COMMUNITY BASED CONDITIONAL CASH TRANSFERS IN TANZANIA

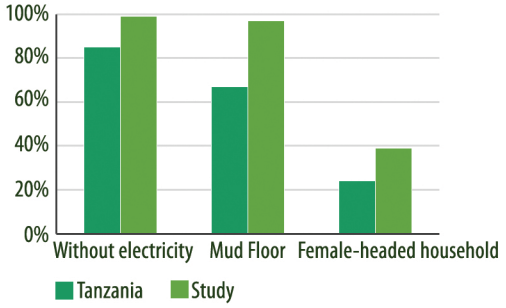
RESULTS FROM A RANDOMIZED TRIAL

David K. Evans, Stephanie Hausladen, Katrina Kosec, and Natasha Reese (January 2014)

Given the success of conditional cash transfer (CCT) programs elsewhere in the world, in 2010 the Government of Tanzania - via the Tanzania Social Action Fund (TASAF) — rolled out a CCT program in three districts. Its aim was to see if, using a model that relied heavily on communities to target beneficiaries and deliver payments, the program could improve outcomes for the poor the way centrally-run CCT programs have in other contexts. What follows is a summary of the pilot program, the methodology used to evaluate it, and its major impacts.

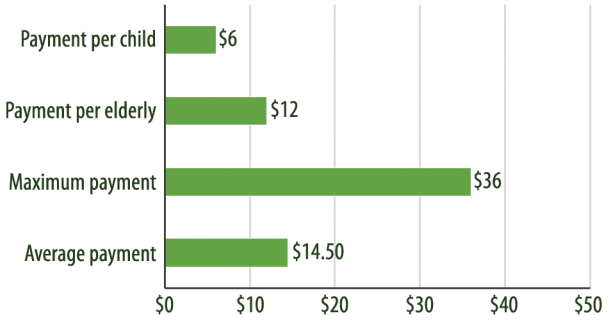
1 The program was piloted in three poor districts (Bagamoyo, Chamwino, and Kibaha), selected in part for their poverty relative to other parts of Tanzania.

How do the study population and the rest of the country compare?



2 The program provided benefits for these poor households based on the number of vulnerable children (age 0-15) and elderly (age 60+) therein. Payments were made every other month, or six times each year.

How large were the bimonthly payments to the families?



3 In order to receive payments, households had to comply with certain conditions. Locally-elected community management committees monitored compliance with these conditions and penalized participating households that did not comply.

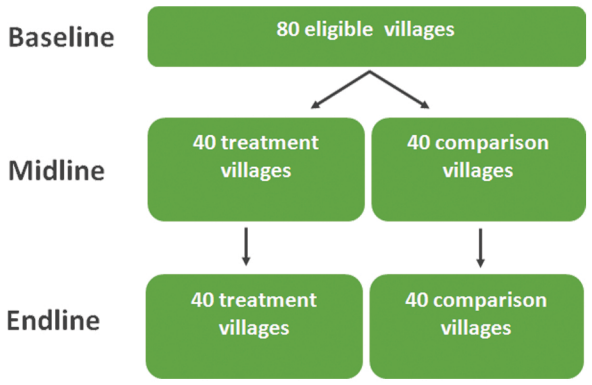
What were the conditions that households needed to meet?

	Education	Health
Children (age 0-5)		Visit clinic 6 times per year
Children (age 7-15)	Be enrolled with 80% attendance	
Elderly		Visit clinic 1 time per year

4 Given scarce resources, TASAF randomly selected 40 villages out of 80 eligible villages in the three study districts to be treated under the pilot program. Communities selected the most vulnerable households to participate before learning which villages were randomly selected to participate in the program.

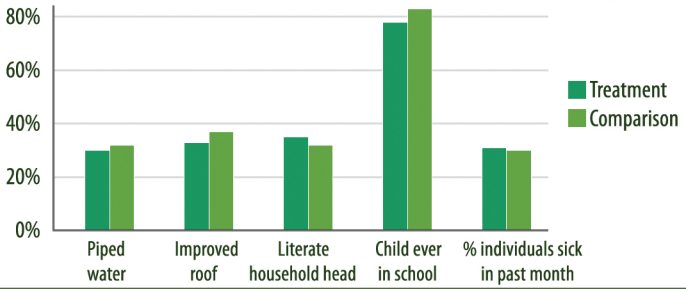
A baseline survey was carried out in early 2009. Transfers began in January 2010. A midline survey was carried out in mid-2011 (18-21 months after transfers began). An endline survey was carried out in late 2012 (31-34 months after transfers began).

A community score card exercise (in which communities rated themselves), two rounds of focus groups, and a set of in-depth interviews complemented the quantitative evaluation.



5 Treatment and comparison households were **comparable** at baseline, with few significant differences across a wide range of characteristics. In the final analysis, we compared changes over time in treatment and comparison households (a method called difference-in-differences) to adjust for small baseline differences, like those shown here.

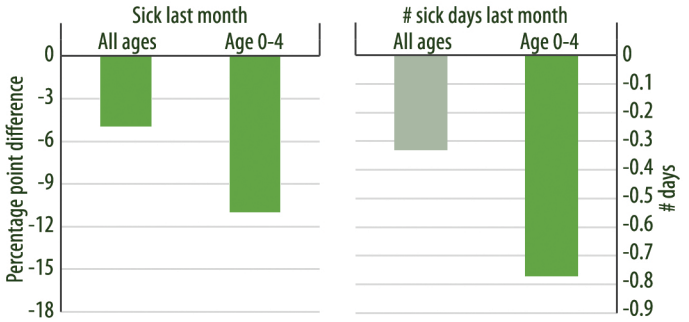
How similar were the treatment and comparison households before the program?



Public Disclosure Authorized

6 After an initial surge in clinic visits among treatment households, 31-34 months into the program (at endline), participating households were attending clinics less often but were **healthier**: their members were 5% less likely to be sick (averaging across all ages), and children age 0-4 were 11% less likely to be sick.

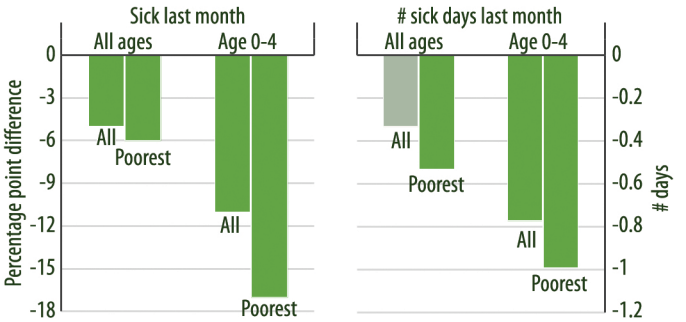
How much less sick were members of treatment households relative to members of households in the comparison group?



(Green indicates significant differences between treatment and comparison; gray indicates that the impact was not statistically significant.)

7 **Health** improvements due to the CCT program are even more marked for the poorest half of treatment households: the poorest of the poor. They experienced a half a day per month reduction in sick days (averaging across all ages), and poor children age 0-4 in particular had a full day per month reduction in sick days.

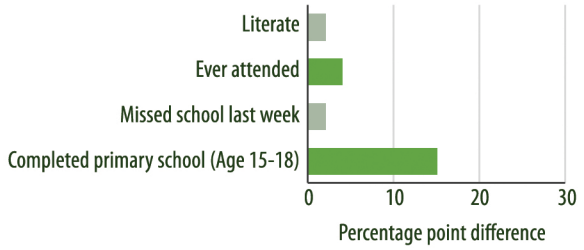
How much less sick were members of the poorest half of treatment households relative to members of the poorest half of households in the comparison group?



(Green indicates significant differences between treatment and comparison; gray indicates that the impact was not statistically significant.)

8 In **education**, the program showed clear positive impacts on whether children had ever attended school or if they completed primary school. Through qualitative data collection exercises, communities reported that the program had dramatic, positive impacts on school attendance. While these positive impacts on absenteeism were not observed in the quantitative data, only 12% of children were reported to be absent during the previous week at baseline, so student absenteeism may not be a major problem. Furthermore, the program's conditions only required 80% attendance at school.

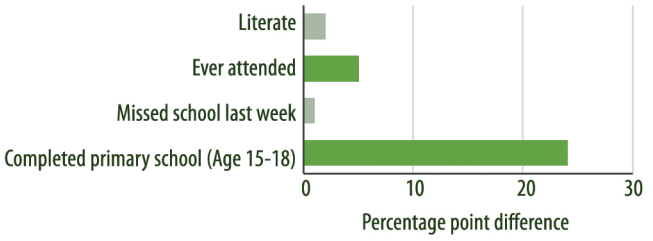
How much better did treatment group children do in literacy, attendance, and completion?



(Green indicates significant differences between treatment and comparison; gray indicates that the impact was not statistically significant.)

9 The primary school completion effect is particularly striking for girls, who were 23 percentage points more likely to complete primary school than were their comparison group counterparts.

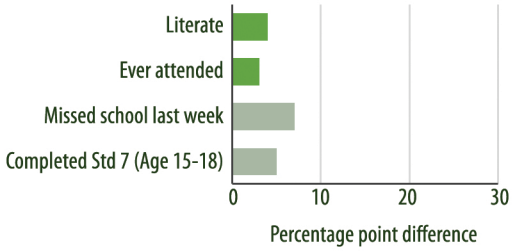
How much better did females in treatment households do in literacy, attendance, and completion?



(Green indicates significant differences between treatment and comparison; gray indicates that the impact was not statistically significant.)

10 In addition, **literacy rates** increased significantly for children who were out of school at baseline.

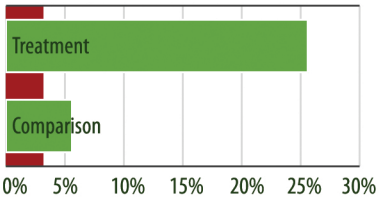
How much better did students out of school at baseline in treatment households do in literacy, attendance, and completion?



(Green indicates significant differences between treatment and comparison; gray indicates that the impact was not statistically significant.)

11 Some of the most consistent changes observed have to do with **health insurance**. Treatment households were much more likely to finance medical care with insurance and much more likely to purchase insurance than were their comparison counterparts. This is important because having health insurance can substantially reduce out-of-pocket expenditures for medical care and increase the propensity to seek treatment for health problems.

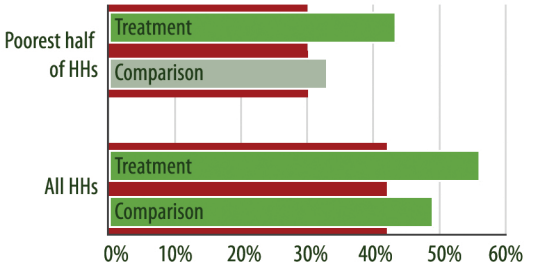
For someone sick in the last month, did you finance treatment with health insurance?



(Baseline average is in red. Green indicates significant increases.)

12 Increases in expenditures, either on food or non-food household items, are not significantly higher for treatment households, with the exceptions of **insurance** and **children's shoes**. Households, on average, are much more likely to purchase children's shoes. This is especially true for the poorest households.

Does the child have shoes?

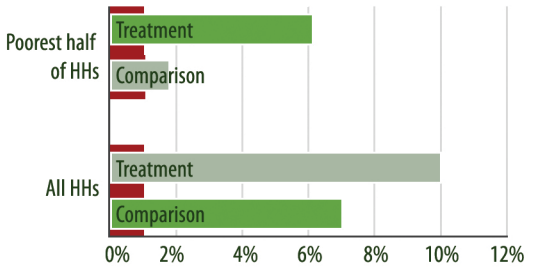


(The baseline average is in red. Green indicates significant increases; gray indicates that the difference is not statistically significant.)

The quality of housing materials improved in treatment villages but more slowly than it did in comparison villages.

13 The program did not significantly affect savings or spending on average, although the poorest half of treated households saw a five-fold, highly significant increase in **non-bank savings.**

What share of households have non-bank savings?

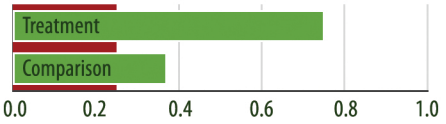


(The baseline average is in red. Green indicates significant increases; gray indicates that the difference is not statistically significant.)

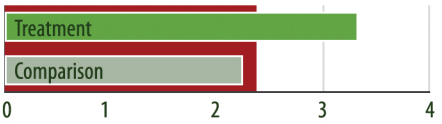
14 Treated households invested in more **livestock** assets. Focus groups revealed that households purchased chickens and other animals and used them to create businesses (e.g., selling eggs or chicks) or in order to have easily sellable, productive savings.

How much did the program affect livestock asset ownership?

Number of indigenous goats owned



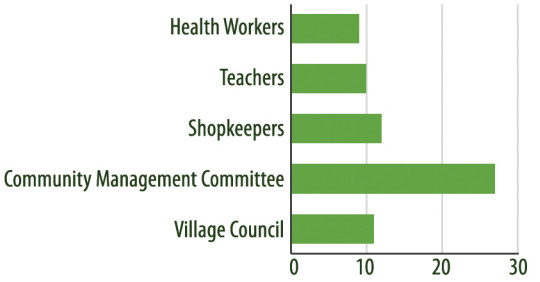
Number of local chickens owned



(The baseline average is in red. Green indicates significant increases; gray indicates that the difference is not statistically significant.)

15 Because this program relies so heavily on communities – to target, to deliver transfers, and to monitor compliance with conditions – there was concern as to its impact on community cohesion. In fact, treatment households were more likely to have attended village council meetings, to have contributed labor to a community development project (for female recipients), and to express trust in a range of community members.

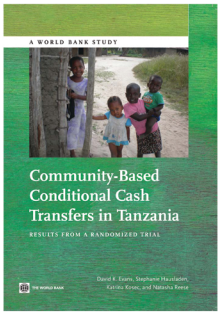
How much more do individuals in treatment communities trust these groups than do individuals in comparison communities?



IN SUM:

The Community-based CCT program led to improved outcomes in both health and education. Households used the resources to invest in livestock, in children's shoes, in insurance, and – for the poorest households – in increased savings. This suggests that the households focused on reducing risk and on improving their livelihoods rather than principally on increasing consumption. There is also evidence that the project had positive effects on community cohesion.

SOURCE:



Evans, David K., Stephanie Hausladen, Katrina Kosec, and Natasha Reese. 2014. Community-Based Conditional Cash Transfers in Tanzania: Results from a Randomized Trial. World Bank Study. Washington, DC: World Bank.

For more information:
David Evans
Senior Economist
(202) 458-4146
devans2@worldbank.org