Medium-Term Impacts of Integrated Social Safety Nets: Cash Transfers, Information Meetings, and Home Visits for Child Development[*]

Richard Akresh
University of Illinois at Urbana-Champaign

Damien de Walque
The World Bank

Harounan Kazianga
Oklahoma State University

Abigail Stocker
University of Illinois at Urbana-Champaign

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Abstract

Cash transfers are a critical part of social safety nets. More recently, integrated programs combining either information or home visits have been adopted to help households overcome barriers to improving child development. Working with the Burkina Faso government, we conduct a randomized experiment in 225 rural villages to assess the impact of an integrated social safety net over the child's life cycle. Villages were randomized to a control group or one of the following treatments: cash transfers; cash transfers plus government-run information meetings focused on children's health and psychosocial development; or cash transfers, information, and home visits reinforcing the information meetings. Fifteen months after the treatment ended, households receiving the cash, information, and home visits have fewer pregnancies, more medically assisted childbirths, enhanced health behaviors, and better educational outcomes. Home visits are critical for improving early childhood development, while cash transfers, with or without information, do not show lasting impacts.

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Contact Information: Richard Akresh, University of Illinois at Urbana-Champaign, Department of Economics. Email: akresh@illinois.edu; Damien de Walque, The World Bank, Development Research Group. Email: ddewalque@worldbank.org; Harounan Kazianga, Oklahoma State University, Department of Economics. Email: harounan.kazianga@okstate.edu; Abigail Stocker, University of Illinois at Urbana-Champaign, Department of Economics. Email: stocker3@illinois.edu

1. Introduction

Over 240 million children under age five in developing countries do not reach their development potential and are less likely to become healthy, productive, and socio-economically successful adults (Grantham-McGregor et al., 2007).[1] For decades, government social safety nets have incorporated cash transfers to poor households to help children reach their full potential (see Fiszbein and Schady, 2009 and Bouguen, Huang, Kremer, and Miguel, 2019 for reviews of this literature). While insufficient income is often cited as a key constraint facing poor households, lack of information may also be critical (see Bhutta et al., 2008; Bhutta et al., 2013; and Ruel et al., 2013 for a review of information campaigns related to maternal and child nutrition).[2] Despite both income and information being potentially essential for child development and many countries implementing these types of interventions, millions of children remain at risk of not accumulating sufficient human capital.

More recently, governments have begun to also focus on the quality of parenting behaviors as these are thought to be critical for early childhood development (Cunha and Heckman, 2008).[3] Home visits focused on changing parental behaviors have attracted significant interest for improving children's development as these visits can overcome household or

[1] A growing body of evidence from developed and developing countries shows that cognitive, non-cognitive, and physical health developments of young children are critical factors for health and socioeconomic well-being in adulthood (Heckman, 2006, Almond and Currie, 2011). These returns are both to individuals—who benefit from increased schooling, labor force participation, wages, and material and socio-emotional well-being—as well as to societies that benefit from higher productivity leading to economic growth, lower inequality, and a more participatory citizenry (Heckman and Masterov, 2007; Walker et al., 2007; Alderman, 2011; Walker et al., 2011; Gertler, Heckman et al., 2014).

[2] Research in Nepal evaluates a randomized control trial that provides cash transfers as well as information on best practices regarding child care, finding significant impacts of the information plus cash treatment arm (Levere, Acharya, and Bharadwaj, 2024). A project in northern Nigeria randomly provides cash transfers and informaiton to mothers related to pregnancy and infant feeding (Carneiro et al., 2021). They find large and significant improvements in anthropometrics and health outcomes, and both information and cash are critical.

[3] In developed country settings, this early childhood development focus typically does not involve changing parents' behaviors and instead involves programs that work directly with children in daycare centers such as the HighScope Perry Preschool Program (Heckman et al., 2010).

individual barriers to change.[4] Seminal work in Jamaica led to large and sustained impacts in adult outcomes decades after the home visits took place (Grantham-McGregor et al., 1991; Gertler et al., 2014).[5] Yet, most longer-term evaluations of home visit interventions find that once the treatments stop, the impacts are greatly reduced (Yousafzai et al., 2016) or completely fade out (Andrew et al., 2018). However, despite efforts to evaluate components of social safety net programs, there exists no evidence measuring the overall impacts of specific parts of an integrated early childhood development intervention that removes both cash and knowledge constraints and provides a mechanism to overcome household barriers to change.

In this paper, we evaluate the impact of the Burkina Faso government's integrated social safety net intervention focused on early childhood development that combines cash transfers, village-level information meetings, and home visits reinforcing the information meetings. Burkina Faso is a low-income environment with relatively weak administrative capacity but where rigorous impact evaluations of social protection programs, such as cash transfers or food transfers, have already been conducted and shown to have impacts (Akresh, de Walque, and Kazianga, 2013, 2024; Kazianga, de Walque, and Alderman, 2014).[6] We conduct a randomized

[4] Group-based parenting interventions are an alternative approach to improving early childhood development by providing information to parents but without the individualized attention from a one-on-one home visit. Evidence from Rwanda (Justino et al., 2023) and Chile (Carneiro et al., 2024) found these programs led to significant improvements in child development.

[5] Recent home visit interventions building on the Jamaica study yield smaller, but still positive, short-term impacts at endline (Attanasio et al., 2014; Grantham-McGregor, 2020; Araujo et al., 2021).

[6] Cash transfers are often given to poor households conditional on the household taking measures to increase their children's human capital (e.g., enrolling their children in school and maintaining their attendance, taking them for regular preventive health care visits). Alternatively, programs can provide unconditional cash transfers where cash is given to poor households without any conditions. There is credible evidence that both types of transfer schemes (conditional and unconditional) substantially improve child education and health outcomes. For evidence of the impact of conditional cash transfers on education: in Mexico see Schultz 2004; de Janvry et al. 2006; in Colombia see Attanasio et al. 2010; in Nicaragua see Maluccio and Flores 2005; Macours, Schady and Vakis 2008; in Honduras see Glewwe and Olinto 2004; in Brazil see Glewwe and Kassouf 2012; in Cambodia see Filmer and Schady 2011; in Indonesia see Cahyadi et al. 2020; in Burkina Faso see Akresh, de Walque, and Kazianga, 2013; for evidence of the impact of unconditional cash transfers on education: in Ecuador see Schady and Araujo 2008; in South Africa see Case, Hosegood, and Lund 2005; Edmonds 2006; in Burkina Faso see Akresh, de Walque, and Kazianga, 2024; and in the United States for the long-term impacts see Aizer et al. 2016. For evidence of the impact

control trial in 225 rural villages where villages were randomly assigned to a control group or one of the following treatments: cash transfers only; cash transfers plus government-run information meetings focused on child health and psycho-social development; or cash transfers, information, and home visits reinforcing the information meetings. Households in the treatment arms receive a quarterly cash transfer of approximately $70 USD. Monthly village-level information meetings for groups of around 30 mothers were run by government facilitators, and government-trained social workers did monthly home visits to monitor progress and follow-up on the physical and cognitive development of the children. The cash intervention lasted for 30 months, while the information and home visits lasted for 18 months.[7]

To measure the impact of the intervention, we conduct a baseline survey prior to the rollout of the treatment, and we were scheduled to conduct an endline survey at the conclusion of the intervention. However, security and conflict issues in Burkina Faso forced us to delay the endline survey until approximately 15 months after the treatment ended, so all results should be interpreted as medium-term impacts after the intervention had ended.

Figure 1 provides an overview of our findings. Due to the data's richness and the large number of outcomes, we want to be careful not to overemphasize any single significant result and so we take two approaches. First, following Kling, Liebman, and Katz (2007), we create an index for each family of outcomes where we aggregate all individual outcomes in that family together. As described further in Section 3, we then estimate standardized effects from exposure to the treatment on these outcome indexes (Banerjee *et al.*, 2015). Second, since we examine

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of conditional cash transfers on health: in Colombia see Attanasio et al. 2005; in Ecuador see Paxson and Schady 2008; in Nicaragua see Macours, Schady, and Vakis 2008; for evidence of the impact of unconditional cash transfers on health: in South Africa see Case and Deaton 1998; Case, Hosegood, and Lund 2005; and Duflo 2003.

[7] Cash transfers started immediately after the baseline survey was completed, while the information meetings and home visits were delayed for approximately 12 months while the Burkina Faso government trained project facilitators to implement those components.

multiple outcomes, we use the randomization inference-based tests proposed by Young (2019) to address the potential issues arising from multiple hypothesis testing.

The consistent pattern seen in Figure 1 is that households in villages receiving the full social safety net intervention (cash, information, and home visits) show improvements across a wide range of outcomes, including pregnancy, health, education, and early childhood development. Mothers that receive the full intervention have fewer pregnancies, and they are older at each birth. Importantly, their most recent birth is also more likely to have been assisted by a medical professional. We find evidence that mothers in those villages adopt healthier behaviors. This includes providing improved nutrition for young children, increased used of mosquito bednets for children, increased number of prenatal visits during the last pregnancy, and mothers being more likely to wash their hands after using the toilet and before meals. None of the fertility or health behavior outcomes show any impacts for households in villages that received only cash or cash plus information meetings.[8]

Older children in households receiving the full intervention have improved educational outcomes, including being more likely to be enrolled in school, completing more years of school, ever attending school, and being educationally on track for their age. Households that receive only cash transfers show impacts on the overall education index, and those effects are concentrated in improvements in ever attending school.

We conduct two distinct tests of early childhood development: the Strengths and Difficulties Questionnaire (SDQ), which comprises 25 items across five different scales (emotional problems scale, conduct problems scale, hyperactivity scale, peer problems scale, and

[8] There are no lasting impacts on the overall child anthropometrics index, but we do observe improvements in children's arm circumference-for-age and weight-for-age in villages that received only cash transfers.

prosocial scale); and the Denver Prescreening Developmental Questionnaire, which has subsections in Language, Fine Motor, Gross Motor, and Personal Social. There is evidence that households receiving cash, information meetings, and home visits improved the SDQ index for their children, but this was driven exclusively by improvements in the prosocial scale. There were no statistically significant improvements in the other four difficulties scales, and there were no improvements in the total Denver score or any of the Denver subsections. We find suggestive evidence that the cumulative addition of home visits to the treatment intervention may be the reason for increases in early childhood development outcomes, in particular on the Denver questionnaire and the SDQ prosocial scales. Cash transfers and information do not improve children's outcomes on these development measures, highlighting that the home visits are a critical component of the social safety net intervention package.

Additionally, we examine the heterogeneity of impacts across poor and non-poor households (as defined by expenditures) and by level of exposure to conflict and insecurity (as defined by being close to conflict events), and we find suggestive evidence that more vulnerable households may have benefitted more from the full intervention. This suggests that targeting package interventions with cash, information, and home visits to more vulnerable households may result in higher impacts, leading the interventions to be more cost effective.

This paper makes three main contributions to the literature. First, this is one of the first papers to evaluate a randomized control trial of an integrated social safety net intervention that provides cash, information, and home visits in the same setting.[9] Governments want to

[9] Carneiro et al. (2021) is probably the most closely related paper to ours. However, in our setting we can disentangle the additional roles played by cash, information, and home visits. Their project in Nigeria differs in several key aspects. First, their project does not have a cash only treatment arm, so they are not able to determine how much of the impacts they find are due to cash and how much to information. Second, they lump together a low-intensity information intervention that includes health talks and radio messages, with a high-intensity information

implement the most effective programs for improving child development and understanding whether removing cash and information constraints and providing home visits to help households overcome barriers to change is critical to doing that.

Second, this is the first paper to separate out the specific roles of cash, information, and home visits to understand what role each component plays in improving child development. Existing evidence shows that alone each component (cash, information, and home visits) could lead to improved early childhood development, but it is not clear where the constraints lie and whether removing these barriers lead to larger impacts. Given that home visits have become popular strategies for improving child development, it is important to understand why they work and whether they are necessary or if simply providing cash or knowledge is sufficient.

Third, due to insecurity in parts of Burkina Faso, the endline survey was delayed by approximately 15 months after the treatment intervention ended. Therefore, all of our program impacts should be interpreted as the medium-term effects once the program ended. There are a limited number of evaluations of home visits that can look at impacts beyond the program ending and given that the previously discussed literature found early childhood development impacts disappeared or faded out, it is therefore somewhat promising that we still are able to observe positive impacts of the full treatment intervention 15 months after the program ended.

The remainder of the paper is organized as follows. Section 2 describes the context of our experiment and the design of the cash transfer, information, and home visit program. In Section 3, we discuss our empirical identification strategy. Section 4 presents the main results for child welfare outcomes. Section 5 concludes.

intervention that bundles small group parenting sessions and home visits, so they are not able to determine what role is played by the home visits and what role is played by removing information constraints.

2. Context and Experimental Design

2.1 Context

Burkina Faso offers an important setting for exploring the effects of cash transfers and early childhood development programs on children's education, health outcomes, and rural fertility. Even by African standards, child education and health in Burkina Faso are poor. The United Nations Human Development Index ranks Burkina Faso 185 out of 193 countries (United Nations Development Program, 2024). In 2010, the net attendance ratio for primary school in rural Burkina Faso was 44.4 (45.5 for boys and 43.1 for girls) and the gross attendance ratio was 64.9 (66.2 for boys and 63.5 for girls) (Institut National de la Statistique et de la Démographie and ICF International, 2012).[10]

Formal education in Burkina Faso consists of six years of primary school, four years of lower secondary school, three years of upper secondary school, and then tertiary education. A national law officially makes school mandatory until age 16. However, this law is not enforced because the government lacks resources to provide education to all school-aged children. In principle, children can attend public primary schools free of charge. However, parents still must pay for various required school fees and school supplies. These expenses must be paid in cash and in a timely manner, with most being paid at the start of the academic year, thus presenting a significant constraint for cash-strapped households. Cash transfers could reduce this constraint in addition to compensating for the opportunity cost of child time.

Health outcomes among children in Burkina Faso are similarly poor. In 2020, approximately 35 percent of children in Burkina Faso under age 5 were considered stunted and

[10] The primary school net attendance ratio is the percentage of children attending primary school who are of the official school age. The primary school gross attendance ratio is the number of primary school students, irrespective of age, as a percentage of the official primary school age population. If there is a significant number of underage or overage students in primary school, the gross attendance ratio will be higher than the net attendance ratio.

18 percent were considered underweight (Ministère de la Santé, 2020).[11] In 2021, only 65 percent of children had received all the recommended vaccinations for their age group, up from 50 percent in 2019-2020 (Cooper et al., 2023).

Fertility rates in Burkina Faso are high and are coupled with poor pregnancy-related outcomes. The average fertility rate in Burkina Faso is five children per woman. While 94% of women in rural areas have their birth assisted by a medical professional, very few women make at least four antenatal care visits, only 31% in rural areas overall and 24% for the poorest households (United Nations Children's Fund, 2018). Given the status of education, health, and fertility in Burkina Faso, there is scope for interventions to improve each of these outcomes.

The cash transfer, information, and home visit interventions that we study were implemented in 225 villages in the Center-Est and Est regions in Burkina Faso, located 250-350 kilometers from the capital, Ouagadougou. Villages were randomly selected from a sampling frame of all villages in the region that had between 90 to 400 households.[12] These 225 villages had an average at baseline of just under 200 households per village. In the Centre-Est region, there is a total population of approximately 1.1 million individuals in 186,000 households. Fifty-three percent of the population is female. Forty-eight percent of the population is under age 15, 47% is between the ages 15-64, and 4% is over 65. In the Est region, the population is approximately 1.2 million individuals in around 192,000 households. Fifty-one percent of the population is female. Fifty-one percent of the population is under age 15, 46% of the population

[11] Stunting is defined as children being below minus two standard deviations from the median height-for-age of a reference population. Underweight is defined as children being below minus two standard deviations the median weight-for-age of a reference population.

[12] We restricted the village sampling frame to villages that had more than 90 households to ensure there would be at least 21 beneficiary households to survey in each village and to villages that had less than 400 households to avoid situations where the households were spread over areas that were too large to survey.

is ages 15-64, and 3% of the population is over 65. Households in these regions are predominantly subsistence farmers growing millet, sorghum, and peanuts.

2.2 Experimental Design: Burkina Faso Social Safety Net Pilot Project Overview (SSNPP)

The 225 villages in the Est and Centre-Est regions were randomly allocated into five groups, stratified at the commune level. These groups are shown in Figure 1, and the groups consisted of: (i) households receiving cash transfers; (ii) households receiving cash transfers and information meetings (one monthly village level meeting and regular group sessions with 25-30 mothers); (iii) households receiving cash transfers, information meetings (one monthly village level meeting and regular group sessions with 25-30 mothers), and home visits twice a month focused on nutrition and health; (iv) households receiving cash transfers, information meetings (one monthly village level meeting and regular group sessions with 25-30 mothers), and home visits twice a month focused on both health issues as well as improving parenting and early childhood development; and (v) a control group.[13] [14] Randomization took place at the village level, there were 45 villages in each treatment arm at the baseline, and only households with children age 5 and under or women who were pregnant at the time of the baseline were eligible to receive the intervention.

In each sampled village, an initial census was conducted to enumerate all households eligible for the program.[15] In this census, the Proxy Means Test (PMT) targeting method was used and a PMT questionnaire was administered to all households of the village that included questions about household composition, consumption, and assets. The data was used to calculate

[13] For most of our analysis, we combine treatment arms (iii) and (iv).
[14] The government also provided home visits to extremely vulnerable households who were in treatment arm (ii) receiving cash and information meetings. In treatment arms (iii) and (iv), all households received the home visits.
[15] In treatment villages, the census was conducted by Filets Sociaux, the implementing partner, with support from Innovations for Poverty Action (IPA). In the control group, IPA conducted the same census to determine households eligible for the program.

a PMT score and to rank households in terms of poverty, with the poorest households (PMT score < -0.60) eligible for the program.[16] In each village, 21 households and seven replacement households were randomly selected from the eligible population.

All households in the treatment groups received quarterly cash transfers: 30,000 FCFA (approximately $60 USD) for households with up to four children, and 40,000 FCFA (approximately $80 USD) for household including five children or more. Each of these households had at least one child aged five or under or a pregnant woman.[17] The cash transfers were originally delivered physically. However, in 2018, the cash transfers were switched over to electronic delivery, so households were also provided with a cell phone which they could use to receive the cash transfers. The treatment arms that provided information to households, treatment arms (ii), (iii), and (iv), did so in the form of one monthly village meetings and additional regular meetings with groups of 25-30 mothers. These meetings were designed to occur monthly. Households in treatment arms (iii) and (iv) also received home visits, twice a month, with households in treatment arm (iii) receiving home visits to reinforce the health information and treatment arm (iv) receiving home visits to reinforce both the health information and parenting behaviors. A list of the topics covered in the information sessions and home visits can be found in Appendix Table A1. The health topics broadly cover food and nutrition for the youngest children, diet during pregnancy, prevention of malaria and anemia, management of child

[16] In the intervention villages, the PMT method was completed by a community validation method: a village meeting was organized, and the assembly could amend the list of eligible households. They had the possibility to report that a household ranked as poor was not poor enough to be in the program. They could also say that a household ranked as not poor was poor enough to be in the program. This method ensures acceptability of the selection among villagers but might undermine the comparability between household finally selected for the intervention and households in the control group, as the latter only had the PMT survey and not the community validation.

[17] To minimize child fostering in response to the program introduction and reduce any potential sample attrition (see Akresh (2009) for evidence on the relationship between income shocks and child fostering), eligibility for cash transfers was based only on the children who were present in the household at the time of the baseline survey.

illnesses, personal hygiene, and family planning. The child development topics include giving affection to children, protecting them from dangerous objects, providing a recreational environment to them, and teaching them to share with others.

The baseline survey was conducted between January and May 2018, the cash intervention started in June 2018, and the information and home visits interventions began in June 2019. All of the interventions ended in December 2020. The COVID-19 pandemic, which occurred during the middle of the intervention, likely impacted the implementation of information sessions and home visits. The endline survey was conducted in early 2022.

Between baseline and endline data collection, the security situation in Burkina Faso deteriorated, particularly in the East region. Conflict spread into the regions targeted by the program, and this impacted the implementation of the endline survey, since many of the villages that were included in the program were deemed unsafe for surveyors to travel to. As a result, we were unable to conduct the endline survey for most of the villages in the East region and some of the villages in the Center-East region. Out of 225 villages at baseline, we were able to return to 74 villages at endline.

Panel A of Table 1 shows baseline summary statistics for the 74 villages in our endline sample. In the 74 villages in our analysis, there are 2566 individuals living in each village on average. Ninety-one percent of villages have a primary school, while only 20 percent of villages have a secondary school. The average distance to the nearest health center is 5 km, and the average distance to the nearest paved road is 22 km. On average, roads are impassable for 3.5 months out of the year.

Panel B of Table 1 shows the baseline summary statistics for the 1513 households in the 74 villages in our endline sample. Eighty percent of the household heads in our sample are male

with an average age of nearly 46, and only 9 percent of household heads ever attended school. On average, there are 9.25 members in each household, of whom five are biological children of the household head under age 15.

3. Empirical Strategy

3.1 Empirical Identification Strategy

The key question we address is whether cash, information, and home visits improve children's human capital and development in the recipient households. The randomized experimental design provides a strong identification strategy that allows us to attribute any differences in outcomes between the treatment and control groups to the impact of the program. To evaluate the intervention, we use data from the endline survey and compare across the treatment and control arms, relying on our randomization into treatment to produce a causal estimate. We have a total of 74 villages and 1513 households in our endline sample, and we pool treatment arms (iii) and (iv), which both receive home visits as well as information and cash. We estimate the following regression:

$$Y_{ihvc} = \alpha + \beta_1 T1_{hvc} + \beta_2 T2_{hvc} + \beta_3 T3T4_{hvc} + \gamma_c + \delta \boldsymbol{X}_{ihvc} + \epsilon_{ihvc} \quad (1)$$

where $T1_{hvc}$ is an indicator for being randomized into treatment arm (i), $T2_{hvc}$ is an indicator for being in treatment arm (ii), $T3T4_{hvc}$ is an indicator for being in treatment arm (iii) or (iv), γ_c is a strata fixed effect (at the commune level), $\boldsymbol{X_{ihv}}$ is a vector of household, village, and individual-level controls, including household head age, child age and gender, and other LASSO-selected controls (specific to each regression and described in more detail below). Robust standard errors are used in all regressions and are clustered at the unit of randomization, which is the village. In this specification, treatment arms (iii) and (iv) are pooled because we do not have a way to verify whether the information provided in the two types of home visits was substantially different.

Regressions for some of the sets of outcomes are run at the individual level (for child-specific outcomes), and others are run at the household level (for outcomes that likely affect all individuals in the household). For the individual-level regressions, we include child age and gender as control variables. For the household-level regressions of child outcomes, we include average child age and gender ratio in the household as control variables. For all regressions, we control for the age of the household head. We use a LASSO procedure to select covariates (at the household and village level) for our main specification, which allows us to control for potential differences in baseline values of these covariates across treatment arms. The LASSO selects the covariates that are important for improving precision in each regression. For the LASSO, we include a set of 81 potential covariates at the household or village level. λ is selected using cross-validation, and the LASSO procedure provides a separate set of optimal controls for each outcome. For robustness, we also run the regressions without controls.

Because many of the survey questions are only asked for children within a limited age range, we do not control for baseline values of the outcome variable in our main specification. Controlling for baseline values would require us to drop a large fraction of the children in our sample, since many of the children surveyed at endline were not yet born at the time of the baseline survey, and many of the children in the baseline survey had aged out of the respective survey sections by the time of the endline survey. For robustness in the sections where the baseline and endline samples have sufficient overlap, we use an ANCOVA specification and control for baseline values of the outcome variables.

For results related to early childhood development, we also analyze the cumulative effects of the stacked interventions, also using only the endline data. This allows us to see the additional effect of information on top of receiving cash and the additional effect of home visits

on top of receiving both information and cash. This requires the assumption that the effects of the various components of the intervention are additive. The regression equation for this specification is as follows:

$$Y_{ihvc} = \alpha + \beta_1 Cash_{hvc} + \beta_2 Info_{hvc} + \beta_3 HomeVisits_{hvc} + \gamma_c + \delta \boldsymbol{X}_{ihvc} + \epsilon_{ihvc} \quad (2)$$

where $Cash_{hvc}$ is an indicator for receiving cash (this occurs in all four treatment arms), $Info_{hvc}$ is an indicator for receiving information (in treatment arms (ii), (iii), and (iv)), $HomeVisits_{hvc}$ is an indicator for receiving home visits (in treatment arms (iii) and (iv)), γ_c is a strata fixed effect (at the commune level), and $\boldsymbol{X_{ihv}}$ is a vector of household, village, and individual-level controls, including household head age, child age and gender, and other LASSO-selected controls (specific to each regression, as described above). Robust standard errors are clustered at the village level. Note that, because all treatment arms received cash, for example, we cannot identify the effects of information alone or home visits alone. Thus, β_2 should be interpreted as the additional effect of receiving information, compared to and conditional on receiving cash, and β_3 should be interpreted as the additional effect of home visits, compared to and conditional on receiving both cash and information.

3.2. Sample and Baseline Balance

The baseline household survey was conducted in early 2018, and the endline household survey was conducted in early 2022.[18] Both baseline and endline surveys measure household demographics and characteristics, child outcomes related to early childhood development and health, parenting behaviors, and fertility-related outcomes.

[18] While the endline survey was originally scheduled to be conducted earlier, it was delayed due to the outbreak of COVID-19 and conflict in the study area.

For mothers with a child under five years old in the household, we have information on birth histories and total number of pregnancies. These women are asked their age at the time of each of their births (up to ten births) as well as more detailed information about their most recent birth, including whether a medical professional assisted the delivery.

Mothers of children ages 0 to 48 months are also asked about prenatal and child health outcomes. For the pregnancies associated with each of those children, mothers are asked about the number of prenatal visits, whether they took vitamin A and iron, and whether the child received any doses of vitamin A in the past 12 months. Additionally, mothers are asked which vaccines their children have received, allowing us to determine whether each child is fully vaccinated based on the recommendations for their age group. Finally, mothers of children below age 5 are also asked about their handwashing habits, specifically whether they wash their hands after using the toilet.

For children below age 5, we have anthropometrics measures for height, weight, and arm circumference. We use these three measures to calculate z-scores for each of the three outcomes, relative to the WHO reference population.

For older children ages 6-15, we have information on whether they are enrolled in school, how many years of schooling they have completed, what grade they are in, and whether they are able to read and write. We also calculate grade progression as actual grade divided by expected grade, where expected grade is calculated based on the child's age and based on the assumption that they start school at age seven.

We have several child-specific development outcomes, including Denver test scores for children ages 0 up to 72 months, and Strengths and Difficulties test scores for children ages 24

up to 72 months.[19] The Denver test consists of a series of items related to childhood development, and the total possible score is given by the number of items that 90 percent of children of a given age group should be able to complete. The child's actual score is a percentage, calculated by dividing the actual number of items that the child completes by the expected number of items for their age group. This percentage score allows for comparisons across age groups, since each age group is expected to complete a different number of items.

The Strengths and Difficulties test consists of a list of statements that may be either positive if true about the child (strengths) or negative if true about the child (difficulties). These lists of statements several categories, and parents answer whether each statement is true for the child. For most sections, a lower score is more desirable, so that answering "true" to the difficulties statements or "false" to the strengths statements adds to the child's total points. The exception is the prosocial section, where a higher score is more desirable.[20]

In Table 2, we use baseline data to confirm that child and household characteristics are balanced across treatment and control groups for all 225 villages before the beginning of the intervention.[21] The variable means for each of the three treatment groups and the control group measured at baseline are shown separately in columns 1, 2, 4, and 6, with p-values for tests of equality between the control group and each treatment group in columns 3, 5, and 7. Note that, for the reasons described above and to be consistent with our analysis in the following section, we combine the households in treatment arms (iii) and (iv). Column 8 shows the p-value of a joint F-test of equality across all four groups, in most cases indicating that we cannot reject

[19] Note that these ECD modules were pretested by IPA to ensure that they were culturally appropriate and correctly translated for the local environment.
[20] As a result, the prosocial score cannot be aggregated with the total score for the other sections, since the two move in opposite directions
[21] To see the baseline balance across the 74 villages used in our analysis, see Appendix Table A2. The patterns are generally similar across the two tables.

equality across all arms. There does seem to be some imbalance in the age of the household head, the household size, and the number of non-related members in the household.[22] In the joint test across all four study groups, we find only three significant outcomes (at the 10 percent level) out of 43 tests, showing that the study groups seem to be balanced at baseline.

3.3. Attrition

At baseline, we have 225 villages, distributed evenly across the four treatment arms and the control group. As described above, one of the challenges associated with the project is the fact that many of the baseline villages could not be re-surveyed at endline due to conflict in the area. As a result, we lost a large number of villages, and the endline survey was only able to capture 74 villages. Because of the large number of villages lost as a result of the conflict and since this could be a concern for identification if the villages lost were not balanced across treatment arms, we perform several tests for differential attrition.

First, in Table A3 we show the number of villages (in Panel A) and the number of households (in Panel B) by treatment arm that were surveyed at endline, out of the 225 villages and 4730 households at baseline. The first row in each panel shows the percentage of baseline villages or households in each arm surveyed at endline, and the second row shows the p-value associated with an F-test comparing the percentage of villages and households returned to in each treatment arm with the percentage of households and villages returned to in the control group. In all cases, we cannot reject that the attrition at the household and village level by treatment arm was the same. The remaining rows in Panel A show the number of baseline and endline villages surveyed, and those in Panel B show the number of households surveyed at

[22] To account for these differences, we include household head age in all regressions and include household size and the number of non-related household members in the options for the LASSO-selected controls.

baseline, the number of households surveyed at baseline in the villages we returned to at endline, and the actual number of endline households surveyed. These numbers are similar across arms. It is also important to note that, in the 74 villages that we returned to at endline, we only lost 1.8 percent of households, which is a relatively low attrition rate.

Table A4 shows the attrition estimates in regression form. The first column shows that, across the treatment arms (with treatment arm (iii) and treatment arm (iv) combined to match our main specification), there is no difference in the probability that the village is present at endline. Column 2 shows the same for households, suggesting that, while conflict led to large overall levels of attrition because we were unable to return to some of the villages for security reasons, this attrition does not seem to be correlated with the treatment.

Finally, in Table A5, we show the baseline household characteristics and child outcomes across the attritor and non-attritor households by treatment arm. Within a treatment arm, there are differences in the characteristics and baseline values of the outcomes across the attritors and non-attritors.[23] Column 9 tests whether the differences across the attritors and non-attritors within each treatment arm are the same across arms. Out of the 43 variables that we test in column 9, the only one with significant differences across the within-arm comparisons is the probability that the household head is male. Based on this table, while attrition due to conflict does not appear to be random, there does not seem to be differential attrition across treatment arms.

3.4. Strategies to Address the Large Number of Outcomes

To address the large number of outcomes and avoid overemphasizing any single significant result, we adopt two strategies. First, we create indices for each family of outcomes following

[23] P-values for the differences within each treatment arm are available upon request.

Kling, Liebman, and Katz (2007). To construct the indices, we define each outcome so that higher values correspond with better outcomes, standardize each outcome into a Z-score by subtracting the mean and dividing by the standard deviation of the control group in the baseline period, and average all the Z-scores. We then estimate the effect of each treatment arm on these standardized outcome indices.

Second, we use the randomization inference-based tests proposed by Young (2019) to address the potential issues arising from multiple hypothesis testing. In the main regression tables, in addition to showing the coefficients and clustered standard errors, we also report randomization inference p-values that are based on exact p-values for the sharp null hypothesis of no treatment effect for each treatment arm. Differences between exact randomization p-values for individual significance tests and the estimates from the clustered standard errors are very small, and the same conclusions (and levels of significance) are generally obtained.

4. Empirical Results

4.1. Program Impacts

In the subsequent tables, we report the results of the impact evaluation. Each table shows the results separately for each treatment arm, following equation (1). The coefficient on the variable "cash" can be interpreted as the impact of the cash only arm (T1), the coefficient on "cash + info" is the impact of the cash and information arm (T2), and the coefficient on "cash + info + home visits" is the impact of the cash, information, and home visits arms (T3 & T4).

Tables showing the results of regressions estimating Equations (1) and (2) with the separate and cumulative treatment specifications include two panels. Panel A shows the results separately for each treatment arm, following equation (1). Panel B focuses on the cumulative effects of cash, information, and home visits. In those panels, the coefficient on the variable

"cash" can be interpreted as the impact of cash transfers, the coefficient on the variable "+ info" can be interpreted as the additional effect of information (conditional on receiving cash), and the coefficient on the variable "+ home visits" can be interpreted as the additional effect of home visits (conditional on receiving cash and information).The p-value for "cash + info + HV" indicates whether the total effect of all three components of the intervention together is statistically different from zero.

4.2. Impacts on Fertility and Pregnancy

We first look at the effects of the intervention on pregnancy, birth spacing, and delivery at the household level. Table 3 shows that there are no effects of cash alone or cash + information. However, the cash + information + home visits arms (treatment arms (iii) and (iv)) cause a reduction in the number of times a mother has been pregnant by 6 percent of the control group mean. This aligns with the results in columns 2-6, showing a later age at each pregnancy, ranging from a statistically insignificant increase of 0.305 years for the first pregnancy to a statistically significant increase of 1.052 years for the fifth pregnancy.[24]

Additionally, women in households in the cash + info + home visits arm are on average 3.5 percentage points more likely to have had their last delivery assisted by a medical professional. Given that 96 percent of women in the control group report having their last delivery assisted by a medical professional, this increase of 3.5 percentage points brings women in the cash + information + home visits arms up to nearly 100% coverage for assisted childbirth. The Kling et al. (2007) index across the pregnancy outcomes is also significant and positive for the households receiving cash + information + home visits, showing improved overall outcomes

[24] While individuals were also asked about later pregnancies, the sample size decreases so much for pregnancies six and beyond that we do not include these results in the regression. The average number of pregnancies in our sample is 4.6, and the fertility rate in Burkina Faso is five.

related to pregnancy, birth spacing, and delivery. There are no effects in the cash only or cash + info arms, indicating that the full package of the intervention is the only one that improves pregnancy-related outcomes.

4.3. Impacts on Household Health Behaviors

Next, we investigate the impacts on outcomes related to child health in Table 4. As in Table 3, the outcomes are calculated as averages at the household level across all children in the relevant age range in the household. Again, we see that the cash only and cash + information treatment arms do not lead to an improvement in prenatal and child health outcomes.

However, the cash + information + home visits treatment arms do result in an increase of 13 percent in the probability that all children in the household receive vitamin A relative to the control group mean, as well as an increase of 3.5 percentage points in the probability of mothers of young children reporting washing their hands after using the toilet. We see increases in the number of prenatal visits during the last birth and improvements in the child not having diarrhea during the last month. There are also increases in the likelihood the child sleeps under a bednet and improvements in the child's nutrition. We do not see effects on the probability that a mother receives vitamin A or iron during her pregnancy or the probability that a child is fully vaccinated. The health behaviors index across all outcomes in the table shows a statistically significant increases for the cash + info + home visits treatment arm.

4.4. Impacts on Child Welfare (Anthropometrics and Education)

Table 5 shows the impacts of the intervention on child anthropometrics. All outcomes are z-scores, calculated using the WHO reference population for the relevant age and gender. The regressions are run at the level of the individual child, and children under 60 months of age at the endline survey are included in the regressions. In column 2, individuals in the cash arm have a

0.27 standard deviation increase in arm circumference for age and a 0.16 standard deviation increase in weight for age in column 3. However, there is no statistically significant effect on height for age; in fact, and the coefficient for the cash arm in column 1 is negative. Receiving cash only does not have a statistically significant impact on the anthropometrics index.

While cash alone improves arm circumference-for-age and weight-for age, cash + information does not have an effect. Across the three individual outcomes and the index, the coefficients are negative and are not statistically significant. In the cash + info + home visits arm, there is an increase of 0.15 standard deviations in the arm circumference for age in column 2. However, there are no statistically significant improvements in height-for-age or weight-for-age. Additionally, the index in column 4 shows no overall changes in anthropometrics across the board.

The anthropometrics results above appear to be driven by changes in children's food consumption. In Table A6, we show the impacts on children's food consumption. The outcome in each column is the number of times that a child ages 0-71 months consumed food items in the respective categories over the past 7 days, averaged at the household level. We see mostly positive effects across the board, though the only statistically significant effects are an increase of 51 percent for milk in the cash + info arm in column 2 and an increase for eggs of 99 percent in the cash arm and 76 percent in the cash + info + home visits arms in column 4. The index in column 6 shows an overall increase in the number of times food groups are consumed for the cash and cash + info + home visits arms, which aligns with the effects on anthropometrics found in Table 5.

We also examine the effects on education for older children, ages 6-15, in Table 6. These regressions are run at the individual level. Surprisingly, cash only has very little impact on

education outcomes, with the only statistically significant increase coming from an 8.7 percentage point increase in the probability of completing any schooling. Cash + information does not have an effect on schooling, either, with the point estimates across all outcomes being quite low and statistically insignificant.

However, cash + information + home visits, on the other hand, has strong positive effects on most education outcomes. The probability of being enrolled in school increases by 7.8 percentage points, children complete an addition 0.3 years of school, the likelihood of completing any schooling increases by 8.5 percentage points, and grade progression (calculated as completed grade divided by expected grade and capped at 1) increases by 0.065. There are no improvements in reading and writing in French. The index, once again, shows a positive and statistically significant increase in education outcomes overall.

4.5. Impacts on Early Childhood Development

While these improvements in health, anthropometrics, and education are promising, we also want to evaluate the impacts on early childhood development, as improvements in this area were one of the goals of the project. Table 7 shows the impacts on Denver test scores at the individual level for children ages 0-72 months at the time of the survey. The first column shows the impacts on the total score, and columns 2-5 break out the individual components of the test: language, fine motor, gross motor, and personal social skills. Panel A shows the estimates with the main specification in equation (1), and we can see that the intervention did not have any positive effects on Denver scores. If anything, cash + information reduced the language and gross motor scores of the children.

In Panel B, on the other hand, we show the estimates for the cumulative specification from equation (2). Again, the impact of cash and the additional impact of information are

generally negative and statistically insignificant. However, this specification shows that the additional effect of receiving home visits, conditional on receiving both cash and information, is positive for most components of the Denver score. For example, the additional effect of home visits is 12 percent of the control mean for the total score in column 1, 12 percent for the language score in column 2, 13 percent for the gross motor score in column 4, and 11 percent for the personal social score in column 5. While we cannot separately identify the effects of home visits on the Denver score, since everyone who received home visits also received cash and information, these results suggest that home visits may be important for improving early childhood development outcomes.

In Table 8, we show additional early childhood development outcomes from the Head-Toes-Knees-Shoulders (HTKS) test. Similar to the Denver test, when looking at the main specification in Panel A, the only statistically significant coefficients are negative effects on cash + information. However, the story looks slightly different when we estimate the cumulative specification in Panel B. We can see that, while cash and information have negative (though not always statistically significant) effects on HTKS scores, the additional effect of home visits, conditional on receiving cash and information, is positive and statistically significant. The additional impact of home visits leads to a 12 percent increase in the official score in column 1, a 12 percent increase in the score on the first three sections of the test in column 2, and an 11 percent increase in the probability of scoring higher than zero in column 3. The HTKS index in column 4 also experiences a statistically significant increase of 0.201.

As our final measure of ECD outcomes, we investigate the impacts on Strengths and Difficulties scores in Table 9. In column 3 of Panel A, cash improves the likelihood of being in the average range for the prosocial score by four percentage points, and the impact on the index

in column 5 is also positive and statistically significant. There is no effect of cash + information. Cash + information + home visits improve the likelihood of being in the average range for the prosocial score by 5.9 percentage points (column 3) and the likelihood of having a z-score for the prosocial component of over 0.5 (column 4). Additionally, the effect of cash + information + home visits is positive and statistically significant for the index in column 5. None of the treatment arms show any statistically significant effect on the total difficulties score (column 1).

Panel B shows the estimates of the cumulative specification from equation (2). Information does not have an effect on outcomes, but the additional effect of home visits on prosocial scores, conditional on receiving cash and information, is positive and statistically significant, at 3.6 percentage point in column 3 and 5.6 percentage points in column 4. However, the effect on the index in column 5 is no longer statistically different from zero.

4.6. Household Perceptions

We also find evidence that the intervention impacted household perceptions. Household heads were asked several questions about perceptions: (i) "Are you very satisfied, satisfied, dissatisfied or dissatisfied with the diet of your household members in the last 12 months?" (ii) "Are you very satisfied, satisfied, dissatisfied or dissatisfied with the state of health of the members of your household in the last 12 months?" (iii) "Are you very satisfied, satisfied, dissatisfied or dissatisfied with the conditions of school education of the members of your household in the last 12 months?" and (iv) "Are you very satisfied, satisfied, dissatisfied or dissatisfied with your household income level in the last 12 months?"

Table A7 shows the impacts on household head's perceptions of their household's status, with the outcome for each column being an indicator for the household reporting to be very

satisfied with the household's status for each of the respective categories.[25] Column 1 shows that the cash + information and cash + information + home visits arms improved the household head's perception of the household's health status (2 and 2.2 percentage points more likely to answer that they were very satisfied, respectively), column 2 shows that cash + information improved the household head's perception of the household's health status (3.9 percentage points more likely to respond that they were very satisfied), and column 3 shows that there was no effect on perceptions of education. Household heads in all treatment arms were more likely to reporting being satisfied with the household's income, as seen in column 4, and the index in column 5 shows that cash + info and cash + info + home visits significantly increased overall satisfaction.

4.7. Intervention Fidelity

To understand the implementation and take-up of the intervention, we also ask households at endline to report their receipt of cash transfers, attendance at information sessions, and participation in home visits. Table 10 shows the impacts on receipt of cash transfers. Column 1 shows that, across all treatment arms, households were 94-96 percentage points more likely than the control group to receive cash transfers. Additionally, the fraction of households receiving cash transfers in the control group is very low, at around one percent. The likelihood of receiving a mobile phone, which was used to deliver the electronic cash transfer payments, increases by a similar amount. The amounts of the last transfer and the total amount received, shown in columns 3 and 4, also appear to be similar across the three treatment arms.

[25] Level of satisfaction was elicited on a 4-point scale, and "very satisfied" was the highest level of satisfaction on the scale.

Table 11 shows the impacts on attendance at information sessions and participation in home visits. The results in this table are not as clean as those in Table 10. In column 1 of Panel A, we see that the likelihood of at least one household member attending any nutrition information sessions increases in all three treatment arms. Additionally, the probability of attending a nutrition information session is 20 percent in the control group. Column 1 of Panel B shows that, while cash increases the probability of attending any nutrition information sessions, the additional effect of being randomized into an information treatment is also positive and statistically significant. A similar pattern is true for behavior information sessions in column 2. The total number of information sessions attended also increases across all arms in column 3 of Panel A, but there is no significant additional impact of information in Panel B.

Column 4 shows that the probability of receiving any nutrition home visits increases for all treatment arms in Panel A, though 22 percent of the control group is also receiving nutrition home visits. In Panel B, being randomized into the cash and home visits arms is the main driver of this increase. Column 5 shows that all treatment arms are more likely to receive behavioral home visits in Panel A, while being randomized into the home visits treatment does not make households any more likely to receive home visits in Panel B. The impact on the total number of home visits is shown in column 6, and the pattern is similar to that in column 4. Being randomized into the home visits treatment does increase the number of home visits received in Panel B.

One caveat to keep in mind with all of the results presented in this section is that we were not able to conduct an immediate endline survey due to delays resulting from the COVID-19 pandemic and insecurity in the region. While the interventions ended in December 2021, it was not until spring of 2022 that the endline survey was administered, leading to a 15-month gap

between the end of the intervention and the endline responses. As a result, this should be interpreted as more of a medium-term effect of the intervention instead of an immediate, short-term effect.

4.8. Heterogeneity

We also investigate heterogeneity in our main results. In Table A8, we show heterogeneity across girls and boys for the child-level outcomes. In nearly all cases, the point estimates for boys and girls are quite similar, indicating that there does not seem to be a large difference in the effects across gender.

Table A9 shows heterogeneity by exposure to conflict based on whether villages were above or below the median distance from the nearest conflict incident. For all outcomes except for the anthropometrics index, point estimates are large and most statistically significant for households below the median distance from the conflict. This suggests that households that are more vulnerable, measured as being closer to the conflict, are more likely to benefit from receiving the package of cash, information, and home visits. Additionally, in the case of health, education, and the Denver score, cash results in improvements in villages that are nearer conflict.

A similar pattern seems to hold in Table A10, which shows heterogeneity by expenditures, based on whether the households had above median or below median expenditures at baseline. Again, the point estimates for the effects in households with below median expenditure are generally larger and more statistically significant than the point estimates in the households with above median expenditure. This suggests that more vulnerable households are more responsive to receipt of cash, information, and home visits.

4.9. Robustness

To show that our results are robust to various specifications and inclusion of controls, for our five main tables we run alternate specifications for the indices or total outcomes for each table. These results are shown in Table A11. Panel A repeats the main estimates of the index for pregnancy outcomes, household health behaviors, anthropometrics, and education as well as the total Denver test score. Panel B shows the results for the same five outcomes without the LASSO-selected controls, but still including controls for age and gender, when relevant. Overall, the estimates are similar in magnitude and significance to those in Panel A. While the effect of "cash + info + home visits" on education index is no longer statistically significant, the point estimate in Panel B is very similar to that in Panel A.

Panel C shows the estimates from an ANCOVA specification that includes controls for baseline values of the outcome variables, when available. The sample sizes in Panel C are smaller than in Panel A because not all individuals who were surveyed at endline were also surveyed at baseline, especially for the anthropometrics outcomes. Fertility-related questions were not asked in the baseline survey, so we cannot run this specification for the pregnancy index. However, the remaining outcomes in columns 2-4 show similar effects to the main specification in Panel A, indicating that our results are not driven by our choice of specification.

5. Conclusion

In this paper, we evaluate a randomized control trial that examines the impacts of an integrated social safety nets program including cash transfers, information meetings, and home visits, on children's human capital and development outcomes. We find a decrease in reported numbers of pregnancies, an increase in age at time of birth, and an increase in medically assisted deliveries among mothers of children under age 5 who received the cash transfers, information meetings, and home visits. Additionally, we find improvements in household health behaviors, education

outcomes, and child anthropometrics. Finally, we find suggestive evidence that home visits, on top of cash and information, may increase early childhood development outcomes, as measured through the Denver, HTKS, and Strengths and Difficulties tests. Cash alone or cash and information does not seem to improve those outcomes, suggesting that the home visits are a critical component of the intervention package for early childhood development.

Additionally, the heterogeneity across high- and low-expenditure households and by level of conflict exposure provide suggestive evidence that more vulnerable households may have benefitted more from the full intervention. This suggests that targeting package interventions with cash, information, and home visits to more vulnerable households may result in higher impacts, leading the interventions to be more cost effective.

Finally, this RCT is unique in that it is a government-run intervention with cash transfers that are provided at scale across the entire country. Issues experienced with implementation, therefore, are representative of the problems that come from a "real-life" policy intervention where the research team is not in full control of the implementation. On the other hand, the results that we find are also "real-life" impacts from a realistic social safety nets policy, meaning that this experiment provides an accurate picture of the impacts that can be expected from this type of intervention in the real world.

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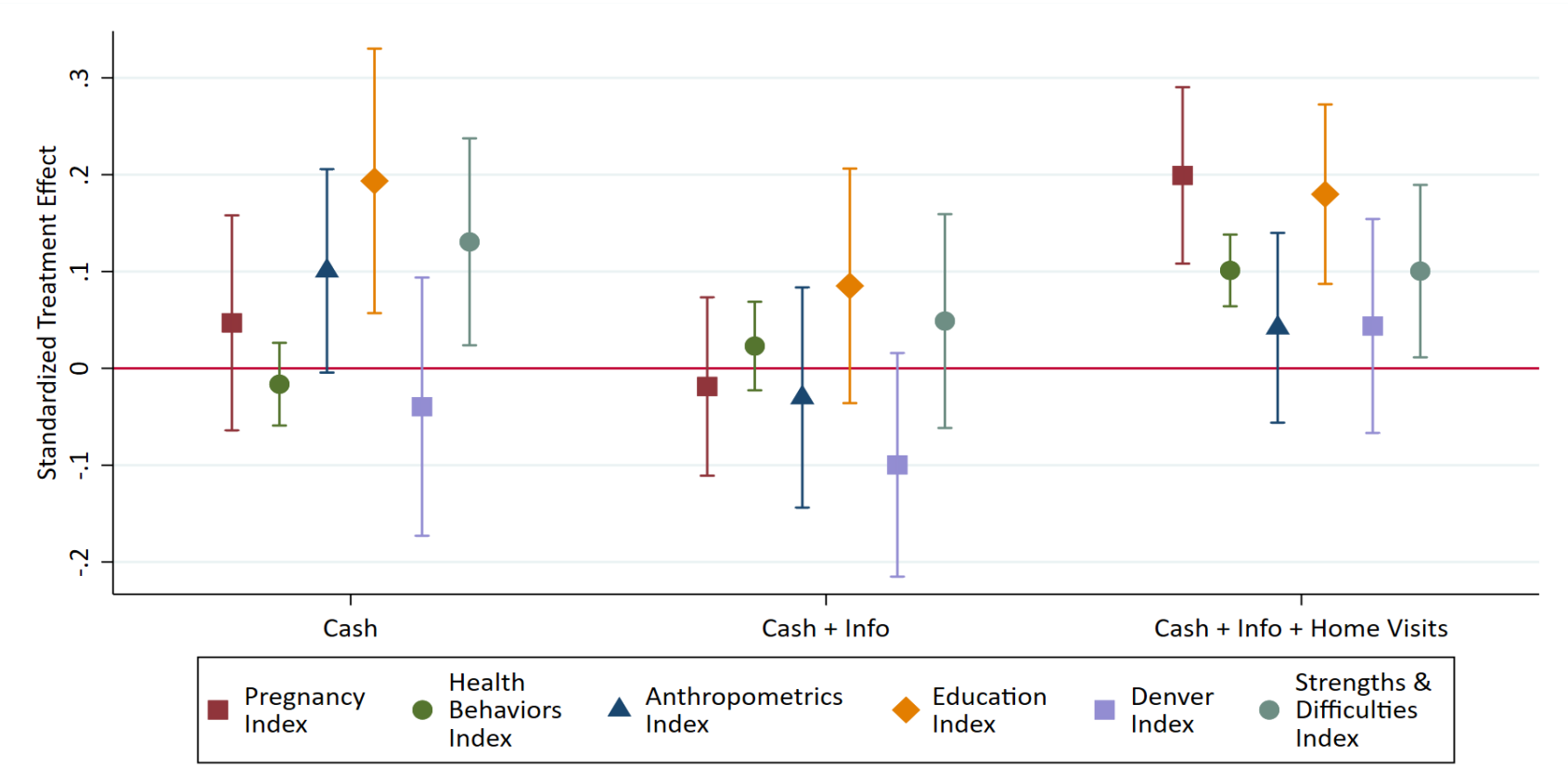
Figure 1: Effect of Cash, Information, and Home Visits on Indexes



Notes: Following Kling, Liebman, and Katz (2007), we define indexes for families of outcomes by defining a Z-score for each outcome relative to the control group. Then we average the Z-scores across all outcomes in the same family to get an index, such as "Pregnancy Index." Following Banerjee *et al.* (2015) to get standardized treatment effects, we then standardize the Kling indexes relative to the mean and standard deviation of the control group. Each dot in the figure represents the coefficient of the indicator variable for that treatment arm. Solid lines represent 90% confidence intervals. The individual outcomes making up the index for each family are listed in Tables 3-8.

Figure 2: Summary of Treatment and Control Group Randomization Plan

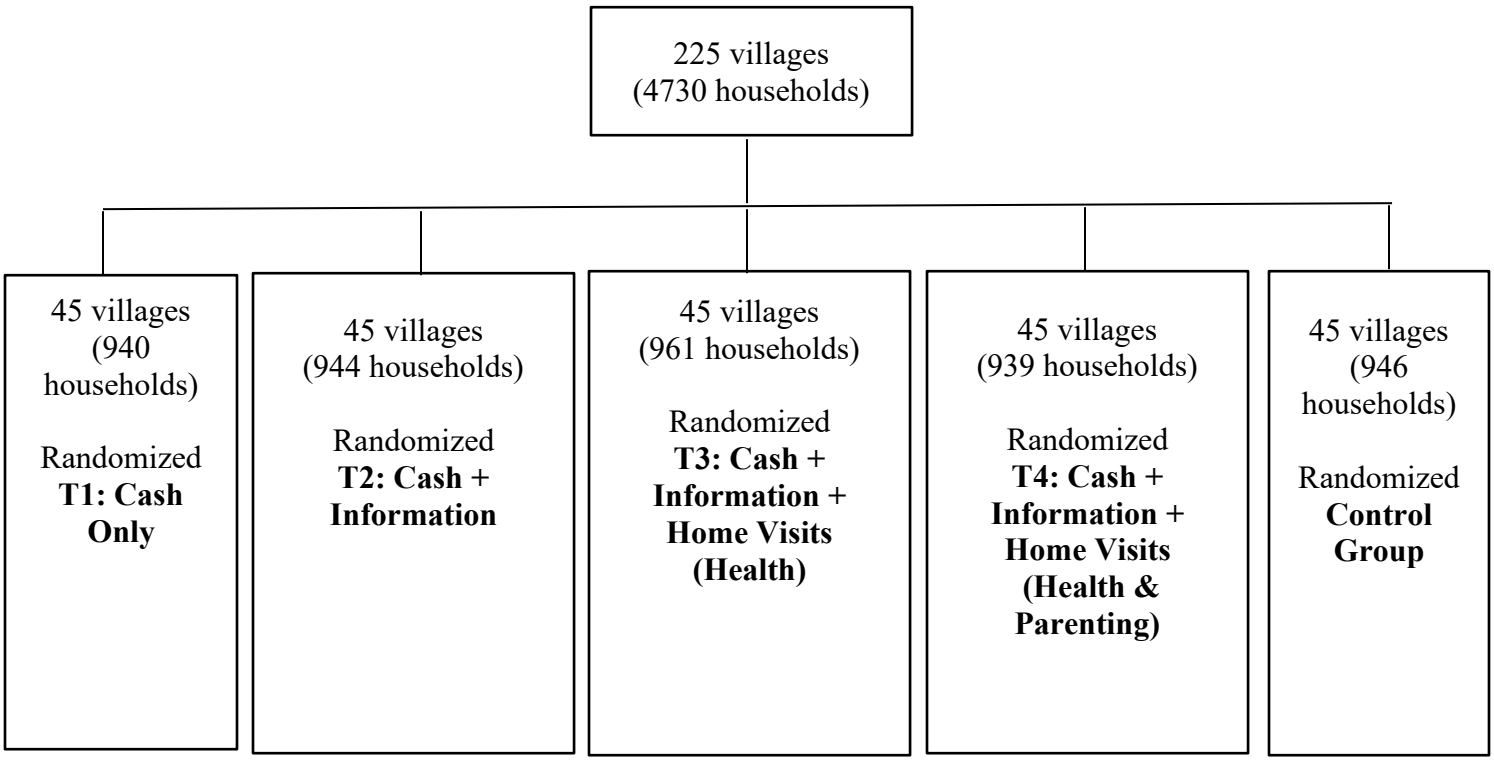


Table 1. Baseline Village and Household Characteristics

Panel A. Village Characteristics		
	Mean	**Standard deviation**
Number of households	198	87
Health center in village	0.15	0.36
Distance to nearest health center (in km)	5.11	4.27
Distance to nearest market (in km)	4.72	4.98
Primary school in village	0.91	0.29
Secondary school in village	0.20	0.4
Distance to nearest secondary school (in km)	6.53	5.6
Distance to nearest paved road (in km)	21.53	15.96
Number of months roads to the village are impassable	3.46	1.91
Number of villages	74	
Panel B. Household Characteristics		
	Mean	**Standard deviation**
Household head male	0.80	0.40
Household head age	45.96	12.68
Household head any education	0.09	0.29
Household size	9.25	4.09
# spouses	1.22	0.82
# children under 15	5.00	2.58
# other household members	2.03	3.29
Household head married	0.92	0.27
Household head monogamous	0.46	0.50
Household head polygamous	0.46	0.50
Household head Gourmanche	0.10	0.29
Household head Mossi	0.43	0.50
Household Head Peulh	0.06	0.24
Household head Yana	0.21	0.41
Household head Catholic or Protestant	0.29	0.45
Household head Muslim	0.70	0.46
Household head animist or no religion	0.02	0.13
Number of households	1513	

Notes: The sample includes the 74 villages and 1513 households surveyed at endline. Panel A shows the village characteristics. Panel B shows household characteristics. # of children under 15 includes only biological children of the household head. # other household members includes members who are not either the spouse or a biological child of the household head (of any age).

Table 2. Baseline Balance, All 225 Villages

	Control	T1	T1=control	T2	T2=control	T3/T4	T3/T4=control	All equal
Village Characteristics	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Number of households	189	177	0.42	197	0.61	209	0.15	0.98
Health center in village	0.11	0.18	0.37	0.29	0.03	0.18	0.29	0.20
Distance to nearest health center (in km)	7.13	0.41	6.01	0.09	6.24	0.07	8.47	0.28
Distance to nearest market (in km)	4.51	0.51	4.18	0.38	3.44	0.14	5.58	0.38
Primary school in village	0.96	0.96	1.00	0.91	0.40	0.97	0.76	0.70
Secondary school in village	0.16	0.11	0.54	0.20	0.58	0.12	0.61	0.64
Dist. to nearest secondary school (in km)	11.22	9.64	0.45	8.87	0.24	9.78	0.43	0.70
Distance to nearest paved road (in km)	37.80	40.77	0.67	38.21	0.95	40.07	0.69	0.96
# of months roads to village impassable	3.13	4.16	0.02	3.58	0.31	3.70	0.10	0.13
Household Characteristics								
Male	0.88	0.84	0.07	0.85	0.10	0.84	0.03	0.11
Age	45.92	43.82	0.01	43.94	0.04	44.38	0.05	0.07
Any education	0.06	0.06	0.60	0.08	0.14	0.08	0.05	0.18
Household size	10.07	8.87	0.00	8.94	0.00	8.90	0.00	0.00
# children	5.40	5.22	0.31	5.17	0.21	5.23	0.32	0.65
Married	0.93	0.94	0.24	0.93	0.50	0.95	0.02	0.13
Monogamous	0.45	0.45	0.77	0.49	0.24	0.47	0.55	0.48
Polygamous	0.47	0.49	0.43	0.45	0.37	0.48	0.70	0.46
Gourmanche ethnicity	0.35	0.35	0.98	0.36	0.92	0.35	0.99	1.00
Mossi ethnicity	0.15	0.20	0.43	0.20	0.49	0.21	0.31	0.76
Peulh ethnicity	0.14	0.09	0.16	0.08	0.04	0.11	0.31	0.21
Yana ethnicity	0.25	0.27	0.72	0.29	0.56	0.26	0.80	0.95
Catholic or Protestant	0.27	0.28	0.99	0.33	0.21	0.31	0.39	0.53
Muslim	0.57	0.57	0.92	0.52	0.54	0.55	0.85	0.89
Animist or no religion	0.16	0.15	0.82	0.14	0.73	0.14	0.55	0.94

Prenatal/Health								
Child receiving vitamin A	0.50	0.47	0.36	0.52	0.64	0.51	0.80	0.54
Child receiving iron	0.50	0.51	0.80	0.52	0.54	0.53	0.38	0.82
Mother receiving vitamin A	0.77	0.77	0.84	0.81	0.29	0.78	0.76	0.65
Mother receiving iron	0.89	0.90	0.55	0.89	0.69	0.88	0.76	0.77
Child fully vaccinated	0.39	0.38	0.84	0.36	0.55	0.40	0.59	0.53
Child sleeps under bednet	0.78	0.73	0.18	0.72	0.15	0.75	0.36	0.45
Index of food groups, children 6-23	0.06	-0.04	0.07	-0.02	0.22	0.00	0.24	0.32
Child has not had diarrhea past 30 days	0.61	0.61	0.91	0.62	0.67	0.64	0.34	0.71
Child given ORS	0.39	0.36	0.37	0.34	0.11	0.36	0.31	0.45
Mother washes hands before feeding	0.82	0.79	0.51	0.79	0.31	0.79	0.33	0.75
Mother washes hands after toilet	0.82	0.80	0.53	0.80	0.51	0.81	0.50	0.90
ECD								
Prosocial score	0.22	0.16	0.08	0.17	0.13	0.17	0.06	0.24
Total activities available to child	4.21	4.24	0.76	4.10	0.34	4.16	0.58	0.56
Child injured in past 12 months	0.01	0.01	0.79	0.01	0.29	0.01	0.98	0.73
Child has birth certificate	0.72	0.71	0.71	0.70	0.67	0.70	0.46	0.90
Index of parenting behaviors	0.05	0.02	0.52	-0.02	0.13	-0.03	0.05	0.19
Anthropometrics								
Height-for-age z	-1.39	-1.28	0.22	-1.32	0.39	-1.32	0.41	0.66
Arm circumference-for-age z	-1.02	-1.08	0.33	-1.11	0.16	-1.13	0.04	0.23
Weight-for-age z	-1.25	-1.19	0.37	-1.27	0.80	-1.26	0.86	0.66
Education								
Enrollment	0.44	0.43	0.88	0.45	0.82	0.43	0.70	0.94
Years of school completed	1.67	1.71	0.77	1.72	0.78	1.58	0.56	0.77
Any school completed	0.48	0.49	0.84	0.48	0.94	0.47	0.86	0.98
Progression	0.44	0.45	0.89	0.45	0.87	0.43	0.66	0.92
Denver								
Total score	0.42	0.42	0.91	0.41	0.95	0.41	0.70	0.96
Language	0.39	0.39	0.66	0.39	0.92	0.38	0.59	0.77
Fine motor	0.40	0.40	0.97	0.40	1.00	0.41	0.91	1.00
Gross motor	0.47	0.47	0.81	0.47	0.89	0.47	0.87	0.98
Personal-social	0.43	0.42	0.79	0.42	0.78	0.42	0.67	0.98

Strengths & Difficulties								
Total difficulties score in avg range	0.28	0.34	0.05	0.31	0.38	0.32	0.10	0.18
Total z-score under -0.5	0.29	0.34	0.09	0.31	0.56	0.32	0.15	0.30
Prosocial in avg range	0.22	0.16	0.08	0.17	0.13	0.17	0.06	0.24
Prosocial z-score over 0.5	0.33	0.27	0.10	0.28	0.11	0.27	0.05	0.22

Notes: Calculations in this table are based on baseline data from all 225 villages. Standard errors are clustered at the village level. The treatment arms are abbreviated as "T1" (cash only), "T2" (cash + information), "T3/T4" (cash + information + home visits). Column 1 presents the baseline mean in the control group; columns 2, 4, and 6 present the baseline means for each of the treatment arms; columns 3, 5, and 7 present p-values from a test of mean equality between the control arm and each of the respective treatment arms; and column 8 shows p-values for an F-test for equality across all four groups. Outcomes from the Prenatal/Health section are reported at the household level: "# of prenatal visits" is calculated as the average number of prenatal visits in for children ages 0-48 months in the household. "Child receiving vitamin A" is the percentage of children ages 0-48 months in the household who received any vitamin A in the past 12 months. "Child receiving iron" is the percentage of children ages 0-48 months in the households who received any iron in the past 12 months. "Mother receiving vitamin A" is the percentage of pregnancies during which mothers of children ages 0-48 received vitamin A. "Mother receiving iron" is the percentage of pregnancies during which mothers of children ages 0-48 months received iron. "Child fully vaccinated" is the percentage of children ages 0-48 months in the household who have received all 10 recommended vaccines. "Child sleeps under bednet" is the percentage of children in the household ages 0-48 months who sleep under a bednet. "Index of food groups, children 6-23" is an index for the different types of food groups consumed by children ages 6-23 months. "Child has not had diarrhea in past 30 days" is the percentage of children in the household ages 0-48 months who report not having diarrhea in the past 30 days. "Child given ORS" is the percentage of children in the household ages 0-48 months who were given oral rehydration solution in the past 30 days. "Mother washes hands after feeding" is the percentage of women in the household with children under five who report washing their hands after using the toilet. "Mother washes hands after toilet" is the percentage of women in the household with children under five who report washing their hands after using the toilet. Anthropometrics outcomes are reported at the individual level for children less than 60 months, and z-scores are calculated using the WHO reference population. Outcomes from the Education section are reported at the individual level, for children who are at least 6 years old and less than 15 years old. "Enrollment" is an indicator for the child being enrolled in school, "years of school" is the number of years of school that the child has completed, "any schooling" is an indicator for completing any years of schooling, and "progression" is the actual grade divided by the expected grade (where children are expected to begin school at age 7) and capped at 1. Outcomes in the Denver section are reported at the individual level for children ages 0-71 months old. "Total Score" is the percentage of questions that a child answered correctly, with a reference population of children in the same age group. The denominator is based on the number of questions that 90% of children in that age group are able to answer correctly. Language, Fine Motor, Gross Motor, and Personal-Social are also percentages for the questions answered correctly in each of the respective categories. In the Strengths & Difficulties section, which is reported at the individual level for children ages 24-71 months old, "Total difficulties score in avg range" is an indicator for the total strengths & difficulties score being in the normal range, "Total z-score under -0.5" is an indicator for the total score being at least 0.5 SD below the mean (where a higher score is worse), "Prosocial in avg range" is an indicator for the prosocial score being in the normal range, and "Prosocial z-score over 0.5" is an indicator for the prosocial score being at least 0.5 SD above the mean (where a higher score is better).

Table 3. Impacts on Fertility and Pregnancy

	# times pregnant	Age at first pregnancy	Age at 2nd pregnancy	Age at 3rd pregnancy	Age at 4th pregnancy	Age at 5th pregnancy	Indicator for last birth assisted by medical professional	Pregnancy index
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Cash Arm	0.022	-0.012	-0.012	0.059	0.337	0.379	0.008	0.047
	(0.127)	(0.219)	(0.227)	(0.221)	(0.277)	(0.406)	(0.021)	(0.067)
	[0.865]	[0.941]	[0.967]	[0.817]	[0.228]	[0.329]	[0.705]	[0.488]
Cash + Info Arm	0.035	-0.017	-0.117	-0.134	0.145	0.532	-0.003	-0.019
	(0.119)	(0.191)	(0.206)	(0.215)	(0.279)	(0.422)	(0.020)	(0.055)
	[0.773]	[0.933]	[0.590]	[0.572]	[0.609]	[0.233]	[0.896]	[0.746]
Cash + Info + Home Visits Arm	-0.294**	0.305	0.380*	0.498**	0.943***	1.052**	0.035*	0.199***
	(0.117)	(0.202)	(0.209)	(0.233)	(0.292)	(0.461)	(0.018)	(0.055)
	[0.016]	[0.146]	[0.082]	[0.037]	[0.005]	[0.033]	[0.059]	[0.002]
Observations	1,054	1,054	991	921	818	694	1,036	1,054
Control Group Mean	4.63	18.69	21.55	24.13	26.48	28.92	0.96	0.00

Notes: These outcomes are aggregated and regressions are run at the household level. Mothers with children under age 5 at the time of the endline are included in the regression. "Cash arm" is an indicator for the household being in a village that is assigned to treatment arm 1, "cash + info arm" is an indicator for the household being in a village that is assigned to treatment arm 2, and "cash + info + home visits arm" is an indicator for the household being in a village that is assigned to either treatment arm 3 or treatment arm 4. The pregnancy index in column 8 is a standardized index across the outcomes in columns 1-7. Standard errors are shown in parenthesis, and randomization inference p-values are shown in brackets below each coefficient estimate. Standard errors are clustered at the village level. *** p<0.01, ** p<0.05, * p<0.1.

Table 4. Impacts on Household Health Behaviors

	Child receiving vitamin A	Child receiving iron	Mother receiving vitamin A	Mother receiving iron during	Child fully vaccinated	Child sleeps under mosquito net	Food group index, children 6-23 months
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Cash Arm	0.008	-0.020	0.009	-0.019	-0.021	0.019	0.074
	(0.042)	(0.043)	(0.029)	(0.016)	(0.052)	(0.050)	(0.139)
	[0.844]	[0.643]	[0.763]	[0.241]	[0.684]	[0.761]	[0.604]
Cash + Info Arm	-0.004	-0.018	-0.015	-0.040*	-0.080	0.083	0.087
	(0.037)	(0.038)	(0.034)	(0.021)	(0.059)	(0.052)	(0.127)
	[0.922]	[0.647]	[0.678]	[0.062]	[0.173]	[0.119]	[0.493]
Cash + Info + Home Visits Arm	0.070*	0.021	0.010	-0.010	-0.009	0.129***	0.376***
	(0.035)	(0.041)	(0.027)	(0.018)	(0.054)	(0.041)	(0.099)
	[0.064]	[0.620]	[0.717]	[0.594]	[0.866]	[0.004]	[0.001]
Observations	959	1,020	1,019	1,019	1,020	1,019	253
Control Group Mean	0.55	0.61	0.85	0.94	0.51	0.74	0.17

Table 4 (continued). Impacts on Household Health Behaviors

	# pregnancies	# prenatal visits, last birth	Indicator for breastfeeding, last birth	Child had no diarrhea last 30 days	Child given ORS	Mother washes hands before feeding children	Mother washes hands after using toilet	Health behavior index
	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)
Cash Arm	0.022	0.062	-0.006	0.101**	-0.020	0.026	-0.007	-0.016
	(0.127)	(0.105)	(0.008)	(0.041)	(0.043)	(0.025)	(0.021)	(0.026)
	[0.865]	[0.575]	[0.488]	[0.014]	[0.662]	[0.309]	[0.724]	[0.536]
Cash + Info Arm	0.035	0.196*	-0.003	0.021	0.022	0.047**	-0.006	0.023
	(0.119)	(0.105)	(0.006)	(0.033)	(0.043)	(0.023)	(0.020)	(0.027)
	[0.756]	[0.060]	[0.675]	[0.527]	[0.628]	[0.048]	[0.754]	[0.414]
Cash + Info + Home Visits Arm	-0.294**	0.203**	0.001	0.104***	-0.019	0.053**	0.030**	0.101***
	(0.117)	(0.101)	(0.004)	(0.034)	(0.042)	(0.021)	(0.015)	(0.022)
	[0.014]	[0.049]	[0.826]	[0.009]	[0.673]	[0.018]	[0.052]	[0.001]
Observations	1,054	1,039	1,039	1,019	1,019	1,142	1,147	1,225
Control Group Mean	4.63	4.67	0.99	0.61	0.53	0.93	0.94	0.11

Notes: These outcomes are aggregated and regressions are run at the household level. The outcomes in columns 1-6 and 11-12 are measured for each child ages 0-47 months in the households and aggregated to the household level. The outcome in column 7 is for children ages 6-23 motnths. The outcomes in columns 8-10 and 13-14 are asked to all mothers of children under age 5 at the time of the endline and are averaged to the household level. The health behavior index in column 15 is a standardized index across the outcomes in columns 1-14. "Cash arm" is an indicator for the household being in a village that is assigned to treatment arm 1, "cash + info arm" is an indicator for the household being in a village that is assigned to treatment arm 2, and "cash + info + home visits arm" is an indicator for the household being in a village that is assigned to either treatment arm 3 or treatment arm 4. For variable definitions, see Table 2. Standard errors are shown in parenthesis, and randomization inference p-values are shown in brackets below each coefficient estimate. Standard errors are clustered at the village level. *** p<0.01, ** p<0.05, * p<0.1.

Table 5. Impacts on Anthropometrics

	Height-for-age Z-score	Arm circumference-for-age Z-score	Weight-for-age Z-score	Anthropometrics index
	(1)	(2)	(3)	(4)
Cash Arm	-0.125	0.267***	0.163*	0.101
	(0.086)	(0.094)	(0.092)	(0.063)
	[0.155]	[0.004]	[0.080]	[0.123]
Cash + Info Arm	-0.133	-0.000	-0.014	-0.030
	(0.089)	(0.089)	-0.100	(0.068)
	[0.138]	[0.996]	[0.888]	[0.657]
Cash + Info + Home Visits Arm	-0.001	0.149*	0.085	0.042
	(0.084)	(0.080)	(0.084)	(0.059)
	[0.991]	[0.067]	[0.325]	[0.478]
Observations	1,944	1,870	1,965	1,967
Control Group Mean	-1.14	-1.11	-1.21	-0.03

Notes: These regressions are run at the individual level for children ages 0-59 months. "Cash arm" is an indicator for the household being in a village that is assigned to treatment arm 1, "cash + info arm" is an indicator for the household being in a village that is assigned to treatment arm 2, and "cash + info + home visits arm" is an indicator for the household being in a village that is assigned to either treatment arm 3 or treatment arm 4. Z-scores are calculated using the WHO reference population. The anthropometrics index in column 4 is a standardized index across the outcomes in columns 1-3. Standard errors are shown in parenthesis, and randomization inference p-values are shown in brackets below each coefficient estimate. Standard errors are clustered at the village level. *** p<0.01, ** p<0.05, * p<0.1.

Table 6. Impacts on Education Outcomes

	Enrolled in school	Years of school completed	Any school completed	Progression (completed/expected)	Education index
	(1)	(2)	(3)	(4)	(5)
Cash Arm	0.042	0.160	0.087**	0.037	0.194**
	(0.032)	(0.158)	(0.037)	(0.036)	(0.082)
	[0.211]	[0.324]	[0.027]	[0.320]	[0.021]
Cash + Info Arm	0.018	0.084	0.032	0.011	0.085
	(0.032)	(0.135)	(0.032)	(0.033)	(0.073)
	[0.591]	[0.515]	[0.297]	[0.724]	[0.231]
Cash + Info + Home Visits Arm	0.078***	0.313***	0.085***	0.065**	0.180***
	(0.024)	(0.117)	(0.026)	(0.026)	(0.056)
	[0.002]	[0.011]	[0.004]	[0.019]	[0.003]
Observations	5,185	5,171	5,165	4,627	5,189
Control Group Mean	0.46	2.17	0.57	0.52	0.03

Notes: These regressions are run at the individual level for children at least 6 years old and less than 15 years old. "Cash arm" is an indicator for the household being in a village that is assigned to treatment arm 1, "cash + info arm" is an indicator for the household being in a village that is assigned to treatment arm 2, and "cash + info + home visits arm" is an indicator for the household being in a village that is assigned to either treatment arm 3 or treatment arm 4. For variable definitions, see Table 2. The education index in column 5 is a standardized index across the outcomes in columns 1-4. Standard errors are shown in parenthesis, and randomization inference p-values are shown in brackets below each coefficient estimate. Standard errors are clustered at the village level. *** p<0.01, ** p<0.05, * p<0.1.

Table 7. Impacts on Denver Early Childhood Development Assessment

Panel A: Separate Treatment Specification

	Total score	Language	Fine motor	Gross motor	Personal social
	(1)	(2)	(3)	(4)	(5)
Cash Arm	-0.008	-0.004	-0.018	-0.018	-0.027
	(0.030)	(0.026)	(0.036)	(0.033)	(0.030)
	[0.799]	[0.870]	[0.653]	[0.617]	[0.381]
Cash + Info Arm	-0.038	-0.039*	-0.032	-0.053*	-0.023
	(0.026)	(0.022)	(0.030)	(0.030)	(0.029)
	[0.148]	[0.087]	[0.274]	[0.089]	[0.434]
Cash + Info + Home Visits Arm	0.016	0.014	0.006	0.014	0.029
	(0.025)	(0.022)	(0.029)	(0.028)	(0.027)
	[0.518]	[0.525]	[0.824]	[0.633]	[0.303]
Observations	2,456	2,456	2,456	2,456	2,456
Control Group Mean	0.46	0.44	0.48	0.52	0.48

Panel B: Cumulative Treatment Specification

	Total score	Language	Fine motor	Gross motor	Personal social
Cash	-0.008	-0.004	-0.018	-0.018	-0.027
	(0.030)	(0.026)	(0.036)	(0.033)	(0.030)
	[0.799]	[0.870]	[0.653]	[0.617]	[0.381]
+ Info	-0.030	-0.034	-0.015	-0.035	0.004
	(0.028)	(0.023)	(0.033)	(0.029)	(0.030)
	[0.292]	[0.139]	[0.646]	[0.250]	[0.881]
+ Home Visits	0.054**	0.0528***	0.039	0.067***	0.052*
	(0.022)	(0.0180)	(0.025)	(0.024)	(0.028)
	[0.021]	[0.004]	[0.124]	[0.004]	[0.063]
Observations	2,456	2,456	2,456	2,456	2,456
Pvalue for Cash+Info+HV	0.52	0.52	0.83	0.61	0.29
Control Group Mean	0.46	0.44	0.48	0.52	0.48

Notes: These regressions are run at the individual level for children ages 0-71 months. Panel A shows the main specification with the estimates for the separate treatment arms. "Cash arm" is an indicator for the household being in a village that is assigned to treatment arm 1, "cash + info arm" is an indicator for the household being in a village that is assigned to treatment arm 2, and "cash + info + home visits arm" is an indicator for the household being in a village that is assigned to either treatment arm 3 or treatment arm 4. Panel B shows the estimates from the cumulative specification. "Cash" is an indicator for being assigned to receive cash (T1, T2, T3, T4), "+ Info" is an indicator for being assigned to receive information (T2, T3, T4), and "+ Home Visits" is an indicator for being assigned to receive home visits (T3, T4). For variable definitions, see Table 2. Standard errors are shown in parenthesis, and randomization inference p-values are shown in brackets below each coefficient estimate. Standard errors are clustered at the village level. *** p<0.01, ** p<0.05, * p<0.1.

Table 8. Impacts on Strengths and Difficulties Assessment

Panel A: Separate Treatment Specification

	Total difficulties in average range	Total z-score under -0.5	Prosocial in average range	Prosocial z-score over 0.5	Strengths & difficulties index
	(1)	(2)	(3)	(4)	(5)
Cash Arm	0.079	0.081	0.040*	0.032	0.131**
	(0.052)	(0.051)	(0.023)	(0.035)	(0.064)
	[0.142]	[0.128]	[0.106]	[0.368]	[0.061]
Cash + Info Arm	0.023	0.035	0.023	0.002	0.049
	(0.052)	(0.054)	(0.019)	(0.031)	(0.066)
	[0.667]	[0.536]	[0.245]	[0.949]	[0.491]
Cash + Info +	0.026	0.038	0.059***	0.058*	0.100*
Home Visits Arm	(0.045)	(0.048)	(0.015)	(0.031)	(0.053)
	[0.558]	[0.404]	[0.000]	[0.048]	[0.069]
Observations	1,655	1,655	1,655	1,655	1,655
Control Group Mean	0.28	0.28	0.06	0.17	-0.18

Panel B: Cumulative Treatment Specification

	Total difficulties in average range	Total z-score under -0.5	Prosocial in average range	Prosocial z-score over 0.5	Strengths & difficulties index
Cash	0.079	0.081	0.040*	0.032	0.131**
	(0.052)	(0.051)	(0.023)	(0.035)	(0.064)
	[0.142]	[0.128]	[0.106]	[0.368]	[0.061]
+ Info	-0.056	-0.046	-0.017	-0.03	-0.082
	(0.054)	(0.054)	(0.024)	(0.032)	(0.075)
	[0.306]	[0.401]	[0.488]	[0.357]	[0.293]
+ Home Visits	0.004	0.003	0.036*	0.056*	0.052
	(0.047)	(0.048)	(0.019)	(0.028)	(0.061)
	[0.947]	[0.948]	[0.044]	[0.040]	[0.400]
Observations	1,655	1,655	1,655	1,655	1,655
Pvalue, Cash+Info+HV	0.56	0.42	0.00	0.06	0.06
Control Group Mean	0.28	0.28	0.06	0.17	-0.18

Notes: These regressions are run at the individual level for children ages 24-71 months. Panel A shows the main specification with the estimates for the separate treatment arms. "Cash arm" is an indicator for the household being in a village that is assigned to treatment arm 1, "cash + info arm" is an indicator for the household being in a village that is assigned to treatment arm 2, and "cash + info + home visits arm" is an indicator for the household being in a village that is assigned to either treatment arm 3 or treatment arm 4. Panel B shows the estimates from the cumulative specification. "Cash" is an indicator for being assigned to receive cash (T1, T2, T3, T4), "+ Info" is an indicator for being assigned to receive information (T2, T3, T4), and "+ Home Visits" is an indicator for being assigned to receive home visits (T3, T4). For variable definitions, see Table 2. The strengths and difficulties index in column 5 is a standardized index across columns 1-4. Standard errors are shown in parenthesis, and randomization inference p-values are shown in brackets below each coefficient estimate. Standard errors are clustered at the village level. *** p<0.01, ** p<0.05, * p<0.1.

Table 9. Impacts on Child Development Outcomes

Panel A: Separate Treatment Specification

	Prosocial in average range	Total categories of toys available to child	Child injured, past yr	Child has birth certificate	Index of parent interactions	Index of child development
	(1)	(2)	(3)	(4)	(5)	(6)
Cash Arm	0.040*	-0.082	-0.002	0.034	-0.105**	0.014
	(0.023)	(0.169)	(0.010)	(0.030)	(0.041)	(0.063)
	[0.095]	[0.637]	[0.846]	[0.290]	[0.009]	[0.829]
Cash + Info Arm	0.023	0.017	-0.007	0.019	-0.030	-0.021
	(0.019)	(0.144)	(0.010)	(0.028)	(0.039)	(0.043)
	[0.252]	[0.915]	[0.445]	[0.494]	[0.443]	[0.645]
Cash + Info +	0.059***	0.022	-0.007	0.031	0.006	-0.008
Home Visits Arm	(0.015)	(0.148)	(0.009)	(0.027)	(0.035)	(0.043)
	[0.003]	[0.905]	[0.516]	[0.253]	[0.883]	[0.834]
Observations	1,655	2,439	2,582	2,456	2,456	2,573
Control Group Mean	0.06	4.33	0.03	0.79	0.10	0.07

Panel B: Cumulative Treatment Specification

	Prosocial in average range	Total categories of toys available to child	Child injured, past yr	Child has birth certificate	Index of parent interactions	Index of child development
Cash	0.040*	-0.082	-0.002	0.034	-0.105**	0.014
	(0.023)	(0.169)	(0.010)	(0.030)	(0.041)	(0.063)
	[0.095]	[0.637]	[0.846]	[0.290]	[0.009]	[0.829]
+ Info	-0.017	0.099	-0.005	-0.015	0.075*	-0.035
	(0.024)	(0.137)	(0.009)	(0.027)	(0.0424)	(0.048)
	[0.499]	[0.495]	[0.568]	[0.589]	[0.071]	[0.486]
+ Home Visits	0.036*	0.004	0.001	0.012	0.036	0.012
	(0.019)	(0.112)	(0.007)	(0.021)	(0.035)	(0.026)
	[0.064]	[0.972]	[0.905]	[0.591]	[0.331]	[0.618]
Observations	1,655	2,439	2,582	2,456	2,456	2,573
Pvalue, Cash+Info+H	0.000	0.884	0.492	0.252	0.868	0.846
Control Group Mean	0.06	4.33	0.03	0.79	0.10	0.07

Notes: These regressions are run at the individual level. Panel A shows the main specification with the estimates for the separate treatment arms. "Cash arm" is an indicator for the household being in a village that is assigned to treatment arm 1, "cash + info arm" is an indicator for the household being in a village that is assigned to treatment arm 2, and "cash + info + home visits arm" is an indicator for the household being in a village that is assigned to either treatment arm 3 or treatment arm 4. Panel B shows the estimates from the cumulative specification. "Cash" is an indicator for being assigned to receive cash (T1, T2, T3, T4), "+ Info" is an indicator for being assigned to receive information (T2, T3, T4), and "+ Home Visits" is an indicator for being assigned to receive home visits (T3, T4). For variable definitions, see Table 2. Standard errors are shown in parenthesis, and randomization inference p-values are shown in brackets below each coefficient estimate. Standard errors are clustered at the village level. *** p<0.01, ** p<0.05, * p<0.1.

Table 10. Impact on Receipt of Cash Transfers

	Any transfers	Any mobile phones	Amount of last transfer	Total amount received
	(1)	(2)	(3)	(4)
Cash Arm	0.943***	0.947***	38,037***	522,752***
	(0.014)	(0.014)	(1,520)	(16,208)
	[0.000]	[0.000]	[0.000]	[0.000]
Cash + Info Arm	0.944***	0.945***	39,990***	558,144***
	(0.015)	(0.016)	(1,319)	(19,192)
	[0.001]	[0.001]	[0.001]	[0.001]
Cash + Info + Home Visits Arm	0.964***	0.968***	40,308***	563,538***
	(0.009)	(0.009)	(1,260)	(15,733)
	[0.000]	[0.000]	[0.000]	[0.000]
Observations	1,512	1,513	1,509	1,513
Control Group Mean	0.01	0.00	405	3366

Notes: These outcomes are reported at the household level. "Cash arm" is an indicator for the household being in a village that is assigned to treatment arm 1, "cash + info arm" is an indicator for the household being in a village that is assigned to treatment arm 2, and "cash + info + home visits arm" is an indicator for the household being in a village that is assigned to either treatment arm 3 or treatment arm 4. Standard errors are shown in parenthesis, and randomization inference p-values are shown in brackets below each coefficient estimate. Standard errors are clustered at the village level. *** p<0.01, ** p<0.05, * p<0.1.

Table 11. Impacts on Information Sessions and Home Visits

Panel A: Separate Treatment Specification

	Any nutrition info sessions	Any behavioral info sessions	Number of info sessions	Any nutrition home visits	Any behavioral home visits	Number of home visits	Information session and home visit index
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Cash Arm	0.346***	0.521***	3.414***	0.281***	0.469***	1.313***	1.349***
	(0.053)	(0.036)	(0.685)	(0.046)	(0.048)	(0.469)	(0.168)
	[0.000]	[0.000]	[0.000]	[0.000]	[0.000]	[0.005]	[0.000]
Cash + Info Arm	0.455***	0.661***	4.168***	0.315***	0.625***	1.610***	1.675***
	(0.052)	(0.033)	(1.126)	(0.037)	(0.042)	(0.415)	(0.182)
	[0.001]	[0.001]	[0.001]	[0.001]	[0.001]	[0.001]	[0.001]
Cash + Info + Home Visits Arm	0.474***	0.659***	3.574***	0.387***	0.681***	3.327***	1.887***
	(0.042)	(0.033)	(0.558)	(0.033)	(0.037)	(0.483)	(0.132)
	[0.000]	[0.000]	[0.000]	[0.000]	[0.000]	[0.000]	[0.000]
Observations	1,513	1,506	1,513	1,508	1,513	1,513	1,513
Control Group Mean	0.20	0.09	0.55	0.22	0.13	0.59	0.00

Panel B: Cumulative Treatment Specification

	Any nutrition info sessions	Any behavioral info sessions	Number of info sessions	Any nutrition home visits	Any behavioral home visits	Number of home visits	Information session and home visit index
Cash	0.346***	0.521***	3.414***	0.281***	0.469***	1.313***	1.349***
	(0.053)	(0.036)	(0.685)	(0.046)	(0.048)	(0.469)	(0.168)
	[0.000]	[0.000]	[0.000]	[0.000]	[0.000]	[0.005]	[0.000]
+ Info	0.109*	0.140***	0.754	0.034	0.156***	0.297	0.326
	(0.062)	(0.043)	(1.087)	(0.053)	(0.052)	(0.570)	(0.224)
	[0.081]	[0.004]	[0.527]	[0.525]	[0.004]	[0.628]	[0.173]
+ Home Visits	0.019	-0.002	-0.594	0.072*	0.056	1.717***	0.211
	(0.051)	(0.036)	(1.009)	(0.037)	(0.037)	(0.535)	(0.186)
	[0.705]	[0.943]	[0.584]	[0.046]	[0.119]	[0.001]	[0.271]
Observations	1,513	1,506	1,513	1,508	1,513	1,513	1,513
Pvalue for Cash+Info+HV	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Control Group Mean	0.20	0.09	0.55	0.22	0.13	0.59	0.00

Notes: These outcomes are reported at the household level. "Cash arm" is an indicator for the household being in a village that is assigned to treatment arm 1, "cash + info arm" is an indicator for the household being in a village that is assigned to treatment arm 2, and "cash + info + home visits arm" is an indicator for the household being in a village that is assigned to either treatment arm 3 or treatment arm 4. Panel B shows the estimates from the cumulative specification. "Cash" is an indicator for being assigned to receive cash (T1, T2, T3, T4), "+ Info" is an indicator for being assigned to receive information (T2, T3, T4), and "+ Home Visits" is an indicator for being assigned to receive home visits (T3, T4).The information session and home visit index in column 7 is a standardized index across the outcomes in columns 1-6. Standard errors are shown in parenthesis, and randomization inference p-values are shown in brackets below each coefficient estimate. Standard errors are clustered at the village level. *** p<0.01, ** p<0.05, * p<0.1.

Table A1. Topics for Information and Home Visits Intervention

Panel A: Health Topics
Compliance with 7 prenatal visits
Exclusive breastfeeding 0-6 months
Feeding the child 6-23 months
Consumption of foods rich in micronutrients (Vitamin A, Iron and Iodine)
Early breastfeeding and breastfeeding technique
Food groups
Diet of the pregnant woman
Prevention of anaemia, malaria in pregnant women
Feeding of breastfeeding women
Iron supplementation in vit. A and prevention of malaria in breastfeeding women
Feeding the sick child
Personal and clothing hygiene and hygiene of the living environment
Family planning
Management of diarrhea at home
Common signs of severe malnutrition
Water and food hygiene and hand hygiene
Panel B: Child Development Topics
Registering the birth and issuing birth certificates of children
Always giving affection to children
Providing a recreational environment for children
Protecting children from dangerous situations and saving children first in emergencies
Teaching children to share what they have with others

Notes: The list of topics for the monthly information meetings and home visits comes from the 5-year intervention report.

Table A2. Baseline Balance, 74 Villages in Endline Sample

	Control	T1	T1=control	T2	T2=control	T3/T4	T3/T4=control	All equal
Village Characteristics	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Number of households	207	197	0.76	197	0.73	194	0.67	0.98
Health center in village	0.12	0.29	0.21	0.20	0.54	0.04	0.39	0.12
Distance to nearest health center (in km)	6.94	4.00	0.06	5.20	0.31	4.58	0.11	0.29
Distance to nearest market (in km)	3.82	5.76	0.26	4.60	0.69	4.68	0.55	0.74
Primary school in village	0.94	0.94	1.00	0.87	0.49	0.88	0.49	0.81
Secondary school in village	0.29	0.12	0.21	0.27	0.87	0.16	0.33	0.53
Dist. to nearest secondary school (in km)	6.53	6.06	0.79	5.23	0.48	7.62	0.59	0.59
Distance to nearest paved road (in km)	17.09	23.35	0.25	19.63	0.62	24.44	0.15	0.45
# of months roads to village impassable	2.65	3.71	0.06	4.07	0.05	3.48	0.14	0.14
Household Characteristics								
Male	0.87	0.79	0.03	0.83	0.25	0.75	0.00	0.00
Age	47.87	44.39	0.02	45.71	0.21	45.87	0.17	0.11
Any education	0.07	0.08	0.87	0.11	0.15	0.11	0.15	0.32
Household size	10.24	8.92	0.01	9.14	0.03	8.86	0.01	0.04
# children	4.93	5.13	0.35	5.08	0.50	4.91	0.91	0.63
Married	0.90	0.92	0.56	0.93	0.20	0.93	0.25	0.54
Monogamous	0.45	0.42	0.55	0.49	0.42	0.48	0.53	0.45
Polygamous	0.45	0.49	0.42	0.44	0.84	0.45	0.91	0.81
Gourmanche ethnicity	0.08	0.08	0.98	0.13	0.52	0.10	0.73	0.91
Mossi ethnicity	0.28	0.42	0.24	0.43	0.29	0.55	0.03	0.17
Peulh ethnicity	0.12	0.05	0.07	0.05	0.07	0.05	0.08	0.29
Yana ethnicity	0.24	0.28	0.79	0.21	0.79	0.15	0.36	0.60
Catholic or Protestant	0.25	0.25	0.96	0.26	0.94	0.35	0.18	0.51
Muslim	0.72	0.74	0.84	0.73	0.89	0.64	0.31	0.54
Animist or no religion	0.03	0.01	0.12	0.01	0.28	0.02	0.38	0.39

Prenatal/Health								
Child receiving vitamin A	0.51	0.44	0.25	0.45	0.29	0.52	0.81	0.38
Child receiving iron	0.53	0.51	0.66	0.46	0.06	0.55	0.59	0.02
Mother receiving vitamin A	0.74	0.76	0.62	0.78	0.43	0.78	0.37	0.79
Mother receiving iron	0.89	0.92	0.29	0.90	0.82	0.89	0.83	0.55
Child fully vaccinated	0.45	0.44	0.83	0.38	0.25	0.50	0.37	0.08
Child sleeps under bednet	0.76	0.70	0.30	0.73	0.64	0.78	0.75	0.52
Index of food groups, children 6-23	0.15	-0.05	0.01	0.05	0.38	-0.07	0.01	0.04
Child has not had diarrhea past 30 days	0.68	0.64	0.29	0.67	0.69	0.71	0.54	0.36
Child given ORS	0.50	0.43	0.21	0.45	0.26	0.45	0.20	0.51
Mother washes hands before feeding	0.86	0.87	0.94	0.82	0.34	0.88	0.76	0.59
Mother washes hands after toilet	0.86	0.86	0.89	0.84	0.71	0.87	0.81	0.92
ECD								
Prosocial score	0.28	0.22	0.34	0.24	0.50	0.25	0.59	0.80
Total activities available to child	4.42	4.38	0.77	4.47	0.81	4.53	0.44	0.60
Child injured in past 12 months	0.01	0.01	0.78	0.01	0.62	0.02	0.29	0.56
Child has birth certificate	0.84	0.85	0.68	0.80	0.42	0.83	0.85	0.61
Index of parenting behaviors	0.08	0.04	0.37	0.02	0.34	0.00	0.08	0.35
Anthropometrics								
Height-for-age z-score	-1.31	-1.29	0.84	-1.24	0.63	-1.10	0.05	0.14
Arm circumference-for-age z-score	-0.94	-0.96	0.79	-0.94	0.96	-0.93	0.99	0.99
Weight-for-age z-score	-1.22	-1.17	0.64	-1.19	0.80	-1.18	0.65	0.96
Education								
Enrollment	0.54	0.53	0.84	0.49	0.38	0.57	0.54	0.65
Years of school	2.16	2.09	0.76	1.97	0.48	2.28	0.62	0.75
Any schooling	0.59	0.58	0.90	0.53	0.28	0.64	0.30	0.38
Progression	0.55	0.53	0.81	0.49	0.35	0.58	0.51	0.58
Denver								
Total score	0.43	0.43	0.80	0.44	0.53	0.44	0.65	0.92
Language	0.39	0.41	0.36	0.40	0.66	0.41	0.41	0.76
Fine motor	0.42	0.41	0.80	0.43	0.63	0.45	0.18	0.33
Gross motor	0.48	0.48	0.99	0.50	0.48	0.50	0.50	0.78
Personal-social	0.43	0.43	0.97	0.45	0.48	0.44	0.71	0.82

Strengths & Difficulties								
Total difficulties score in avg range	0.32	0.42	0.07	0.34	0.63	0.43	0.02	0.06
Total z-score under -0.5	0.33	0.42	0.11	0.36	0.62	0.44	0.02	0.08
Prosocial in avg range	0.28	0.22	0.34	0.24	0.50	0.25	0.59	0.80
Prosocial z-score over 0.5	0.37	0.29	0.21	0.33	0.56	0.31	0.29	0.61

Notes: Calculations in this table are based on baseline data from all 225 villages. Standard errors are clustered at the village level. The treatment arms are abbreviated as "T1" (cash only), "T2" (cash + information), "T3/T4" (cash + information + home visits). Column 1 presents the baseline mean in the control group; columns 2, 4, and 6 present the baseline means for each of the treatment arms; columns 3, 5, and 7 present p-values from a test of mean equality between the control arm and each of the respective treatment arms; and column 8 shows p-values for an F-test for equality across all four groups. For variable definitions, see Table 2.

Table A3. Attrition by Treatment Arm

	Control	T1	T2	T3	T4	All groups
Panel A: Village-level attrition, Est & Centre-Est	(1)	(2)	(3)	(4)	(5)	(6)
Percentage of Baseline Villages Surveyed at Endline	37.8	37.8	33.3	28.9	26.7	32.9
P-value for F-test Against Control	-	1	0.66	0.38	0.26	0.717
Number of Baseline Villages	45	45	45	45	45	225
Number of Endline Villages	17	17	15	13	12	74
Panel B: Household-level attrition, Est & Centre-Est	**Control**	**T1**	**T2**	**T3**	**T4**	**All groups**
Percentage of Baseline Households Surveyed at Endline	37.2	36.8	32.6	27.3	26.1	32.0
P-value for F-test Against Control	-	0.97	0.65	0.31	0.25	0.675
Number of Baseline Households	946	940	944	961	939	4730
Number of Baseline Households in Villages Surveyed at Endline	357	356	315	267	246	1541
Number of Endline Households	352	346	308	262	245	1513

Notes: Calculations in this table are based on baseline data from all 225 villages. The first row in each panel shows the percentage of villages or households that were surveyed at endline, and the second row contains the p-value for a test of equality between each of the treatment arms and the control group. Standard errors are clustered at the village level. The treatment arms are abbreviated as "T1" (cash only), "T2" (cash + information), "T3" (cash + information + nutrition home visits), "T4" (cash + information + nutrition & behavioral home visits). The remaining rows show the raw numbers of villages and households.

Table A4. Attrition by Treatment Arm

	Village present at endline	Household present at endline
	(1)	(2)
Cash Arm	0.000	-0.004
	(0.103)	(0.100)
Cash + Info Arm	-0.044	-0.046
	(0.102)	(0.099)
Cash + Info + Home Visits Arm	-0.100	-0.105
	(0.087)	(0.085)
Observations	225	4,730
Control Group Mean	0.38	0.37

Notes: "Cash arm" is an indicator for the household being in a village that is assigned to treatment arm 1, "cash + info arm" is an indicator for the household being in a village that is assigned to treatment arm 2, and "cash + info + home visits arm" is an indicator for the household being in a village that is assigned to either treatment arm 3 or treatment arm 4. Standard errors are shown in parenthesis and are clustered at the village level. *** p<0.01, ** p<0.05, * p<0.1.

Table A5. Attrition by Arm, All 225 Villages

	Control non-attritted village	Control attritted village	T1 non-attritted village	T1 attritted village	T2 non-attritted village	T2 attritted village	T3/T4 non-attritted village	T3/T4 attritted village	Differences equal across arms
Village Characteristics	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Number of households	207	178	197	165	197	197	194	215	0.29
Health center in village	0.12	0.11	0.29	0.11	0.20	0.33	0.04	0.23	0.05
Distance to nearest health center (in km)	6.94	9.39	4.00	9.04	5.20	6.42	4.58	6.88	0.52
Distance to nearest market (in km)	3.82	6.64	5.76	3.75	4.60	3.97	4.68	2.97	0.32
Primary school in village	0.94	0.96	0.94	0.96	0.87	0.93	0.88	1.00	0.70
Secondary school in village	0.29	0.07	0.12	0.11	0.27	0.17	0.16	0.11	0.58
Dist. to nearest secondary school (in km)	6.53	14.07	6.06	11.82	5.23	10.68	7.62	10.61	0.49
Distance to nearest paved road (in km)	17.09	50.38	23.35	51.35	19.63	47.50	24.44	46.09	0.61
# of months roads to village impassable	2.65	3.43	3.71	4.43	4.07	3.33	3.48	3.78	0.35
Household Characteristics									
Male	0.87	0.89	0.78	0.88	0.82	0.86	0.74	0.88	0.04
Age	47.71	44.84	44.14	43.62	45.74	43.05	45.66	43.91	0.45
Any education	0.07	0.05	0.08	0.05	0.10	0.07	0.12	0.07	0.87
Household size	10.25	9.96	8.86	8.87	9.08	8.87	8.81	8.93	0.87
# children	4.94	5.68	5.11	5.29	5.04	5.24	4.88	5.36	0.25
Married	0.90	0.94	0.92	0.95	0.93	0.94	0.93	0.96	0.75
Monogamous	0.45	0.46	0.43	0.46	0.49	0.49	0.48	0.46	0.83
Polygamous	0.46	0.48	0.49	0.50	0.44	0.45	0.45	0.49	0.91
Gourmanche ethnicity	0.08	0.51	0.08	0.52	0.13	0.47	0.10	0.44	0.75
Mossi ethnicity	0.27	0.08	0.43	0.06	0.42	0.08	0.55	0.08	0.18
Peulh ethnicity	0.12	0.15	0.05	0.12	0.05	0.10	0.05	0.13	0.74
Yana ethnicity	0.25	0.24	0.27	0.27	0.21	0.33	0.15	0.30	0.54
Catholic or Protestant	0.25	0.29	0.25	0.29	0.25	0.37	0.35	0.30	0.33
Muslim	0.72	0.47	0.74	0.47	0.73	0.42	0.64	0.52	0.23
Animist or no religion	0.03	0.23	0.01	0.23	0.01	0.21	0.02	0.18	0.64

Prenatal/Health									
Child receiving vitamin A	0.51	0.50	0.44	0.48	0.45	0.56	0.52	0.51	0.36
Child receiving iron	0.53	0.48	0.51	0.51	0.46	0.55	0.55	0.52	0.04
Mother receiving vitamin A	0.74	0.79	0.76	0.77	0.78	0.82	0.78	0.78	0.76
Mother receiving iron	0.89	0.88	0.92	0.89	0.90	0.89	0.89	0.88	0.96
Child fully vaccinated	0.45	0.35	0.44	0.34	0.38	0.35	0.50	0.37	0.43
Child sleeps under bednet	0.76	0.79	0.70	0.74	0.73	0.72	0.78	0.74	0.60
Index of food groups, children 6-23	0.15	0.01	-0.05	-0.03	0.05	-0.06	-0.07	0.03	0.07
Child has not had diarrhea past 30 days	0.68	0.56	0.64	0.59	0.67	0.60	0.71	0.61	0.59
Child given ORS	0.50	0.33	0.43	0.32	0.45	0.29	0.45	0.33	0.61
Mother washes hands before feeding	0.86	0.79	0.87	0.75	0.82	0.77	0.88	0.76	0.54
Mother washes hands after toilet	0.86	0.80	0.86	0.77	0.84	0.79	0.87	0.78	0.83
ECD									
Prosocial score	0.28	0.19	0.22	0.14	0.24	0.15	0.25	0.15	0.99
Total activities available to child	4.42	4.09	4.38	4.15	4.47	3.93	4.53	4.04	0.29
Child injured in past 12 months	0.01	0.01	0.01	0.01	0.01	0.02	0.02	0.01	0.15
Child has birth certificate	0.84	0.66	0.85	0.63	0.80	0.66	0.83	0.65	0.48
Index of parenting behaviors	0.08	0.03	0.04	0.01	0.02	-0.04	0.00	-0.04	0.99
Anthropometrics									
Height-for-age z-score	-1.31	-1.44	-1.29	-1.27	-1.24	-1.35	-1.10	-1.40	0.19
Arm circumference-for-age z-score	-0.94	-1.06	-0.96	-1.15	-0.94	-1.19	-0.93	-1.19	0.69
Weight-for-age z-score	-1.22	-1.27	-1.17	-1.20	-1.19	-1.30	-1.18	-1.29	0.91
Education									
Enrollment	0.54	0.38	0.53	0.37	0.49	0.42	0.57	0.37	0.37
Years of school	2.16	1.35	2.09	1.47	1.97	1.58	2.28	1.33	0.37
Any schooling	0.59	0.41	0.58	0.43	0.53	0.46	0.64	0.41	0.22
Progression	0.55	0.37	0.53	0.39	0.49	0.43	0.58	0.37	0.29
Denver									
Total score	0.43	0.41	0.43	0.41	0.44	0.40	0.44	0.40	0.89
Language	0.39	0.38	0.41	0.38	0.40	0.38	0.41	0.37	0.71
Fine motor	0.42	0.40	0.41	0.40	0.43	0.39	0.45	0.39	0.42
Gross motor	0.48	0.46	0.48	0.47	0.50	0.45	0.50	0.46	0.72
Personal-social	0.43	0.42	0.43	0.42	0.45	0.41	0.44	0.41	0.76

Strengths & Difficulties									
Total difficulties score in avg range	0.32	0.27	0.42	0.30	0.34	0.29	0.43	0.29	0.28
Total z-score under -0.5	0.33	0.27	0.41	0.30	0.34	0.29	0.43	0.29	0.30
Prosocial in avg range	0.28	0.19	0.22	0.14	0.24	0.15	0.25	0.15	0.99
Prosocial z-score over 0.5	0.39	0.29	0.30	0.25	0.35	0.24	0.32	0.25	0.83

Notes: Calculations in this table are based on baseline data from all 225 villages. Standard errors are clustered at the village level. The treatment arms are abbreviated as "T1" (cash only), "T2" (cash + information), "T3/T4" (cash + information + home visits). Columns 2, 4, 6, and 8 present the baseline means for the group of villages that we did not return to at endline, by treatment arm. Columns 1, 3, 5, and 7 present the baseline means for the group of villages that we did return to at endline, by treatment arm. Column 9 presents p-values for an F-test of equality across the differences within the pairs of columns (e.g. comparing the differences between the means in columns 1 and 2 with the differences between the means in columns 3 and 4, columns 5 and 6, and columns 7 and 8. For variable definitions, see Table 2.

Table A6. Impacts on Children's Food Consumption

	Fruits	Milk	Legumes	Eggs	Meat	Food group consumption index
	(1)	(2)	(3)	(4)	(5)	(6)
Cash Arm	0.208	0.020	0.645	0.149**	0.034	0.145**
	(0.320)	(0.155)	(0.463)	(0.073)	(0.137)	(0.072)
	[0.516]	[0.896]	[0.158]	[0.049]	[0.810]	[0.053]
Cash + Info Arm	0.033	0.336***	-0.646	0.011	0.057	0.069
	(0.273)	(0.124)	(0.538)	(0.080)	(0.123)	(0.082)
	[0.912]	[0.013]	[0.246]	[0.909]	[0.663]	[0.441]
Cash + Info + Home Visits Arm	0.288	0.193	0.347	0.114*	0.213	0.207***
	(0.282)	(0.135)	(0.416)	(0.058)	(0.132)	(0.067)
	[0.310]	[0.166]	[0.408]	[0.049]	[0.117]	[0.001]
Observations	1,013	1,019	1,019	1,017	1,019	1,017
Control Group Mean	2.15	0.66	7.93	0.15	0.69	0.31

Notes: These outcomes are aggregated and regressions are run at the household level. Children ages 0-71 months are included in these regressions. "Cash arm" is an indicator for the household being in a village that is assigned to treatment arm 1, "cash + info arm" is an indicator for the household being in a village that is assigned to treatment arm 2, and "cash + info + home visits arm" is an indicator for the household being in a village that is assigned to either treatment arm 3 or treatment arm 4. For columns 1-5, the outcome is the number of times in the past 7 days that a child consumed foods in that food group, averaged at the household level. The food consumption index in column 6 is a standardized index across the outcomes in columns 1-5. Standard errors are shown in parenthesis, and randomization inference p-values are shown in brackets below each coefficient estimate. Standard errors are clustered at the village level. *** p<0.01, ** p<0.05, * p<0.1.

Table A7. Impacts on Household Perceptions

	Perception of food	Perception of health	Perception of education	Perception of income	Perceptions index
	(1)	(2)	(3)	(4)	(5)
Cash Arm	0.017	0.011	0.008	0.016**	0.078
	(0.012)	(0.015)	(0.015)	(0.007)	(0.056)
	[0.151]	[0.464]	[0.635]	[0.011]	[0.163]
Cash + Info Arm	0.020*	0.039**	0.026	0.019*	0.165**
	(0.012)	(0.017)	(0.017)	(0.010)	(0.067)
	[0.092]	[0.017]	[0.126]	[0.061]	[0.012]
Cash + Info + Home Visits Arm	0.022*	0.02	0.005	0.015*	0.104*
	(0.012)	(0.016)	(0.016)	(0.008)	(0.060)
	[0.084]	[0.214]	[0.759]	[0.067]	[0.100]
Observations	1,511	1,512	1,486	1,503	1,512
Control Group Mean	0.01	0.03	0.03	0.01	-0.02

Notes: "Cash arm" is an indicator for the household being in a village that is assigned to treatment arm 1, "cash + info arm" is an indicator for the household being in a village that is assigned to treatment arm 2, and "cash + info + home visits arm" is an indicator for the household being in a village that is assigned to either treatment arm 3 or treatment arm 4. Household heads are asked how satisfied they are with the food, health, education, and income of their households, and the outcomes in these regressions are indicators for the household head reporting that they are "very satisfied" with that category (the highest possible level of satifaction on a 4-point scale. The perceptions index in column 5 is a standardized index across the outcomes in columns 1-4. Standard errors are shown in parenthesis, and randomization inference p-values are shown in brackets below each coefficient estimate. Standard errors are clustered at the village level. *** p<0.01, ** p<0.05, * p<0.1.

Table A8. Heterogeneity, by Gender

	Anthropometrics index		Education index		Denver total score	
	Boy	Girl	Boys	Girls	Boys	Girls
	(1)	(2)	(3)	(4)	(5)	(6)
Cash Arm	0.155*	0.073	0.071	0.049	0.017	-0.037
	(0.081)	(0.088)	(0.087)	(0.081)	(0.040)	(0.031)
	[0.063]	[0.419]	[0.431]	[0.564]	[0.691]	[0.243]
Cash + Info Arm	-0.083	0.020	0.071	-0.035	-0.041	-0.036
	(0.080)	(0.089)	(0.079)	(0.076)	(0.032)	(0.029)
	[0.296]	[0.856]	[0.408]	[0.645]	[0.191]	[0.233]
Cash + Info + Home Visits Arm	0.023	0.103	0.144*	0.124**	0.012	0.017
	(0.064)	(0.088)	(0.078)	(0.061)	(0.034)	(0.028)
	[0.715]	[0.246]	[0.069]	[0.052]	[0.722]	[0.541]
Observations	993	974	2,645	2,545	1,241	1,215
Control Group Mean	-0.08	0.03	0.06	0.00	0.46	0.46

Notes: "Cash arm" is an indicator for the household being in a village that is assigned to treatment arm 1, "cash + info arm" is an indicator for the household being in a village that is assigned to treatment arm 2, and "cash + info + home visits arm" is an indicator for the household being in a village that is assigned to either treatment arm 3 or treatment arm 4. This table contains the KLK indices (or in the case of columns 5 and 6, the total score) from Tables 5 through 7, separately for boys and girls. Standard errors are shown in parenthesis, and randomization inference p-values are shown in brackets below each coefficient estimate. Standard errors are clustered at the village level. *** p<0.01, ** p<0.05, * p<0.1.

Table A9. Heterogeneity, by Distance from Conflict

	Pregnancy index		Health behaviors index		Anthropometrics index		Education index		Denver total score	
	Close to conflict	Far from conflict	Close to conflict	Far from conflict	Close to conflict	Far from conflict	Close to conflict	Far from conflict	Close to conflict	Far from conflict
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
Cash Arm	-0.036	0.043	-0.009	-0.041	-0.010	0.317***	0.185**	0.036	0.053*	-0.047
	(0.078)	(0.070)	(0.035)	(0.039)	(0.069)	(0.087)	(0.072)	(0.095)	(0.028)	(0.039)
	[0.650]	[0.543]	[0.784]	[0.285]	[0.877]	[0.000]	[0.016]	[0.710]	[0.070]	[0.239]
Cash + Info Arm	-0.020	-0.093	0.000	-0.043	-0.081	0.082	0.119*	-0.129**	-0.010	-0.044
	(0.078)	(0.056)	(0.035)	(0.049)	(0.078)	(0.129)	(0.068)	(0.062)	(0.030)	(0.029)
	[0.819]	[0.111]	[0.996]	[0.387]	[0.289]	[0.582]	[0.097]	[0.052]	[0.759]	[0.155]
Cash + Info +	0.287***	0.076	0.120***	0.059	0.059	0.137	0.268***	0.163**	0.069**	0.009
Home Visits Arm	(0.073)	(0.065)	(0.031)	(0.041)	(0.083)	(0.101)	(0.073)	(0.060)	(0.028)	(0.029)
	[0.002]	[0.251]	[0.001]	[0.176]	[0.495]	[0.227]	[0.000]	[0.015]	[0.020]	[0.714]
Observations	541	517	648	577	1,026	941	2,729	2,462	1,273	1,183
Control Group Mean	-0.02	0.02	0.10	0.11	0.01	-0.08	0.05	0.00	0.46	0.47

Notes: "Cash arm" is an indicator for the household being in a village that is assigned to treatment arm 1, "cash + info arm" is an indicator for the household being in a village that is assigned to treatment arm 2, and "cash + info + home visits arm" is an indicator for the household being in a village that is assigned to either treatment arm 3 or treatment arm 4. This table contains the KLK indices (or in the case of column 9 and 10, the total score) from Tables 3 through 7 as the outcome variables, separately split into whether the village was below or above the median distance from the nearest conflict site. Standard errors are shown in parenthesis, and randomization inference p-values are shown in brackets below each coefficient estimate. Standard errors are clustered at the village level. *** p<0.01, ** p<0.05, * p<0.1.

Table A10. Heterogeneity, by Baseline Expenditures

	Pregnancy index		Health behaviors index		Anthropometrics index		Education index		Denver total score	
	Poor	Non-poor	Poor	Non-poor	Poor	Non-poor	Poor	Non-poor	Poor	Non-poor
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
Cash Arm	0.009	0.010	-0.048	0.003	0.150	0.03	0.127	0.031	-0.025	-0.003
	(0.070)	(0.106)	(0.047)	(0.041)	(0.103)	-0.073	(0.086)	(0.073)	(0.033)	(0.038)
	[0.899]	[0.928]	[0.311]	[0.947]	[0.139]	[0.687]	[0.154]	[0.679]	[0.487]	[0.946]
Cash + Info Arm	-0.095	-0.006	-0.007	-0.022	0.024	-0.094	0.091	-0.022	-0.044	-0.017
	(0.070)	(0.090)	(0.040)	(0.043)	(0.126)	(0.060)	(0.084)	(0.083)	(0.035)	(0.028)
	[0.173]	[0.945]	[0.848]	[0.625]	[0.838]	[0.107]	[0.282]	[0.832]	[0.224]	[0.538]
Cash + Info +	0.236***	0.143*	0.033	0.101***	0.098	0.025	0.235***	0.065	0.052*	0.009
Home Visits Arm	(0.071)	(0.081)	(0.033)	(0.034)	(0.077)	(0.063)	(0.074)	(0.067)	(0.028)	(0.026)
	[0.002]	[0.087]	[0.317]	[0.004]	[0.199]	[0.699]	[0.004]	[0.364]	[0.076]	[0.726]
Observations	509	549	597	628	846	1,119	2,380	2,809	1,078	1,378
Control Group Mean	-0.05	0.02	0.15	0.08	-0.13	0.03	-0.03	0.07	0.46	0.47

Notes: "Cash arm" is an indicator for the household being in a village that is assigned to treatment arm 1, "cash + info arm" is an indicator for the household being in a village that is assigned to treatment arm 2, and "cash + info + home visits arm" is an indicator for the household being in a village that is assigned to either treatment arm 3 or treatment arm 4. This table contains the KLK indices (or in the case of column 9 and 10, the total score) from Tables 3 through 7, separately based on whether the household was below or above the median level of expenditures at baseline. Standard errors are shown in parenthesis, and randomization inference p-values are shown in brackets below each coefficient estimate. Standard errors are clustered at the village level. *** p<0.01, ** p<0.05, * p<0.1.

Table A11. Heterogeneity, by Health Clinic in Village

	Health behaviors index		
	Health clinic in village	**No health clinic in village**	**Interacted with health clinic indicator**
	(1)	(2)	(3)
Cash Arm	0.006	-0.030	-0.008
	(0.134)	-0.030	(0.032)
	[0.715]	[0.300]	[0.800]
Cash + Info Arm	-0.008	-0.002	0.033
	(0.066)	(0.032)	(0.029)
	[0.931]	[0.960]	[0.287]
Cash + Info +	0.297*	0.082***	0.105***
Home Visits Arm	(0.157)	(0.026)	(0.023)
	[0.135]	[0.003]	[0.001]
Health Clinic x Cash Arm			0.128
			(0.136)
			[0.396]
Health Clinic x (Cash +			-0.018
Info Arm)			(0.048)
			[0.762]
Health Clinic x (Cash +			0.321**
Info + Home Visits Arm)			(0.142)
			[0.065]
Observations	181	1,040	1,225
Control Group Mean	0.182	0.097	0.107

Notes: Regressions are run at the household level. "Cash arm" is an indicator for the household being in a village that is assigned to treatment arm 1, "cash + info arm" is an indicator for the household being in a village that is assigned to treatment arm 2, and "cash + info + home visits arm" is an indicator for the household being in a village that is assigned to either treatment arm 3 or treatment arm 4. "Health Clinic" is an indicator for the village having a health clinic. Standard errors are shown in parenthesis, and randomization inference p-values are shown in brackets below each coefficient estimate. Standard errors are clustered at the village level. *** p<0.01, ** p<0.05, * p<0.1.

Table A12. Impacts on Main Indices, Alternative Specifications

Panel A: Indices for Main Tables

	Pregnancy index	Health behaviors index	Anthropometrics index	Education index	Denver total score
	(1)	(2)	(3)	(4)	(5)
Cash Arm	0.047	-0.016	0.101	0.194**	-0.008
	(0.067)	(0.026)	(0.063)	(0.082)	(0.030)
	[0.488]	[0.536]	[0.123]	[0.021]	[0.799]
Cash + Info Arm	-0.019	0.023	-0.030	0.085	-0.038
	(0.055)	(0.027)	(0.068)	(0.073)	(0.026)
	[0.746]	[0.414]	[0.657]	[0.231]	[0.148]
Cash + Info + Home Visits Arm	0.199***	0.101***	0.042	0.180***	0.016
	(0.055)	(0.022)	(0.059)	(0.056)	(0.025)
	[0.002]	[0.001]	[0.478]	[0.003]	[0.518]
Observations	1,054	1,225	1,967	5,189	2,456
Control Group Mean	0.00	0.107	-0.03	0.03	0.46

Panel B: Indices for Main Tables - No Controls

	Pregnancy index	Health behaviors index	Anthropometrics index	Education index	Denver total score
Cash Arm	-0.005	-0.022	0.082	0.046	-0.008
	(0.060)	(0.032)	(0.062)	(0.100)	(0.030)
	[0.937]	[0.492]	[0.192]	[0.665]	[0.799]
Cash + Info Arm	-0.048	-0.004	-0.048	0.002	-0.038
	(0.0502)	(0.031)	(0.070)	(0.092)	(0.026)
	[0.344]	[0.898]	[0.491]	[0.981]	[0.148]
Cash + Info + Home Visits Arm	0.171***	0.072***	0.050	0.143*	0.016
	(0.057)	(0.025)	(0.060)	(0.084)	(0.025)
	[0.002]	[0.006]	[0.400]	[0.110]	[0.518]
Observations	1,054	1,225	1,967	5,189	2,456
Control Group Mean	0.00	0.107	-0.03	0.03	0.46

Panel C: Indices for Main Tables - ANCOVA Specification

	Pregnancy index	Health behaviors index	Anthropometrics index	Education index	Denver total score
Cash Arm	-	0.046	0.246**	0.058	0.028
	-	(0.034)	(0.100)	(0.062)	(0.044)
	-	[0.130]	[0.024]	[0.338]	[0.535]
Cash + Info Arm	-	0.046	-0.010	0.067	-0.021
	-	(0.037)	(0.073)	(0.050)	(0.040)
	-	[0.219]	[0.904]	[0.198]	[0.597]
Cash + Info + Home Visits Arm	-	0.149***	0.095	0.120***	0.058
	-	(0.030)	(0.076)	(0.045)	(0.047)
	-	[0.001]	[0.232]	[0.007]	[0.235]
Observations	-	1,153	342	2,898	733
Control Group Mean	-	0.133	-0.03	0.03	0.46

Notes: "Cash arm" is an indicator for the household being in a village that is assigned to treatment arm 1, "cash + info arm" is an indicator for the household being in a village that is assigned to treatment arm 2, and "cash + info + home visits arm" is an indicator for the household being in a village that is assigned to either treatment arm 3 or treatment arm 4. Each panel contains the KLK indices (or in the case of column 5, the total score) from Tables 3 through 7. Panel A repeats the results with the main specification, Panel B shows the results without lasso-selected covariates, and Panel C shows the results from an ANCOVA specification that controls for baseline values of the outcome (lasso-selected controls are also included in this specification). Standard errors are shown in parenthesis, and randomization inference p-values are shown in brackets below each coefficient estimate. Standard errors are clustered at the village level. *** p<0.01, ** p<0.05, * p<0.1.

Table A13. Options for LASSO-selected controls

	Mean	Standard Deviation
Household head male	0.80	0.40
Number of months household head absent in past year	0.11	0.84
Household head absent any time in past year	0.03	0.18
Household head married	0.92	0.27
Household head monogamous	0.46	0.50
Household head polygamous	0.46	0.50
Household head Gourmanche	0.10	0.29
Household head Yana	0.21	0.41
Household head ethnic subgroup nobles	0.43	0.49
Household head ethnic subgroup landchief	0.13	0.33
Household head muslim	0.70	0.46
Household head Catholic/Protestant	0.29	0.45
Household head animist/no religion	0.02	0.13
Household head animist	0.02	0.13
Household head any education	0.09	0.29
Household head literate	0.12	0.33
Household size	9.25	4.09
# child of household head under 15	5.00	2.58
# other household members (not spouse or child)	2.03	3.29
Household head age in years	45.96	12.68
Household head age in years, squared	2273	1274
Household uses pump in dry and rainy season	0.80	0.40
Household uses pump in dry or rainy season	0.86	0.35
Primary light source for household: flashlight	0.87	0.34
Monthly cost of lighting	1898	2510
No latrine in household	0.69	0.46
Household uses the mill	0.98	0.14
Number of rooms in house (topcoded)	3.93	2.05
Number of rooms with a tin roof	1.90	1.82
Any rooms in house with a tin roof	0.75	0.44
Number of rooms with a tin roof (topcoded)	1.85	1.64
Percent of rooms in house with a tin roof	0.49	0.38
Number of rooms with cement walls	0.75	1.31
Any rooms in house with cement walls	0.36	0.48
Number of rooms with cement walls (topcoded)	0.70	1.13
Percent of rooms in house with cement walls	0.19	0.32
Number of rooms with cement floors	1.55	1.97
Any rooms in house with cement floors	0.56	0.50
Number of rooms with cement floors (topcoded)	1.49	1.76
Percent of rooms in house with cement floors	0.39	0.42
Total value of assets	323,297	519,642
Informal savings	7,024	24,386
Indicator for having a ROSCA	0.07	0.25

Tropical Livestock Units	2.71	4.96
Total value of annual food consumption	732,334	1,034,613
Total value of expenditures	604,353	547,277
Total value of expenditures and consumption	1,336,687	1,347,446
Village population	2,580	2,193
Health center in village	0.15	0.36
Distance to nearest market	4.73	4.93
Distance to nearest health center (km)	5.14	4.25
Village has a pump in both rainy and dry seasons	0.85	0.36
Village has a pump in either rainy or dry seasons	0.90	0.29
Primary school in village	0.90	0.30
Distance to nearest primary school (km)	0.33	1.37
0-3 classes in school	0.20	0.40
Meals provided at school	0.82	0.38
Secondary school in village	0.20	0.40
Distance to nearest secondary school (km)	6.60	5.59
Adult literacy program in village in past year	0.10	0.30
Cost for transportation to regional capital	2165	1592
Cost for transportation to Ouagadougou	4848	1548
Distance to nearest paved road (km)	21.45	15.91
Number of months roads to village impassable	3.47	1.91
Any months roads to village impassable	0.94	0.23
Any epidemics in village in past 12 months	0.30	0.46
Number of months in year with dry wells in village	1.22	1.77
Any months with dry well in village	0.42	0.49
Number of months in year with dry marigot in village	4.53	2.78
Any epidemics that killed animals in past year	0.88	0.33
Any development projects in village	0.24	0.43
Very bad rainy season in past 12 months	0.31	0.46
Pests destroyed more than 1/2 of crops in past 12 months	0.25	0.43