through which SSNs affect childhood violence, whether positively or negatively. Most available evidence concerns broader child protection issues rather than childhood violence specifically. For example, systematic reviews have examined links between social protection and child protection outcomes, including birth registration, child labor, family separation and early marriage (Barrientos et al. 2014; Sheahan 2011); and impacts of small- and medium-scale economic strengthening interventions on child labor, child marriage, sexual violence, physical violence, gender-based violence (GBV) and inadequate care in crisis settings (Chaffin 2011; Chaffin and Mortenson Ellis 2015; Markus and Page 2014). Despite their stated focus, neither the Markus and Page (2014) nor the Barrientos et al. (2014)
reviews found examples of empirical evidence linking social transfer programs to reductions in sexual or physical violence. The Chaffin and Mortenson Ellis (2015) review included only one study with a measure on GBV, namely ‘having sex unwillingly’ asked of adolescent girls. This review also considered adverse effects of economic strengthening interventions on child well-being outcomes, and found that while most programs reported one or more positive effects on child well-being, about one in five also reported at least one adverse effect. No clear patterns emerged regarding these adverse impacts, but they often included increased participation by children in work activities. Finally, a review paper examining the role of cash transfers in the protection of children in emergencies highlighted the lack of evidence around program impacts on psychosocial distress, sexual exploitation and physical violence (Thompson 2014). Across existing reviews, authors conclude that while these programs may have had the potential to affect violence, this potential has not been evaluated.

This paper aims to address this research gap by reviewing the evidence base in LMICs linking SSNs and experiences of childhood violence. In particular it aims to assess to what extent and through which pathways non-contributory SSNs can help protect children from childhood physical, emotional and sexual violence drawing on definitions proposed by UNICEF and Together for Girls (UNICEF 2010; UNICEF 2014a; Together for Girls 2016). We focus on the following questions: 1) What are the key pathways through which SSNs have the potential to affect childhood violence? 2) What rigorous evidence exists on the impact of SSNs on childhood violence? 3) Through which mechanisms are impacts realized, or in the cases where no impacts were found, what hypotheses exist as to mechanisms which could strengthen impacts? 4) Where SSNs have actively tried to address issues related to childhood violence, what program modifications or strategies have been pursued? and 5) What are some of the key research questions and gaps looking forward?

This paper does not constitute a systematic review of the evidence; rather, it is a comprehensive synthesis of a largely emerging and fragmented evidence base, with a focus on understanding existing evidence and gaps that need to be filled in order to support policy makers seeking to utilize SSNs in their effort to prevent childhood violence. Section 2 presents a framework, Section 3 describes the
methodology, and Section 4 discusses the findings from this review. Section 5 concludes with a discussion of the limitations of the review, implications for program design and highlights ongoing research efforts and key gaps on the evidence base linking SSNs and childhood violence.

### 2. Social Safety Nets and Childhood Violence: A Framework

In this section we present a framework of hypothesized ways in which SSNs can influence childhood violence. First, we define some key concepts.

Consistent with the UNCRC, a child is defined as a person under the age of 18. Following the standard UN-wide categorization of adolescents and young people, an adolescent is defined as a person aged 10–19 years and young people as those aged 10–24 years (UNICEF 2012).

Our focus on SSNs includes five of the six main types of programming identified in the World Bank’s state of Social Safety Nets 2015. These include 1) conditional cash transfers (CCTs), 2) unconditional cash transfers (UCTs), 3) unconditional in-kind transfers, 4) public works (PW) or cash for work (CfW) and 5) vouchers or fee waivers. SSN programming bundled with other services or intervention components, for example additional livelihoods training, or community information sessions are considered and referred to in this review as ‘plus’ (e.g. ‘CCT plus’ or ‘PW plus’).

Although we recognize that all forms of child maltreatment are important, we focus on childhood physical, emotional and sexual violence experienced by children under the age of 18, drawing on definitions proposed by UNICEF and Together for Girls (UNICEF 2010; UNICEF 2014a; Together for Girls 2016). We therefore do not consider outcomes such as child marriage, neglect or negligent treatment, female genital mutilation/cutting (FGM/C), child labor or witnessing IPV among adult

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1 As the focus of the review is on the level of the household, school feeding programs were excluded. Insurance schemes were also excluded unless they were part of a bundled program – as the mechanisms are likely to be quite different than for traditional SSNs.

2 We refer to ‘plus’ as any additional programming which may be bundled with basic SSNs, while recognizing that this design variation is infinitely diverse, ranging from light add programming such as messaging and behavioral change communication, to large multi-component interventions which may even be larger than the economic component of the SSN itself.
We consider violence perpetrated by peers, intimate partners or adults, in the context of the home, school or community. In addition, while recognizing that children are themselves common perpetrators of violence, we consider only victimization, and not perpetration of violence. Physical violence, both fatal and non-fatal, is understood to include homicide, violent physical discipline (also known as corporal punishment) and all other forms of torture, cruel, inhuman or degrading treatment or punishment as well as physical bullying and hazing. Emotional violence is understood to include violent psychological discipline and all other non-physical forms of hostile and degrading behavior, as well as psychological bulling and hazing. Sexual violence comprises sexual abuse (i.e. abusive sexual contact, attempted non-consensual sex acts, coerced/forced sex acts), sexual exploitation (the exploitative use of a child in commercial sexual activities or other unlawful sexual practices in which cash, goods or favors are exchanged for sex acts) and non-contact sexual violence (e.g. verbal sexual harassment, use of children in pornographic performances and materials). Although the discrete categorization of the different forms of childhood violence ignores the fact that children are often exposed to simultaneous and overlapping forms of violence, it has been organized as such for analytical purposes. In addition, while we are guided by these broad definitions, each study included operationalizes its own unique definitions of violence indicator(s), falling into the broad categories as defined above.

Our framework (Figure 1) articulates hypothesized direct and indirect pathways by which SSNs may positively or negatively affect childhood violence (Jaffe et al. 1990; Repetti et al. 2002). We draw on frameworks by Fein and Lee (2003), Markus and Page (2014) and Barrientos et al. (2014), who examine social protection and child well-being, however either differ in their definition of programming, and/or do not describe in detail the specific pathways and impacts on childhood physical, emotional or sexual violence, as we aim to do here. As highlighted in Fein and Lee (2003), the number and nature of different

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3 While exposure to IPV among adult household members is often considered a form of emotional violence, we do not include it in our definition of emotional violence, as evaluation studies examining the link between SSNs and IPV rarely assess if children witnessed (were exposed) to IPV or not, and impacts of SSNs on IPV experienced by adults are being reviewed elsewhere.

4 Note that perpetration also includes self-harm (fatal and non-fatal). Despite search criteria that allowed us to assess potential impacts of SSNs on suicide, we did not find any studies which measured impact on this outcome.
pathways of potential influence are such that we cannot predict the net impact of SSNs on experiences of childhood violence precisely. However, we can hypothesize the direction of various relationships and the impacts that SSNs can have on factors along the causal pathway. Hence, pathways in our framework are hypothetical, and as yet, not necessarily supported by evidence from the studies reviewed. Rather the framework serves as a starting point for understanding empirical findings and research gaps, and aims to inform future evaluation studies.

Given that SSNs generally target households, our framework is focused on potential mechanisms at the micro (household- and individual-) level. It considers these mechanisms in the wider context of the meso- and macro-level context (structural, institutional and community). For SSNs to affect the risk of violence, the impacts are generally hypothesized to work first through household-level mechanisms, and subsequently through caregiver/interpersonal-level mechanisms or directly through child-level mechanisms (or both). In Figure 1, drawing on existing literature, we illustrate hypothesized pathways between mechanisms where positive relationships are denoted by large dash arrows, negative relationships by small dash arrows and ambiguous relationships by solid arrows.

2.1 Household-level mechanisms

At the household-level, SSNs may affect economic security, labor force participation, intra-household power dynamics (e.g. women’s bargaining power), and overall stress levels. Income transfers have been shown to improve poverty-related outcomes such as food insecurity, consumption, asset ownership, and housing conditions (Adato and Bassett 2009; Davis et al. 2016; FAO 2015; Fiszbein et al. 2009; Kenya OVC-CT Evaluation Team 2012). Further, these programs may alter labor participation of household members (including children), which has further implications for income and time use (de Hoop and Rosati 2014; Handa et al. 2016). Related, household economic survival strategies and poverty can play an important role in decisions around early marriage (Walker 2012). Early marriage in turn is a risk factor for childhood violence. The evidence to date around cash transfers and early marriage is mixed (Baird et
al. 2011; Handa et al. 2015; Nanda et al. 2014), but does suggest that cash transfers may help to delay marriage, particularly in the context of sub-Saharan Africa (SSA).

Economic insecurity, including food insecurity are major sources of daily stress. By alleviating this insecurity, transfers may reduce both acute and chronic stress. Studies of two cash transfer programs (one governmental in Mexico and one non-governmental program in Kenya) showed mixed results on cortisol levels, a biomarker of chronic stress, among adults and children living in beneficiary households (Fernald and Gunnar 2009; Haushofer and Shapiro 2016). Evidence linking cash transfers and self-reported perceived stress, is also mixed, with some studies reporting reductions in stress (Haushofer and Shapiro 2016; Ozer et al. 2011) and at least one other finding no impacts (Paxson and Schady 2010).

Transfers (and increased access to cash, information, social networks, and services that sometimes complement cash benefits), as well as increased female labor force participation through PW/CfW, may alter intra-household power dynamics and women’s bargaining power. A review of programming aimed at strengthening household economic security (including CCTs and UCTs) on women’s empowerment and nutrition found mixed evidence from quantitative impact evaluations, with positive impacts on women’s empowerment generally found only in qualitative evaluations of CCTs (van den Bold et al. 2013). Mixed and non-significant impacts of SSN on quantitative measures of women’s empowerment and decision-making may be a function of poor or inconsistent measurement of the concept, as well as the diversity of gendered contexts which affect conclusions (Peterman et al. 2015).

In turn, the aforementioned changes at the household-level may affect the risk of childhood violence. Economic insecurity, including food insecurity, income poverty, and inadequate housing are risk factors for childhood violence (Akmatov 2011; Berger 2004; Butchart et al. 2006; Cancian et al. 2013; Gilbert et al. 2009; Jacob et al. 2013; Meinck et al. 2015; Pelton 2015). Economic insecurity may be a driver of engagement in transactional sex, and parents may directly or indirectly encourage such relationships to obtain food and other goods (Heise et al. 2013; Stoebenau et al. 2016). Unemployment also increases the risk of childhood violence (Pelton 2015; Stith et al. 2009); however, the extent to which
this effect is mediated through material hardship, especially among the poor, is not fully understood (Pelton 2015).

2.2 Caregiver- (Interpersonal-) level mechanisms

Transfer-induced improvements in economic security, changes to labor force participation and time use, reductions in stress, and more equitable intra-household power dynamics may in turn influence factors at the caregiver and interpersonal level, including substance misuse, psychosocial well-being, caregiving behaviors, intra-household conflict and interpersonal violence (including IPV), and caregiver’s supervision of children.

Transfers or other income support may improve psychosocial well-being—including aspects such as personal stress, anxiety, depression, self-esteem, and psychopathology—among caregivers, either directly, or indirectly through positive effects of increased participation in productive activities on self-esteem. Conversely, cash transfer programs may adversely affect psychosocial well-being through stress related to fulfilling program conditions. Poverty and poor mental health are mutually reinforcing (Lorant et al. 2003; Lund et al. 2011). Poverty is a risk factor for mental health disorders, through malnutrition, stress, substance abuse, social exclusion and exposure to trauma and violence. Likewise, poor mental health increases the risk of poverty, through increased health expenditures, reduced productivity, stigma and loss of employment and earnings (Lund et al. 2011). Furthermore, poverty-induced stress may cause sadness and anger, thereby increasing short-sighted and risk-averse decision-making which reinforce the cyclical nature of poverty (Haushofer and Fehr 2014). A study in Kenya demonstrated that cash transfers improved happiness and life satisfaction and lowered depression (Haushofer and Shapiro 2016).

Caregiver psychosocial well-being undermine one’s ability to cope with poverty and its stressors and pose a significant threat to child safety and well-being (Belsky 1993; Black et al. 2001; Gilbert et al. 2009; Meinck et al. 2015; Pelton 2015; Stith et al. 2009). Research suggests that economic resources may allow parents to be more responsible, warm and consistent (Fernald and Hidrobo 2011; Wachs et al. 2009), and that these parenting characteristics are associated with a reduced risk of childhood violence.
The impacts of transfer programs on caregiving behaviors is understudied (de Groot et al. 2016), however transfer-induced changes in such behaviors have the potential to decrease the risk of childhood violence, (including the frequency and severity of violent discipline), through decreases in household-level stress and improved caregiver psychosocial well-being. Furthermore, positive caregiving behaviors and children’s problem behaviors are mutually reinforcing, so that improvements in one of these outcomes are likely to lead to improvements in the other (Butchart et al. 2006; Epps and Huston 2007; Pinheiro 2006).

SSNs also have potential to reduce childhood violence through the intra-household conflict pathway. Intra-household conflict may reduce children’s psychosocial well-being, increase problem and risk behaviors, or increase the time children spent in high-risk settings (including residential care, the street or in gangs). Further, there is a growing body of evidence documenting the potential for cash transfers to reduce the risk of IPV among adults (Bobonis et al. 2013; Fernald and Gunnar 2009; Hidrobo and Fernald 2013; Hidrobo et al. 2016; Perova 2010), and given that maternal experience of IPV is a risk factor for childhood violence (Meinck et al. 2015), these documented reductions are promising for reducing childhood violence.

Caregiver supervision of children may also have implications for the risk of childhood violence. On the one hand, transfers may allow caregivers to spend more time with their children, while on the other, PWs/CfW programs and stringent program conditions may reduce this time (Beecroft et al. 2002; Bloom et al. 2000; Fein and Lee 2003; Gennetian and Miller 2002). Increased employment or engagement in productive activities, as well as time consuming conditions linked to transfers, change time-use patterns of caregivers and may leave children without adequate supervision, increasing their susceptibility to violence and abuse, particularly in settings where quality childcare is limited. Among older children and adolescents, inadequate caregiver supervision may be associated with their engagement in problem and risk behaviors.

In theory, SSNs, and income transfers in particular, can influence substance misuse, but the direction of hypothesized impacts is ambiguous: improvements in psychosocial well-being and economic security may decrease motivations to engage in substance misuse, or purchase of these so-called ‘luxury’
goods may increase through an income effect. A systematic review from LMICs of the effects of cash transfers on the use of temptation goods (mostly alcohol and tobacco) showed non-significant or negative impacts on expenditures on such goods from 19 studies in Africa, LAC and Asia (Evans and Popova 2014). Substance abuse is a common factor in incidents of child abuse (Famularo et al. 1992; Gilbert et al. 2009; Meinck et al. 2015; Milner and Chilamkurti 1991; Walsh et al. 2003).

2.3 Child-level mechanisms
At the child-level, transfers—either directly or through the aforementioned pathways—can affect time spent in school, psychosocial well-being, time in high-risk settings, child marriage, and problem and risk, which in turn all affect childhood violence risk.

Decisions around time use are influenced by transfers and increased economic security. These decisions simultaneously affect the amount of time that children spend in school, home, productive activities (i.e. labor), and high-risk settings (such as unsafe work environments) (de Hoop and Rosati 2014). While cash transfers have been shown to have large, positive impacts on school enrolment (de Hoop and Rosati 2014; Baird et al. 2013b), the impacts of school enrolment on childhood violence risk are ambiguous. Increased time spent in school may lead to decreases in exposure to (hazardous) work environments, thus decreasing the risk of physical and sexual violence. However, children may increase both hours spent in school and work simultaneously as a result of SSNs (de Hoop et al. 2015), and thus both protective and adverse consequences are possible resulting from program-induced changes in time use patterns and resulting exposure to school and work environments. Conversely, time spent in school may increase childhood violence risk, as teachers and peers may be perpetrators of various types of violence, and children, especially girls, may be at risk of sexual violence while traveling to school (African Child Policy Forum (ACPF) 2014; Dunne et al. 2006; Lalor 2004; Ogando Portela and Pells 2015). On the other hand, research from Ethiopia, India, and Vietnam suggests that out-of-school children are more likely to be physically bullied than their in-school counterparts (Jones and Pells 2016).
Psychosocial well-being, as well as problem and risk behaviors may be influenced by transfers through the economic security, caregiver psychosocial well-being, intra-household conflict, caregiving behavior and caregiver supervision pathways. Evidence from Kenya and Malawi has shown that cash transfer programs have potential to improve adolescent mental health, including depression and distress (Baird et al. 2013a; Kilburn et al. 2016). Problem behaviors include externalizing (e.g., aggression, disobedience, bullying) and delinquent behaviors, and interact with time spent in school as well as time spent in high-risk settings. Studies in LMICs have found reductions in problem behaviors (Fernald et al. 2009; Fernald and Hidrobo 2011; Figueroa 2014; Macours et al. 2012; Ozer et al. 2009; Paxson and Schady 2010) and delinquent behaviors (Chioda et al. 2015; DSD et al. 2012) resulting from CCTs and housing voucher programs. Problem behaviors are significantly correlated with the risk of childhood violence (Epps and Huston 2007; Stith et al. 2009). Relatedly, in adolescence, sexual and health risk behaviors may be a function of economic insecurity and other aforementioned pathways, and these in turn may increase the risk of childhood violence, particularly sexual violence. Poverty (both absolute and relative) may, for example, drive adolescents, especially girls, into commercial sex work, or more commonly, transactional or age-disparate sexual relationships (termed ‘intergenerational’ if the age gap is large), all with important limits as to their sexual agency (Austrian et al. 2016; Hallman 2005; Lorant et al. 2003; Markus and Page 2014; Stoebenau et al. 2016). The likelihood of these pathways resulting in negative outcomes may increase in emergencies due to increased vulnerability of separated and unaccompanied children, and vary by the poverty levels of their caregivers and perceptions around protecting children’s ‘honor’ (Thompson 2014).

2.4 Contextual factors and vulnerability characteristics

The aforementioned pathways describe how SSNs can work through household-, caregiver-, and child-levels to influence the risk of childhood violence. The strength of these relationships may vary depending on child, caregiver, and household vulnerability characteristics that influence susceptibility to childhood violence, and also by contextual factors that influence associations at the community-, institutional-, or
structural-level, as recognized by ecological frameworks for childhood violence risk (Cicchetti and Lynch 1993; Lynch and Cicchetti 1998; Scannapieco and Connell-Carrick 2005). Examples of contextual factors include policy and institutional frameworks; legal frameworks; economic and human development; migration patterns; power relations, class structures and levels of inequality; socio-cultural (gender and authoritarianism) norms, beliefs, and practices; and generalized levels and types of violence (may be a function of conflict settings and other forms of community violence). At the household level, vulnerability characteristics may include household structure/composition, social isolation, parental loss or separation and social support networks, and discrimination based on HIV, chronic illness or disability (Belsky 1993; Meinck et al. 2015; Pinheiro 2006; Stith et al. 2009). At the caregiver-level, vulnerability characteristics may include gender and social support, as well as caregiver age, education levels, biological relationship to the child, and personal histories of childhood violence (Belsky 1993; Fang and Corso 2007; Gilbert et al. 2009; Meinck et al. 2015; Pinheiro 2006; Stith et al. 2009). At the child-level, vulnerability characteristics include age, gender, sexual orientation, and HIV, disability, and orphan status (Butchart et al. 2006; Gilbert et al. 2009; Markus and Page 2014; Meinck et al. 2015; Pinheiro 2006).

Finally, a variety of factors related to program design characteristics, including targeting, program conditions, duration, regularity of payments, payment size, and recipients’ gender may affect the direction and strength of relationships and/or the plausible pathways outlined above. In the case of PW/CfW, such characteristics as type of work, wage, hours and seasonalities of work, as well as potential child care and supervision arrangements which may be part of programming are important for potential impact pathways and determine whether these are positive, negative or ambiguous.

3. Methodology

The review required a methodology appropriate to navigate an emerging and fragmented evidence base. We aimed to review published or publicly available (grey literature) studies, as well as ongoing work (presentations, study protocols), from January 2000 to April 2016 which links SSNs and childhood violence outcomes of interest. As previously defined, a child is considered anyone under the
age of 18, however as to not exclude relevant evidence, we include studies which span a larger age range, as long as they include individuals under 18 years.5

We considered quantitative and/or mixed methods approaches that utilized an experimental or quasi-experimental design. In addition, we draw from key qualitative studies to help explain and discuss mechanisms, complementing findings from quantitative studies. We limit our core review to studies conducted in LMICs; however we discuss evidence from high income countries as a contrast to reported findings. Studies were identified through searches in electronic databases, relevant journals, and on institutional websites.6 In addition, experts in the field were consulted, and forward and backward citation searches were performed as studies were identified.

As we expected the evidence base to be scattered and childhood violence to be rarely the primary focus of interest, we deliberately did not seek to conduct a meta-analysis or systematic review. We adopted broad search terms most likely to identify evaluations fitting our criteria.7 Abstracts or executive summaries were screened against inclusion and exclusion criteria. When these did not provide sufficient information to determine relevance, the full article was retrieved for further examination. While articles in Spanish were included, we only conducted formal database searches in English. A total of 117 articles were scanned as meeting some criteria or marginally relevant, but ultimately not included. It is worth noting that the majority of studies included here do not necessarily focus on childhood violence as the objective of the evaluation, and in several cases analyze violence only as a robustness check rather than a main outcome (Rasella et al. 2013; Rodríguez 2015). Further, measures considered as part of sexual abuse and exploitation (transactional sex and age-disparate sex) can have multiple interpretations. Particularly in

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5 In total, six of the 14 studies reviewed include measures in a sample of individuals age 18 or over (ranging up to age 28).
6 Databases including google scholar, PubMed and ScienceDirect were searched. In addition, journals searched include: Child Abuse and Neglect, Child Maltreatment, Journal of Interpersonal Violence Children, Youth Services Review, The Lancet, and Journal of Adolescent Health. Institutional websites searched include: World Bank, UNICEF, Overseas Development Institute (ODI), Sexual Violence Research Initiative (SVRI), Child Protection in Crisis (CPC) Learning Network, Socialprotection.org and the Transfer Project.
7 These terms included for example: child* OR adolesc* OR girl* OR boy* OR youth OR “young people” AND “social protection” OR “cash transfer*” OR “food transfer*” OR “in-kind transfer*” OR “public work*” OR voucher* OR “fee waiver*” OR “social assistance” OR “social safety net*” OR “food stamps.”
SSA, some argue these indicators represent complex social interactions with multiple interpretations (Fielding-Miller et al. 2016; Poulin 2007; Stoebenau et al. 2016). In addition, a number of studies aggregate indicators into a composite measure or a scale (e.g. Home Observation for Measurement of Environment (HOME scale)), and in such instances, it is unclear if the impact (or lack thereof) is a function of variation and change in specific violence measures, or is driven by non-violence factors in the scale.\(^8\)

From each of the core studies identified, we abstracted information about the program (location, program name, implementer), the intervention (modality, conditionality, size and regularity of benefits), the target population (age, sex), the study (design, data, sample size) and childhood violence impact results (if available, including baseline prevalence, impact estimates and hypothesized mechanisms). Summary tables organized by region, and alphabetically by country within region were constructed and used to summarize evidence and link back to unpack mechanisms hypothesized in the framework.

4. Results

4.1 Summary of programs reviewed

Table 1 summarizes the program components from the identified core papers, organized by region SSA, LAC, Asia and Middle East and Northern Africa (MENA), and country (in alphabetical order) within region. In total, we identified 14 studies meeting our inclusion criteria: three studies were ongoing, 11 were completed. Of the completed studies (with results), 10 were published in peer-reviewed papers, one was a technical report. Approximately 50\% (seven studies) were from SSA, 36\% (five studies) from LAC, 7\% (one study) from Asia, and 7\% from MENA (one study). In total, 10 countries

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\(^8\) For example, Rasella et al. (2013) examine Brazil’s Bolsa Familia program and meet the inclusion criteria for this review by examining under five death due to ‘external causes’ which includes homicide. However, in further discussion with authors, they note that only 7\% of the total external causes are homicide cases, whereas the majority are accidents, exemplifying this limitation (personal communication with authors July 12, 2016). In other instances, including Macours et al. (2012) who operationalize the HOME score, the measure combines indicators of physical and emotional violence with those related to more general caregiving behaviors (see Table 2, notes for specific definitions by study). Therefore, one could argue that it is better to refer to these composite measures as general measures of a negative home environment, rather than violence per se (personal communication with lead author, November 10, 2016).
were represented, with multiple studies in each of Kenya, South Africa and Ecuador. Only two cases, the Palestinian National Cash Transfer Programme (PNCTP) and the Wajir setting in North Eastern province of the Kenyan Adolescent Girls Initiative (AGI-K), qualify as humanitarian or emergency settings.

All SSN program implementers were national or local government bodies with the exception of three programs in SSA (the HIV Prevention Trails Network 068 [HPTN 068], the Malawi Zomba cash transfer program and the AGI-K) and one in Asia (Bangladesh Transfer Modality Research Initiative), which were run by research study teams, NGOs or UN organizations (Column 4). While government-run programs are often limiting in terms of research and program design, this implies that results may have a higher degree of external validity and generalizability. Across program typologies (Column 5), there is a clear majority of CCT and UCT programming (approximately 41%, or seven programs each), followed by in-kind programming (12% and two programs) and a minority of PW/CfW programming (6% or one program). Further, there are clear differences by region, where cash transfers in SSA tend to have a mix of UCT/CCTs, while in LAC nearly all programs are CCTs. Importantly, nearly 29% of programs have some type of ‘plus’ component, for example, linkages to services, information or training.

Virtually all programs implemented some type of means-based targeting to identify extremely poor households as beneficiaries. In SSA, typically a vulnerability criteria was operationalized, including OVC or labor-constrained categories and in several cases adolescent girls were specifically targeted in HIV-risk motivated programming. LAC programming has a greater focus on early childhood development (health and primary education) alongside income-based targeting. In nearly all cases (Column 6), with the exception of three studies in SSA (the Malawi Zomba cash transfer program, the AGI-K and the South African HPTN 068), benefits were given to an adult household member, often designated as primary caregivers (generally females). In the three SSA programs where benefits were given directly to adolescent girls, additional benefits were often given to an adult household member.

9 Note that some programs could represent several typologies in one, if they combine multiple components (for example, a CCT with a PW/CfW component), thus totals do not sum to the number of distinct programming types. In addition, at times, multiple studies evaluated the same program, in which case, it is only counted once.
Program operational details vary widely. On one hand, very basic models, such as the Kenyan Cash Transfer for Orphans and Vulnerable Children (Kenyan CT-OVC) or South African Child Support Grant (CSG) give cash payments with simple messaging about use with no additional conditions or components attached. On the other hand, the majority of the LAC implementation includes more complex conditions around human capital development, such as school attendance and enrolment requirements and health components, including health check-ups, nutrition trainings or child vaccinations. One notable design variation is the extent that programs explicitly incorporate violence-specific components. We find only one program which has a specific violence prevention component, namely community conversations to address norms around the value of adolescent girls in the AGI-K.

Finally, benefit levels range from approximately 6%-25% of baseline household income or expenditures with the large majority of benefits in the 10-15% range (Column 9).\(^\text{10}\) Approximately half of the programs involved a flat benefit rate per beneficiary or household, while the remaining implemented a variable benefit rate, generally based on household composition (including number of children within specific age ranges or attending different school levels). Unless tied to specific cycles (e.g. education terms), or given as a lump sum transfer, most programs delivered benefits on a monthly basis (Column 10).

### 4.2 Summary of evaluations and research findings

Table 2 summarizes the evaluation or research findings of the 14 studies summarized in Table 1 (region of origin and by country alphabetically). Nearly all study designs involved some sort of experimental design, primarily either cluster, household or individual-level randomized controlled trials (RCTs) (Column 2). The remaining employed quasi-experimental techniques, including propensity score matching (PSM) or other matching techniques or natural experiments. The Palestine paper (Abu-Hamad \et\ 2014), was the only truly mixed methods evaluation reviewed.

\(^{10}\) Not all evaluations provided information comparing benefit levels to baseline income or expenditure (four studies did not). In particular, this information was missing for programs with multi-tiered variable benefits.
Nearly all research involved primary data collection at several points before and after program implementation (Column 3). The exceptions were two LAC studies, which used government and program administrative data either alone or combined with primary data (Rasella et al. 2013; Rodríguez 2015). Within the primary data collections, a variety of tools were used, including both parental/caregiver reports, caregiver/child interactions or observational data and survey administration to children or adolescents themselves (Column 4). Quantitative sample sizes range from 551 adolescents (Handa et al. 2014) in Kenya to 5,547 young children (Paxson and Schady 2010) in Ecuador.

The studies examined various childhood violence outcome indicators (Column 5). Overall, 57 indicators were found across the 11 completed studies. In total, five measures of physical violence only (three indicators of homicide, two indicators of other physical violence [dating or partner violence and violence against minors from administrative data], 23 measures of physical and/or emotional violence (21 violent discipline indicators and two indicators of bullying) and 29 measures of sexual violence (20 indicators of sexual exploitation including transactional sex, and nine indicators of sexual abuse including age-disparate sex). In most cases, studies analyzed results for the same indicator in a variety of ways (e.g. varying subgroups of the target population) or examining both prevalence and incidence. For completeness, we include all variations, regardless of statistical significance—as to not bias summary figures. This means that some studies have only one qualifying violence outcome (e.g. Rodríguez 2015), however the number presented ranges up to 12 (e.g. Rosenberg et al. 2014). There is significant regional variation in the evidence across childhood violence indicators. For example, the vast majority of sexual abuse and exploitation measures come from SSA and are collected among adolescents (age 13 and above, particularly female adolescents), where there has been more attention to dynamics around youth HIV risk behaviors. Likewise, the bulk of violent discipline evidence, both physical and psychological, comes from LAC where greater emphasis has been placed on early childhood development (ECD) and is collected among children under five or primary school aged children. Indicators which are relatively rare, such as homicide, are only collected in settings were administrative or large-scale program data is available—
relatively higher income LAC countries such as Brazil. Finally, we found no evidence for non-contact sexual violence.

Columns 6, 7 and 8 present the specific indicators operationalized in the data, the baseline mean (or control group at endline if not available) and the effect size with accompanying significance level or confidence interval. For the mean and effect size, we have maintained the same number of significant digits or reporting as in reviewed papers. Across all 57 indicators, approximately 11 (or 19%) are statistically significant at the p<0.10 level or higher. This percentage varies between category of violence examined: In total, 20% of physical violence only indicators (0% for homicide, 50% for other physical violence [100% dating or partner violence and 0% violence against minors]), 9% of physical and/or emotional violence indicators (10% for violent discipline and 0% for bullying) and 40% of sexual violence indicators (20% for sexual exploitation and 44% for sexual abuse) were statistically significant. In all cases when statistically significant findings are found, SSNs have a protective effect (reduce violence) among the treatment group in comparison to the control group.

In interpreting these findings, it is worth noting that for several studies with multiple variations of the same indicator, there was varying significance levels across sub-groups—indicating that even within settings or studies, heterogeneities may exist. In addition, although all studies have provided motivation and validation for their specific measures operationalized, it is worth noting that many of the baseline mean figures are low (less than 5%), and this limits the power of evaluations to detect statistically significant program impacts. Further, there is variation in indicator definition between studies, which may drive some variation in results.

We do not consider evidence from high income countries as part of the core review, as programs tend to be complex bundled interventions and rely more heavily on social services and policy levers including tax breaks and benefits, with low comparability to programs in LMICs. However, to enrich the discussion, we include similar summaries of evidence from nine studies in high income countries (namely the US and Canada) in supplementary appendix material (Beecroft et al. 2002; Bloom et al. 2000; Bloom et al. 2002; Cancian et al. 2013; Fein and Lee 2003; Gennetian and Miller 2002; Huston et al. 2008;
Jacob et al. 2013; Miller and Samson 2012). Across the nine studies, 44 measures of childhood violence are collected, 12 (27%) of which show significant protective effects, while one (2%) shows a significant increased risk effect due to the program. The majority of indicators analyzed were specific to young children, including indicators of violent discipline or abuse. It should be cautioned that many of these effects are not full program impacts, but rather test a variation in program design, for example placing conditions on CfW programs or allowing a tax pass through on child support benefits. In addition, these studies tend to be older as compared to the core papers reviewed here, with data being collected from mid-1990s to 2009 and often are limited to one state in the US, thus potentially with lower generalizability.

Despite these evidence gaps, the three ongoing studies identified hold some promise to add to the evidence base. In particular, Austrian et al. (2016) is collecting a wide range of emotional, physical and sexual violence indicators within the context of a NGO-implemented adolescent girl’s bundled intervention in Kenya, including community conversations addressing violence. In addition, Palermo and colleagues (forthcoming) have also collected emotional, physical and sexual violence among female youth aged 14-28 at baseline in the context of the government of Tanzania’s CCT, UCT and PW, plus program. Finally, Ahmed et al. (2016) have completed an evaluation of a UCT and in-kind transfer program with behavior change and communication (BCC) components and plan to examine violent discipline among young children in Bangladesh—making this the only study in Asia catalogued to date.

4.3 Summary of mechanism proposed and evaluated

The hypothesized or investigated mechanism(s) outlined among completed studies in Column 9 generally cover all of the pathways described in our theoretical framework, with the exception of substance misuse, caregiver supervision of children and time spent in high risk settings. Apart from economic security, which was implicit in nearly all the studies, the most commonly hypothesized mechanisms for changes in childhood violence experience (all highlighted by three studies each), were schooling (Baird et al. 2012; Handa et al. 2014; Rosenberg et al. 2014), changes in caregiving behaviors (Fernald and Hidrobo 2011;
Macours et al. 2012; Paxson and Schady 2010), and parents’ improved mental health and psychosocial well-being (Abu-Hamad et al. 2014; Macours et al. 2012; Paxson and Schady 2010). The stress pathway was mentioned by two studies (Abu-Hamad et al. 2014; Rodríguez 2015), as was children’s problem or risk behaviors (Baird et al. 2012; Cluver et al. 2013). Finally, one study each mentioned the following pathways: changes in intra-household conflict through women’s empowerment (Rodríguez 2015) and empowerment which allows adolescent girls to leave abusive relationships (Pettifor et al. 2016). These pathways are largely not empirically tested in the papers reviewed, but rather hypothesized in the discussion after impacts were detected, or elicited from qualitative interviews.

5. Discussion and conclusion

Global initiatives seeking to promote evidence-informed practice around violence prevention and response have identified carefully designed economic empowerment programs, including SSNs, as key interventions to prevent violence and reduce risk behaviors associated with it. These include THRIVES, developed by the US Centers for Disease Control and Prevention (CDC) (Hillis et al. 2015), and INSPIRE, a multi-national partnership led by the World Health Organization (WHO). The most recent, INSPIRE, launched in July 2016, promotes three types of income and economic strengthening as ‘effective’ for reducing childhood violence: 1) cash transfers, 2) group saving and loans combined with gender equity training, and 3) microfinance combined with gender norm training (Butchart and Hillis 2016). The latter two approaches have been under criticism by a number of recent reviews for their general lack of transformative effects for households and women specifically, with some evidence of negative effects, which calls into question the choice of these types of instruments for sustaining

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11 The INSPIRE package was led by the WHO in collaboration with the CDC, End Violence Against Children: The Global Partnership, the Pan American Health Organization (PAHO), the President’s Emergency Program for AIDS Relief (PEPFAR), Together for Girls, the United Nations Children’s Fund (UNICEF), United Nations Office on Drugs and Crime (UNODC), United States Agency for International Development (USAID) and the World Bank. The seven evidence-based strategies include: 1) Implementation and enforcement of laws, 2) norms and values, 3) safe environments, 4) parent and caregiver support, 5) income and economic strengthening, 6) response and support services and 7) education and life skills.
meaningful economic strengthening, as well as their potential to reduce childhood violence (Banerjee et al. 2015; Duvendack et al. 2011; Stewart et al. 2010; Stewart et al. 2012; Vaessen et al. 2014).

We only considered the first instrument (i.e. cash transfers) in this review, and our conclusions from a comprehensive view of the evidence point to large variations in potential for impacts and substantial gaps in the literature on the intersection between SSNs and childhood violence. The lack of evidence is particularly striking when compared with the bodies of evidence on SSNs and other outcomes—including topics such as education, gender and empowerment or child nutrition—all of which have been topics of multiple evidence and systematic reviews as well as meta-analyses (Baird et al. 2012; Bastagli et al. 2016; de Groot et al. 2016; Lagarde et al. 2007; Leroy et al. 2009; van den Bold et al. 2013). Despite these findings, SSNs may play an important role in affecting the frequency and severity of childhood violence, aspects which are not necessarily captured in the current evidence base. In addition, it is also possible that SSNs have impacts on childhood violence indicators, particularly witnessing violence in the home and community, which were excluded from this review. For example, there is increasing evidence that cash transfers in particular can lead to reductions in IPV among adult women, hypothesized to work through many of the same mechanisms as proposed in this review (Bobonis et al. 2013; Buller et al. 2016; Hidrobo and Fernald 2013; Hidrobo et al. 2016; Rodríguez 2015). In addition, we do not consider outcomes of community violence or exposure to such violence. However, a recent review examining the potential of PW/CfW and cash transfer programming to promote economic growth and mitigate risks of violent conflict, largely through channels of productivity gains and economic growth, concludes that the body of evidence is also weak (Beazley et al. 2016).

Our review also points to significant regional variation. We found major evidence gaps by region, for example, there were no violent discipline specific indicators for children in SSA. Likewise we found no measures of sexual violence (including transactional and age-disparate sex) or violence perpetrated against adolescents by intimate partners in LAC. MENA had only one study with particular evidence and Asia had no completed studies—making it difficult to draw conclusions. We also find regional variation
in hypothesized mechanisms, which may reflect program typologies and objectives (as previously touched upon). For example, in LAC, where programs are largely CCTs, the mechanisms tend to focus on schooling, caregiver stress, and the parent-child relationship. Conversely, in SSA, where many programs are implemented in the context of generalized HIV epidemics, aim to help households with OVCs and are unconditional (thus potentially having the ability to influence broader outcomes), the mechanisms tend to focus on schooling, adolescent risk behaviors, caregiver stress, exposure to high-risk environments, community norms and girls’ empowerment. The only study from MENA, and the only mixed methods study, hypothesized pathways focusing on stress and positive peer relationships driven by increases in household economic security (Abu-Hamad et al. 2014). Countries vary with respect to the generalized levels of poverty, the capacities of implementing agencies to monitor compliance with conditions, coordinate across sectors and offer appropriate referrals and support services, and the maturity of their social protection and child protection systems, and thus their ability to integrate or link the two to maximize violence prevention and response opportunities.

Future research on SSNs and childhood violence should not only focus on filling regional gaps, but also seek to unpack differential effects of various program design and implementation variations. As a priority, all programs must be designed to minimize potential harm. Despite their potential to reduce childhood violence, SSNs may also bring about unintended adverse effects, for example in terms of children’s participation in work activities (Chaffin and Mortenson Ellis 2015; de Hoop and Rosati 2014) or exposure to peer-violence, most notably bullying due to program-related stigma or discrimination (Abu-Hamad et al. 2014; Jones and Samuels 2015; Zhang 2016). In addition, while acknowledging differences in the sophistication of social protection and child protection systems across countries, there is potential for: 1) light-touch complementary interventions—for example, BCC strategies delivered within existing program structures (e.g. program registration, pay points and monitoring activities), utilizing the wide coverage and unique ability of SSNs to reach people at the level of the household, as done for example within the Kenya CT-OVC (Handa et al. 2014) or the Bangladesh Transfer Modality Research Initiative (Ahmed et al. 2016); 2) intensive or specialized complementary interventions—when dedicated
programming is layered onto or integrated within the conditions of existing SSN structures, such as an adapted version of the Sinovuyo Parenting Program from South Africa introduced as part of family development sessions conditional for beneficiaries of the Philippines’ Pantawid Pamilyan Pilipino Program (Madrid 2016); and 3) integration and system linkages—focused on case management and referral systems using single registries and program monitoring as key entry points, with the strongest examples in countries with more evolved and institutionalized social protection systems, such as Chile’s Solidario (Ministerio de Desarrollo Social 2016). While the latter, followed by intensive complementary services, hold the greatest potential to prevent and respond to childhood violence, it should be emphasized that we found no completed rigorous evaluations of programs utilizing a systems approach or integrating violence-specific components in LMICs. Further, SSNs bundled with light-touch interventions have the potential to reach large numbers of people and achieve impacts at the margin, without overburdening emerging or fragmented systems with extensive or specialized add-ons. It is important to note that these additional services should not necessarily be seen as program ‘conditions’, which may inadvertently exclude the most vulnerable beneficiaries from accessing benefits.

In conclusion, we demonstrate that the linkages between non-contributory SSNs and childhood violence are understudied, but there exists some emerging evidence to suggest the potential of such programming to reduce aspects of multiple violence typologies across age, gender and regions. These effects may be significant and relevant from a policy perspective and help inform the global violence prevention debate as to the role of economic empowerment programs. Yet, to fully understand their potential, it is essential for future research to collect validated measures of childhood violence, where ethical and other objectives align, within rigorous impact evaluation (UNICEF 2006; Child Protection Monitoring and Evaluation Reference Group 2014). Further, to move beyond impacts to generalize to other settings and program typologies, it is essential to include quantitative analysis testing pathways of impact, and where they are found, explore the mechanisms behind them using qualitative approaches. Finally, it is important to emphasize that SSNs, as stated, are never designed, nor should be designed,
with violence prevention as the primary objective, and thus should not be looked at alone to reduce the broad-based and interrelated risks and vulnerabilities linked to childhood violence. With this caveat in mind, integrated social and child protection systems and SSN programming appear to be a promising way forward to reduce risk associated with childhood violence.
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Figure 1. Theoretical Framework Linking Social Safety Nets and Childhood Violence
| No | Authors | Country | Program name | Implementer | Modality | Target population | Recipient | Program details | Benefits |
|---|---|---|---|---|---|---|---|---|---|
| 1 | Handa et al. (2014)† | Tanzania | Cash Transfer for Orphans & Vulnerable Children | Ministry of Gender, Children & Social Development (Govt) | UCT | HHs identified as extremely poor & caring for at least one OVC aged <18 | Primary caregivers | HHs told at enrollment the cash is for the care and development of OVCs, however no monitoring or conditions imposed. HHs no longer eligible when child turns 18. | 3000 KES (~USD 40). Approx. 20% of monthly total HH expenditure. Every 2 months |
| 2 | Rosenberg et al. et al. (2014)‡ | South Africa | Baird et al. Cluver et al. Rosenberg et al. Palermo et al. Handa et al. | Austrian et al. (2015)‡ Austrian et al. (2016)‡ | CET & CCT | Female adolescents aged 11-15 years | HH head (or designated HH member) | Four treatment arms: 1. Violence prevention (VP) (community conversations); 2. VP + Education (cash & in-kind transfers); 3. VP + Education + Health (health & life skills education delivered in weekly girls groups by female mentor); 4. VP + Education + Health + Wealth Creation (savings & financial education + start-up savings). Education transfer has four components (conditional on ≥80% school attendance & continued enrollment): 1. HH Cash Transfer; 2. Schools Fees (paid to the school); 3. School Incentive (paid to the school); 4. Schooling Kits (every new term). | Kibera: 2250 KES per term (~USD 23) Wajir: 3000 KES per term (~USD 25) Approx. 10% of average HH expenditure for 4 month period. Every 2 months (for 6 school terms) |
| 3 | Austrian et al. (2015)‡, Austrian et al. (2016)‡ | Tanzania | Adolescent Girls Initiative-Kenya | Plan International (Kibera) & Save the Children (Wajir) | CCT Plus | HH Cash Transfer; Conditional on maternal age, marital status & gender of child | HH head (or designated HH member) | Program stratified on enrollment status of young women at baseline. All baseline dropouts assigned to CCT. Baseline schoolgirls randomly assigned to UCT or CCT (conditional on ≥80% school attendance). | Young women: USD 1, 2, 3, 4 or 5 (lottery) Parents: USD 4, 6, 8, or 10 (RS by EA) Average transfer to HHs: USD 10 or approx. 10% of HH consumption expenditure. Ten monthly installments per year |
| 4 | Bard et al. (2012)† | Tanzania | Zomba Boys School Health & Education Development Plan | Invest in Knowledge Initiative (2008) & Wadonda Consultants (2009) | CCT & UCT | HHs with children aged <19 based on income means test | Primary caregivers | Recipients required to participate in "development program" and have children immunized at program introduction. Conditions lifted in 2001 when studies showed the most vulnerable children were excluded as a result. | ZAR 280 (~USD 35) for each qualifying child (caps of ZAR 33,600/year for single caregivers and ZAR 67,000/year for married couples) Monthly |
| 5 | Cliver et al. (2013)‡ | Tanzania | Child Support Grant† | Social Security Agency (Govt) | UCT | HHs with children aged <19 based on income means test | Primary caregivers | Recipients required to participate in "development program" and have children immunized at program introduction. Conditions lifted in 2001 when studies showed the most vulnerable children were excluded as a result. | ZAR 280 (~USD 35) for each qualifying child (caps of ZAR 33,600/year for single caregivers and ZAR 67,000/year for married couples) Monthly |
| 6 | Pettifor et al. (2016)‡ | Tanzania | HIV Prevention Trials Network 008 | HIV Prevention Trials Network 008 study team | CCT | HHs with children aged <19 based on income means test | Primary caregivers | Funds deposited into separate bank accounts, conditional on ≥80% school attendance. | Young women: ZAR 100 (~USD 10) Parents: ZAR 200 (~USD 20) Approx. 15.7% of BL HH expenditure Monthly |
| 7 | Pakrmo et al. (forthcoming)‡ | Tanzania | Tanzania’s Productive Social Safety Net | Tanzania Social Action Fund (Govt) | CCT, UCT & PW, Plus | HHs below the food poverty line | Adult women (mothers) | Treatment is comprised of 3 components: 1. Variable UCT/CCT for all HHs; 2. PW for one able-bodied adult per eligible HH aged ≥18 in the lean season; 3. Livelihoods strengthening. UCT to all eligible HHs with an additional transfer to HHs with children <18. CCT involves grants to (i) HHs with pregnant women or children ≤5 conditional on health check-ups (for pregnant women & child); or (ii) HHs with school age children, conditional on ≥80% school attendance. | UCT: TZS 10,000 (~USD 6)/ TZS 14,000 (~USD 8.5) if children <18 CCT: max. TZS 38,000 (~USD 23) per HH PW: max. TZS 138,000 (~USD 83) annually‡ | CCT/UCT: Monthly PW: Daily for 4 months a year |
| No | Authors                          | Country      | Name of program               | Implementer                                                                 | Modality | Target population               | Recipient                  | Program details                                                                                                                                                                                                 | Benefits                                                                 |
|----|---------------------------------|--------------|-------------------------------|-----------------------------------------------------------------------------|----------|-------------------------------|-----------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|
| 8  | Rasella et al. (2013)‡          | Brazil       | Bolsa Familia Program         | Ministry of Social Development with Ministry of Health & Education (Govt)   | CCT Plus | Extremely poor HHs and HHs deemed poor with children <17 years or lactating women | Adult women (mothers)      | Education conditionalities include ≥85% attendance for children 9-15 and ≥75% attendance for children 16-17. Health conditions include vaccination and compliance with health and growth check-ups for children < 7 years; and pre- and post-natal visits and health and nutritional educational activities for lactating women. | USD 18 for each pregnant women or child aged <17 years (cap by category). Additional USD 35 to extremely poor HHs. Total benefit ranges between USD 18-175 per HH. Monthly |
| 9  | Rodríguez (2015)†               | Colombia     | Familias en Acción            | Acción Social (Govt)                                                       | CCT      | Extremely poor HH based on PMT      | Adult women (mothers)      | Education conditionalities include ≥80% attendance for children 7-18. Health conditionalities include regular medical check-ups for children < 7 years. Benefits paid through pre-programmed ATMs starting in 2007. | Health: USD 25-30 for HH with any children 0-6; Education: USD 6 per primary school child + up to USD 24 per secondary school child in 2014 Approx. 25% of legal minimum wage (HH with 2 children aged 6 and 12). Monthly |
| 10 | Paxson & Schady (2010)‡          | Ecuador      | Bono de Desarrollo Humano     | Ministry of Social & Economic Inclusion (Govt)                             | UCT      | Low-income mothers with children aged 0-16 based on PMT | Adult women (mothers)      | Originally conceived as a CCT, conditional on preventive health check-ups and minimum school attendance for school-aged children–however lack of verification of compliance led to implementation of a UCT. Program advertised as a child benefit. | USD 15. Approx. 6-10% of baseline HH expenditures. Monthly |
| 11 | Fernald & Hidrobo (2011)‡        | Nicaragua    | Atención a Cris                             | Ministry of the Family (Govt)                                             | CCT Plus | Poor HHs (based on PMT)          | Primary caregivers         | Three treatment arms: 1. CCT conditional on regular preventive health check-ups (not monitored) for HHs with children aged 0-5. HHs with children aged 7-15 in primary school eligible for an additional educational transfer conditional on school enrollment and regular attendance (monitored); 2. CCT + training package (vocational and business-skills training for up to HH member); 3. CCT + lump-sum payment package (to start a small non-agricultural activity conditional on the HH developing a business plan). All beneficiaries exposed to repeated information and communication efforts during enrollment and paydays. Beneficiaries also expected to attend regular meetings with local program promoters to discuss program objectives and conditionalities. | CCT: USD 20 if no children or children <7. HHs with children aged 7-15 additional USD 8 per HH and USD 2 per child. Approx. 15% of per capita expenditures. Lump-sum package: USD 175 in May 2006 and USD 25 in Sept 2006. Approx. 11% of per capita expenditures. Every 2 months |
| No | Authors | Country | Name of programme | Implementer | Modality | Target population | Recipient | Program details | Benefits |
|----|---------|---------|-------------------|-------------|----------|-------------------|-----------|----------------|----------|
| 13 | Ahmed et al. (2016)† | Bangladesh | Transfer Modality Research Initiative | Eco-Social Development Organization (Gouv), operational & technical support from World Food Programme | UCT & in-kind, Plus | Ultra-poor HHs with at least one child 0-24 months and not receiving benefits from other SSN interventions | Mothers | Five treatment arms: 1. UCT; 2. Food transfer; 3. 50% UCT, 50% food transfer; 4. UCT + BCC (north only); 5. Food transfer + BCC (south only). BCC involved weekly group meetings and focus on nutrition. Community nutrition workers also visited beneficiaries in their homes to observe level practice and encourage the adoption of positive behaviors. | UCT (full): Taka 1,500 (~USD 18). Approx. 25% HH consumption expenditures. Food transfer (full): 30kg of rice, 2kg lentils & 2 liters fortified cooking oil. Monthly |
| 14 | Abu-Hamad et al. (2014)‡ | Occupied Palestinian Territories | Palestinian National Cash Transfer Program | Ministry of Social Affairs (Gouv) | UCT & in-kind | Extremely poor HHs (consumption-based PMT) with specific consideration for vulnerable groups* | HH representative | Combines two cash transfers: 1. EU-funded Social Hardship Case program; 2. Social Safety Net Reform Project. HHs also entitled to other state-provided assistance, including health insurance, school fee waivers, and cash grants to help with one-off emergency needs. All beneficiaries receive in-kind food assistance through non-state provisions. | 750-1800 NIS (~USD 195-468) per HH (to bridge the 50% poverty gap) Quarterly |

Abbreviations: BBC = behavior change communication; BL = baseline; CCT = conditional cash transfer; EA = Enumeration area; HH = household; KES = Kenyan Shillings; NIS = New Israeli Shekel; OVC = Orphans or vulnerable children; PMT = proxy means test; PW = public works; RS = randomly selected; SRH = Sexual and reproductive health; SSN = Social Safety Net; TZS = Tanzanian shilling; UCT = unconditional cash transfer; USD = United States dollar; VP = violence prevention; ZAR = South African rand

Notes: ‡ refers to peer-reviewed journal article; † refers to working paper or technical report

1. Ultra-poor defined as belonging to the lowest expenditure quintile. OVC defined as having one or more deceased parent, or whose parent or main caregiver is chronically ill.
2. Indicator also included beneficiaries of the Foster Grant, targeted to HHs with children <19 years (or 21 years if attending school) who are orphaned, abandoned, at risk, abused or neglected. However, only 23 (0.7%) of 3,401 participants received a Foster Grant, suggesting that preventative effects were probably driven by the CSG.
3. The CCT offers (i) a grant (TZS 4,000 per month) to HHs with pregnant women or children under 5 who are in compliance with pre and post-natal exams and regular child health check-ups; (ii) a grant (TZS 2,000) to households with children with demonstrating an 80% primary school attendance rate; (iii) an individual grant (TZS 4,000) for children demonstrating an 80% lower secondary school attendance rate; and (iv) an individual grant (TZS 6,000) for children demonstrating an 80% upper secondary school attendance rate where such services are available. The PW component provides TZS 2,300 per day (approx. 1 USD).
4. Female-headed HH, ≥ 1 HH member aged 65+, or members who are chronically ill, disabled or orphaned.
| No | Authors | Study design | Data (years) | Sample (size) | Violence outcome | Measure(s) | Measure of effect(s) | Hypothesized mechanism |
|----|---------|--------------|--------------|--------------|------------------|------------|---------------------|------------------------|
| 1  | Handa et al. (2014)† | cRCT (exp.) | Primary data collection in 28 Locations (14 T/14 C) in 7 districts: Kisumu, Homa Bay, Migori, Saba, Naivoni, Garissa, & Kwale (2007 - 2011) | 551 youth aged 15-25 (≤3 youth per HH) | Sexual exploitation | Ever received or given gifts | aOR: 0.711 (95% CI 0.295-1.713) | Suggests two pathways: i) increase in schooling may reduce sexual risk behaviors, ii) increased economic well-being may reduce engagement in transactional sex. Authors hypothesize that especially for young women, increased economic well-being may reduce dependence on male partners (unwanted sexual relationships). |
| 2  | Rosenberg et al. (2014)‡ | cRCT (exp.) | Primary data collection in 28 Locations (14 T/14 C) in 7 districts: Kisumu, Homa Bay, Migori, Saba, Naivoni, Garissa, & Kwale (2007 - 2011) | 684 youth aged 15-25 who reported sexual partner in last 24 months (≤3 youth per HH) | Sexual exploitation (male) | Transactional sex | aOR: 0.65 (95% CI 0.23-1.80) | Suggests cash pay recipients in contact with safer sex partners through two mechanisms: i) keeping youth in school, where they are more likely to find partners of their own age, and ii) offset the economic motive to engage in transactional sex. |
| 3  | Austrian et al. (2015)†, Austrian et al. (2016)‡ | Individual and cRCT (exp.) | Primary data collection in urban settlements in Kibera (T), Hururu (C), & rural Wajir County (T) (2015 - 2017 - 2019) | 4,544 girls aged 11-14 at BL | Emotional violence | Emotional violence (lifetime; Kibera; ages 11-12) | aOR: 0.79 (95% CI 0.40-1.58) | Suggests the combination of interventions is key: i) CCT expected to reduce risks (sex/marriage) driven by a lack of economic resources and to increase educational attainment; ii) Community dialogues expected to prevent violence through changes in attitudes, perceptions and norms; reducing non-consensual sex and increasing educational attainment; iii) in schools; however, Wald tests fail to distinguish between aORs of CCT vs. UCT arms, suggesting income effect dominates. |
| 4  | Baird et al. (2012)‡ | cRCT (exp.) | Primary data collection in 176 EAs (88 T/88 C) from urban & rural Zomba district (2007 - 2008) | 3,796 never married girls aged 13-22 at BL | Sexual abuse | Sexual partner aged ≥ 25 years (BL schoolgirls) | aOR: 0.21 (95% CI 0.07-0.62) | Results suggest an income effect, as well as potential link between education and reduced risky sexual behaviors (however, Wald tests fail to distinguish between aORs of CCT vs. UCT arms, suggesting income effect dominates). |
| No | Authors | Study design | Data (years) | Sample (size) | Violence outcome | Measure(s) | Baseline Mean | Measure of effect(s) | Hypothesized mechanism |
|----|---------|-------------|-------------|---------------|-----------------|------------|--------------|-------------------|------------------------|
| 5  | Cluver et al. (2013)‡ | Individual PSM (quasi-exp.) | Primary data collection in 2 rural & 2 urban health districts in Mpyumungu & Western Cape (2009/10 - 2011/12) | 2,668 adolescents aged 12-18 years (one RS per HB) | Sexual exploitation (female) | Transactional sex (incidence) | 0.05* | aOR: 0.42 (95% CI 0.22-0.79) | Suggests cash targets sex and risk-specific risk behaviors and may interrupt those risks driven by economic necessity. |
|   |         |             |             |               | Sexual abuse (female) | Transactional sex (prevalence) | NR | aOR: 0.43 (95% CI 0.23-0.78) |                      |
|   |         |             |             |               | Age-disparate sex (incidence) | Age-disparate sex (prevalence) | 0.04* | aOR: 0.28 (95% CI 0.13-0.62) |                      |
| 6  | Ferrão et al. (2016)‡ | Individual RCT (exp.) | Primary data collection in 28 villages in Ehlensesu district (2012 - 2015) | 2,533 young women aged 13-20 at BL | Physical violence | Physical violence from a partner (12 months) | 0.28* | RR: 0.66 (95% CI 0.59-0.74) | Suggests cash may enable young women to leave or not engage in violent relationships. |
|   |         |             |             |               | Sexual abuse | Partner age difference ≥5 years | 0.20 | RR: 0.90 (95% CI 0.72-1.12) |                      |
|   |         |             |             |               | Sexual exploitation | Transactional sex | 0.14 | RR: 0.95 (95% CI 0.78-1.15) |                      |
| 7  | Palemo et al. (forthcoming)‡ | cRCT (exp.) | Primary data collection in 84 villages (48 T/36 C) in 8 districts (Masingwai, Kalamu, Kikulwento, Handeni, Mbulu, Iluma & Uyu) (2015-2017) | 1,357 youth aged 14-28 at BL | Emotional violence | Emotional violence (12 months) | 0.55 |                      |                      |
|   |         |             |             |               | Physical violence | Physical violence (12 months) | 0.29 |                      |                      |
|   |         |             |             |               | Sexual exploitation | Transactional sex (12 months) | 0.13 |                      |                      |
|   |         |             |             |               | Sexual violence | Sexual violence (12 months) | 0.22 |                      |                      |
|   |         |             |             |               | Sexual violence | Sexual violence (lifetime) | 0.19 |                      |                      |

**LATIN AMERICA AND THE CARIBBEAN**

| 8  | Ratsela et al. (2013)‡ | Mixed ecological design (quasi-exp.) | Longitudinal data from several databases at the municipality level (2004 - 2009) | 2,853 municipalities | Family violence | HOME score (2008, CCT vs. Lump-sum payment) | 1.23 | RR: 1.03 (95% CI 0.95-1.13) | Mortality attributed to external causes was originally included as a robustness check and no program impacts were expected. |
|    |         |             |             |               | Harsh discipline | HOME score (2008; with HH expenditure controls) | 1.00 | RR: 0.92 (95% CI 0.79-1.06) | Although no significant impact found on violence against minors (similar to other community violence examined), there was a significant impact on IPV among adult women (6% reduction). Authors hypothesize mechanisms of women's empowerment and poverty-related stress, however are unable to directly test pathways. |
| 9  | Rodriguez (2015)‡ | Administrative data from Institute of Legal Medicine (2007 - 2010) alongside program-administrative monthly payment data | Primary data collection in 118 parishes in 6 provinces (79 T/39 C) (2004 - 2005) | 1,030 municipalities | Physical violence | Violence against minors (per 10,000 people) | 0.54 | OLS: -0.0067 (0.0181) |                      |
| 10 | Paxson & Schady (2010)‡ | cRCT (exp.) | Primary data collection in 118 parishes in 6 provinces (79 T/39 C) (2003/04 - 2005/06) | 5,547 children aged 3-7 years (follow-up)\(^{10}\) | Violent discipline | HOME score\(^{11}\) (1st quartile, poorest) | NR | OLS: -0.318* | Suggests potential of transfers to improve maternal mental health and the quality of parenting received by children. |
|    |         |             |             |               | HOME score (top 3 quartiles, wealthiest) | NR | OLS: -0.031 (NS) |                      |
| 11 | Fernando & Hidrobo (2011)‡ | cRCT (exp.) | Primary data collection in 118 parishes in 6 municipalities (2005 - 2006) | 1,196 children aged 12-35 months (follow-up)\(^{10}\) | Violent discipline | Harsh parenting\(^{12}\) (HOME score) | 2.4 | OLS: 0.21 (NS) | Suggests income may improve psychological well-being through reductions in subjective feelings of financial strain and deprivation. As poverty affects the ways parents monitor, provide stimulation, and respond to children's needs, increased access to economic resources may allow parents to be more responsive, warm and consistent. |
|    |         |             |             |               | Harsh parenting (HOME score, rural) | NR | OLS: -0.49 (NS) |                      |
|    |         |             |             |               | Harsh parenting (HOME score, urban) | NR | OLS: 1.06 (p < 0.10) |                      |
| 12 | Macours et al. (2012)‡ | cRCT (exp.) | Primary data collection in 106 communities (56 T/50 C) in 6 rural municipalities (2005 - 2006 - 2008/09) | 4,021 HHs with children aged 0-6 years (3,002 T/1,019 C) | Violent discipline | HOME score\(^{13}\) (2006, full intervention) | 4.018 | OLS: -0.265 (0.291) | No hypothesized mechanism, however suggests parenting behavior/home environment is a determinant (potential risk factor) of child development broadly. |
|    |         |             |             |               | HOME score (2006, with HH expenditure controls) | 4.018 | OLS: -0.088 (0.284) |                      |
|    |         |             |             |               | HOME score (2006, CCT only vs. C) | 4.018 | OLS: -0.204 (0.308) |                      |
|    |         |             |             |               | HOME score (2006, CCT vs. Lump-sum payment) | 3.76 | OLS: -0.103 (0.182) |                      |
|    |         |             |             |               | HOME score (2006, full intervention) | 4.072 | OLS: -0.081 (0.120) |                      |
|    |         |             |             |               | HOME score (2006, with HH expenditure controls) | 4.072 | OLS: -0.078 (0.119) |                      |
|    |         |             |             |               | HOME score (2006, CCT only vs. C) | 4.072 | OLS: -0.128 (0.135) |                      |
|    |         |             |             |               | HOME score (2006, CCT vs. Lump-sum payment) | 3.85 | OLS: 0.151 (0.142) |                      |
**TABLE 2. REVIEW OF CORE PAPERS (EVALUATION COMPONENTS) (continued)**

| No | Authors | Study design | Data (years) | Sample (size) | Violence outcome | Measure(s) | Baseline Mean | Measure of effect(s) | Hypothesized mechanism |
|----|---------|--------------|--------------|---------------|-----------------|------------|---------------|---------------------|------------------------|
| 13 | Ahmed et al. (2016)† | cRCT (exp.) | Primary data collection in 250 villages in northwest (Kurigram & Rangpur) 250 villages in south (Bhola, Pataunkhali, Proina, Barisal & Khulna) (2012 - 2013 - 2014) | 5,000 HH with child aged 0-24 months at baseline | Parent hit child last week | Ongoing | Parent hits back or other physical punishment if child hit parents | Ongoing | NR |

**MIDDLE EAST AND NORTH AFRICA**

| 14 | Abu-Hamad et al. (2014)† | Difference in mean (quasi-exp.) | Primary data collection in the Gaza Strip (2013) | Quant: 641 HHs (17.5 T/30.0-C) & 200 adolescents aged 11-17 (RS at every third HH) | Qual: beneficiary children & adults | Violent discipline | Caregivers did not allow any child to leave the house (past month) | Mean: 43.5 (T), 46.0 (C) (NS) |

Notes: † refers to peer-reviewed journal article; ‡ refers to working paper or technical report and † refers to mean of control group at baseline. Significance levels are: * p < 0.10; ** p < 0.05; *** p < 0.001

Abbreviations: Study design, cRCT = cluster randomized control trial; exp. = experimental; PSM = propensity score matching; quasi-exp. = quasi-experimental; BCT = randomized control trial. Measure of effect(s): aOR = adjusted odds ratios; CI = confidence interval; ME = marginal effects; NS = non-significant; OLS = ordinary least squares; OR = odds ratio; RR = risk ratio. Other: BFP = Bolsa Familia Program; BL = baseline; C = control; CCT = conditional cash transfer; HH = household; HOME = Home Observation Measurement of the Environment; IPV = Intimate partner violence; NA = not applicable; NR = not reported; RS = randomly selected; T = treatment; UCT = unconditional cash transfer.

1 Module on sexual behavior with up to three HH members aged 15-25 implemented at follow-up in 2011.
2 Qualitative research including semi-structured interviews of beneficiaries and key adult stakeholders in 2016 and 2018 will supplement and complement the quantitative research findings.
3 Data was also collected on age-departure sex, transactional sex and forced sexual debut in Khergaon and Wajir, and on lifetime sexual violence in Wajir, however not reported due to small sample size.
4 Data on partner aged 25 years or older collected at 12-month follow-up only.
5 Young women were interviewed at baseline and annually for up to three follow-up visits until the study completion date (March 2015), or at their planning high school completion, whichever came first.
6 Information systems from the Ministry of Health (health-related variables), the Ministry of Social Development (BFP coverage), and the Brazilian Institute of Geography and Statistics (socioeconomic variables); as well as the national census databases (covariates).
7 Mortality attributed to ‘external causes’ includes transport accidents, homicides, and accidental injuries. The percentage classified as homicide is approximately 7%.
8 BFP municipality population coverage: Low (0.0-17.1%), Intermediate (17.2-32.0%), High (>32.0%), and Consolidated (>32.0% and target population coverage ≥100 for at least 4 years).
9 HHF municipality population coverage: Low (0-17.1%), Intermediate (17.2-32.0%), High (>32.0%), and Consolidated (>32.0% and target population coverage ≥100 for at least 4 years).
10 Analyses focuses on rural HHs only (51 T/26/C parishes); no evidence of impacts found on any outcome considered for urban areas. The later rollout of the program in urban areas meant HHs had less exposure to the program at follow-up.
11 HOMEscore is based on the Home Observation for Measurement of the Environment (HOME) scale; measures infant/punishment and lack of warmth, with lower values corresponding with better outcomes. The score includes 8 out of 11 interviewed assessed item. HOME score is standardized to a score. Direct program impact, NR, only variations by income quartile.
12 HOMEscore uses two sub-scales of the HOMEscale, measures harsh parenting, with lower values corresponding with better outcomes. The score includes 8 out of 11 interviewed assessed item. HOME score is divided into responsivity (said kind words or phrases at least twice; responded verbally to any child’s vocalization at least once; told any child the name of an object at least once; praised any child at least twice; conveyed positive feelings toward or about any child; caressed or criticized any child; had positive interactions with any child; hit any child; scolded or criticized any child; forbade any child from doing something more than three times). Item 3 on the punishment sub-scale is considered violent physical discipline, and items 1, 2 & 4 on the same sub-scale are considered violent psychological discipline.
13 HOMEscore (shortened version of the HOMEscale) includes 11 observational items (ranges 0-11) and negative parenting behaviors (punishment - sub items in footnote 12) and negative parenting behaviors (punishment - sub items in footnote 12). Lower values correspond with better outcomes. One item is considered violent physical discipline (hit any child) and three items are considered violent psychological discipline (expressed annoyance or hostility towards any child; yelled at any child; scolded or criticized any child). Each item received an answer of “yes” or “no”. The HOME score is equal to the number of answers of “no” to the positive item, plus the numbers of answers “yes” to the negative item.
14 Qualitative data collection took place in June/July 2013 in two cities in the north of Gaza and Gaza city. Participants were purposefully selected from quantitative data to represent specific conditions such as disability or violence in the HH. In total, 71 children took part in small group discussions, 10 children took part in in-depth interviews, 2 households were observed, 6 in-depth interviews took place with caregivers, 14 adults took part in focus group discussions and 11 Key Informant interviews were undertaken with key stakeholders.
### Supplementary Appendix Material

#### APPENDIX A. OECD PAPERS (PROGRAM COMPONENTS)

| No | Authors | Country | Program name | Implementer | Modality | Target population | Recipient | Program details | Program details | Benefits |
|----|---------|---------|--------------|-------------|----------|-------------------|-----------|-----------------|-----------------|----------|
|    |         |         |              |             |          |                   |           |                 |                 | Size     |
|    |         |         |              |             |          |                   |           |                 |                 | Regularity |
| 1  | Morris & Michalopoulos (2003)† | Canada (New Brunswick & British Columbia) | Self-Sufficiency Project (SSP) | Vinge and Associates Ltd. (British Columbia); Family Services Saint John, Inc. (New Brunswick) | CIW Plus | Single-parents on welfare (≥1 year) | Welfare recipients (single-parents) | Demonstration project offering a temporary (max. 3 years) earnings supplement to parents leaving welfare and working ≥30 hours a week, irrespective of HH composition. Supplement roughly equal to 50% of the difference between actual and target level earnings (target levels: Can$ 30,000 in New Brunswick and Can$ 37,000 in British Columbia in 1994). | Earnings supplement: Can$ 250-585 | Monthly |
| 2  | Jacob et al. (2013)‡ | USA (Chicago) | Moving to Opportunity (MTO) | Department of Housing & Urban Development | Housing vouchers | Low-income HHs with children in public housing in high-poverty census tracts | HHs | Vouchers subsidize housing in the private market at a rate equal to the difference in 'fair market rent', depending on metropolitan area, HH income and HH size. After receiving the voucher, HHs had 3-6 months to find an apartment. No special restrictions placed on location. | USD 8,000 (average subsidy value). Approx. 30% of HH income. | Annual |
| 3  | Bloom et al. (2002)‡ | USA (Connecticut) | Jobs First | Connecticut Department of Social Services | CIW Plus | Low-income HHs on welfare | Welfare recipients | Main features of Jobs First: 1. Time limit on cash benefits at 21 months, unless granted an exemption or an extension 2. Full earnings disregard as long as earned income falls below the federal poverty line 3. Requirements to participate in employment-based services | Parent with 2 children earning USD 6.25 per hour: 40 hours/week: USD 688 20 hours/week: USD 364 | Monthly |
| 4  | Fein & Lee (2003)‡ | USA (Delaware) | A Better Chance Welfare Reform Program (ABC) | Delaware's Division of Social Services (Govt) | CIW Plus | Single-parent HHs | Primary caregivers | Employment services (job search, job retention, workforce activities) and financial incentives (tax breaks, expanded health insurance, child care coverage), conditional on working in a workforce job on a pay-after-performance basis with strict noncompliance penalties. ABC also contains a series of provisions stressing parenting and other responsibilities. | NR | NR |
| 5  | Bloom et al. (2000)‡ | USA (Florida) | Family Transition Program (FTP) | Florida Department of Children & Families (Govt) | CIW Plus | Low-income HHs on welfare | Welfare recipients (single-parents) | Key features of FTP: 1. Time limit on cash assistance (24/60 months for most recipients and 36/72 months for the least job-ready) 2. Financial work incentives (higher earnings disregard, higher asset limit for cash assistance, longer child care assistance when leaving welfare to work) 3. Enhanced services and requirements (case management, referral to other benefits and requirements around employment-based services) 4. Parental responsibility mandates (requirements around school attendance and child immunization) Failure to meet employment-based requirements and/or parental responsibility mandates leads to sanctions (grants cancelled or reduced). | Parent with 2 children earning USD 5.15/hour: 20 hours/week: USD 99 | Monthly |
| 6  | Beecroft et al. (2002)‡ | USA (Indiana) | Indiana Welfare Reform | Division of Family & Children in Indiana's Family & Social Services Administration (Govt) | CIW Plus | Low-income HH with children <19 years | Primary caregivers | Key features of Indiana Welfare Reform: 1. Income eligibility ceiling ("zero grant" policy involving retention of Temporary Assistance for Needy Families (TANF) (and thereby Medicaid) eligibility as long as income is below the federal poverty line) 2. Work requirements (monitored) and sanctions (enforced) 3. Time limit (24-month lifetime limit for eligible adults, benefits for children continue indefinitely) 4. Family and personal responsibility requirements (no increase for children born ≥10 months after start of benefits; and requirements around child immunization, school attendance, quality of the home environment, and parental illegal drug use - Sanction of USD 90 a month until compliance). | NR | NR |
| No | Authors | Country | Program name | Implementer | Modality | Target population | Recipient | Program details | Benefits |
|---|---|---|---|---|---|---|---|---|---|
| 7 | Huston et al. (2008)† | USA (Milwaukee) | New Hope Project | New Hope Project, Inc. | CIW Plus | Low-income adults (income threshold) | Low-income working adults | Package of benefits available for 3 years: 1. Job search assistance, including referral to time-limited community service jobs for those unable to find market-based employment 2. Earnings supplement 3. Subsidized child-care for parents with children aged <13 4. Subsidized health insurance Benefits conditional on full-time work (≥30 hours a week). Earnings supplements adjusted upward for HH size (max. 2 adults and 4 children). Other financial benefits—health insurance and child care—extended to all eligible HH members, regardless of HH size. | Earnings supplement: USD 120 Monthly |
| 8 | Gennetian & Miller (2002)‡ | USA (Minnesota) | Minnesota Family Investment Program (MFIP) | Minnesota Department of Human Services (Govt) | CIW Plus | Low-income HHs on welfare | Welfare recipients (single-parents) | Main features of MFIP: 1. Requirements to work or participate in employment-focused services 2. Financial incentives for either full- or part-time work (higher basic benefits and earnings disregard) 3. Child-care expenses paid directly to service providers (rather than reimbursement of recipients) 4. Simplified public assistance rules for program synergies Families randomly assigned to MFIP or Aid to Families with Dependent Children (AFDC) (traditional welfare) to test effects of employment mandate, urban counties were assigned to a third group (MFIP Incentives Only) | Financial incentives: USD 150-250 Monthly |
| 9 | Cancian et al. (2013)‡ | USA (Wisconsin) | Wisconsin Works (W-2) & Wisconsin Child Support Program | Wisconsin Department of Children & Families (Govt) | CIW Plus & UCT | Low-income HH with children <19 years | Primary caregivers | Beneficiaries assigned to different tiers based on work history and employment barriers. Upper tier placements involve case management services (no cash stipend). Lower tiers involve a cash stipend where beneficiaries are assigned to one category: 1. Community service jobs (benefits reduced for each hour of mandated activities missed); 2. Transitions tier (for beneficiaries with barriers to employment); 3. Newborn support (mothers of children <12 weeks). Among those receiving W-2 benefits, subgroup randomized into full pass-through and disregard of child support (assignment only affected income if W-2 benefits and child support received in the same month). | Community service jobs (full): USD 673 W-2 transitions/ caretaker of newborn: USD 628 Full pass-through & disregard of child support: USD 101-102 (USD 180-174 if child support order at assignment) Monthly |

Notes: † refers to peer-reviewed journal article; ‡ refers to working paper or technical report

Abbreviations: CIW = cash for work; HH = household; NR = Not reported; UCT = unconditional cash transfer; USD = United States dollar; Can$ = Canadian dollar.

1 SSP supplement only available to those who found full-time work within 12 months of entering the study.
2 Noncompliance results in a 2-month, 1/3 grant reduction at the first instance; a 2-month, 2/3 reduction at the second instance; and permanent case closure upon the third instance. After 48 months, HHs become ineligible for further cash assistance, though may request up to two 6-month extensions. DSS staff monitor compliance and apply sanctions accordingly, which escalate with continued noncompliance and lead to case closure within 6 months.
3 Including child immunization and attendance standards, parenting classes, a health clinic visit to obtain family planning information, and substance abuse treatment (when needed).
4 A unique feature of W-2 was a full pass-through and disregard of child support paid on behalf of HHs receiving W-2 benefits. As the policy required a federal waiver, the federal government required a randomized controlled trial to evaluate impact (through the Child Support Demonstration Evaluation 1997-98). Hence, two programs are relevant to the study, though information reported here focuses on W-2 as the entry program.
| No | Authors                      | Study design | Data (years)           | Sample (size) | Violence outcome       | Measure(s) | BL Mean  | Measure of effect(s) | Hypothesized mechanism                                                                 |
|----|------------------------------|--------------|------------------------|---------------|-------------------------|------------|----------|----------------------|----------------------------------------------------------------------------------------|
| 1  | Morris & Michalopoulos      | Individual RCT (exp.) | Demographic data at BL (1992/95), state administrative records, & primary data collection in New Brunswick & British Columbia at 36-months follow-up (1995/98). | 3,259 single parents (1,654 T; 1,605 C) with 5,078 children aged 3-18 at follow-up (2,582 T; 2,496 C) | Negative parenting (children aged 15-18)

| 2  | Jacob et al.               | RCT (nat. exp.) | Voucher application forms & administrative records from Illinois Department of Human Services; Mortality records from National Death Index (NDI) (1997-2000). | 11,680 children ≤18 living in public housing at baseline (2,487 T; 9,189 C) | Homicide (per 100,000 individuals aged <18 years) | Homicide | 14.6 OR: 1.07 (95% CI 0.60-1.79) | Suggests that an important risk/protective factor to health outcomes of young children involves the physical/institutional environment and its effect on parental behavior. Suggests that for older children and adolescents, their own behavior is increasingly important in determining health outcomes (influenced by "neighborhood effects"). |
| 3  | Bloom et al.              | Individual RCT (exp.) | Demographic data at BL (1996/97), state administrative records and primary data collection in Manchester and New Haven at 3-year follow-up (1999/2000). | 1,469 single-parents with children aged 5-12 at follow-up (one RS per HH) | Harsh parenting (full sample) | Mean: 0.009 (T), 0.010 (C) (NS) | 0.12 OLS: -0.11** | Suggests that earnings disrepart, time limits, services and requirements may directly affect parental economic outcomes, which, in turn, may affect intermediate outcomes (resources and the home environment, parent-child relationship and family functioning). Authors hypothesize that the "message" such program-components convey may directly affect parental functioning, and, in turn, children's outcomes. |
| 4  | Fein & Lee               | Individual RCT (nat. exp.) | Administrative data from Delaware's Family & Child Tracking System (FACTS) matched to IDs for welfare children (10/1995 - 09/1998) | 3,959 single-parent cases in 5 pilot offices who entered ABC between Oct 1995 & Sept 1996 (2,138 T; 1,821 C) | Physical & emotional violence | Physical/ emotional abuse (substantiated) | Physical/ emotional abuse (<1 year welfare/past 5 years) | Mean: 0.006 (T), 0.006 (C) (NS) | Two principal channels hypothesized: parents’ psychosocial wellbeing, and the quantity and quality of adult supervision. Main pathways: i. Increased employment: May lead to increased income and self-esteem, reducing stress leading to abusive behavior. May also increase stress and leave children without adequate supervision. Whether the balance is favorable or not depends on employability, nature of employment, and quality of social support system; ii. Decreased benefits: Affects child abuse/neglect through parental depression, increased tension and stress in HHs, and possibly increased substance abuse. May also increase work efforts leading to pathways above. Recipients may opt for marriage/cohabitation to boost HH income; resulting in new sources of positive or negative treatment of children. iii. Increased benefits: Effects found in the opposite direction from benefit reductions; iv. Improved parenting behavior: In case of required attendance of parenting classes. Could improve supervision and reduce corporal punishment. Some parents will choose not to cooperate, leading to sanctions and effects as above. |
| 5  | Bloom et al.              | Individual RCT (exp.) | Demographic data at BL (1994/96), state administrative records & primary data collection in Escambia County at 4-year follow-up (1996/99). | 1,108 single-parents with a child aged 5-12 at follow-up (one RS per HH) | Physical/ emotional abuse (no previous report abuse/neglect) | Physical/ emotional abuse (white) | Physical/ emotional abuse (youngest child aged <6) | Mean: 0.009 (T), 0.009 (C) (NS) | Authors hypothesise two contrasting pathways: i. Increases in employment, through job satisfaction, may benefit HHs through increased regularity of home routines, improved maternal emotional well-being, and positive parenting practices; ii. Increases in hours of work may lead to higher levels of stress, or may negatively affect parental supervision. |

Measures of effect(s): OLS: Ordinary Least Squares; OR: Odds Ratio; NS: Not Significant; C: Control; T: Treatment.

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## Appendix A: OECD Papers (Evaluation Components)

### Fein & Lee (2003)

- **Hypothesis:**
  - **Measures:** Sexual abuse (substantiated), physical/sexual abuse (substantiated), physical/sexual abuse (<1 year welfare/past 5 years), physical/sexual abuse (1-3 years welfare/past 5 years), physical/sexual abuse (4-5 years welfare/past 5 years), physical/sexual abuse (<12 years of school), physical/sexual abuse (≥12 years of school), physical/sexual abuse (new report abuse/neglect), physical/sexual abuse (no previous report abuse/neglect), physical/sexual abuse (white), physical/sexual abuse (youngest child aged <6), physical/sexual abuse (youngest child aged 6-18 years), physical/sexual abuse (highest age child aged ≥25 years), physical/sexual abuse (adult head aged ≥25 years), physical/sexual abuse (adult head aged 35-39 years), physical/sexual abuse (adult head aged ≥40 years), physical/sexual abuse (adult head aged ≥50 years), physical/sexual abuse (adult head aged ≥60 years), physical/sexual abuse (adult head aged ≥70 years), physical/sexual abuse (adult head aged ≥80 years), physical/sexual abuse (adult head aged ≥90 years), physical/sexual abuse (adult head aged ≥100 years).

- **Data:**
  - Demographic data at BL, state administrative records, & primary data collection in New Brunswick & British Columbia at 36-months follow-up (1995/98).

- **Sample:**
  - 3,259 single parents (1,654 T; 1,605 C) with 5,078 children aged 3-18 at follow-up (2,582 T; 2,496 C).

- **Violence:**
  - Negative parenting (children aged 15-18).

- **Effect:**
  - OLS: -0.05 (T), 0.010 (C) (NS).

- **Hypothesis:**
  - Suggests that an important risk/protective factor to health outcomes of young children involves the physical/institutional environment and its effect on parental behavior. Suggests that for older children and adolescents, their own behavior is increasingly important in determining health outcomes (influenced by "neighborhood effects").
| No | Authors                  | Study design | Data (years) | Sample (size) | Violence outcome | Measure(s)                                    | BL Mean | Measure of effect(s) | Hypothesized mechanism |
|---|--------------------------|--------------|--------------|---------------|------------------|-----------------------------------------------|---------|----------------------|------------------------|
| 6 | Beecroft et al. (2002)† | Individual RCT (exp.) | State administrative records and primary data collection with HH who entered Indiana's welfare reform program in its first year (05/1995 - 04/1996) at 5-year follow-up (2000) | 1,679 single-parent families with a child aged 5-12 at follow-up (one RS per HH) | Violent discipline | Harsh parenting (full sample)² | 1.6⁰ | OLS: -0.1 (NS) | Authors hypothesize two contrasting pathways: i. If increased employment leads to higher HH income and/or improved mental health of mothers, the result might be improved parenting practices; ii. If increased maternal employment leads to greater stress balancing work and family demands this could adversely affect parenting behavior and HH relationships. |
| 7 | Huston et al. (2008)†   | Individual RCT (exp.) | Demographic data at BL (1994/95), state administrative records & primary data collection in two areas in Milwaukee, Wisconsin at 8-year follow-up | 595 HHs with 866 focal children aged 9-19 at 8-year follow-up (≤2 children per HH) | Violent discipline | Effective child management (full sample)² | 3.8⁰ | OLS: 0.18*** | Suggests that increased income and employment affects HH resources, parents' psychosocial well-being, and parent-child relationships (including harsh and non-supportive parenting). |
| 8 | Cennerud & Miller (2002)† | Individual RCT (exp.) | Demographic data at BL, state administrative records of follow-up & primary data collection in three urban counties in Minnesota at three-year follow-up (1994 - 1997). | 879 single-mother long-term recipient families with focal child aged 5-12 at follow-up (one RS per HH) | Violent discipline | Harsh parenting (MFIP vs. AFDC)² | 1.7⁹ | OLS: 0.0 (NS) | Two primary pathways hypothesized (which may in turn have feedback effects): i. Resources: Access to material and nonmaterial resources; ii. Socialization: Family functioning, parenting practices, and the presence of role models. |
| 9 | Cancian et al. (2013)†   | Individual RCT (nat. exp.) | Child Support Demonstration Evaluation (CSDE) (1997/98) & the Wisconsin Statewide Automated Child Welfare Information System (WiSACWIS)² | 13,062 mothers of children aged 0-18 born out of wedlock who entered W-2 between 9/1997 & 6/1998² | Emotional, physical & sexual violence | Screened-in reports of abuse & neglect | 0.20 | OR: 0.881**(0.050) | Mechanisms proposed include: i) poverty may reduce parental ability to provide for a child’s basic needs, ii) economic hardships may affect parental mental health, caregiving behaviors, and/or HH dynamics, iii) poverty may increase the visibility and scrutiny of low-income HHs to mandated maltreatment reporters, and iv) selection accounts for associations between income or poverty status and child maltreatment. |

Notes: † refers to peer-reviewed journal article; †† refers to working paper or technical report; # refers to mean of control group at endpoint. Significance levels are: * p < 0.10; **p < 0.05; ***p < 0.001

Abbreviations: Study design (exp = experimental; nat. exp. = natural experiment; RCT = randomized control trial). Measure of effect(s) (OR = odds ratios; OLS = ordinary least squares; CI = confidence interval; NS = non-significant). Other: T = treatment; C= control; BL = baseline; HH = household; RS = randomly selected; ABC = A Better Chance Welfare Reform Program; ID = identification data.

1. Using a 7-item scale developed for the National Longitudinal Survey of Children and Youth in Canada: i) forget rules, ii) nag about small things, iii) keep rules when suits myself, iv) get angry and yell, v) threaten punishment, vi) punish depending on mood, and vii) hit or threaten to hit, asked of parents of children aged 15-18, and of children aged 12-18.
2. Number of times the mother i) spanked, ii) scolded, yelled, or threatened, or iii) got really angry at the focal child during the past week (items adapted from the HOME scale). Items recoded on a 4-point scale (1 = none of the time, 4 = all of the time) from which a mean score is calculated, with higher scores corresponding to harsher parenting.
3. While the authors also report impacts in Year 1 and Year 2, we focus on impacts in Year 3 for all indicators, as results did not vary substantially.
4. Control group subjected to traditional welfare (Aid to Families with Dependent Children) rules. Differences found in work requirements, time limits, parenting provisions, more generous financial and service supports. So that the source of difference is the welfare reform.
5. Measures how often parents engaged in one of three harsh behaviors towards a child in the past week, namely scolding or yelling, getting angry and Spanking. Items recoded across four levels (never, 1-6 times, 7 times, or ≥8 or more times). Overall score computes taking the average score across the three items; higher scores present greater harshness.
6. Composite variable including: i) high control (or few problems), ii) infrequent discipline or punishment, iii) low parenting stress, and iv) high confidence in the ability to prevent harm, with higher scores corresponding with better outcomes. Particularly, frequency of discipline considers 6-items assessing the frequency, in the prior week, with which parents punished the child by grounding, taking away privileges, and Spanking. Tables included in the study present separate stats for problems with control and parenting.
7. On welfare for at least 24 of 36 months prior to random assignment.
8. CSDE was used for measures of experimental status and other control variables; WiSACWIS was used for administrative data on screened-in child abuse or neglect reports.
9. Mothers are tracked in the administrative data for a period of 2 years from the time that they entered W-2 and were assigned to the experimental or control group.