

Evidence Gap Map: Social Protection Cash Transfers and Cash Plus Programs in Low- and Middle-Income Countries

This policy brief presents the findings of an [Evidence Gap Map \(EGM\)](#) that depicts the available evidence on cash transfers and cash plus programs across a wide range of outcomes in low- and middle-income countries (LMICs). The EGM facilitates evidence-informed decision-making in social protection by enabling easy access to the existing rigorous evidence.

Why do we need this EGM?

Cash transfers (CTs) are among the primary tools in social protection aimed at reducing poverty and enhancing people's lives. To increase their impact, there is a growing trend of combining CTs with additional interventions, such as information campaigns and awareness-raising activities, psychosocial support, or food or other in-kind transfers. When CTs are coupled with such complementary support, the interventions are referred to as cash-plus programs (CTs+).

In recent years, the body of evidence on the effects of CT and CT+ interventions has grown significantly, particularly in LMICs. The outcomes targeted by CTs range from health to education, consumption, and women's empowerment. As more studies become available, the need for evidence-mapping and synthesis increases.

This EGM seeks to address the current lack of a systematic mapping of the evidence on the impact of CTs. It provides a visual and interactive representation of impact evaluations (IEs) and systematic reviews (SRs) on CT and CT+ programs since 2005. This policy brief pinpoints critical areas and populations for which limited or no evidence exists, and hence suggests potential avenues for closing those knowledge gaps. Additionally, the characteristics of studied CT programs are summarized.

MAIN FINDINGS

EXISTING EVIDENCE

- Most evidence comes from Sub-Saharan Africa and Latin America and the Caribbean.
- Conditional cash transfers with or without plus components are studied most extensively.
- Most evidence exists for outcomes related to health, education, and living standards and consumption.
- More recently, studies also investigate outcomes in areas such as financial inclusion and gender equality and empowerment.
- Abundant evidence exists for the impact on women, children, adolescents, and the elderly.
- Abundant evidence exists for studies conducted three years or less after intervention starts, for interventions targeting 10,000 or more beneficiaries, and for interventions partly or fully implemented by governments.

EVIDENCE GAPS

- Evidence is lacking for gender equality and social cohesion outcomes.
- Evidence gaps exist for certain vulnerable groups, such as indigenous peoples, refugees, and the LGBTQ+ community.
- More evidence is needed to understand how and whom to target for cash transfers to be most effective.

This EGM serves as a comprehensive repository of knowledge, consolidating robust evidence on CTs across diverse contexts and intervention characteristics. Through its various filter options, it allows development practitioners to gain insights into specific aspects of CT interventions of interest and to design appropriate interventions accordingly. Additionally, the EGM reveals key evidence and synthesis gaps, emphasizing the need for policy makers and academics to generate knowledge in these areas to further support evidence-informed decision-making.

A total of 709 IEs and 33 SRs are included in the EGM.



● Impact Evaluation / (quasi-)experimental study ● Low confidence systematic review or meta-analysis
 ● Medium confidence systematic review or meta-analysis ● High confidence systematic review or meta-analysis



How to read the EGM:

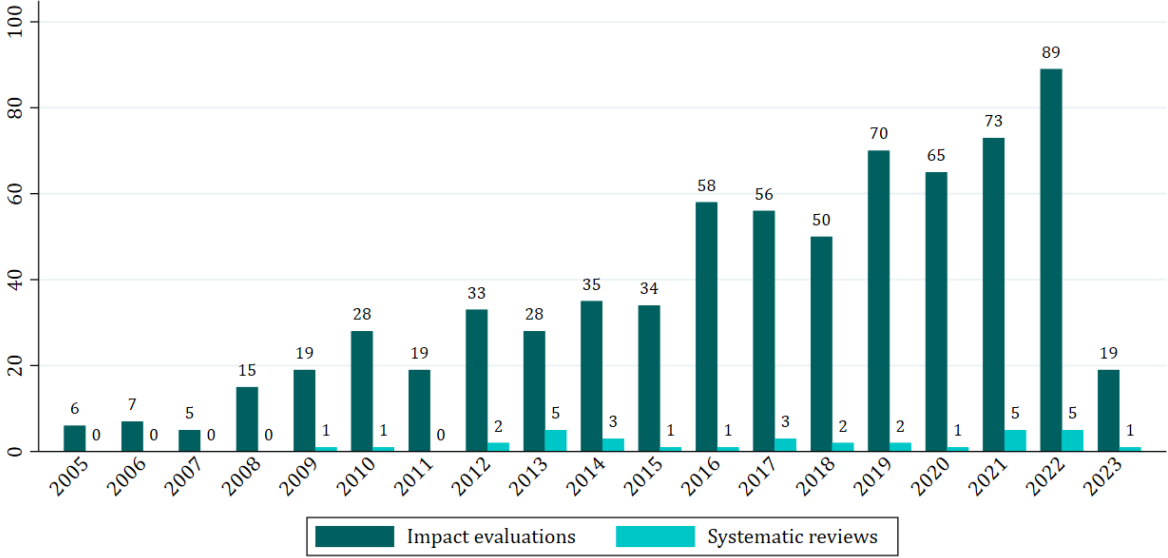
Rows list different CT and CT+ intervention types, whereas columns show the different outcome categories. Each cell represents a specific intervention-outcome combination. The bubble size corresponds to the number of studies for this specific combination. Blue bubbles refer to IE studies, while the colors red, yellow, and green illustrate the confidence level of the existing SRs.

Absolute gaps occur in cells where very small, or no IE bubbles exist.

Synthesis gaps occur in cells with large IE bubbles, but small or no SR bubbles.

The evidence landscape

There has been a continuous rise in the number of IEs published on CTs and CTs+.



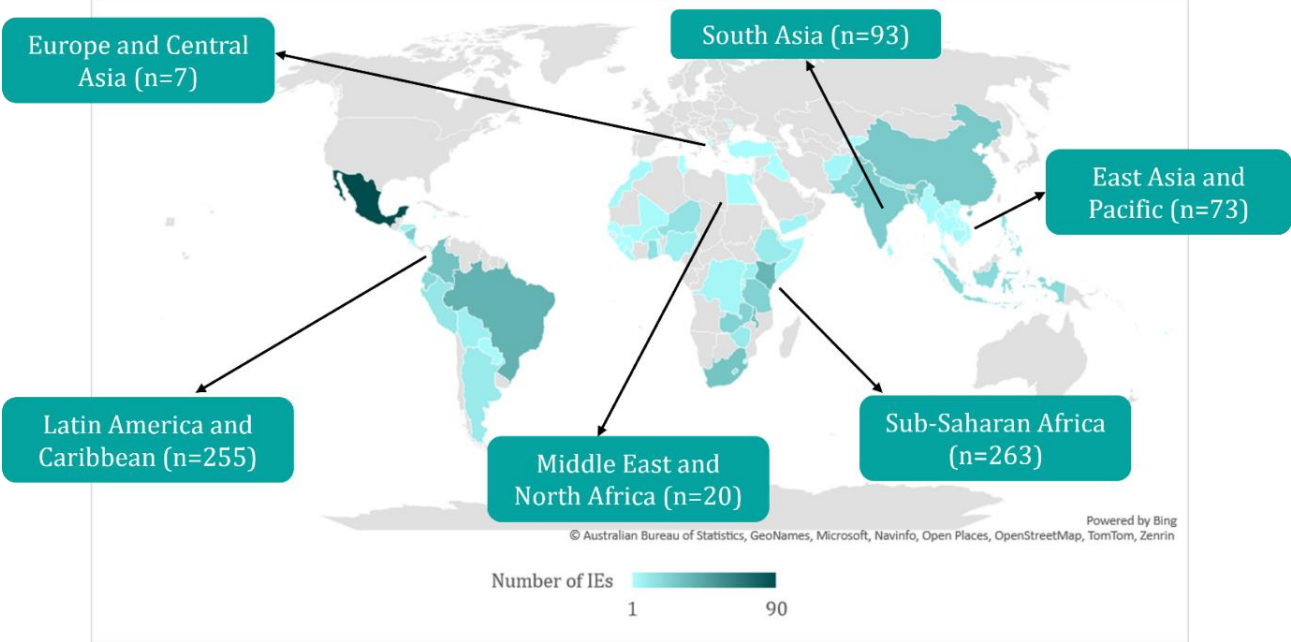
Note: The small number of studies found in 2023 is due to our search taking place in March and April and studies published later that year not being included.

Evidence for the effects of CTs has become more abundant over time. There has been a large increase in the number of IEs published each year, from six IEs in 2005 to 89 IEs in 2022. The number of SRs has not increased proportionately, but syntheses were carried out continuously.

Most evidence is concentrated in Sub-Saharan African and Latin America and

the Caribbean. For Sub-Saharan Africa, most evidence is available for Kenya (37 IEs), Malawi (32 IEs), and South Africa (30 IEs). In Latin America and the Caribbean, Mexico (90 IEs), Brazil (39 IEs), and Colombia (31 IEs) are well-studied. The majority of SRs also focus on these regions. Only 6% of IEs investigate the impact of CTs in humanitarian settings.

Evidence is concentrated in Sub-Saharan Africa and Latin America and the Caribbean.



Intervention types and outcomes

Conditional cash transfers (CCTs), with or without additional components, are studied most extensively. 54% of all IEs included in the EGM study CCTs, compared to 45% studying unconditional cash transfers (UCTs).

CCTs are more likely to be combined with supplementary components than UCTs. 72% of CCTs are combined with plus components, while this is the case for only 29% of UCTs.

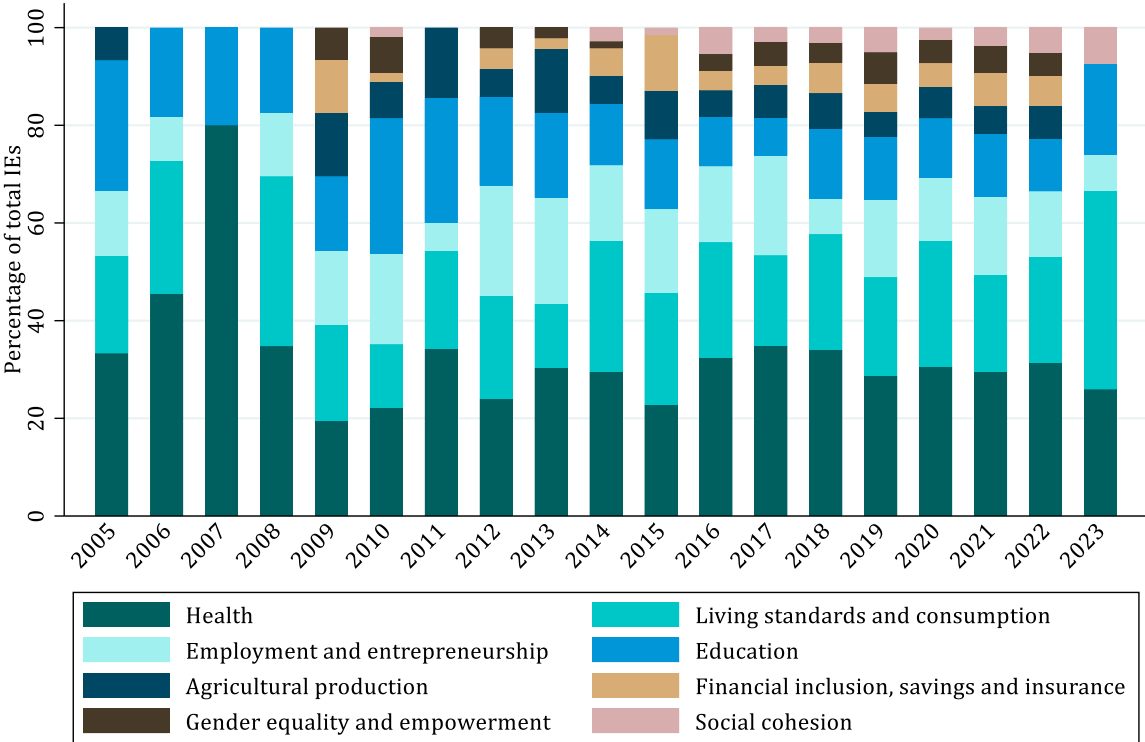
The most common plus components across both CCTs and UCTs are interventions that provide information, nudges, or use behavioral change communication (148 IEs and five SRs). The least evidence exists for the provision of psychosocial support in conjunction with CTs (23 IEs and one SR).

CTs are most frequently studied when addressing outcomes related to health

(61% of IEs) **and living standards and consumption** (44% of IEs). 31% of IEs study outcomes related to employment and entrepreneurship, and 28% study the effects on education.

Since 2009, the areas of outcomes in which CTs are studied have diversified over time, but outcomes such as health, living standards, and education are still prominent. Prior to 2009, evidence from IEs was only available for impacts of CTs on five outcome categories: i) health, ii) living standards and consumption, iii) education, iv) employment and entrepreneurship, and v) agricultural production. While outcomes such as financial inclusion, gender equality and empowerment, and social cohesion are gaining attention over time, the largest share of the evidence base still lies within these five outcome categories.

The outcome areas for which evidence from CTs is made available have diversified over time.

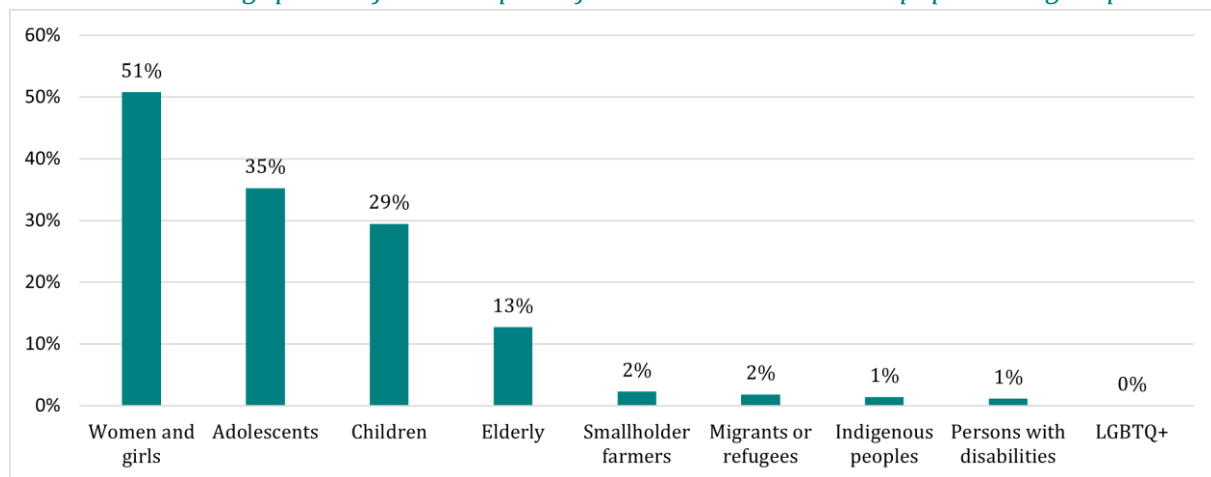


Evidence for vulnerable population groups

Policy makers can draw on an abundance of evidence for women and girls (51%), children (29%), adolescents (35%), and the elderly (13%). Evidence on the impact of CCTs is the most abundant for the first three vulnerable population groups mentioned. For the elderly, most studies report on the impact of UCTs, especially pension programs.

Evidence is lacking for other vulnerable population groups. Very few studies report on the impact of CTs for smallholder farmers, migrants or refugees, indigenous peoples, or persons with disabilities. No study reports on the impact of CTs for persons of the LGBTQ+ community. Assessing the impact of CTs on these vulnerable population groups is a critical area for future research.

Absolute evidence gaps exist for the impact of CTs on some vulnerable population groups.



Note: Proportion of IEs by population group. The groups overlap for some studies; thus, the total sum exceeds 100%.

Evaluation and intervention characteristics

IEs are predominantly conducted three years or less after interventions start, test CTs targeting 10,000 or more beneficiaries, and focus on interventions partly or fully implemented by the government. 65% of IEs are conducted three years or less after the start of the intervention, while only 7% of IEs investigate outcomes ten years or longer after interventions have been initiated. 78% of IEs study interventions either totally or partially implemented by governments, and only 20% of IEs include interventions implemented exclusively by non-governmental organizations. Government interventions tend to be more large-scale than exclusively non-governmental interventions, with 97% of government interventions targeting at least 10,000 beneficiaries.

Only 30% of IEs report whether the CT is delivered in cash or digitally. Of these studies, the split between physical and digital transfers is roughly half (53% and 46% respectively), with 1% of IEs investigating both.

GAPS ON HOW AND WHOM TO TARGET

- Only five IEs (and no SR) investigate the most effective methods for targeting potential beneficiaries, such as comparing community-based targeting versus criteria-based targeting.
- Only 15 IEs and one SR investigate whom to target to achieve the best results, such as whether to target women versus men, or children versus their parents.

Implications for policy makers and practitioners

This EGM can assist policy makers in designing effective and inclusive social protection systems. Policy makers and practitioners can draw on IEs for every combination of interventions and outcomes, as shown by the amount and distribution of the evidence. In the area of health, SRs can be used to easily identify success factors across contexts. In addition, the ample evidence for women and for vulnerable age groups may provide insights regarding a target group-specific design of CT programs. Similarly, the abundant evidence from Sub-Saharan Africa and Latin America and the Caribbean holds promise for learning about important features of successful CT interventions in these regions.

The wide variety of studies investigating CT+ programs provide policy makers

with information on the different component types being used when designing CT interventions. For example, the large number of studies that investigate the provision of information, nudges, or behavioral change communication offers a substantial basis for policy makers to learn in which contexts they are applied and for which outcomes they are more often used.

Policy makers are encouraged to commission studies that look into the effectiveness of different CT delivery modes. While mobile money platforms are increasingly utilized in LMICs, especially in Sub-Saharan Africa, and may increase coverage and take-up, testing the different delivery modes against each other is needed to learn more about their (cost-) effectiveness.

Implications for researchers

More IEs are needed to learn about effects of CTs on vulnerable population groups, the role of different targeting methods, and the effectiveness of CTs in less-studied regions. Firstly, there are only few to no IEs measuring the effects of CTs on certain population groups (e.g. the LGBTQ+ community, refugees, and indigenous populations), that are meaningful given their vulnerability. Secondly, only five IEs and no SR investigate the targeting of beneficiaries, which has the potential to affect a program's success. Thirdly, comparatively little evidence stems from regions other than Latin America and the Caribbean, and Sub-Saharan Africa.

More SRs are needed to facilitate the decision-making process for

practitioners and policy makers. Summarizing the large body of evidence on outcomes related to living standards and consumption, employment and entrepreneurship, and agricultural production is an important step towards making the results of the IEs more accessible and deriving learnings across different contexts. Furthermore, distinguishing between effects that are measured immediately after the intervention ends and those two to three years or more after the intervention has phased out could create realistic expectations towards the effects of CT programs. Finally, investigating regional effects through SRs could support policy makers in designing tailor-made interventions.

About this EGM

This policy brief is based on a report titled **“Cash Transfers and Cash Plus Programs in Low- and Middle-Income Countries”** written by Atika Pasha, Viviana Urueña, Christiaan de Swardt, and Mathilda Featherston-Lardeux from the Center for Evaluation and Development (C4ED), and Stefanie Knoll, Kathrin Wolf, and Denise Hörner from the German Institute for Development Evaluation (DEval).

A systematic search was performed over seven databases and two websites of agencies and research institutes for both peer-reviewed studies and grey literature assessing the impact of CTs in LMICs

published between 2005 to 2023. Studies were evaluated and included based on extensive, transparent, and reproducible inclusion and exclusion criteria.

The EGM consists of 709 IEs and 33 SRs. A quality appraisal was performed for the latter, the results of which are incorporated in both the report and the EGM tool. Additionally, the EGM tool visualizes intervention-outcome combinations across different types of CTs and CTs+, and eight broad outcome categories with a total of 37 outcome subcategories. The accompanying report provides additional information about the state of the evidence.
