OPTIONS FOR A ‘CASH PLUS’ INTERVENTION TO ENHANCE ADOLESCENT WELL-BEING IN TANZANIA:

An introduction and review of the evidence from different programme models in eastern and southern Africa

Background Paper for a Stakeholder Workshop
Dar es Salaam, Tanzania, 11-12 February 2016

Prepared by Carol Watson, Consultant
in collaboration with Tia Palermo, UNICEF Office of Research - Innocenti, Florence
Contents

List of tables, figures and boxes ........................................................................................................ ii
Acronyms and abbreviations ........................................................................................................ iii
Acknowledgements ..................................................................................................................... iv

1. Context and introduction ........................................................................................................... 1
   1.1 Cash transfers and a potential ‘cash plus’ model for Tanzania ........................................ 1
   1.2 Adolescents in Tanzania ..................................................................................................... 1
   1.3 Programming for adolescents in eastern and southern Africa ......................................... 2
   1.4 Purpose and structure of the paper ..................................................................................... 3

2. Social protection and cash transfers ......................................................................................... 4
   2.1 Social protection ................................................................................................................ 4
   2.2 Cash transfers: evidence of impact in eastern and southern Africa ............................. 4
   2.3 Cash ‘plus’: an emerging model ....................................................................................... 5

3. TASAF and PSSN ....................................................................................................................... 8
   3.1 Background ......................................................................................................................... 8
   3.2 PSSN Programme elements ............................................................................................. 8
   3.3 Evaluations ........................................................................................................................ 9

4. Adolescent empowerment initiatives ...................................................................................... 11
   4.1 Background and overview ............................................................................................... 11
   4.2 Evidence and examples ...................................................................................................... 12
   4.3 Concluding discussion points ........................................................................................... 14

5. Parenting programmes ........................................................................................................... 16
   5.1 Background and overview ............................................................................................... 16
   5.2 Evidence and examples ...................................................................................................... 17
   5.3 Concluding discussion points ........................................................................................... 18

6. Community mobilisation for social norm change ................................................................. 19
   6.1 Background and overview ............................................................................................... 19
   6.2 Evidence and examples ...................................................................................................... 20
   6.3 Concluding discussion points ........................................................................................... 21

7. Key issues for consideration in choice of ‘Cash plus’ programme options .......................... 23
   7.1 Recap of programmes and evidence base ......................................................................... 23
   7.2 Other points for consideration in Tanzania ....................................................................... 23
   7.3 Considerations for evaluation ........................................................................................... 24

References ...................................................................................................................................... 28

List of experts consulted ............................................................................................................... 35
Annex 1. Summary table of adolescent empowerment initiatives ........................................ 36
Annex 2. Summary table of parenting programmes .......................................................... 44
Annex 3. Summary table of community mobilisation around social norms ......................... 48

List of tables, figures and boxes

Table 1. PSSN fixed and variable transfers........................................................................ 9
Table 2. Topics covered in Sinovuyo Teen programme, SA............................................. 17

Figure 1. The impact of cash transfers on adolescents: A conceptual framework ............... 5
Figure 2. Asset-building conceptual framework ............................................................... 11
Figure 3. Ecological framework with life course ................................................................ 19
Figure 4. Evaluation decision tree .................................................................................... 27

Box 1. What are life skills?.................................................................................................. 11
Box 2. Combined life skills, microfinance and gender empowerment programmes in eastern and southern Africa....................................................................................... 13
Box 3. What are social norms? ......................................................................................... 19
Options for ‘Cash Plus’ Programming for Adolescents in Tanzania: Background Paper

Acronyms and abbreviations

AIDS Acquired Immune Deficiency Syndrome
AU African Union
CB Community-based
CCT Conditional Cash Transfer
CDC Centers for Disease Control (US)
CEDOVIP Centre for Domestic Violence Prevention (Uganda)
C4D Communication for Development
ELA Empowerment and Livelihood for Girls (Uganda)
FGM/C Female Genital Mutilation/Cutting
GBV Gender-Based Violence
GREAT Gender Roles, Equality and Transformations (Uganda)
HIV Human Immunodeficiency Virus
IEC Information, Education and Communication
IHDC Institute for Health and Development Communication (South Africa)
IMAGE Intervention with Microfinance for AIDS and Gender Equity
IPV Intimate Partner Violence
IRH Institute for Reproductive Health (Georgetown University)
ITS Interrupted Time Series
KMG Kembatta Mentii Gezzima-Tope (Ethiopia)
LEAP Livelihood Empowerment against Poverty
LMICS Low and Middle Income Countries
MKUKUTA Tanzania National Strategy for Growth and Reduction of Poverty
MKUZA Zanzibar Strategy for Growth and Reduction of Poverty
NGO Non-Governmental Organisation
OECD Organisation of Economic Cooperation and Development
OVC Orphans and vulnerable children
PAA Project Authority Area (Tanzania)
PEPFAR President’s Emergency Plan for AIDS Relief
PLH Parenting for Lifelong Health
PSNP Productive Safety Net Programme (Ethiopia)
PSSN Productive Social Safety Net (Tanzania)
RCT Randomised Control Trial
REPOA Policy Research for Development (Tanzania)
SHARE Safe Homes and Respect for Everyone (Uganda)
SHAZ Shaping the Health of Adolescents in Zimbabwe
SRH Sexual and Reproductive Health
TACAIDS Tanzania Commission for AIDS
TASAF Tanzanian Social Action Fund
THRIVES Training in parenting; Household economic strengthening; Reduced violence through legal protection; Improved services; Values and norms that protect children; Education and life skills; Surveillance and evaluation.
TRY Tap and Reposition Youth (Kenya)
UNICEF United Nations Children’s Fund
VAC Violence against Children
VAWG Violence against Women and Girls
WB World Bank
WHO World Health Organisation
ZAC Zanzibar AIDS Commission (ZAC)
Acknowledgements

This paper was written at the request of UNICEF Office of Research – Innocenti (Florence) with generous support from Oak Foundation in Geneva. Thanks are due to colleagues at the UNICEF country office in Tanzania, Beatrice Targa and Jennifer Matafu, who provided comments on and added additional information to the draft write-up on TASAF/PSSN (chapter 2). Sincere appreciation is also extended to the different experts consulted during the course of our research: these individuals generously gave of their time to provide information and insights on various forms of adolescent programming and the evidence that exists on their impacts. The full list of names is provided after the list of references reviewed. While inputs and insights from all are acknowledged, any errors in interpretation or presentation are our own.

Photos on the cover page are from the UNICEF Tanzania (2011) report, ‘Adolescents in Tanzania.’
1. Context and introduction

1.1 Cash transfers and a potential ‘cash plus’ model for Tanzania

Cash transfer programmes are a key tool in social protection for combating chronic poverty and hunger, and they are also seen as a tool for increasing investment in human capital. Having rapidly expanded across sub-Saharan Africa, cash transfer programs are motivated by the premise that income poverty has highly damaging impacts on human development and that cash empowers families living in poverty to make their own decisions on how to improve their lives. These programmes have proven effective in improving food security, productive activities, and secondary school attendance rates, among other outcomes (The Transfer Project, 2014). Cash transfer programmes may also have the potential to impact a broader range of outcomes linked specifically to adolescents. Evidence shows that government cash transfer programmes in Africa have helped to facilitate safe transitions to adulthood by delaying sexual debut and pregnancy and reducing transactional sex and age-disparate sex (Cluver et al. 2013; Handa et al. 2014; Handa et al. 2015; Heinrich et al. 2012).

There is now increasing interest in linking cash transfers to complementary inputs that will further strengthen and expand such positive outcomes for adolescents and young people, building on the emerging ‘cash plus’ model that is developing in different countries around the world.

In Tanzania, government and partners are interested in designing and testing a ‘cash plus model’ within the context of Tanzania’s Productive Social Safety Net (PSSN), which is implemented by the Tanzanian Social Action Fund (TASAF). There is particular interest in a plus component that may help facilitate safe transitions to adulthood, including reducing the risk of HIV infection and violence against children and adolescents. To date, there are no studies providing rigorous evidence on a cash plus model, where the plus programming is specifically targeted to adolescents and that is within the framework of a government cash transfer programme.

1.2 Adolescents in Tanzania

Adolescence is a key period in which events and transitions have long-term impacts on an individual’s future health, well-being, and productivity. Decisions about sexual debut, schooling, and partnerships determine an individual’s trajectory and can impact earning potential, agency in marriage, future experience of violence, and a range of outcomes that impact not only the individual, but their future children as well. A recent study highlighted key issues facing youth in Tanzania, including early marriage and pregnancy, children living without their parents, violence, and HIV risk (Population Council, Tanzania Commission for AIDS (TACAIDS), Zanzibar AIDS Commission (ZAC), & UNICEF Tanzania, 2015). The report highlighted that school-dropout among girls spikes around age 12 in rural areas, and 31 to 37% of girls are married before age 18. Further, according to the 2010 Tanzania Demographic and Health Survey, 4% of women aged 25 to 49 had given birth by age 15 (National Bureau of Statistics (NBS) [Tanzania] & ICF Macro, 2011) and 6.7% of women aged 15 to 49 in Tanzania were married or in union before age 15 (Palermo, Myamba, Peterman, & Handa, 2015).

One quarter and one-fifth of girls and boys aged 10-14 years, respectively, live without their biological parents—and this proportion rises to half of girls aged 15-17 years in urban areas (Population Council et al., 2015). Parental absence and reduced parental support and supervision may have widespread implications for a range of outcomes during the transition to adulthood, including decisions related to allocation of household resources and decisions of whether to send an adolescent to school and decisions about sexual debut and formation of relationships, as adolescents may seek to replace parental love and support (Heymann & Kidman, 2009; Kidman & Anglewicz, 2014).

Violence and HIV risk are other issues that youth in Tanzania face (UNICEF Tanzania, United States Centers for Disease Control and Prevention (CDC), & Muhimbili University of Health and Allied Sciences, 2011). Thirty percent of females and 20% of males reported their sexual debut as forced, and half of married females aged 15 to 24 had a partner ten or more years older, which increases risk of violence and HIV (Population Council et al., 2015). Further, the first national study of violence against children in Tanzania, conducted in 2009, found that 3 in 10 females and 1 in 7 males experienced sexual
violence before age 18, and three-quarters of males and females experienced physical violence by an adult or intimate partner before age 18 (UNICEF Tanzania et al. 2011).

While adolescents are at great risk from a broad range of social, economic and health problems, they are also full of promise, and key to the bright future of Tanzania. Over the next 10-15 years, Tanzania’s largest ever youth population will enter their economically productive years. The adolescent population is expected to increase by 130% by 2050 (UNICEF NY 2014, cited in Jensen and Bangser 2015). The investments made now will determine whether this unique time in Tanzania’s history will result in accelerated economic growth, peace and stability, or in a lost opportunity (Jensen and Bangser 2015).

1.3 Programming for adolescents in eastern and southern Africa

Many of the programme interventions around adolescents and ‘safe passages’ in eastern and southern Africa been initiated in the context of HIV prevention efforts and include both sexual and reproductive training and inputs, as well as behavioural change efforts as well and, increasingly, broader ‘structural responses’ designed to strengthen the overall ‘enabling environment’. HIV infection and intimate-partner violence share a common risk environment in much of southern Africa, so much of the work around HIV is of direct relevance to violence prevention (and vice versa). Underdevelopment, lack of economic opportunities for both sexes, and entrenched gender inequalities in the distribution of power, resources, and responsibilities between men and women create a risk environment that supports high levels of both HIV infection and violence. In addition to having common risk factors, violence, particularly intimate partner violence, and HIV can also heighten risk or vulnerability to the other (Durevall & Lindskog 2014; Maman, Campbell, Sweat, & Gielen 2000; Maman et al. 2002).

The cycle of violence is learned early, as children exposed to intimate partner violence in the home have increased risk of perpetration and experience of violence in intimate partnerships as adults (Abramsky et al. 2011; Fleming et al. 2015; Jennings, Richards, Tomsich, & Gover 2015). Early experience of physical, sexual, and emotional violence also increases the risk of post-traumatic stress disorder (PTSD), depression, suicide, increased number of sexual partners, and violence victimization and perpetration in adulthood (Abramsky et al. 2011; Devries et al. 2014; Jennings et al. 2015; Paolucci, Genuis, & Violato 2001; Ports, Ford, & Merrick 2015).

Among children and adolescents, risk factors for sexual abuse and exploitation include disrupted families and weakened support networks, violence in families and communities, economic insecurity, being out-of-school, and peer norms (such as being supported by a group in which sexual exploitation is common practice) (Warburton 2014), and many of these factors are also risk factors for HIV infection. Thus, targeting structural determinants of both violence and HIV, particularly economic insecurity, may reduce vulnerability to each. Further strengthening of protective factors through cash plus programming may improve the ability of cash transfer programmes to improve these outcomes.

Structural interventions seek to affect risk environments by altering the context in which ill-health occurs, addressing upstream determinants of health, including poverty, that have the potential to affect multiple endpoints (Pronyk et al. 2006). The recent (draft) guidance paper on HIV prevention for countries involved in the DREAMS initiative notes that while no single intervention has emerged that can avert most new infections in adolescents and young people, there are a range of high-quality studies on cash-transfers, empowerment programmes, interventions that reduce levels of gender-based violence and pre-exposure prophylaxis that suggest a new, more effective strategy for reducing HIV incidence. The guidance paper states, ‘It is time to move boldly forward with comprehensive packages of social, economic and biomedical interventions to both reduce girl’s vulnerability to HIV and increase their agency.’ (PEPFAR 2016)

Among stand-alone violence prevention and related interventions, some have been designed to address specific forms of gender-based vulnerabilities, such as child marriage, or female genital mutilation/cutting; these often focus on girls and young women, though there is an increasing recognition of the importance of bringing in men and boys through gender equality and transformation efforts. Programmes may be community-based interventions or school or health facility-based. Some focus on expansion of vocational education or training; others seek to expand overall educational
opportunities for girls as a force for expanded capability development and protection. Many programmes for adolescents combine broad-based ‘life skills’ information and support with other elements such as training in livelihoods or economic asset creation. Broad-based communications initiatives and community ‘dialogues’ have also been developed and implemented to address harmful or discriminatory social norms that can often weaken the enabling environment for adolescent development and safe transition to adulthood. Programmes often include different combinations of interventions; these are, moreover, often tailored to the particular context or outcomes identified.

A number of programmes for adolescents have been subject to rigorous evaluation; others less so. While knowledge is building around programme effectiveness, a number of critical questions remain, including about the specific pathways for change, the optimal combination or ‘dosage’ of interventions for the most positive outcomes, sustainability of change processes set in motion, and potential for scale-up.

1.4 Purpose and structure of the paper

The purpose of this paper is to provide an overview of different types of programme initiatives underway or previously implemented in eastern and southern Africa and of the evidence base that exists in terms of their impact on positive outcomes for adolescents. The aim is to provide government officials and key partners with a presentation and analysis of options to consider for the ‘plus’ component for a ‘cash plus’ intervention linked to the PSSN. The paper will serve as a background document for a planned national workshop in Dar es Salaam in February 2016 which will draw a broad group of stakeholders together for discussion of these options.

The paper is structured as follows. After this introductory Chapter 1, Chapter 2 provides a brief overview of basic concepts and mechanisms of social protection, a review of some of the evidence of impacts of cash transfers as one specific social protection mechanism, and a brief overview of the ‘cash plus’ models that are emerging in different forms around the world. Chapter 3 presents some of the key features of the PSSN cash transfer programme in Tanzania. The next three chapters focus on the adolescent programme initiatives that have been categorized into three types or models: adolescent empowerment initiatives (Chapter 4); parenting programmes (Chapter 5); and community sensitisation or mobilisation approaches (Chapter 6). Each of these chapters presents the programme model or and conceptual framework along with examples of specific programmes implemented in different countries in eastern and southern Africa, accompanied by the existing evidence on their effectiveness. Chapter 7 offers some key issues for consideration for the feasibility and appropriateness of the different programming models as the ‘plus’ component for PSSN in Tanzania as well as some considerations for the design of an evaluation of the potential programme that will be an essential input into the ever-growing evidence base on such initiatives around the world.

The report includes an extensive bibliography of key references and list of experts consulted, along with annexes with detailed tables of the different programme interventions discussed and the evidence base on their effectiveness.
2. Social protection and cash transfers

2.1 Social protection

Social protection has emerged in recent years as one of the key policy frameworks and mechanisms for addressing poverty and vulnerability. Social protection can be understood as a set of public and private actions which address not only income poverty and economic shocks, but also social vulnerability, thus taking into account the inter-relationship between poverty and exclusion (Sabates-Wheeler and Devereux 2008; UNICEF 2012). A growing evidence base around the world is documenting the role of social protection in improving well-being, securing livelihoods, promoting resilience, and supporting and enhancing the effectiveness of economic growth strategies for poverty reduction.

At the global level, social protection figures prominently in the sustainable development goals where it is seen as critical to ensuring that all people enjoy a decent standard living, to eliminating poverty, and to reducing inequality within and among countries. In Africa, the African Union (AU) has called on governments to include social protection as a key component of their national development plans and to establish and coordinate inter-sectoral programmes at the highest level. Investment in social protection is seen as crucial in developing human capital, breaking the inter-generational transmission of poverty, and reducing the growing inequalities that hinder equitable social development on the continent (AU 2008). More and more countries in Africa are developing national social protection policies, strategies and programmes of various types.

Social protection is commonly seen to comprise several components. Social assistance is support to extremely poor individuals and households, typically including regular/predictable transfers in cash and kind aimed at reducing poverty and vulnerability, increasing access to basic services, and promoting human capital development and asset accumulation. Social insurance includes measures designed to protect against the risks and consequences of livelihood, health and other shocks and support access to services in times of need. This typically takes the form of subsidized risk-pooling mechanisms, with potential contribution payment exemptions for the poor (‘insuring the uninsured’) by extending social security. Social services include those specialised services established for marginalised groups who may need special care or would otherwise be denied access to basic services based on particular social characteristics or conditions (disability, chronic illness; victims of violence/conflict). Social justice and equity measures commonly refer to those features of the larger social policy, legal and regulatory frameworks that seek to promote realization of economic and social rights for all. These could include such things as anti-discrimination legislation; policies of social service fee abolition; and information, communication and sensitisation campaigns to shift inequitable social norms and practices.

Social protection mechanisms, when integrated into a system, can thus operate along multiple dimensions in terms of protection of the most vulnerable, prevention against shocks, and promotion of human capital development. Social protection can also be transformational through social justice and equity measures designed to address marginalisation and exclusion (see Devereux and Sabates-Wheeler 2004).

2.2 Cash transfers: evidence of impact in eastern and southern Africa

Cash transfers are one form of social transfer. They are predictable direct transfers to individuals or households to protect them from the impacts of shocks and support the accumulation of human, productive and financial assets. With the cash, the recipients can potentially mitigate one or several vulnerabilities. Cash transfers can take a variety of forms, including pensions, child benefits, poverty-targeted transfers and seasonal transfers. There may or may not be conditions to receiving the transfer. Conditional grants require some qualifying or ongoing action by recipients such as full time school attendance by school-age children. Unconditional grants do not require ongoing action by the recipient. The effect of such transfers on poverty reduction has received great attention in national and global policy debate. Their impacts are well studied in high income nations, some middle income countries, and a growing number of low income countries. There has been a significant expansion in the number and coverage of cash transfer programmes in developing countries, including in Africa (UNICEF 2015).
There is a growing evidence base demonstrating the ability of cash transfer programmes to facilitate safe transitions to adulthood and reduce HIV-risk behaviour and violence. African government cash transfer programmes have had large, positive impacts on secondary school attendance (Handa and de Miliano 2015), an important human capital outcome on its own but also an intermediate outcome which positively impacts broader youth well-being. Furthermore, government cash transfer programmes in South Africa and Kenya were found to have reduced adolescent sexual activity and pregnancy, delayed sexual debut, and reduced transactional sex and age-disparate sex (Cluver et al. 2016; Handa et al. 2014; Heinrich et al. 2012; Rosenberg et al. 2014). Preliminary evidence from the Transfer Project also suggests that, in Zimbabwe, a government cash transfer programme reduced forced sex (Palermo et al. 2015), and in Malawi, the government-run cash transfer programme reduced pregnancy and transactional sex and delayed sexual debut (Malawi SCT Evaluation Team 2015). Other non-governmental cash transfer programmes have also reduced HIV and herpes simplex 2 (Baird et al. 2012), delayed sexual debut (Baird et al. 2010), reduced intimate partner violence (Pettifor et al. 2015), and reduced psychological distress among adolescent girls (Baird, De Hoop and Özler 2013).

Transfers can empower adolescents to make positive protection choices in the shorter and longer terms. Findings from Zimbabwe and South Africa on risky behaviours show adolescents engaging in protective behaviour by attending school and avoiding sexual exploitation, and by reducing involvement in gangs (leading to a reduction in violence and juvenile justice encounters). (UNICEF 2015, citing evidence from The South African Child Support Grant Impact Assessment and the Zimbabwe Harmonized Social Cash Transfer).

Figure 1 depicts the pathways through which cash transfers to households are conceptualised to impact adolescents.

Figure 1. The impact of cash transfers on adolescents: A conceptual framework

Source: The Transfer Project

2.3 Cash ‘plus’: an emerging model

‘Cash Plus’ refers to the programme option of combining cash transfers with other sorts of support. The rationale is that cash alone is not always sufficient as a means to reduce the broad-based and interrelated social and economic risks and vulnerabilities that the targeted beneficiary populations face, and that
additional support is needed. On the framework above, the ‘plus’ elements would be seen as intensifying the impact of the ‘moderators’ on positive adolescent outcomes.

A number of examples of ‘Cash plus’ programming come from other parts of the world. In Latin America, for example, the Chile Solidario / Programa Puenta programme has been developed as a form of social contract for each family, with psycho-social support placed at the centre of the model. Cash plus approaches are also evident in many OECD countries where assistance is provided along with incentives for work, one-stop shops for job services and benefits, and social support and links to other services (Lindert 2014).

In Zambia, the government, in conjunction with UNICEF Zambia, implemented a form of cash plus programming by linking social welfare and adolescent health departments at the national and district levels, but this cash plus model among adolescents is on-going and has not been rigorously evaluated (Olson 2016). Other examples of ‘Cash Plus’ approaches in Africa can be found in Mali, Niger, Burkina Faso and Chad where cash transfers are accompanied by information and awareness-raising seminars for female beneficiaries on family care practices including nutrition, health and hygiene. Materials for the training sessions are often drawn or adapted from the evidence-based 16 key family and community practices on child care promoted by WHO and UNICEF, focusing in particularly on younger children, pregnant women and mothers (Hill et al. 2004)\(^1\). Some cash transfer programmes implemented as ‘productive safety nets’ may also include training and awareness-raising around productive practices, such as in the Productive Safety Net programme (PSNP) in Ethiopia (Lindert 2014) or CARE’s cash transfer programme aimed at enhancing resilience in Chad (Watson at al. 2016 in draft).

Such programmes may be considered as examples of ‘cash for learning’: beneficiaries receive both cash and training/information on themes or topics identified as essential for enhancing welfare. A second type may be a ‘cash for assets’ model which is basically a labour-intensive public works approach in which beneficiaries work on community service or infrastructural development projects in return for cash, with the rationale that the projects identified will promote longer term resilience. A number of programmes implemented by World Food Programme and its partners are increasingly taking this form.

In South Africa, there is suggestive evidence that cash plus may reduce HIV-risk behaviours among adolescents, however no study to date has specifically examined impacts on these outcomes of a cash plus intervention in the context of a government cash transfer. One observational study asked respondents whether they received the government’s Child Support Grant (or other government cash grant) and additionally, receipt of other services (school feeding, soup kitchen feeding, home-based carer support), positive parenting behaviours (using a scale which assess warmth, support, etc.), and social, practical and emotional support from teachers (Cluver et al. 2014).

Results from this study showed that girls in households receiving cash support demonstrated reduced HIV-risk behaviours. Further, boys and girls in households that reported both cash or food support in addition to caregivers reporting positive parenting behaviours (not an intervention or social programme) or teacher support were also less likely to report HIV-risk behaviours. A second study used quasi-experimental methods and found that receipt of the Child Support Grant was associated with reduced risk behaviours in girls, but not boys (Cluver et al. 2013). However, in this latter study, positive parenting behaviours were not associated with reductions in HIV-risk behaviours among boys or girls.

Sometimes, ‘soft conditions’ are added to cash transfer programmes, with the intention of amplifying the positive benefits of cash in terms of directing investment into human capital development or linking

\(^1\) A technical review of the evidence of the 12 key family and community practices on child care promoted by WHO and UNICEF and feasibility of interventions to improve them—here referred to as “The Review”—was conducted by WHO in collaboration with the London School of Hygiene and Tropical Medicine in 2004. This followed The Lancet series on child survival (2003). More recently (2011), the World Health Organization (WHO), the Aga Khan University, the Partnership for Maternal, Newborn & Child Health (PMNCH) and 14 partners have carried out a review to identify key interventions to reduce maternal, newborn and child deaths. The review has confirmed the importance of the interventions identified earlier to promote those practices and has updated them. http://www.emro.who.int/child-health/community/family-practices
beneficiaries up to other services. In Ghana, for example, the Livelihood Empowerment Against Poverty (LEAP) programme seeks to supplement the incomes of ‘dangerously poor households’ through the provision of cash transfers and to link them with complementary services so that they can, over time, ‘leap out of poverty’. ‘Soft conditions’ (i.e. ones that are encouraged but not necessarily used as a basis for exclusion if not taken up) have included registration of children’s births and non-involvement in child labour and trafficking, as well as minimum requirements such as vaccinations, health check-ups and school attendance (Jones and Holmes 2010).

Some practitioners consider that conditional cash transfers can as a whole be considered to be a form of ‘cash plus’ in that they provide incentives for investment in education and health (Lindert, WB 2014). It is, however, not always clear whether it is the condition per se or the cash that is most responsible for positive outcomes. In a hybrid model, Malawi saw first-time enrolment increase among families receiving both an unconditional cash transfer (US$2.30–5.50 per month) and an additional conditional transfer (US$0.70 for primary school, US$1.40 for secondary school) (UNICEF 2015). Some suggest that it is not the conditions themselves, but the additional awareness raising around the conditions that enhance the impact of cash transfers. In its global review of evidence, UNICEF concluded that:

‘Unconditional cash grants generate the broadest range of benefits and offer maximum flexibility and respect for beneficiary views, in line with a rights-based approach to programming. If there is an advantage to conditionality, it is the claimed ability to ensure a single over-riding goal is achieved, such as education. But in fact, populations tend to value those goals highly, and will invest to reach them with their unconditional grants. Unconditional grants elicited major changes in education, for example, while also inducing many other important investments and retaining beneficiary freedom of action. This strengthens the argument in favour of unconditional grants’ (UNICEF 2015).
3. TASAF and PSSN

3.1 Background

The Tanzania Social Action Fund (TASAF) was established in 2000 as part of the Government’s overall poverty reduction strategy. Phase I (2000-2005) focused on improving social service delivery, capacity enhancement, and addressing income poverty for food insecure households. Phase II (2005-2013) built on the Millennium Development Goals (MDGs) and expanded nationally to address a shortage of social services, income poverty, and capacity enhancement (UNICEF and REPOA 2015; TASAF PPT 2011; WB 2012). As a social fund, TASAF mobilised more than 100,000 members of Community Project Committees around community-driven local infrastructure and development projects. A pilot community-based conditional cash transfer was also designed and implemented during this period, with 13,081 beneficiaries in three poor districts of the country (TASAF PPT 2011).

In its current phase (TASAF III), TASAF intends to transform from a social fund to a public institution crucial for the implementation of a nationwide social safety net, with the Productive Safety Net (PSSN) programme the first step in the transition from one-off support for community infrastructural development to a system of regular and predictable social transfers (WB 2012). Other elements of TASAF III include support to community-driven interventions to enhance livelihoods; targeted infrastructure development (health, education, water); and capacity development at national and local government levels. TASAF III is in line with MKUKUTA/MKUZA-II (National and Zanzibar Strategies for Growth and Reduction of Poverty) objectives and the advancement of the social protection agenda (TASAF PPT 2011).

3.2 PSSN Programme elements

The PSSN has been designed to support the poor and vulnerable section of the Tanzanian population. It is expected to significantly reduce the poverty headcount and poverty gap by 5% and 30%, respectively. The PSSN aims to improve both consumption and human capital accumulation through a mix of cash transfers (unconditional and conditional) and public works accompanied by community savings promotion (WB 2012). It targets poor households through a three-stage approach combining geographical targeting, community-based targeting, and verification through a proxy means test (WB 2015b).

The unconditional transfer (Tsh 10,000) is provided to all enrolled households, with an additional transfer (Tsh 4,000) to households with children under 18. The conditional transfers offer (i) a grant (Tsh 4,000 per month) to households 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 (Tsh 2,000) to households with children demonstrating an 80% primary school attendance rate; (iii) an individual grant (Tsh 4,000) for children demonstrating an 80% lower secondary school attendance rate; and (iv) an individual grant (Tsh 6,000) for children demonstrating an 80% upper secondary school attendance rate where such services are available.

Additional workshops are to be planned on good child care practices, sanitation and hygiene, education. This component is expected to reduce household monetary constraints on health and on education and as a result, improve human capital accumulation of the children. Primary recipients in the household are adult women (primarily mothers) (WB 2012; and UNICEF Country Office). Maximum total benefit per household for this group of transfers is set at Tsh 38,000 (see table 1).²

---

² Due to fluctuations in the exchange rates, the dollar equivalents have dropped from what is reflected in the accompanying table. Based on current rates (Jan 2016) 10,000 = around US$4.57
The labour – intensive public works component is for beneficiary households from the above two groups with able-bodied members (maximum two per household); it offers approximately US$1.35 per day (though now lower, given fluctuations in the exchange rate, as noted above) for up to 60 days of work per household during the lean season. It aims to contribute to the overall objective of food security and help build resilience to climate-related shocks (drought, floods) as well as to support creation of community assets. Work is mostly in the areas of agriculture, soil and water conservation and management, and rehabilitation of degraded areas, with the longer-term objective of enhancing livelihoods (WB 2012).

The public work scheme is complemented by a community savings promotion and investment sub-component which aims to encourage beneficiary households to develop a culture of savings arising from the security offered by a regular cash transfer and also to invest in small projects. This builds on progress achieved in this area in TASAF II and will focus on the promotion of a group savings methodology through community sensitisation and mobilisation; institutional and capacity building for the groups (including training on group management, financial literacy, record-keeping) and innovative ICT promotion in building different savings products at community level. The groups will continue to receive technical support and supervision as they begin to save, as well as further potential training on issues such as gender, HIV/AIDS or nutrition (WB 2012).

The overall PSSN covers around 1.1 million extremely poor households across the country (6.5 million people), with varying degrees of benefits. The approach adopted is to target multiple interventions to the same households. Within this framework, and subject to household composition, eligible households may receive a wide range of transfers. The highest amount represents 35% of the enrolled households’ consumption. This combination of interventions (which has not previously been tested) aims to maximise the impact of the safety net in reducing vulnerability, increasing household food security and wellbeing, and promoting utilisation of available schools and health facilities by children and pregnant women (WB 2012).

3.3 Evaluations

Evaluations of the pilot CB-CCT

The community-based conditional cash transfer pilot (CB-CCT) was the first government-run, strictly conditional transfer in Africa (other evaluations of cash transfers in Africa have been of unconditional government programmes in several countries); its performance and impact have been rigorously assessed in order to inform expansion and the eventual design of the PSSN. Evaluations included a process evaluation (completed in September 2011); a targeting assessment (carried out between April and July 2011); an impact evaluation based on quantitative analysis of baseline and two follow up surveys (Baseline in February 2009, follow up survey in September 2011, end-line survey in October 2012); a qualitative assessment based on focus groups (first set of focus groups in August 2011, second
set in December 2011); and a social accountability exercise using Community Score Cards (finalised in August 2011) (WB 2012).

The primary objective of the impact evaluation was to test the combined effectiveness of (a) a CCT programme in Tanzania and (b) a community-based model to implement the programme. The underlying question was whether this community-based model was effective at achieving health, education, and consumption gains as has been the case of more centrally administered models used elsewhere. Among the key results: significant improvements in health, particularly for the poorest households; positive impacts on primary school attendance and – for girls – an impact on completion (girls in beneficiary households were 23 percentage points more likely to complete standard 7 compared to the control). There was also a greater tendency for treatment households to purchase health insurance compared to the control (Evans et al 2013).

**Planned impact evaluation of PSSN**

The overall monitoring and evaluation system for the PSSN will include data generation through the MIS system as well as regular process evaluations and assessments which will inform programme adjustments and the design of trial evaluations. A comprehensive impact evaluation is being designed to measure the impact of PSSN using a randomized control trial, comparing three treatment and one control group over 36 months, based on the villages selected for the first year of programme implementation. (WB 2012) The impact evaluation will seek, particularly, to (i) measure the overall impact of the PSSN on key indicators; (ii) evaluate differential impacts of receiving CCTs only compared to CCTs plus public works; and (iii) assess the programme’s targeting performance. On the mainland, the evaluation will cover the subset of 16 Project Area Authorities (PAAs) randomly selected from the 99 PAAs in Waves 4 and 5 of the scale up out of a total of 161 PAAs covered by the programme; an additional ten PAAs will be covered in Zanzibar. To the extent feasible, the evaluation will also assess beneficiary and community perceptions of the programme. Among the key questions and outcome indicators is one related to programme effects on the incidence of violence among women (WB 2015b). Baseline evaluation data were collected in mid-2015.

**Other planned evaluations**

REPOA and UNICEF are currently conducting an impact evaluation of the PSSN on youth well-being and the transition to adulthood, within the context of REPOA’s larger study on PSSN impacts on women’s empowerment. The study is a randomized-control trial (RCT) with two waves of data collection (baseline was conducted in 2015 and endline is scheduled for 2017). Surveys were conducted among youth ages 14 to 28 at baseline, with same-sex enumerators (due to the sensitive nature of some questions), and using tablet technology. Preliminary baseline findings indicate high rates of depressive symptoms (63% of youth interviewed), sexual debut (62% of youth), pregnancy (54% of females), concurrent sexual relationships (21% of all youth who had ever had sex), and transactional sex (22% of all youth) (Palermo, 2016). Results from the impact evaluation will inform design of future iterations of the Government’s social protection and other complementary programming supporting the safe transition of Tanzanian youth.
4. Adolescent empowerment initiatives

4.1 Background and overview

Programmes designed primarily to promote adolescent ‘empowerment’ cover a wide variety of types of interventions, ranging from ‘life skills’ education of various sorts to economic empowerment, including promotion of micro-finance and savings and loans groups, promotion of vocational education and other types of income-generation support. While some of these interventions can be implemented as ‘stand-alone’ programmes, often they are ‘bundled’ together, based on a combined livelihoods and ‘assets-building’ framework that suggests that empowerment derives from the strengthening of different forms of ‘capital’ to build up multiple forms of assets, or stores of value. Many of these programmes include focused economic strengthening components - sometimes described as ‘structural interventions’ (Gibbs et al. 2012) - based on analysis that shows that livelihood insecurities can fuel poverty-driven behaviours with negative outcomes for young people, including, for example, transactional sex particularly for females (Gibbs et al. 2012). Because gender inequality may exacerbate risks related to economic insecurity, many programmes also include some kind of ‘gender empowerment’ elements that can also be seen in other types of programmes designed to address social norms as structural features patterning adolescents’ lives and contributing to various risk factors for HIV and AIDS. (See more details on the latter applied at community level in the next chapter)

Much of the conceptual development around adolescent empowerment programmes has taken place around adolescent girls where the asset-building framework has been a key theoretical underpinning for the design of interventions (see figure 2). The theory of change in such models posits that girls need a combination of social, health, and economic assets to make a healthy transition into adulthood, which in turn will reduce poverty. Having one kind of asset (i.e., knowledge of HIV and pregnancy) is not sufficient, because often a girl’s economic situation overshadows her knowledge of risky behaviour. Similarly, only having a savings account or a vocational skill is not enough for girls to take control of their health or to have the self-esteem and networks through which to capitalise on economic opportunities (Austrian et al. 2012). The key for these programmes is to offer an

---

3 These are often identified as financial capital, human capital, social capital, natural capital and physical capital (Leach et al. 1997; Bebbington 1999; and Scoones 2009, cited in Gibbs et al. 2012)
appropriate mix of interventions though which girls may simultaneously reduce their social, health and economic vulnerabilities and expand their opportunities. Many such programmes therefore work through a ‘safe spaces’ model that offers a platform for girls to come together – often with female mentors – to learn, discuss, and gain confidence, while also accessing other activities such as savings and loans support (Muthengi, 2016, personal communication).

A number of reviewers have compiled and analysed the evidence arising from such ‘bundled’ empowerment initiatives, suggesting that these are promising approaches for a variety of positive outcomes, many linked to ‘safe transitions’ through adolescence (see for example Kennedy et al. 2014; Gibbs et al. 2012; McAslan 2012; Fewer et al. n.d.). Some point specifically to their efficacy in addressing violence, particularly against women and girls (see for example Ellsberg et al. 2014), though also caution that some micro-finance initiatives for women and girls may have unintended negative consequences in terms of gender-based violence and so need to be complemented by other interventions and safeguards (see, for example, McAslan 2012). Nevertheless, the evidence on microfinance and violence risk is mixed, and one study using quasi-experimental methods failed to find a link between micro-finance and increased violence in Bangladesh and concluded that previous analyses documenting such a link likely suffered from selection bias, whereby microcredit participants were systematically more disadvantaged with respect to socioeconomic status and thus at increased risk of intimate partner violence as compared to non-participants (Bajracharya & Amin 2013).

Global initiatives seeking to promote evidence-based practice around adolescents have identified appropriately designed economic empowerment programmes in varying dimensions as key interventions to reduce risky behaviours, prevent violence, and protect adolescents from HIV transmission. THRIVES, for example, the US Centers for Disease Control (CDC) partnership initiative, highlights microfinance combined with gender norm/equity training as a promising approach for violence reduction efforts, citing in particular evidence from the Intervention with Microfinance for AIDS and Gender Equity (IMAGE) programme in South Africa, which reduced intimate partner violence by 55% (Pronyk et al., 2006, cited in Hillis et al. 2015). WHO (2010) also refers to the IMAGE study in its recommendations around microfinance programmes and incorporating education sessions and skills-building workshops to help change gender norms, improve communication in relationships and empower women as a promising approach to violence reduction.

Guidance for countries involved in the DREAMS initiative supported by the President’s Emergency Plan for AIDS Relief (PEPFAR) identifies approaches that combine economic and social empowerment interventions as having more consistent effects on both behavioural and violence outcomes than stand-alone economic empowerment programmes, noting that the ‘social empowerment’ elements supported by the literature include discussion groups on GBV/IPV and couples communication, mentoring, and comprehensive, evidence-based HIV prevention curricula (PEPFAR 2016).

4.2 Evidence and examples

Adolescent empowerment with micro-finance components

A number of programmes are designed to address women or girls’ lack of financial capital and financial knowledge seen as critical barriers to gender-equitable relations. They are often combined with training on business skills and gender transformation. In a review of evaluations of interventions in southern and eastern Africa that seek to address simultaneously poverty and unequal gender norms as structural drivers of HIV, Gibbs et al. (2012) analysed outcomes as well as the strengths and weaknesses of different types of interventions, including those with micro-finance components (see box 2). A number of other examples have also been found in the literature.

---

4 THRIVES: Training in parenting; Household economic strengthening; Reduced violence through legal protection; Improved services; Values and norms that protect children; Education and life skills; Surveillance and evaluation

5 See fuller details in annex 1
Box 2. Combined life skills, microfinance and gender empowerment programmes in eastern and southern Africa

- **IMAGE (Intervention with Micro Finance for AIDS and Gender Equity) in South Africa** offered micro-loans to poor women (average age 42) over 10 to 20 week cycles accompanied by 10 participatory learning sessions and 6-9 months of community mobilisation. Relevant outcomes among participants include a 55% reduction in the experience of inter-partner violence (IPV) in all age groups and a 24% decrease in unprotected sex with non-spousal partner among those aged 14-35.

- **TRY (Tap and Reposition Youth) in Kenya** provided a modified microfinance scheme to out of school adolescent girls and young women, with trained mentors leading educational discussion groups. The programme experienced high drop-out (66%); while there were marginal improvements in gender attitudes and increased ability to insist on condom use, there was no improvement in reproductive health knowledge.

- **Micro-enterprise services for sex workers over 18 in Kenya** (average age 41) added microfinance onto an on-going peer education programme. Results include 45% reporting who reported leaving sex work, a decline in the mean number of sex partners in the past week, and an increase in condom use with regular partners, but no statistically significant change in self-reported weekly mean number of casual partners. Results were also highly age-specific, with older women reporting better outcomes.

- **Shaping the Health of Adolescent Girls in Zimbabwe (SHAZ!**) offered vocational training supplemented by micro-grants (rather than loans) and financial literacy training to adolescent girls and orphans aged 16-19 along with an adaptation of the Stepping Stones gender empowerment interventions including training on negotiation skills and integrated social support. Initial programme outcomes after 6 months had mixed results, including increased HIV risk through new mobility and economic strategies. Programme outcomes in the second two-year phase included a 58% reduction in physical and sexual violence and an increase in gender equitable norms.

Source: Gibbs et al. 2012

- **Safe Savings for Girls, Uganda**: Austrian and Muthengi (2014) tested the asset-building framework for adolescent empowerment in a programme for adolescent girls aged 10-19 in Uganda, comparing outcomes on a variety of indicators for girls who participated in the full-intervention model (Savings PLUS safe groups with reproductive health and financial education training) with girls who only received savings accounts (Savings Only). A key finding was that girls who benefitted from the full intervention were less likely to experience sexual harassment than girls benefiting from savings accounts only. The authors suggest that it is possible, therefore, that an increase in economic assets without the support the proper social support and health and life skills training can increase certain aspects of girls’ vulnerability—specifically related to experience of sexual harassment and violence. It seems, on the other hand, that the social and health assets created through the integrated intervention model were protective against the experience of sexual harassment. This is similar to the results of the SHAZ initiative in Zimbabwe outlined in the box above, showing that a sole focus on economic asset building may increase vulnerable adolescent girls’ experience of sexual harassment and violence (Dunbar et al. 2010 as cited in Gibbs et al. 2012).

- **SUUBI, Uganda**: This economic asset-building and empowerment initiative offered workshops on financial planning and asset building combined with monthly peer monitoring and a child’s saving account to adolescent school boys and girls who had lost one or both parents to AIDS. In a randomized control study, children in the treatment group had significantly lower intentions to have sexual intercourse compared with the control group, though boys were more willing to engage in sexual risk-taking than girls, and older adolescents overall were more likely to report intentions to engage in sexual risk-taking behaviours overall (Ssewamala et al. 2010a). A limitation of this study is that impacts were measured on intentions, and not actual behaviours, as only seven adolescents out of a total study sample of 260 reported sexual debut.
Adolescent empowerment with financial literacy or vocational training

A number of programmes are similar to the above, but stop short of actual micro-finance interventions; instead integrating elements of financial literacy or vocational training onto broader-based ‘life skills’ programmes which usually include a reproductive health focus. Examples include the following:

- **Stepping Stones and Creating Futures, South Africa**: Stepping Stones is a well-known and widely implemented participatory learning approach to violence and HIV-prevention, with the ‘gender transformative’ aim of building more equitable relationships and communications between partners through life skills training and critical discussion. In response to limited positive outcomes for women in the programme (as compared to men), an economic empowerment intervention (Creating Futures) was added in the form of help for finding work or setting up a business (but no provision of cash or credit). Results for the combined approach for both men and women showed positive livelihood results (increased earnings) and positive changes in gender-equitable attitudes along with a reduction in IPV and improvements in mental health (Jewkes et al. 2014).

- **Empowerment and Livelihood for Adolescent Girls (ELA) Uganda (BRAC)**: Adolescent development centres were established as ‘safe spaces’ for girls who were guided in life skills training by female mentors, coupled with training in livelihoods and vocational skills. A randomized control trial tracking 4800 girls over two years found that the combined provision of ‘soft’ life skills and ‘hard’ vocational skills lead to substantial advances in economic empowerment and control over the body for girls in treated communities compared with the control groups. Key outcomes include a 26% reduction in rates of early child-bearing and 58% reduction in rates of marriage/cohabitation while share of adolescent girls reporting having had sex unwillingly was 6 percentage points lower in treatment compared to control group (Bandiera et al. 2015).

- **Street Smart, Uganda**: A combined vocational and health-training programme focused on HIV prevention for high-risk urban youth (male and female), this intervention included apprenticeships with local artisans and entrepreneurs for the control group. For both groups, there were significant decreases over time in the number of sexual partners and conduct problems accompanied by increases in abstinence, condom use during sex, and social support (Rotherham-Borus et al. 2010 and Kennedy et al.)

- **Siyakha Nentsha, South Africa**: This is a school-based initiative combining life skills and reproductive health training to build social and health capabilities (the basic model) with financial training to build financial capacities (the enhanced model) to school age boys and girls (14-16). Preliminary results after 4 years for both versions include increased HIV-AIDS-related knowledge and in the enhanced version increased self-esteem among girls and reduction in boys in onset of sexual activities and number of partners. Other results of the combined programme included increased knowledge and autonomy around financial-planning and decision-making power (Hallman and Roca 2011; also reported in Gibbs et al. 2012).

4.3 Concluding discussion points

A number of general observations and lessons may be drawn from the interventions outlined above:

- Many use either explicitly or implicitly some version of the assets creation and capital development framework positing that multiple forms of assets and capital are critical for adolescent empowerment;
- Most start from a general ‘life skills’ approach including reproductive health training and add in a focused economic component – either through training, financial literacy or micro-savings/credit facilitation;
- Many add in additional gender empowerment elements in the life skills content and activities or focus specifically on girls, identified as the most vulnerable or ‘at risk’;
- While the intent of both economic and gender empowerment elements is to address ‘structural’ drivers of risk and vulnerability such as poverty and gendered power imbalances, the focus is, in
fact, on strengthening individual attitudes, capabilities and behaviours – not on affecting broader societal changes in norms or structures;

- Experience indicates that micro-savings are more appropriate than micro credit for adolescent girls, and that these need to be embedded in other activities and measures to ensure against negative effects;

- Programmes report a variety of positive outcomes relating to both violence-reduction and reduction of other ‘risky behaviours’ as well as to broader-based ‘empowerment’, suggesting that the models are relevant for a broad array of adolescent initiatives; and

- Overall, the models suggest that life skills training (enlarged to combine reproductive health information, confidence-building, social awareness and social capital promotion, gender empowerment, and financial ‘literacy’) provides a needed ‘space’ and process for positive empowerment through more focused economic support (such as micro-savings) to occur.
5. Parenting programmes

5.1 Background and overview

Parenting programmes are interventions designed to increase parental skills and knowledge of child development, improve parent-child relationships, and strengthen parents’ ability to cope with children’s behavioural demands in ways that are positive and socially beneficial. Their goals include reducing behavioural problems in children, such as aggression and oppositional behaviour, and addressing core aspects of parent-child relationships (WHO 2015). They normally offer a combined service of parenting knowledge, skills-building, competency enhancement, and support to parents (Chen and Chan 2015). Basic components of parenting programmes include active skills training or coaching for parents involving video or live modelling skills, practice of skills, feedback following direct observation of parent-child interaction, and some between-session ‘homework’ (Mejia et al 2015).

Most of the evidence on the effectiveness of parenting programmes derives from evaluations in wealthy countries and much focuses on younger children rather than adolescents (WHO 2015; Cluver 2016; Cluver et al, nd). A systematic review of reviews (Mikton and Butchart 2009) identified a number of programmes with a promising evidence base for child abuse prevention, but noted the weaker evidence base in low and middle income countries (LMICs). It noted specifically that while there are small and medium effects for parent education programmes, the evidence mostly shows improvement in risk factors rather than actual child maltreatment.

A later review of initiatives in LMICs (Knerr et al. 2013) suggested that effective parenting interventions are potentially adaptable and applicable across cultures, countries and income groups, with evidence under-pinned by longitudinal studies, showing that even in low-income contexts, responsive, consistent styles of parenting play a protective role, buffering effects of family and community poverty on children’s development, including aggression and violent behaviour. The reviewers concluded that parenting interventions have been shown to reduce the risk and incidence of child physical maltreatment in low-income environments by enhancing positive parenting skills and providing effective but non-physical forms of discipline. Furthermore, parenting interventions contribute to reducing family stress and maternal mental ill-health important risk factors for maltreatment. However, an even more recent systematic review of child maltreatment programmes for parents (Altafim and Linhares 2016) confirms the paucity of evidence to date from LMICs (only two studies identified), with few randomised control trial evaluations; and also notes that while programmes promote effective and positive parenting practices which may subsequently reduce violence, few directly measure violence outcomes.

Based on the existing evidence, parenting programmes have been identified as a promising strategy for the prevention of child abuse and youth violence by WHO (2015) and a suite of affordable parenting programmes is currently being developed and tested by partners working within the Parenting for Lifelong Health (PLH) programme, initiated in 2012. 6 THRIVES also identifies parenting programmes as a critical part of a package of complementary strategies to prevent violence against children (Hillis et al. 2015). And recent guidance on HIV prevention efforts focused on adolescent girls and young women promotes parenting and caregiver programmes as a means of strengthening the family and preventing risky behaviours in young people, with the rationale that having a positive relationship with a parent, caregiver, or other caring adult is a consistent protective factor for young women and girls against a variety of negative health and social outcomes, citing evidence (from Wight and Fullerton 2013) that skills-building programmes involving parents and caregivers have shown promise to change HIV related sexual behaviours among youth including use of male and female condom, delayed sexual debut, as well as decreased exposure to negative outcomes such as violence and abuse (PEPFAR 2016).

Key principles that have been identified as central for the content of effective parenting programmes derive from social learning theory and include: modelling of learned behaviour; positive parenting skills

---

6http://www.who.int/violence_injury_prevention/violence/en/
before discipline; positive instruction-giving; ignoring negative attention-seeking; non-violent limit-setting/discipline; client-led collaboration; group-based approaches; role plays and coaching; and home practice of parenting skills (Barlow et al. 2011, cited in Cluver 2016). Considerations for adaptation of existing programmes for LMIC settings include use of minimal materials; use of role plays instead of videos, and implementation by non-professional staff (Cluver 2016).

5.2 Evidence and examples

- **Sinovuyo Caring Families Teen Programme, South Africa:** The only existing evidence on parenting programmes for adolescents in eastern and southern Africa arises from the ‘Sinovuyo Teens’ initiative being implemented by a consortium of partners as a 12-week parenting programme for adolescent boys and girls and their caregivers in rural and peri-urban areas of Eastern Cape Province. Implementation is by a local NGO. Sessions cover a variety of topics (see tables 2), with some conducted as joint activities with parents and teens, and others conducted separately. The programme and study are designed to contribute to the evidence base for the scale-up of effective and affordable models in LMICs.

Table 2. Topics covered in Sinovuyo Teen programme, SA

<table>
<thead>
<tr>
<th>1: Defining goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>2: Building warmth: special time</td>
</tr>
<tr>
<td>3. Praise</td>
</tr>
<tr>
<td>4: Talking about emotions</td>
</tr>
<tr>
<td>5. What do we do when we are angry?</td>
</tr>
<tr>
<td>6. Putting out the fire: problem-solving</td>
</tr>
<tr>
<td>7. Making family budgets</td>
</tr>
<tr>
<td>8. Dealing with problems without conflict I</td>
</tr>
<tr>
<td>9. Dealing with problems without conflict II</td>
</tr>
<tr>
<td>10. Family rules and routines</td>
</tr>
<tr>
<td>11. Making family savings plans</td>
</tr>
<tr>
<td>12. Keeping teens safe in the community</td>
</tr>
<tr>
<td>13. Responding to crisis</td>
</tr>
<tr>
<td>14. Widening circles of support</td>
</tr>
</tbody>
</table>

Source: Cluver 2016

The initiative has been subject to two pre-post evaluations (Cluver et al. n.d.a; and Cluver et al n.d. b), with a randomised control trial currently underway. While the pre/post evaluation designs are unable to definitely attribute causal impacts on outcomes of interest to the parenting intervention, the findings do, however, suggest improvements in a range of primary adolescent and caregiver outcomes including, for the most recent evaluation: reductions in *child abuse within the home* reported by both adolescents (from 63.0% to 29.5%) and caregivers (from 75.5% to 36.5%); improvements in *positive parenting* reported by both adolescents (from 48.71% to 51.62%) and caregivers (from 49.23% to 53.83%); and decrease in *adolescent behavioural problems* (delinquency/ aggression) reported by both adolescents (from 8.64% to 6.40%) and caregivers (from 16.16 % to 12.14%). Positive secondary outcomes were also reported, including: *access to improved social support* reported by caregivers (from 29.2% to 33.56%) and *improved social*  

---

7 See Annex 2 for details
support from parents reported by adolescents (from 29.29% to 33.56). Reduced depression reported by both adolescents (from 3.02% to 1.37%) and caregivers (from 23.23% to 14.06%). Significant decreases were also reported by caregivers in parenting stress (from 26.43 to 21.46) and in caregiver substance use (from 0.74 to 0.40). A more rigorous RCT evaluation of this intervention currently underway will provide more conclusive evidence of whether this programme does in fact reduce violence-related outcomes.

- **Home visit programme, South Africa**: Home visits are common aspects of parental support programmes in many contexts. One programme in South Africa aimed to assess the overall effectiveness of home visits to families receiving the Child Support Grant and Foster Child Grant in improving psychological well-being of children and their caregivers (Thurman et al. 2014) and to evaluate the relative effectiveness of para-professional or volunteer home visitors on uptake of the grants (Thurman et al. 2015). While the second study showed that trained para-professionals proved more effective than volunteers in supporting grant uptake, the first study showed no measurable improvements in psychological well-being for either model, while outcomes worsened on three indicators. The authors conclude that findings underscore the need for programmes serving HIV-affected families to add focused evidence-based psychological interventions to supplement traditional home visiting (Thurman et al. 2014). It may also be suggested that home visits as stand-alone interventions, not linked into broader parental support programmes, may have considerable limitations.

### 5.3 Concluding discussion points

- Parenting programmes focus on enhancing parental skills and attitudes – including around positive discipline – and strengthening parent-child communication, with the ultimate aim of improving child outcomes;
- Evidence on the impact of parenting programmes has to date derived primarily from interventions in higher income countries and from programmes targeting younger children; nevertheless there is emerging evidence on initiatives in lower and middle income countries and a concerted effort underway to strengthen this evidence base;
- A general set of principles has been established to guide programming around parenting initiatives, as well as key points for consideration about how to adapt existing programmes to low resource settings;
- The current Sino Teens initiative offers emerging evidence which suggest there may be beneficial impacts on a arrange of primary and secondary adolescent and caregiver outcomes, based on two small pre-post evaluations; a larger randomized control trial is currently underway that will offer more rigorous evidence on whether this programme can improve outcomes of interest; and
- On the basis of current evidence, different consortia of international partners have recommended consideration of parenting programmes as part of a larger suite of interventions to address violence against children as well as HIV prevention.
6. Community mobilisation for social norm change

6.1 Background and overview

A number of programmes go beyond a sole focus at individual or household/family level to address broader structural causes of HIV risk behaviours, violence and disempowerment of adolescents which are seen to be operating at the societal level. This may be in the form of deeply entrenched social norms, beliefs, and attitudes that promote or discourage particular practices in a given community (see box 3).

Many such programmes stem from a conceptual framework known as ‘the social ecological model’ that has been developed to help illustrate the multiple risk and protective factors for adolescents across the different levels of individual, family, community and society. The model highlights the complex interplay of factors within and between the levels, and has therefore been useful for the design of particular programme interventions at different levels (Heise and Fulu 2014; CDC nd).

The model itself and social norms theory more generally have been widely applied either explicitly or implicitly in analysis and programming around violence (Heise, 1998; Vyas and Watts 2009); gender justice and equality (IRH 2014); risky behaviours around HIV and AIDS including gender-based violence (Usdin et al. 2005); early marriage and female genital mutilation/cutting (UNICEF n.d.); and work on ‘masculinities’ (Peacock and Levack 2008; Peacock and Barker 2014; Edstrom et al. 2015). One recent initiative in Uganda applied the ecological model in its Gender Roles, Equality and Transformations (GREAT) project, with an added life-cycle dimension that helped in the design of age-specific interventions (see figure 3).

Many programmes designed to address social norms use communications of some sort to stimulate critical thinking and mobilise communities around potential for change. A recent review of a broad spectrum of communications-based initiatives for adolescent girls showed that such approaches could be an effective way of challenging gender-discriminatory attitudes and practices, reaching a variety of stakeholders with both broad pro-gender equality messages and messages on

Box 3. What are social norms?

Cultural and social norms are rules or expectations of behaviour within a specific cultural or social group. Often unwritten and not always fully articulated, these norms offer social standards of appropriate and inappropriate behaviour, governing what is (and is not) acceptable and co-ordinating our interactions with others. Cultural and social norms persist within society because of i) individuals’ preference to conform, given the expectation that others will also conform; and ii) fear of sanctions if one does not conform, including the threat of social disapproval or punishment and feelings of guilt and shame that result from the internalization of norms.

Cultural and social norms do not necessarily correspond with an individual’s attitudes (positive or negative feelings towards an object or idea) or beliefs (perceptions that certain premises are true), although they may influence these attitudes and beliefs if norms becomes internalized. Distinctions have been made between ‘descriptive’ norms (showing the pattern of behaviours that actually occur) and ‘injunctive norms’ (expressing what society holds to be the ideal type of behaviours). Cultural and social norms also vary widely

Various sources, in WHO 2010; Hillis et al. 2015; Marcus and Harper et al. 2015.

Figure 3. Ecological framework with life course

Source. IRH 2014 (GREAT project, Uganda)

8 Defined broadly to include mass media and social media; information, education and communication (IEC) dissemination; community dialogue and reflection; non-formal education including life skills; mentoring and peer education; public ceremonies; training and capacity-building for professional personnel; and hybrid approaches of the above (Marcus and Page 2014)
specific discriminatory norms. While no one approach was found to be clearly more effective than others, programmes with more than one communication component and those integrated with non-communications activities were found to achieve a higher proportion of positive outcomes. Effective approaches included dialogue-based processes that create opportunities for reflection and help people shift both attitudes and practices, face-to-face communication with a diversity of target groups; creation of appealing TV and radio characters that both facilitate dialogue and act as role models; and provision of supportive information, education and communication (IEC) materials (Marcus 2014; Marcus and Page 2014; Marcus 2015).

Many reviewers note that community sensitisation/mobilisation interventions are more difficult to evaluate than others types of programmes. In contrast to the targeting of specific individuals through group training programmes, such as the ones reviewed in the previous chapter, community mobilisation efforts aim to reduce targeted behaviours at the population level through changes in public discourse, attitudes and norms; this involves complex interventions engaging many stakeholders at different levels, making precise evaluation challenging (Ellsberg et al. 2014).

Nevertheless, on the basis of the evidence that does exist, community mobilisation approaches have been identified as promising initiatives for violence reduction efforts overall (WHO 2010), including within the recommended package of promising interventions developed by the THRIVES initiative to address violence against children. Such efforts may include parenting training delivered in small groups in community settings or broader community mobilisation and campaigns aimed at changing social norms that accept or allow indifference to violence is necessary to prevent violence against children (Mercy 2015, cited in Hillis et al. 2015). Community sensitisation effort approaches have also been recommended in broader HIV prevention work where it is seen as an important pathway to engaging men, boys and the broader community in addressing the social norms that increase HIV risks (PEPFAR 2016).

6.2 Evidence and examples

- **Stepping Stones, South Africa**: While not a community mobilisation approach per se, the Stepping Stones participatory learning approach involving small groups of individuals or partners includes a community meeting as well to engage the wider public in addressing, among other things, motivations for behaviour. The initiative has reported positive impacts primarily on male self-reported violent or ‘risky’ behaviours, but more limited impact on women, leading to the addition of the ‘Creating Futures’ economic empowerment component (Jewkes et al. 2008, and Jewkes et al. 2014; also cited in WHO 2010 and Hillis et al. 2015) (see chapter 4 on adolescent empowerment).

- **Soul City, South Africa**: Described as one of the ‘best-known and most carefully evaluated media programmes’ (WHO 2010), Soul City uses multi-media interventions to address a variety of social norms and behaviours, including HIV risk behaviours and gender-based violence. It has been widely cited for its development of ‘edutainment’ through drama to draw viewers/listeners into stories modelling social issues. Evaluation of its 4th series on gender-based violence found significant shifts in knowledge and attitudes around domestic violence including a 10% increase in respondents disagreeing that domestic violence was a private affair and a 22% shift in perceptions of social norms on this issue (Usdin et al. 2005).

- **SASA! Uganda**: A community mobilisation intervention to prevent violence and reduce HIV risk behaviours in, SASA! works through community activists, media and advocacy, and dissemination of information materials to shift community attitudes and norms particularly around gender-based violence and gender inequality. In Abramsky (2014), positive impacts are reported in attitudes among women, however reductions in experiences of violence against women were not statistically significant. Among men, there were no statistically significant impacts on attitudes, but there was

---

9 See Annex 3 for fuller details
a reduction in multiple partners reported by men. Analysis from a recent presentation by Abramsky further explored various violence outcomes and found statistically significant reductions in intensity of violence, continuation of intimate partner violence, and emotional violence (Abramsky 2016). Further, while families in treatment communities reported a 64% reduction in children’s exposure to intimate partner violence in the home, this finding was also not statistically significant (Kyegombe et al. 2015). Overall, the SASA! findings suggest possible positive impacts of the programme on a range of promising outcomes, but given the small number of randomised clusters in the study design, the study may be underpowered to detect significant programme impacts.

- **SHARE Uganda**: The Safe Homes and Respect for Everyone (SHARE) project is a combination IPV and HIV prevention intervention adapted from the SASA! initiative in Uganda and Stepping Stones in South Africa and based on an ecological model of social change. A large randomised control cohort study indicated that SHARE was associated with statistically significant declines in women’s experience of physical and sexual IPV; men’s reports of perpetration of emotional IPV (PRR=0.88); and men’s (but not women’s) HIV incidence among men but not women (Wagman et al. 2012, 2015a).

- **GREAT Uganda**: Also based on the ecological model of social change, the Gender Roles, Equality and Transformation (GREAT) project uses a serial radio dramas, community dialogues, and age-specific adolescent information/communication/discussion groups to promote shifts in attitudes around gender inequalities, including gender-based violence, and improve sexual and reproductive health knowledge and practices. Preliminary findings from an end line evaluation indicate, among other things, an increase in stated beliefs on gender equality among older adolescents (65% compared to 37% in the control group) and a significant improvement in reported IPV (only 5% reported by newly married/parenting adolescents compared to 21% in the control group) (IRH 2014; IRH et al. 2015).

- **Sonke Gender Justice’s One Man Can Campaign, South Africa**: A pre/post evaluation of this initiative (there was no control/comparison group), based on working specifically with men, suggests positive impacts: 50% of participants reported taking action to address acts of gender-based violence in their community; 25% accessed HIV voluntary counseling and testing services; and 61% reported increased use of condoms. Some participants also reported having subsequently talked with friends or family members about HIV and AIDS, gender, and human rights (Colvin, Peacock, and Human 2009, reported in Peacock and Barker 2014).

- **Kembatta Mentti Gezzima-Tope (KMG) Ethiopia**: While some of the most solid evidence on the effectiveness of community mobilisation efforts around female genital mutilation/cutting arise from the Tostan initiative in Senegal (see, for example, UNICEF 2008), evidence from quantitative and qualitative surveys of the KMG programme in Ethiopia indicate a massive shift in approval rates for FGM (from 97% approval to 96% disapproval) as well as in social acceptance for uncut girls (85% of participants reporting that such girls are ‘no longer despised’). However, these decreases cannot be directly attributed to the programmes examined due to the observational nature of the study methodology (lack of a comparison/control group). The intervention operates through mobilisation approaches such as community conversations, rallies, with public declarations of abandonment, and public weddings for uncut girls (Dagne 2010).

6.3 Concluding discussion points

- The social ecological model provides a conceptual basis for programme interventions seeking to address social norms seen as ‘structural’ factors that impinge on adolescent safety and wellbeing;

- Programmes operating at this level seek to go beyond the focus on the individual, and extend to the broader enabling environment, in an effort to effect broader, societal wide change through community sensitization and mobilisation efforts with a strong communications and dialogue component;
Evidence from such programmes indicates promising results, particularly in terms of improvement in attitudes and experiences of gender-based violence and other ‘risky behaviours’;

Nevertheless, much of the evidence comes from small pilot studies (with small numbers of participants and/or small numbers of clusters, which limits power in statistical analyses to detect programme impacts) or from studies which lack a comparison group, and thus cannot definitely attribute causality to the programme evaluated.

Indeed, evaluations of the impacts of such broad-based community mobilisation efforts are complex, and more research is needed, including on the longer-term impacts over time.
### 7. Key issues for consideration in choice of ‘Cash plus’ programme options

#### 7.1 Recap of programmes and evidence base

The previous chapters have briefly presented programming models and reviewed the evidence on a variety of outcomes from a number of initiatives underway around adolescents in eastern and southern Africa. Interventions have been classified into three main categories (though some may also combine different approaches):

- **Adolescent empowerment programmes** that target adolescents as individuals and in groups, offering a varying mixture of life skills, including sexual and reproductive health information, gender equality awareness, and economic literacy or micro-finance, with the overall aim of enhancing their accumulation of different forms of ‘capital’ (social, health, economic/financial) seen as necessary for well-being, empowerment, and safe transitions to adulthood.

- **Parenting programmes** that target families through the dyad adolescent/caregiver, providing workshops for information transmission and discussions around key themes, with the overall objective of improving intergenerational communication and relationships that will in turn improve a variety of outcomes for adolescents.

- **Community mobilisation programmes** that target the wider community and a broad swathe of stakeholders including adults/young people, local leaders/decisions makers etc., with multiple forms of messaging and communications as well as spaces for dialogue and discussion, with the aim of shifting social norms (and ultimately behaviours) around key issues that are seen to be detrimental to adolescent development and safe transitions to adulthood.

The adolescent empowerment programmes in eastern and southern Africa seem to have produced the most evidence so far through the numerous evaluations and studies that have been underway for some time. There are also a number of studies and evaluations of community mobilisation programmes, though the evaluation challenges in this type of programming have been highlighted in the literature and existing evidence comes largely from studies using non experimental methods or small numbers of clusters or participants. The parenting programmes for adolescents have less of a rigorous evidence base, though current initiatives in South Africa are suggesting promising results.

#### 7.2 Other points for consideration in Tanzania

Beyond the ‘evidence’ itself emanating from programmes in other countries, there are a number of issues that the government of Tanzania and its partners may wish to take into consideration as they select the most appropriate and feasible option (or combination of options) for the ‘plus’ component of the ‘cash plus’ programming being considered around the PSSN.

- **The type and nature of key risks for adolescents and young people**: It is clear from the available information that adolescents and young people in Tanzania – particularly those in the poorest and most vulnerable households - face a broad array of risks jeopardizing their safe transition to adulthood. Many of these stem from the ‘supply side’ (lack of appropriate youth-friendly health services; lack of access to high-quality education; limited legal services; lack of job prospects or employment) which need to be addressed through the different sectors. But others stem from more ‘demand-side’ factors (including household-level poverty; family structures or practices, etc.). Still others stem from the enabling environment, or the community- and societal-level factors in the ecological model, such as prevailing norms around gender and violence. Collective thinking based on a clear analysis of the nature and magnitude of these second types of risks and some prioritisation would be useful as a first step in the development of appropriate programme responses.

- **Key programme outcomes envisioned**: Linked to the above, it would be important to collectively agree on the key outcomes the potential programme would be expected to produce. Is the focus to be on a particular risk (for example violence within the family, gender-based violence, unsafe sex,
Options for ‘Cash Plus’ Programming for Adolescents in Tanzania: Background Paper

early marriage/cohabitation/pregnancy, etc.) which particular programme interventions would need to be designed to address, or is the intent rather to offer a broader programming framework to address multiple risks to safe transitions to adulthood?

- **National policy around youth and adolescents, child rights, gender:** Any programme that is developed would need to take into consideration and align with key national policy thrusts and directives and thereafter serve as instruments to translate these policies into action on the ground.

- **Existing interventions, gaps, and capacities of local actors:** It would be important to have at the outset a clear mapping of the field of adolescent programming experiences in Tanzania as well as an overview of outcomes and lessons learned from these experiences. What problems have been addressed? What have not? What programme interventions have either worked or not and why? What are the strengths that can be built upon or – conversely – the gaps that might need to be filled? And what is the existing capacity of local actors (local government, NGOs, CSOs) to implement different kinds of adolescent programme interventions?

- **Characteristics of PSSN and TASAF:** Since the adolescent programme is to be designed as a ‘cash plus’ initiative, building upon the national PSSN cash transfer programme, it is important to frame it appropriately around the design of the PSSN. The PSSN has a number of different components, including unconditional transfers, conditional transfers, public works, and a community savings and investment intervention. Other objectives within TASAF as a whole include social infrastructure-strengthening. In such a context, what would work best as an ‘add on’ that could enhance existing positive impacts for adolescents? What PSSN implementation structures on the ground might already serve as a foothold for additional programming? Is there some scope, for example, to consider building an adolescent savings/investment component onto the exiting community savings initiative? Would it be important to target adolescents who are out of school in households that receive only the unconditional grants or better to design programmes for both in-school (conditional recipients) and out of school children?

These and other questions might usefully serve as a basis for discussion at the social protection plus workshop in Tanzania and beyond.

**7.3 Considerations for evaluation**

In the ‘cash plus’ study being conceived, ideally we would like to say something about what cash alone can do, what the ‘plus’ component alone can do, and how they may work together to improve outcomes above and beyond impacts of either alone (i.e. synergistic impacts). A rigorous evaluation of the cash plus option is being considered, and there are several key points to keep in mind surrounding any such evaluation.

The proposed evaluations would aim to demonstrate impacts of the cash plus programme by showing what would have happened if participants had participants not received the intervention (in evaluation terms, the “counterfactual”). Counterfactuals may consist of a randomized control group, a comparison group in quasi-experimental studies, or even the treatment group itself prior to treatment in a pre/post design. An ideal study design would have the following groups, to which participants would be assigned randomly:

1) **pure control group (no cash, no plus intervention):** studying this group would allow us to understand what happens to youth if they receive no intervention

2) **cash only group (cash, no plus intervention):** studying this group would allow us to understand what happens to youth if they receive only cash, compared to 1) nothing at all, 2) only plus, or 3) cash plus.

3) **plus only group (no cash, plus intervention) :** studying this group would allow us to understand what happens to youth if they receive only the plus intervention, compared to 1) nothing at all or 2) only cash, or 3) cash plus.
4) cash plus group (cash, plus intervention): studying this group would allow us to understand what happens to youth if they receive cash and plus, compared to 1) nothing at all; 2) plus only; and 3) cash only.

Randomisation, if done successfully, ensures that the group receiving the treatment is identical to the group not receiving the treatment (e.g. all are food insecure or meet similar poverty classifications). This also means that participants do not choose whether to participate (thus there is no selection bias if treatment individuals are more intrinsically motivated or otherwise differ from control individuals). In addition, by having a randomized, longitudinal study design, we could control for trends over time which may have impacted outcomes (e.g., drought, rapid economic development, etc.), by observing changes in outcomes among the control group over the period studied (this is an advantage over a pre/post study design).

In this longitudinal design, households and youth in all of these groups would ideally be surveyed at baseline (before random assignment or at least before implementation of any programme) and again at follow-up (12 to 24 months after the intervention start date – a longer period allows more time for effects to materialize).

This ideal study design described above is likely not possible for the cash plus evaluation. Specifically, the ideal design would require that some study areas are not phased into the PSSN programme for at least another two years (to maintain a pure control group) and that phasing in happens in a controlled staggered manner (to establish comparable intervention groups). If scale-up occurs more rapidly across the country (for example, by March 2016) and includes all food insecure households in Tanzania, then households not in the programme could not serve as a true control group because they would be by definition different than those in TASAF/PSSN households (i.e., they do not meet food insecurity and poverty criteria as defined by the government of Tanzania for programme eligibility). Therefore, any differences in outcomes after the intervention may be due to the intervention, or they may be due to initial differences in the individuals and households related to poverty and other characteristics.

Assuming that it will not be possible to implement the optimal study design, the remainder of this section outlines three alternative potential evaluation designs. Which of these three designs is most appropriate depends on a number of issues such as timing and scale of programme roll-out, and availability of targeting and disbursement data. At the end of the section, we present a decision tree that will help to determine which of these evaluation options is appropriate and the information needed to take a final decision about the evaluation approach.

**Option 1**

The first potential evaluation approach could be applied if the programme is expected to be brought to national scale in the near future. Within enumerated areas, households are assigned to the program based on community-based targeting and then a proxy means score. Poor households with a proxy means score below a pre-specified threshold are assigned to the programme, the remaining households are not. It may be possible to exploit this assignment procedure to identify the effect of the program. The idea would be to compare households that barely missed the cut-off for programme eligibility and assume that (youth in) these households (the comparison group) are comparable to (youth in) households that just made the cut-off (the treatment group). These two groups of households (and youth in these households) should be comparable at baseline (in evaluation terms, a so-called regression discontinuity identification).

Among the comparison youth, some could be randomised to plus only to test impacts of the plus intervention, and others would be randomized to no treatment (the comparison group). This randomisation would produce an interesting (stand-alone) experiment in and of itself to test programme impacts of the plus intervention. Then among treatment households, some will be randomized to cash

---

10 A common concern is that non-beneficiary households may indirectly be affected by programs in their geographical area. Such “spillover effects” could bias comparisons of beneficiary and non-beneficiary households within the same geographical area. However, in case the program is rolled out at national scale, these so-called spillover effects become less relevant. Because all non-beneficiary households in the country will be affected similarly, netting out the spillover effect will not be particularly informative.
only and others will be randomized to cash plus. This procedure implies that the “plus” intervention would have to be implemented at the individual- and not community-level. A limitation is that we would not have baseline data on youth outcomes for current TASAF households, but using targeting enumeration data we can test whether households are balanced on key poverty indicators and then assume they would also be the same on youth transition-related outcomes.

This evaluation approach could be implemented in any of the geographical areas that still need to be phased into the program, including control areas of the current World Bank evaluation study (once the study has concluded in 2017). Key requirements would be that targeting enumeration (proxy means) data on households for TASAF III are available to us, household eligibility is indeed determined based on a strict threshold in the proxy-means score, and TASAF payment data can be linked to the poverty means scores. The timing on this option is flexible because it does not involve the use of control households as comparisons.

**Option 2**
The second potential evaluation approach could be applied if the program will not be rolled out at national scale in the foreseeable future and controlled staggered roll-out is not feasible. In that case, geographical areas that still need to be phased into the program, including control areas of the current World Bank evaluation (once their evaluation has ended), could become our treatment households in the cash plus intervention. Households in these former control (new treatment areas) will be randomized to cash only or cash plus. Similar urban areas not being rolled into the TASAF programme could be selected as the comparison group. Again households in these areas could be randomized into no intervention and plus intervention only, giving us a stand-alone experiment.

This evaluation approach would require the existence of appropriate data to identify comparable urban areas. We would have to (re-)enumerate households in both the treatment and comparison areas. We would follow the timeline below:

**Option 3**
Test impacts of plus programme among cash households. All households will receive cash. Some will be randomised to cash plus and the remaining will only receive cash. This will allow us to test the impacts of the plus programme rigorously among a sample of youth already in TASAF households. It will also allow us to do a process evaluation of implementing a plus programme within a government cash transfer. However, this design will not allow us to test the synergies of cash plus versus cash alone, or cash plus versus no treatment (a true control). Essentially it would be testing the impacts of the “plus” intervention among households receiving cash (i.e., cash plus care v. cash only).

Additionally, there could be an option here of doing an additional randomization to top up more cash at the household level—then we would have: 1) TASAF only, 2) TASAF + extra cash (tagged for adolescent care?), 3) TASAF + plus and 4) TASAF + plus + extra cash. This could help determine if there are synergies, but we would have to interpret it slightly differently.

**Other considerations**
- In all options summarised above, we would additionally conduct a process evaluation, and collect qualitative and costing data (synergies cost different than programs implemented standalone etc.).
- Timing of these different options may limit where we can work. For example, we cannot provide “plus” interventions to treatment households currently in the WB evaluation for the duration of the evaluation (through February 2017).

**Some key questions we would need clarification on to proceed are the following:**
1. What are the exact months when roll-out to control households will occur in 2017?
2. Are there any districts or geographic areas which will not have been brought into the program during the scale-up? Or will all eligible households country-wide be participating in TASAF by 2017?
3. Alternatively, are there geographic areas of cities (communities, blocks, etc.) that were not rolled into the program based on the belief that there were not enough poor households in those communities so they were not enumerated?
4. Can we access the household targeting enumeration data that was used to determine which households were eligible in the intended intervention areas (i.e. selected urban/ peri-urban areas)?

5. Can we access World Bank evaluation baseline data for household characteristics? We would not target any of the TASAF-treated households in the World Bank evaluation for any “plus” intervention, but access to their data may help determine an adequate comparison group.

Figure 4. Evaluation decision tree
References

References for chapter 1: Introduction and context


Heymann, J., & Kidman, R. (2009) 'HIV/AIDS, declining family resources and the community safety net.' *AIDS Care*, 21(S1), 34-42


Olson, R. (2016, 7 January 2016) [Email on Zambia’s Cash Transfer programme and linkages for adolescent sexual and reproductive health].


Options for ‘Cash Plus’ Programming for Adolescents in Tanzania: Background Paper


References for chapter 2: Social protection and cash transfers


Watson, C., Devereux, S. and Abdoulaye, Y. (draft under review 2016) ‘Cash transfers and resilience in Chad: Overview of experiences and case study of CARE’s interventions.’ (Draft report submitted to UNICEF)

References for chapter 3: TASAF and PSSN


TASAF Management Unit (2016b) ‘Productive Social Safety Net second quarter implementation progress report October-December 2015.’

‘TASAF scale-up’ programme document
‘TASAF: Project to programme’ PPT presentation at TFESSD Learning Forum, Kunduchi Beach Hotel and Resort, 15-17 November 2011, Dar Es Salaam.


References for Chapter 4: Adolescent empowerment initiatives


30


References for Chapter 5. Parenting programmes


References for Chapter 6: Community mobilisation for social norm change


Options for ‘Cash Plus’ Programming for Adolescents in Tanzania: Background Paper

Soul City Institute. Johannesburg (http://www.soulcity.org.za
UNICEF (n.d.) ‘Module 1: Understanding the social ecological model (SEM) and communication for development (C4D) www.unicef.org/cbcs/files/Module_1_-_MNCHN_C4D_Guide.docx

Additional resources

34
List of experts consulted

- Lucie Cluver, Oxford University
- Brigette De Lay, Oak, Geneva
- Myriam Ghorbel, Global Fund
- Andrew Gibbs, University of KwaZulu-Natal
- Heidi Loenig, UNICEF Office of Research - Innocenti
- Franziska Meinck, Oxford University
- Chris Mikton, WHO
- Eunice Muthengi, Population Council, Nairobi
- Dean Peacock, Sonke Gender Justice, South Africa
- Catherine Ward, University of Cape Town
### Annex 1. Summary table of adolescent empowerment initiatives

<table>
<thead>
<tr>
<th>Programme Basics</th>
<th>Overview/Description</th>
<th>Study/evaluation methodology</th>
<th>Relevant results</th>
</tr>
</thead>
</table>
| Stepping Stones and Creating Futures  
SOUTH AFRICA  
NGO Project Empower  
References: Jewkes et al. 2014 | Stepping Stones (participatory life skills programme) followed up with economic empowerment intervention  
Creating Futures (livelihood strengthening through help for finding work/settling up business but not provision of cash or loans)  
Creating Futures is a facilitated group intervention covering eleven, three-hour sessions in single sex groups of approximately twenty people over 12 weeks. It was developed by drawing on sustainable livelihoods theory and practice  
Target group: out-of-school youth (male and female) aged 18-30 in 2 informal settlements of Durban | Observational, pre/post methodology (the authors term this “shortened interrupted time series”) with complementary qualitative assessment. | Results for combined approach (in Jewkes et al. 2014):  
Positive livelihood results for men and women (increased earnings); positive changes in gender equitable attitudes (men and women) and behaviours (men). Reduction in IPV. Improvements in mental health  
Men’s mean earnings in the past month increased by 247% from R411 (~$40) to R1015 (~$102), and women’s by 278% R 174 (~$17) to R 484 (about $48) (trend test, p < 0.0001). Significant reduction in women’s experience of the combined measure of physical and/or sexual IPV in the prior three months from 30.3% to 18.9% (p = 0.037). Among men, there was no decrease in reported perpetration of IPV. However both men and women scored significantly better on gender attitudes and men significantly reduced their controlling practices in their relationship. The prevalence of moderate or severe depression symptomatology among men and suicidal thoughts decreased significantly (p < 0.0001 and p = 0.01).  
Key comparisons: Stepping Stones alone showed no impact on women’s experiences of IPV; whereas combined approach did.  
Conclusion: As with the IMAGE project, Stepping Stones/Creating Futures shows promise that building young women’s economic and gender power can reduce experiences of violence.  
Innocenti assessment: This was a proof of concept study; results cannot conclude causal impacts of the programme as definitely as would a randomised design. | |
| Intervention with Microfinance for AIDS and Gender Equity (IMAGE)  
SOUTH AFRICA, Limpopo Province  
Rural AIDS and Development Action Research Programme, School of Public | A combined microfinance and training intervention to reduce HIV risk behaviour in young females  
Group-based micro-loans to poor women over 10 to 20 week cycles accompanied by 12-15 month ‘Sisters for Life Programme’ participatory training programme (on gender roles, cultural beliefs, power relations, self-esteem, communication, domestic violence, HIV, critical thinking and leadership) and 6-9 months of | Pair-matched and randomly allocated study design at village level (n=4 treatment; n=4 control) compared control group (receiving nothing); group receiving microfinance only (provided by an NGO); and group receiving full packet ‘Sisters for Life programme’ (Kim et al. 2009). | Full packet ‘Sisters for Life’:  
After two years, improvements in all nine indicators of empowerment were observed. Participation in IMAGE was associated with greater self-confidence, financial knowledge, increased assets, expenditures, and membership in informal savings groups (Kim et al. 2007).  
A 55% reduction in the experience of inter-partner violence (IPV) over 2 years in all age groups and a 24% decrease in unprotected sex with non-spousal partner among those aged 14-35. Participants reported fewer experiences of controlling behaviour by their partners (34% of participants versus 42% of those in the control group). Participants were more likely to have progressive attitudes to intimate partner violence (52% of participants versus 35% of the control group) (Pronyk et al. 2006; Pronyk et al. 2008) |
### Options for ‘Cash Plus’ Programming for Adolescents in Tanzania: Background Paper

<table>
<thead>
<tr>
<th>Community Mobilization among Youth and Men</th>
<th>Aim of Study to Determine Whether Programme Could Reduce Vulnerability to HIV Through 1) Improving Women’s Household Economic Wellbeing, Social Capital, and Empowerment and Thus Reduce Vulnerability to Intimate Partner Violence; and 2) Raising Community Awareness and Action on HIV and Gender</th>
<th>Qualitative Data Suggest That Women Who Were Empowered by the IMAGE Intervention Were Able to Challenge the Acceptability of Violence, Expect and Receive Better Treatment from Partners, Leave Violent Relationships, Give Material and Moral Support to Those Experiencing Abuse, Mobilize New and Existing Community Groups, and Raise Public Awareness About the Need to Address Both Gender-Based Violence and HIV Infection (Kim et al. 2007).</th>
</tr>
</thead>
<tbody>
<tr>
<td>This Combined Intervention Was Designed to Be Mutually Reinforcing, Strengthening Individual Client Agency as Well as Improving Household Wellbeing, Communication and Power Relations (RADAR, 2002, Cited in McAslan Fraser 2012).</td>
<td>Compared to Control, Young Participants Aged 14-35 Had Higher Levels of HIV-Related Communication; Were More Likely to Have Access Voluntary Counselling and Testing; and Less Likely to Have Unprotected Sex at Last Intercourse with Non-Spousal Partner (Pronyk et al. 2008).</td>
<td>Higher Rates of Condom Use at Last Sex with All Non-Spousal Partners Compared to Control and Microfinance-Only Participants; Greater Likelihood of Voluntary HIV Counselling and Testing Compared to Control Group; Improved Outcomes on Knowledge, Attitudes, Communication Violence, Gender Roles, Collective Action and Social Engagement Compared to Control, But No Difference in Frequency of Multiple Partnerships (Kennedy et al. 2014).</td>
</tr>
</tbody>
</table>

**References:**
### Options for ‘Cash Plus’ Programming for Adolescents in Tanzania: Background Paper

| Siyakha Nentsha KwaZulu-Natal, SOUTH AFRICA 2008- | From WHO 2010 One of the most rigorously evaluated and successful programmes is South Africa’s Intervention with Microfinance for AIDS and Gender Equity (IMAGE). This targets women living in the poorest households in rural areas, and combines financial services with training and skills-building sessions on HIV prevention, gender norms, cultural beliefs, communication and intimate partner violence. The programme also encourages wider community participation to engage men and boys. It aims to improve women’s employment opportunities, increase their influence in household decisions and ability to resolve marital conflicts, strengthen their social networks and reduce HIV transmission. A randomized controlled trial found that, two years after completing the programme, participants reported 55% fewer acts of violence by their intimate partners in the previous 12 months than did members of a control group. Compared with controls, these women reported fewer experiences of controlling behaviour by their partners (34% of participants versus 42% of those in the control group), despite having suffered higher levels of this behaviour than members of the control group before entering the programme. In addition, participants were more likely to disagree with statements that condone physical and sexual violence towards an intimate partner (52% of participants versus 36% of the control group). Furthermore, a higher percentage of women in the programme reported household communication about sexual matters and attitudes that challenged gender roles. The programme did not, however, have an effect on either women’s rate of unprotected sexual intercourse at last occurrence with a non-spousal partner or HIV incidence. |
| Population Council and Isihlangu Health and Development Agency References: Hallman and Roca 2011; Also reported in Gibbs et al. 2012; Fewer et al. (nd); WHO 2010 | School-based life skills + financial training for multiple asset-building through 2-3 one hour classroom sessions per week. **Basic version:** life skills training to build social and health capabilities **Enhanced version:** life skills plus financial training to enhance financial capabilities **Target group:** Boys and girls ages 14-16 (in grades 10 & 11) | Quasi-experimental, mixed methods evaluation after 4 years. Baseline and follow-up survey 18 months apart, supplemented by focus group discussions |
| SUUBI, UGANDA Educational and economic asset-building and empowerment | Both versions of programme resulted in increased HIV/AIDS-related knowledge among both boys and girls (for example where to obtain condoms); enhanced self-esteem among girls in expanded programme; reduction among boys in onset of sexual activity and number of partners. Other results: increased knowledge and autonomy around financial planning and decision-making; greater likelihood for girls in enhanced programme to have birth certificate and for boys to have a national ID card. | Quantitative (cluster randomized) random assignment at school level | Ssewamala et al. 2010a Children in the treatment group had significantly lower intentions to have sexual intercourse compared with the control group; however boys exhibited a statistically
### References:
- Ssewamala et al. 2010a; 2010b; and 2009
- Also reported in Gibbs et al. 2012; Kennedy et al. 2014

<table>
<thead>
<tr>
<th>Empowerment and Livelihood for Adolescent Girls (ELA) UGANDA (2008-2010)</th>
</tr>
</thead>
<tbody>
<tr>
<td>BRAC Uganda, with support from MasterCard Foundation and Nike Foundation Programme also in Tanzania and S. Sudan, but study not completed</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Target group: Adolescent school boys and girls who had lost one or both parents to AIDS; median age 13.9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cluster randomised control trial, tracking 4800 girls over two years. 100 treatment communities (each with one club) and 50 control communities Baseline (2008) and follow-up (2010) household panel survey</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Intervention consisting of: 1) twelve 1-2 hour workshops over a 10-month period (financial planning and asset building); 2) monthly peer mentoring on future planning; and 3) a 2:1 matched child savings account dedicated to paying for secondary school or a small family business (all participants chose schooling) and the matched fund was paid directly to the school (with children/parents contributing the rest)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(n=15 schools; 148 control individuals and 138 treatment individuals), with control group receiving usual care for orphaned children (including counseling, educational supplies, and national school-based health education) 90-minute individual interview was conducted at baseline and at 10-month follow up interview. Two year study overall</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Conclusions/implications:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dramatic illustration of the program enabling girls to become empowered in their relations with men. This impact is likely a direct result of three program features: (i) girls being able to act on specific soft skills accumulated through the life skills sessions; (ii) the additional hard skills provided raise girls’ engagement in and earnings from self-employment, and such economic empowerment likely reinforces girls’ control over their bodies (iii) the fact that the clubs provide a safe location for girls, especially in the after-school period in the afternoon when their parents might not be back from work.</td>
</tr>
</tbody>
</table>

4 years post intervention, with additional elements added, the study found that those girls in treated villages that have the highest two-year gains in terms of aggregated indices of economic empowerment and control over the body, are most likely to migrate away from their home village that a significant impact of the intervention is to increase geographic mobility.
<table>
<thead>
<tr>
<th>Street Smart</th>
</tr>
</thead>
<tbody>
<tr>
<td>UGANDA</td>
</tr>
<tr>
<td>Uganda Youth Development League; Semel Institute for Neuroscience and Human Behavior, Center for Community Health, UCLA; Center for AIDS Prevention Studies, UCSF</td>
</tr>
<tr>
<td><strong>References:</strong> Rotheram-Borus et al. 2012; also reported in Kennedy et al. 2014</td>
</tr>
<tr>
<td><strong>Vocational training with health education</strong></td>
</tr>
<tr>
<td>All participants received the ‘Street Smart’ intervention, a 10-week, 10-session HIV prevention intervention. Participants were randomized to receive immediate or delayed vocational training consisting of apprenticeships with local artisans (hairstyling, catering, tailoring, mechanics, electronics, carpentry, cell phone repair, and welding). Youth attended classes regularly for 4–8 hours, 5 days a week. Artisans received a 5-day training on how to talk to youth (generally and about HIV), conflict resolution, HIV prevention, and coping with unprofessional behaviour.</td>
</tr>
<tr>
<td><strong>Target group:</strong> High risk urban youth – male and female age range from 13-23.</td>
</tr>
<tr>
<td><strong>Randomised assignment to treatment (N=50) and delayed treatment (N=50):</strong> Baseline, 4-month and 24 months surveys. Difference-in-differences methodology (treatment x time interaction; N=74).</td>
</tr>
<tr>
<td><strong>Results:</strong> No significant differences between treatment and control youth with respect to sexual risk at 4-month follow-up (when only treatment group had received intervention). By 24 months, control group had received delayed treatment, but originally treated group saw decreases in sexual partners and increases in abstinence, condom use, and social support. Engaged in sex: Intervention: BL: 58%; FU: 59%; Control: BL: 80%; FU: 91% Number of partners. Mean (SD): Intervention: BL: 2.10 (3.33); FU: 0.88 (0.90); Control: BL: 1.82 (1.51); FU: 1.36 (0.81) Abstinent or 100% condom use: Intervention: BL: 54%; FU: 95%; Control: BL: 29%; FU: 64% .</td>
</tr>
<tr>
<td>For both groups there were significant decreases over time in the number of sexual partners, increases in abstinence and condom use during sex and increases in social support. Mental health symptoms were stable from baseline to 24 months, but alcohol and marijuana use and hard drug use decreased significantly during that time (Rotheram-Borus et al. 2012; also reported in Kennedy et al. 2014)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Safe and Smart Savings Programme for Adolescent Girls</th>
</tr>
</thead>
<tbody>
<tr>
<td>UGANDA &amp; KENYA (2008-2012)</td>
</tr>
<tr>
<td>Population Council and MicroSave Funding from Nike Foundation and Financial</td>
</tr>
<tr>
<td><strong>Combination microfinance, and social and health asset building</strong></td>
</tr>
<tr>
<td>• Weekly group meetings providing a safe physical space and group of same-sex friends facilitated by a young woman mentor from the community;</td>
</tr>
<tr>
<td>• Health and life skills education based on Tuko Pamoja: Adolescent Reproductive Health and Life Skills Curriculum (PATH &amp; Population Council, 2005), with 30 sessions (puberty,</td>
</tr>
<tr>
<td><strong>Quantitative evaluation in Uganda examining difference between comparison group (no intervention) with two treatment groups: one receiving full intervention (safe spaces + reproductive health and financial training + savings account) and one receiving savings account only.</strong></td>
</tr>
<tr>
<td><strong>Findings indicate that the full intervention was associated with improvement in girls' health and economic assets. While girls who only had a savings account increased their economic assets, they were also more likely to have been sexually touched (OR = 3.146; P &lt; 0.01) and harassed by men (OR = 1.962; P &lt; 0.05). This suggests that economic asset building on its own, without the protection afforded by strengthening social assets, including social networks, as well as reproductive health knowledge, can leave vulnerable girls at increased risk of the sexual violence.</strong></td>
</tr>
<tr>
<td><strong>Details</strong></td>
</tr>
<tr>
<td>Sexual harassment: Among Savings PLUS girls, there was no significant change in the proportion of girls who experienced indecent touching (7% to 8%) or who were teased</td>
</tr>
</tbody>
</table>
**Options for ‘Cash Plus’ Programming for Adolescents in Tanzania: Background Paper**

**References:**
Austrian et al. 2012; Austrian and Muthengi 2014

<table>
<thead>
<tr>
<th>Education Fund</th>
<th>Options for ‘Cash Plus’ Programming for Adolescents in Tanzania: Background Paper</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reproduction, family planning, HIV/AIDS and other STIs, drug abuse, communication, sexual feelings, self-efficacy, gender based violence, and peer pressure.</strong></td>
<td></td>
</tr>
<tr>
<td>Financial education (prioritizing, budgeting, saving, income generating opportunities adapted from Microfinance Opportunities “Young People: Your Future Your Money” universal youth financial education curriculum), with savings diary and workbook</td>
<td></td>
</tr>
<tr>
<td>Opening of individual savings accounts.</td>
<td></td>
</tr>
<tr>
<td><strong>Target group:</strong> adolescent girls divided into 3 age groups: 10-14; 15-19 (In Uganda: vulnerable adolescent girls aged 10-19 in low income area of Kampala)</td>
<td></td>
</tr>
</tbody>
</table>

Bivariate analysis compared proportions across the three categories (Austrian and Muthengi 2014)

Based on the asset building framework, the study tests the following hypotheses:
(1) girls who participated in the full intervention will have increased social, health and financial assets, (2) girls who received savings accounts only will have increased financial assets, but not social and health assets, and (3) social and health assets are protective against sexual harassment. (Austrian and Muthengi 2014)

For Savings Only girls, the proportion who experienced indecent touching significantly increased from 9% to 15% ($P < 0.05$), while the proportion who had been teased by males increased from 19% to 25% at end line ($P < 0.1$). Compared to girls in the comparison area, Savings Only girls were more likely ($OR= 3.146; P < 0.01$) to say they had been touched indecently within the previous six months, and 96% more likely to say they had been teased by people of the opposite sex ($P < 0.05$).

Verbal harassment: For Savings + girls who showed improvements from baseline to end line, knowing someone to borrow money from decreased the odds of verbal harassment by 52% ($P < 0.05$). Improvement in reproductive health knowledge indicators – knowledge of sexual transmission of HIV and knowledge of a contraceptive method – decreased the odds of experiencing verbal harassment by 65% ($P <0.05$). Girls who had gotten an HIV test at end line but not at baseline had 50% lower odds of experiencing harassment ($P < 0.05$) than those who had not.

Austrian et al. 2012

Increasing girls’ access to financial assets incurs some risks.

- Some girls participating in safe spaces reported parents or guardians taking or borrowing girls’ money without their consent; parents not providing for girls’ needs; harassment from boys; and the possibility of girls engaging in risky behaviors in order to acquire money for saving.

- Girls not in groups only discussed the potential danger of money being stolen by strangers, which was not directly associated

Recommended strategies to reduce risks: educating parents, helping parents set up their own accounts, engaging boys, and providing training or opportunities for girls to earn money legitimately.

But increased access to financial assets can also help reduce risks and vulnerability:
Girls reported being enabled to refuse sexual advances from men; to be less dependent on men; and to be more prepared for daily needs (sanitary towels, uniforms) and family expenses (food; hospital costs). Girls expressed a sense of pride at being able to help their families in times of need.

Innocenti assessment: Comparison group was not randomized, but rather recruited separately and differed significantly from those in intervention arms at baseline with respect to age (younger), religion, educational status, living arrangements, (more likely to live with neither parent), identification (less likely to have photo ID), and socioeconomic status (poorer).
| **Tap and Reposition Youth (TRY)**  
**KENYA**  
Population Council and Kenya Rural Enterprise Programme, with funding from Ford Foundation and Dfid | A modified microfinance scheme, with trained mentors leading educational discussion groups. Interventions included access to microcredit and savings; business training, and life-skills training addressing reproductive health and rights.  
**Target group:** out-of-school adolescent girls and young women aged 16-22 living in low income and slum areas of Nairobi | Longitudinal matched case-control design (matched on individuals based on neighborhood, age, education, marital status, parity and work status). Baseline 2002-2003 and endline 2003-2005 as clients existed the programme. N=326 matched pairs at baseline; N=222 matched pairs at endline. | The programme experienced high drop-out (66%); while there were marginal improvements in gender attitudes and increased ability to insist on condom use, there was no improvement in reproductive health knowledge  
From Fewer et al. nd  
In 2005, an evaluation of the program showed that TRY participants exhibited stronger financial outcomes compared to the control group, including higher incomes, more savings, and a greater tendency to keep savings in a bank, rather than at home. However, the program experienced high drop-out rates (two-thirds of the participants) which researchers attributed to delays in receiving loans and non-flexible savings schemes (Erulkar and Chong, 2005). Further exploration revealed that many girls felt the program’s requirements, including the business training and microcredit loans, were unreasonable or irrelevant. The study showed, however, that girls were specifically interested in savings accounts. The girls reported that they needed access to their own savings, a secure place to keep their savings, and financial literacy training. The study also highlighted the benefit of saving with a group for increased social support and networks (Amin, 2011). The Population Council made adjustments to the TRY model and formed “young savers clubs” that created a social space for girls to build relationships with peers and mentors (USAID, 2008). These changes resulted in a doubling of savings by young adolescents over what they had been previously (Hall, 2006)  
From Erulkar, 2006: TRY’s challenges and adjustments highlight the need to have adolescent-centered savings programs and the role of building social support in these strategies |
| **Berhane Hewan (Light for Eve)**  
**ETHIOPIA** (Amhara region) 2004-2006  
Population Council, UN Population Fund | Focus on child marriage and girls’ education  
Girls’ groups led by adult female mentors; encouragement to girls to remain in school and economic incentives to parents (receipt of goat) if daughters stay unmarried and remain in school until project’s end; non-formal education for those out of school (including literacy and life skills training); and ‘community conversations’ with five groups covering topics including early marriage;  
**Target group:** Girls 10-19 in Amhara region | Population-based surveys in control and intervention villages examining attitudes and behaviors pre- and post-intervention  
460 total baseline respondents; endline – 464 control respondents and 462 treatment respondents | Reduced marriages of girls ages 10-14 (OR=0.09) but increased rates of marriage among older girls (15-18 years; OR=2.41).  
Programme girls three times more likely to be in school than control girls  
Program megirls also more knowledgeable on HIV, STDs, family planning and were three times more likely to have used any method of family planning |
Shaping the Health of Adolescents in Zimbabwe (SHAZ!)

ZIMBABWE

Pangaea Global AIDS Foundation; Zimbabwe AIDS prevention programme at the University of Zimbabwe; Chitungwiza Hospital Opportunistic Infection Unit

References:
Dunbar et al. 2010; and 2014; Nhamo 2014; (reported as well in Fewer et al. nd; Gibbs et al. 2012; and Kennedy et al. 2014)

Pilot phase: Life-skills-based HIV education; business training and mentorship; microcredit loans for business development

Post pilot 2nd phase (SHAZ II): An integrated intervention combining 1) a 10-month a life-skills curriculum adapted from Stepping Stones (HIV/STD and reproductive health; gender and relationship negotiation; strategies to avoid physical and sexual violence; identifying safe spaces in the community); 2) choice of vocational or livelihoods training with practical component; and 3) microcredit grant from a local microfinance organization on successful completion of training; 4) SRH services

Target group: adolescent girls ages 16-19 in urban and peri-urban communities in Harare (average age 17.5)

Study of pilot testing of a micro-credit intervention for 50 female out-of-school orphans aged 16-19. (Dunbar 2010)

Nhamo (2014) and Dunbar et al. (2014): Randomized control trial assessment of second 2-year phase comparing control group (life skills and HIV/SRH services only) with intervention group (life skills, livelihoods, and HIV/SRH services) (N= 315)

Critical weaknesses in the initial pilot, based on micro loan rather than grant, included poor implementation processes and low rates of ability to repay loans (6%) (Fewer et al. nd). Initial programme outcomes after 6 months had mixed results, including increased HIV risk through new mobility and economic strategies (Gibbs et al. 2012). Adolescent girls qualitatively reported threats to their personal safety while transporting goods to market, including harassment by men and police, and lacked safe accommodation or secure places to store money against theft (Dunbar et al. 2010). Conclusions were that micro-credit is not a suitable intervention for adolescent girls (Dunbar et al. 2010). Led to reformulation of the programme away from micro-credit to livelihoods training and micro-grants.

Programme outcomes in the second two-year phase included a 58% reduction in physical and sexual violence and an increase in gender equitable norms (Gibbs et al. 2012).

The evaluation revealed promising effects of intervention participation on structural and behavioural outcomes, such as significant improvements and/or expected trends among intervention participants in improving economic factors (food security and income) and decreasing HIV risk factors (e.g. transactional sex, condom use and experience of violence). Results include 40% reduction in unintended pregnancy. Such results suggest important potential for the SHAZ! model to mitigate HIV risk among out-of-school adolescent female orphans, even in challenging economic contexts, and echo findings from the IMAGE study and Stepping Stones/Creating Futures evaluation in South Africa(Dunbar et al 2014)
### Options for ‘Cash Plus’ Programming for Adolescents in Tanzania: Background Paper

#### Annex 2. Summary table of parenting programmes

<table>
<thead>
<tr>
<th>Programme Basics</th>
<th>Overview/Description</th>
<th>Study/evaluation methodology</th>
<th>Relevant results</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sinovuyo Caring Families Teen Programme</strong> (Sinovuyo = We have joy)</td>
<td>Current 12-week parenting programme (each session from 2-2.5 hours) for adolescent boys and girls and their caregivers (8 sessions joint; 4 sessions separate adolescents and caregivers). Programme implemented by local NGO childcare workers in public spaces such as church halls or outside, with lunch provided (at request of participants). (Cluver et al nd b ‘reducing child abuse…’)</td>
<td>2012: Qualitative, 100 families in South Africa; International consultation: 50+ experts, other manuals</td>
<td>2013: (Cluver et al nd a; Development of a parenting support programme…) Medium to large programme effects in reducing child abuse and adolescent problem behaviour, as well as large effects in improvements of positive parenting, and perceived parent and adolescent social support.</td>
</tr>
</tbody>
</table>

- **Primary outcomes:** Comparisons between pre and post tests showed reduction in violence or abusive discipline from both parents (p = .001) and adolescents reports (p = .024). Parent report of child behaviour problems using the CBCL showed reductions in adolescent rule-breaking behaviour (p = .003) with a medium effect size (d = -0.35, 95% CI [-0.86, 0.17]) and adolescent aggressive behaviour (p = .005) with a medium effect size (d = -0.41, 95% CI [-0.92, 0.12]). Adolescent report showed no differences in either behaviour subscales.

- **Secondary outcomes:** Positive parenting using the APQ showed improvements in both parent (p < .001) and adolescent report (p = .001), with large effects for parent report (d = 1.05, 95% CI [0.43, 1.63]) and medium effects for child report (d = 0.68, 95% CI [0.08, 1.25]). Results also showed large effects for both increased perceived access to social support for parents (p = .001) and adolescents (p < .001).

  Study overall showed high levels of programme acceptability, pre-post test improvements in parent and adolescent outcomes, and no negative effects (Cluver et al nd b ‘Reducing child abuse…’).

  - 2014: Second draft manual; Pre-post test + qualitative N=230 rural and peri-urban, Eastern Cape Province, South Africa

<table>
<thead>
<tr>
<th>SOUTH AFRICA (rural &amp; peri-urban)</th>
<th></th>
<th>2013: First draft manual: Pre-post test + qualitative N=60 deep rural South Africa</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participating partners: NAAWC (National Association of Child and Youth Care Workers); Keisikamma Trust; Clowns without Borders; Child and Youth Care Centres; provincial and national Departments of Social Development; UNICEF SA; Oxford University; University of Cape Town; University College London…</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>References:</strong> Cluver et al nd a (‘Development of a parenting support programme…’); Cluver et al nd b (‘Reducing child abuse…’); Cluver 2016; WHO PLH website;</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2014 (Cluver et al: nd b ‘Reducing child abuse…’) Comparing pre and post tests:

- **Primary outcomes:** Reductions in child abuse within the home reported by both adolescents (from 63.0% pre-test to 29.5% post-test) and caregivers (from 75.5% pre-test to 36.5% post-test), both p<0.001: This is a drop from an average score of 4.33 to 1.33 for adolescents and from 7.32 to 1.68 for caregivers. Significant improvements in positive parenting reported by both adolescents (from 48.71 to 51.62) and caregivers (from 49.23 to 53.83). Decrease in poor monitoring/inconsistent discipline reported by both adolescents (19.64 to 15.52) and...
Options for ‘Cash Plus’ Programming for Adolescents in Tanzania: Background Paper

The programme uses social learning and parent management training principles, with group-based parent, adolescent, and joint parent-adolescent sessions. Follows core evidence-based principles of parenting programmes: collaborative (rather than didactic) problem-solving, home practice and discussion, and skills-based active participation. Sessions include: praising each other, managing anger, joint parent-teen sessions; home visits (as needed).

Content: Uses a combination of relevant content elements of family-based programmes tested in sub-Saharan Africa. Evidence-based parenting principles as building blocks for parent-teen communication, increased praise and responses to behavior problems. Parent-teen problem-solving for risks outside the home. Joint parent and teen workshops on abuse risks and problem-solving. Home practice, SMS reminders and boosters, illustrated stories using picture codes, traditional stories, role-play, modeling, interactive exercises, stress reduction, and group problem solving. Collaborative facilitation approach. Manualized with culturally relevant materials translated into local language. Facilitators: Community workers with some relevant qualifications. Training: 30 hours initial training, 60 hours ongoing training and supervision during initial programme implementation. (WHO PLH website)

2015-16: Third draft manual; Randomised controlled trial + qualitative. N=1200, 40 sites, rural and urban South Africa (results being analysed)

caregivers (from 24.36 to 16.87) p<.001. Decrease in adolescent behavioural problems (delinquency/ aggression) reported by both adolescents (from 8.64 to 6.40) and caregivers (from 16.16 to 12.14) p<.001. No harmful effects.

- **Secondary outcomes:** Access to improved social support reported by caregivers (from 29.2 to 33.56) and improved social support from parents reported by adolescents (from 34.26 to 36.71) p<.001. Reduced depression reported by both adolescents (from 3.02 to 1.37) and caregivers (from 23.23 to 14.06), p<.001. Significant decrease reported by caregivers in parenting stress (from 26.43 to 21.46) p<.001 and caregiver substance use (from 0.74 to 0.40) p<.002. No changes in adolescent substance use and no reported changes by either caregiver or adolescent of past-month sexual abuse of adolescents outside the home (though rates very low to assess). Adolescents reported decrease in witnessing violence in the community (from 3.25 to 1.54); no significant changes in caregivers’ reports of adolescents witnessing violence, though most caregivers indicated concern at their lack of knowledge of their adolescents’ exposure to violence in the community. No negative effects were detected.

- **Diffusion effects:** In all communities, participants reported that they had actively disseminated programme sessions to other families

Innocenti assessment: Pre/post nature of the pilot study methodology cannot definitely attribute causality to the programme and thus an RCT is currently underway.
and stress, joint problem-solving, non-violent discipline, rules and routines, keeping adolescents safe in the community, and responding to crises. Key differences from programmes in high income countries: use of role-plays (instead of videos), simplified session content, adding mindfulness-based physical exercises for stress reduction, and additions of culturally-relevant songs and games. Peer-support system - ‘Sinovuyo buddies’ - introduced to help participants between sessions, as low literacy levels limits use of written materials. (Cluver et al ndb ‘reducing child abuse…’) (Note: initial pilot of 10 sessions over 5 weeks) Cluver et al nd a)

**Target population:** adolescents (boys and girls) aged 10-17 and parents/caregivers in poor communities

<table>
<thead>
<tr>
<th>Home visiting programme for OVCs on child grant</th>
<th>SOUTH AFRICA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>References</strong></td>
<td>Thurman et al. 2014 and 2015</td>
</tr>
</tbody>
</table>

**Home visits to vulnerable families**

| **Target population:** | children and families benefiting from Child Support Grant and Foster Child Grant |

| **2014:** Longitudinal quasi-experimental (pre/post) design to explore whether home visits yield concomitant gains in psychological outcomes among beneficiaries. Baseline and follow-up data were collected over a two-year period from children aged 10-17 at the time of programme enrolment and their caregivers, with 80% retention. In this sample of 1487 children and 918 caregivers, the psychological health outcomes of those enrolled in programs with home visitors who receive intensive training.  |

Thurman et al. 2014

Applying multilevel logistic regression, no measurable improvements were found among paraprofessional enrollees, and three outcomes were significantly worse at follow-up regardless of programme model. Children’s behaviour problems became more prevalent even after adjusting for other factors, increasing from 29% to 35% in girls and from 28% to 43% in boys. Nearly one-quarter of girl and boys reported high levels of depression at follow-up, and this was a significant rise over time for boys. Rates of poor family functioning also significantly worsened over time, rising from 30% to 59%. About one-third of caregivers reported high levels of negative feelings at follow-up, with no improvements observed in the paraprofessional group. Results highlight that children’s and caregivers’ psychological outcomes may be relatively impervious to change even in paraprofessional home visiting models. Findings underscore the need for programmes serving HIV-affected families to add focused evidence-based psychological interventions to supplement traditional home visiting
organisational support, and regular compensation (termed “paraprofessional”) were compared to those enrolled in programs offering limited home visiting services from lay volunteers.

2015: Quasi-experimental study (pre/post) examining differences in grant uptake over a two year period among 1487 children enrolled in one of two types of supportive home visiting programming: volunteer-based or paraprofessional.

Thurman et al. 2015
Results show that programmes staffed with trained paraprofessionals who received training, compensation and other support were significantly more effective at linking families to social grants for children. Controlling for important covariates, at follow-up participants in the paraprofessional model programmes were nearly three times as likely as volunteer-based service recipients to have access to the highest grant they were eligible to receive. Grant receipt was also positively associated with household food security and children's obtainment of basic educational and material resources. Effective strategies for promoting social grant access among HIV-affected households therefore have the potential to yield significant improvements in wellbeing for orphans and vulnerable children.
Annex 3. Summary table of community mobilisation around social norms

<table>
<thead>
<tr>
<th>Programme Basics</th>
<th>Overview/Description</th>
<th>Study/evaluation methodology</th>
<th>Relevant results</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stepping Stones</strong>&lt;br&gt;S. AFRICA</td>
<td>A participatory learning approach to violence and HIV prevention with the ‘gender transformative’ aim of building more gender-equitable relationships and better communication between partners. It operates through life skills training involving critical reflection, role play, and drama delivered in 13 3-hour single sex sessions plus 3 mixed peer discussions and a final community meeting. The programme spans about 50 hrs and runs for 6-8 weeks. Themes include: gender and peer influences; sex and love; risks and sexual problems; unwanted pregnancy; sexually transmitted diseases and HIV; safer sex and condoms; gender-based violence; motivations for sexual behaviour; dealing with grief and loss; and communication skills (Jewkes et al. 2008). The sessions are mainly held on school premises after school hours (Jewkes et al. 2008).&lt;br&gt;Originally developed in Uganda in 1995, Stepping Stones has been used in over 40 countries with hundreds of thousands of individuals, adapted for 17 settings (including South Africa in 1998), and translated into 13 languages (Jewkes et al. 2008).&lt;br&gt;Target group:&lt;br&gt;Young men and women aged 15-26 in rural areas in Eastern Cape Province</td>
<td>Evaluation over a 2-year period in a randomized control trial for impact on HIV incidence and risk factors (incidence of herpes simplex type 2 (HSV-2) and risky behaviours) accompanied by qualitative research.</td>
<td>Results for Stepping Stones (Jewkes et al. 2008)&lt;br&gt;• No reduction of HIV&lt;br&gt;• Incidence of genital herpes (HSV-2) significantly lower for men and women in the Stepping Stones arm than the control arm.&lt;br&gt;• Male self-reported perpetration of intimate partner violence reduced by 38% but no reduction in women’s experience of violence&lt;br&gt;• Men in Stepping Stones arm reported less transactional sex at 12 months, less perpetration of intimate partner violence (significant at 24 months, suggested at 12 months), less problem drinking at 12 months, and less drug misuse at 24 months. There was a suggestion of change in several other outcomes in men, including fewer partners at 12 months, less likelihood of casual partners, less rape at 12 months, and less depression at 24 months&lt;br&gt;• Women in Stepping Stone arm reported more transactional sex with casual partner at 12 months (but not at 24 months) and there is a suggestion of more unwanted pregnancies at 24 months&lt;br&gt;• It has been suggested that the limited positive impact Stepping Stones had on women (compared to men) may have been due to differential reporting bias; but may also have resulted from their lack of external sources of power (such as economic leverage); hence phase 2 added the ‘Creating Futures’ component (see companion table on ‘bundled interventions’)&lt;br&gt;• The findings from the qualitative research suggests that women were sometimes able to change their behaviour with younger partners while not doing so with their older main partner. This raises the possibility of Stepping Stones having a positive longer term impact on women’s HIV risk beyond the period of observation of the study.&lt;br&gt;• The changes in sexual and violent behaviour of men were supported by the findings of qualitative research</td>
</tr>
</tbody>
</table>
Soul City
S. AFRICA

Soul City Institute for Health and Development Communication (SC: IHDC - a SA multi-media health promotion project) for the media platform and National Network on Violence Against Women, SA for the community mobilisation.

References:
Usdin et al. 2005; also reported in WHO 2010

| The Soul City vehicle uses mass media for social change and consists of prime time radio and television dramas (edutainment) and print material. Edutainment has been shown to achieve strong audience identification with characters and stories in a phenomenon termed ‘parasocial interaction’ and is an important device to (i) enhance feelings of individual self and collective efficacy; and (ii). Promote role modelling of positive norms, attitudes and behaviours, including help-seeking and help-giving actions (Usdin et al. 2005). WHO (2010) describes Soul City as ‘one of the best-known and most carefully evaluated media programmes.’

The fourth series of Soul City media episodes focused on gender-based violence. Taking an ecological approach, recognising that behavioural change interventions aimed solely at individuals have limited impact, the intervention was designed to impact at multiple mutually reinforcing levels; individual, community and socio-political environment through the multi-media vehicle and an advocacy campaign (Usdin et al. 2005).

The intervention aimed to catalyse community dialogue, mediate shifts in social norms, facilitate collective action and create an enabling legal environment. The intention was to support individual and social change which recursively developing stronger, more equal relationships between those of different gender.

Versions of the programme have been evaluated in a variety of countries (45); however, the most thorough study is a randomized controlled trial in the Eastern Cape province of South Africa, with participants aged 15–26 years-old. This indicated that a lower proportion of the men who had participated in the programme committed physical or sexual intimate partner violence in the two years after the programme, compared with the men in a control group (46).

| A pre/post evaluation (no comparison/control group) of the fourth series of media episodes used a random sample of the national population and conducted two sets of survey interviews, eight months apart: pre and post intervention between June 1999 and February 2000, accompanied by a national qualitative impact assessment (Usdin et al. 2005; WHO 2010).

Surveyed population: N=2000 people aged 16–65 (66% aged between 16 and 35) representative of target population in 9 provinces across SA and with a 2:1 ratio of women to men.

Usdin et al 2005; WHO 2010

Soul City successfully reached 86%, 25% and 65% of audiences through television, print booklets and radio, respectively. The study reported an association between exposure to the Soul City series and changes in knowledge and attitudes towards intimate partner violence. While it is not known whether these changes would have occurred without the intervention (there was no comparison group), higher exposure to the intervention was associated with more positive attitudinal changes.

On an individual level there was a shift in knowledge around domestic violence including 41% of respondents hearing about the helpline. Attitude shifts were also associated with the intervention, with a 10% increase in respondents disagreeing that domestic violence was a private affair and a 22% shift in perceptions of social norms on this issue. The percentage agreeing with the statement that ‘no woman ever deserves to be between’ increased from 77% to 88% while the percentage disagreeing with the statement ‘Women who are abused are expected to put up with it’ increased from 68% to 72%. However, there were no significant changes reported in other attitudes such as ‘As head of household, a man has the right to beat his wife’; moreover, the study design was not able to establish if there was an impact on violent behaviour.

Qualitative data analysis suggests the intervention played a role in enhancing women’s and communities’ sense of efficacy, enabling women to make more effective decisions around their health and facilitating community action. The evaluation concluded that implementation of the Domestic Violence Act can largely be attributed to the intervention. While demonstrating actual reductions in levels of domestic violence was not possible, the evaluation shows a strong association between exposure to intervention components and a range of intermediary factors indicative of, and necessary to bring about social change (Usdin et al. 2005).

An observed strength of the intervention was the combination of a popular mass media vehicle, with the social muscle of a national coalition, and interconnecting support structures; however this was also one of the its key challenges in terms of coordination. (Usdin et al. 2005)
### Options for ‘Cash Plus’ Programming for Adolescents in Tanzania: Background Paper

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>S. AFRICA</strong></td>
<td>Programme initiatives in late 2006 in partnership with a variety of South African and international organisations. The OMC campaign’s major goal is to support men and boys to advocate for gender equality, to promote and sustain change in their personal lives, and to change the gender norms that drive the rapid spread of HIV. The OMC Campaign is rooted firmly in the belief that all men can become advocates for gender equality and active participants in efforts to respond to HIV and AIDS (Colvin and Peacock).</td>
</tr>
<tr>
<td>References:</td>
<td>Colvin and Peacock 2009; Peacock and Barker 2014;</td>
</tr>
<tr>
<td><strong>SASAI UGANDA</strong></td>
<td>A community mobilisation intervention to prevent violence and reduce HIV-risk behaviours in Kampala.</td>
</tr>
<tr>
<td>Partners</td>
<td>Designed by Raising Voices implemented in Kampala by Centre for Domestic Violence Prevention (CEDOVIP), (both Uganda-based NGOs)</td>
</tr>
<tr>
<td>References:</td>
<td>Abramsky et al. 2012; 2014; Kyegombe et al. 2015; Watts et al. 2014; Raising Voices and CEDOVIP 2008</td>
</tr>
<tr>
<td><strong>Target group:</strong></td>
<td>Community members (men and women) (an estimated 260,000 reached with activities)</td>
</tr>
<tr>
<td><strong>Four research components:</strong></td>
<td>Four research components: a pair-matched cluster randomised controlled trial with baseline and endline cross-sectional surveys in 8 communities; a nested qualitative study (82 in depth interviews); an economic evaluation; and operational research. Conducted over 4 years between 2007 and 2012.</td>
</tr>
<tr>
<td><strong>Key aim to assess the community level effect of a community mobilisation intervention on the social acceptance of gender inequalities and IPV, prevalence of IPV, community responses to IPV and sexual risk behaviors</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Programme has demonstrated significant positive impact:</strong></td>
<td>50% of participants reported taking action to address acts of gender-based violence in their community; 25% accessed HIV voluntary counselling and testing services; and 61% reported increased use of condoms. More than four of the five participants also reported having subsequently talked with friends or family members about HIV and AIDS, gender, and human rights (Colvin, Peacock, and Human 2009, reported in Peacock and Barker 2014).</td>
</tr>
<tr>
<td>Innocenti assessment:</td>
<td>Given that the evaluation did not have a comparison group, changes in outcomes cannot be definitely attributed to the programme, but appear promising.</td>
</tr>
</tbody>
</table>

**Abramsky et al. 2014.**
- Significantly lower social acceptance of IPV among women (adjusted risk ratio 0.54, 95% confidence interval (CI) 0.38 to 0.79) and lower (but not statistically significant) acceptance among men (0.13, 95% CI 0.01 to 1.15); |
- Significantly greater acceptance that a woman can refuse sex among women (1.28, 95% CI 1.07 to 1.52) and men (1.31, 95% CI 1.00 to 1.70); |
- 52% lower (but not statistically significant) past year experience of physical IPV among women (0.48, 95% CI 0.16 to 1.39); and lower (but not statistically significant) levels of past year experience of sexual IPV (0.76, 95% CI 0.33 to 1.72). (To note: reports of sexual IPV did not go down in intervention sites during the course of the study (staying level); rather they increased in control communities). |
- Women experiencing violence in intervention communities were more likely to receive supportive community responses. |
- Reported past year sexual concurrency by men was significantly lower in intervention compared to control communities (0.57, 95% CI 0.36 to 0.91). |

**Abramsky 2016:**
- Reduction in controlling and emotional IPV. |
- Reductions in high intensity physical/sexual IPV (p<.10). |
- Reductions in continuation of IPV (p<.05).
The findings suggest that SASA! impacted children’s experience of violence in three main ways.

- Quantitative data suggest that children’s exposure to IPV was reduced. Authors estimate that reductions in IPV combined with reduced witnessing by children when IPV did occur, led to a 64% reduction (but not statistically significant) in prevalence of children witnessing IPV in their home (aRR 0.36, 95% CI 0.06–2.20).

- Among couples who experienced reduced IPV, qualitative data suggests parenting and discipline practices sometimes also changed-improving parent–child relationships (spending more time with children) and for a few parents, resulting in the complete rejection of corporal punishment as a disciplinary method.

- Some participants reported intervening to prevent violence against children. The findings suggest that interventions to prevent IPV may also impact on children’s exposure to violence, and improve parent–child relationships. They also point to potential synergies for violence prevention, an area meriting further exploration.

Together with the Safe Homes and Respect for Everyone (SHARE) project in Rakai, Uganda (Wagman et al., 2014), SASA! is one of only two community mobilization interventions that seek to achieve primary prevention of IPV and HIV in a low- or middle-income country of which we are aware (Kyegombe et al. 2015. (But see also GREAT project)

Conclusions (Abramsky et al. 2014) This is the first CRT in sub-Saharan Africa to assess the community impact of a mobilization program on the social acceptability of IPV, the past year prevalence of IPV and levels of sexual concurrency. SASA! Achieved important community impacts, and is now being delivered in control communities and replicated in 15 countries. Importantly, and in contrast to most current evidence, the intervention effects are demonstrated at the community level, and are not limited to those with high reported levels of intervention exposure. This attests to the success of the community diffusion process at the heart of the intervention model. It is also suggestive of the importance of the multiple strategies and social levels through which the intervention may have its intended impacts (for example, through community responses to violence in addition to personal change within relationships).

Innocenti Assessment: Overall, the SASA! findings suggest possible positive impacts of the programme on a range of promising outcomes, but given the small number of randomised clusters in the study design, the study may be underpowered to detect significant programme impacts.

WHO 2010
In Uganda, Raising Voices and the Centre for Domestic Violence Prevention run a community initiative for males and females, designed to challenge gender norms and
**Options for ‘Cash Plus’ Programming for Adolescents in Tanzania: Background Paper**

| Safe Homes and Respect for Everyone (SHARE) | The ‘Safe Homes and Respect for Everyone’ (SHARE) project is a combination IPV and HIV prevention intervention implemented in rural Uganda between 2005 and 2009. SHARE adapted IPV prevention strategies from Raising Voices and Stepping Stones and based on a public health approach. **Target group:** adolescent girls and boys and women and men aged 15-49 in 4 regions of Rakai, Uganda |
| References: Wagman et al. 2012; Wagman et al. 2015a and 2015b | The cohort study used pre-existing clusters of communities randomised as part of a previous family planning trial. Four intervention group clusters from a previous family planning trial were provided (1) standard of care HIV services plus (2) a community-level mobilisation intervention to change attitudes, social norms, and behaviours related to IPV; and (3) a screening and brief intervention to promote safe HIV disclosure and risk reduction in women seeking HIV counselling and testing services (the SHARE Project). | Overall: SHARE was associated with significant declines in physical and sexual IPV and overall HIV incidence, and its model could be adopted as a promising practice in other settings (Wagman et al. 2012, 2015a) |  |

Specific findings:
Compared with control groups, individuals in the SHARE intervention groups had fewer self-reports of past-year physical IPV (346 [16%] of 2127 responders in control groups vs 217 [12%] of 1812 responders in intervention groups; aPRR* 0·79, 95% CI 0·67-0·92) and sexual IPV (261 [13%] of 2038 vs 167 [10%] of 1737; 0·80, 0·67-0·97). Incidence of emotional IPV did not differ (409 [20%] of 2039 vs 311 [18%] of 1737; 0·91, 0·79-1·04). SHARE had no effect on male-reported IPV perpetration. At follow-up 2 (after about 35 months) the intervention was associated with a reduction in HIV incidence (1·15 cases per 100 person-years in control vs 0·87 cases per 100 person-years in intervention group; aIRR 0·67, 95% CI 0·46-0·97, p=0·0362). (2015b) |

Conclusions/recommendations:
SHARE could reduce some forms of IPV towards women and overall HIV incidence, possibly through a reduction in forced sex and increased disclosure of HIV results. Findings from this study should inform future work toward HIV prevention, treatment, and care, and SHARE's ecological approach could be adopted, at least partly, as a standard of care for other HIV programmes in sub-Saharan Africa.
### Gender Roles, Equity and Transformations (GREAT)

**UGANDA**

Institute for Reproductive Health, Georgetown University; Pathfinder Fund, with funding from USAID

**References:** IRH 2014; IRH et al. 2015

---

| **GREAT** aims to promote gender-equitable attitudes and behaviours among adolescents (ages 10-19) and their communities with the goal of reducing gender-based violence and improving sexual and reproductive health outcomes in post-conflict communities in northern Uganda.

The GREAT intervention package is based on the ‘ecological’ model of social change and includes the following components:

- Serial radio drama to catalyse discussion and reflection at scale
- Scalable toolkit to promote reflection and dialogue. The toolkit consists of Coming of Age Flipbooks for very young adolescent boys and girls and a Community Engagement Game and Activity Cards for all ages. The toolkit will be rolled out through existing small groups with guidance and support by community groups and field workers from GREAT partners
- Community Action Cycle (CAC) conducted with community leaders to strengthen their capacity to promote and sustain change
- Training and engaging Village Health Teams to improve access to and quality of youth-friendly SRH services

| Pre and post test 2014 (full evaluation report not yet available but preliminary findings reported)

Sample size (calculated as 352 based on an estimated 4,110 adolescents participating in 137 platforms in the four sub-counties)

| The end-line evaluation found that GREAT led to significant improvements in attitudes and behaviours among exposed individuals as compared to a matched control group. For example: 48% of older adolescents exposed to GREAT report believing that men and women are equal, compared to 37% of the control group; young husbands among GREAT participants (65%) were more likely to be involved in childcare or helping with household chores than were those not involved (65% compared to 53%); and some 43% of newly married/parenting couples exposed to GREAT were using family planning, compared to 33% in the control group. Attitudes and behaviours around intimate partner violence had also improved: only 5% of newly married/parenting adolescents reported reacting violently to their partners compared to 21% among the control group (IRH et al. 2015).

Adults exposed to GREAT were also more likely to provide supportive advice to adolescents than those not exposed (61% compared to 59%). However, the fact that such changes were not generally diffused within the wider community among those not reached directly by the interventions suggests that while GREAT has been successful in achieving individual change, greater depth and breadth of coverage is needed to reach a ‘tipping point’ of community change; this in turn implies the need for more time for further implementation (IRH et al. 2015).
### Options for ‘Cash Plus’ Programming for Adolescents in Tanzania: Background Paper

| Kembatta Mentti Gezzima-Tope (KMG) ETHIOPIA | Aim to prevent FGM/C through community conversations, rallies, public weddings for uncut girls, building relationships between government/NGOs.
| **Target groups:** adolescent girls, parents and communities. Different programmes: example; KMG in Kembatta/Tembaro zone. Strategies include: (i) Providing information through to increase knowledge about FGM/C and human rights so that communities can consider non-cutting as an alternative (linked to integrated community development projects); (ii) Mobilizing and organizing social forces through Community Conversation – a tool for community discussion; (iii) organization of community members into groups for collective action; (iii) creating public pressure against FGM/C through community events and rallies, public weddings for uncircumcised girls, public declarations, rescue actions, and other compelling events; and (iv) enforcing abandonment by strengthening alliances between government and CSOs and implementation of existing laws. | Quantitative and qualitative surveys in districts where the intervention took place, no comparison/control group. Two studies conducted in 2006 and 2008 by focusing on experiences in three regions of Ethiopia with different ethnic and linguistic characteristics: Amhara (2006), Afar (2006) and the Southern Nations, Nationalities and People Region (SNNPR, 2006 and 2008). In the SNNPR, two different experiences in different locations were examined: Kembatta/Tembaro Zone (2008) and Wolayta Zone (2006). The studies combined qualitative and quantitative research (Dagne). | Study reports that 97% approval of FGM/C at outset changed to 96% disapproval of the practice and 85% of respondents reporting that uncut girls are no longer despised in villages.

**Innocenti assessment:** Decreases cannot be directly attributed to the programmes examined due to study’s lack of a comparison/control group. |