



Tanzania: Can Local Communities Successfully Run Cash Transfer Programs?

Conditional cash transfer programs have proven successful at reducing poverty, promoting health and boosting education among the world's poorest. But these programs generally

require strong central government bureaucracies to administer the program and transfer the payments, potentially limiting the use of these programs where governments are less experienced or stable.

Development experts are interested in new models for delivering cash transfers in countries with weak or inexperienced central governments. One possibility is to rely on communities themselves—rather than a central bureaucracy—to administer the cash transfers. But can communities run the programs as efficiently and ensure that benefits are equally and regularly distributed?

The World Bank is committed to reducing extreme poverty and boosting shared prosperity. As part of that goal, the World Bank works closely with countries to implement pro-

grams that encourage the poor to seek health care and send their children to school, both of which are crucial for meeting the United Nations Millennium Development Goals. In Tanzania, the World Bank teamed up with the government to create an innovative conditional cash transfer program that relied on local communities to play a central administrative role in identifying beneficiaries, monitoring conditions, and handling payments. The impact evaluation built into the program found that the cash transfers led to positive changes in both health and education, and also improved community cohesion. The program's effects were greatest among those who needed it most—the poorest of the poor. This suggests that conditional cash transfer systems can be adapted to work well in low-income countries—even in the absence of a strong central government to administer them. **The Government of Tanzania has already more than doubled enrollment in the program to 100,000 households. The government expects that the program will reach more than 900,000 households within the next two years, creating a comprehensive social safety net that would benefit some 5.5 million of the country's poorest citizens.**



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Context

Though the economy in Tanzania continues to grow, poverty remains widespread, especially in rural areas where some 30 million people—three quarters of the population—live. Since 2001, the

level of poverty in rural areas has remained stagnant at around 37 percent to 40 percent. In 2000, the Government of Tanzania, with support from the World Bank, created the Tanzania Social Action Fund (TASAF) as part of a broader strategy to reduce poverty by stimulating local economies. Among other activities, TASAF has funded community-run projects to build health clinics and schools, giving communities experience managing funds, hiring contractors, and monitoring projects.

In 2010, the national government rolled out the conditional cash transfer program via TASAF, piloting it in three of

Did You Know...

In Tanzania, 44 percent of children under 5 are stunted, 17 percent are underweight and four percent wasted.

Fifteen percent of deaths of children under five are due to pneumonia and 12 percent to diarrhea.

Data from Nutrition at a Glance: Tanzania, World Bank <http://siteresources.org/NUTRITION/Resources/281846-1271963823772/Tanzania.pdf>

the country's poorest districts: Bagamoyo, Chamwino and Kibaha. Unlike many cash transfer programs that rely on a central bureaucracy for identifying beneficiaries and arranging payments, the program was designed to be managed and implemented by communities themselves. In the initial pilot phase of the program, which covered 2,500 households, communities involved had all previously received financial training and had successfully managed at least one TASAF-supported project through their publicly-elected community management committee. In this case, program beneficiaries were identified and screened by their community management committee, which identified the poorest half of households. Then, in conjunction with the local government authority and TASAF, the committees assessed these households' eligibility using proxy means testing—which measures a family's well-being based on things like housing quality, household goods and education. Once beneficiaries were chosen, committees were kept informed of people's adherence to the requirements through moni-

toring reports kept by schools and clinics. If beneficiaries failed to comply, they received a warning, and after that, a 25 percent reduction in their next payment. After two unheeded warnings, they were suspended, but were given the option of reapplying. Committees were responsible for informing beneficiaries of program requirements, distributing cash payments and using peer pressure to ensure compliance with the program's health and education conditions.

Payments were computed based on the number of children and elderly in eligible households. Households received payment six times a year: \$6 for every child under the age of 15 and \$12 for every adult over the age of 60, with a maximum bimonthly total of \$36 for the household. On average, households received \$87 a year. For families to receive the money, children up to the age of five had to visit a health clinic at least six times a year, children ages 7–15 had to be enrolled in school and have at least 80 percent attendance, and elderly people needed to visit a health clinic once a year.

Evaluation

The World Bank-supported conditional cash transfer program included a built-in impact evaluation that aimed to test both the effectiveness of the Tanzania program as well as the reliability of the community-based model. Of the 80 eligible villages in the three study districts, 40 were randomly selected to receive funding as part of the pilot program, while the other 40 served as the control. Communities were randomized into treatment and control groups based on their size and district so that similarly-sized communities in the same district had equal chances of being in the treatment group and being in the control group. Communities selected the poorest households to participate in the program before learning whether their community had been randomly selected to be in the treatment group.

A baseline survey was carried out in early 2009 and transfers began in January 2010. A midline survey was carried out between July and September 2011 and an endline survey was carried out between August and October 2012. Treatment and control groups were comparable at the baseline and researchers used a method called difference-in-difference to compare changes between the two groups over time.

The evaluation also included a qualitative component, namely a community scorecard exercise (in which communities rated themselves), two rounds of focus groups, and a series of in-depth interviews to determine the program's impact using self-reported results. The qualitative evaluation began in November 2010 with the community scorecard exercise and lasted through August 2013, with the last of the focus groups and in-depth interviews.

Based on the paper "Community based conditional cash transfers in Tanzania: Results from a randomized trial" by David K. Evans, Stephanie Hausladen, Katrina Kosec and Natasha Reese. World Bank Group, Washington, D.C., 2014, World Bank.

Findings

The community-based model led to better health.

Members of households that qualified for the cash transfers were 5 percentage points less likely to get sick than those in communities that didn't receive the cash transfers, and children four and under were 11 percentage points less likely to get sick. Interestingly, this wasn't because people were visiting health clinics more frequently; they weren't. The end-line survey, close to three years into the program, found that people who qualified for the cash transfers visited clinics less often than their counterparts in the control group. But the midline survey showed that participants visited clinics more often. These check-ups early on may have helped people stay healthier.

The poorest families got the biggest health boost in terms of a reduction in the number of days they were sick every month.

The poorest of the poor were less likely to lose days of work because of illness. Adults in the poorest half of the treatment group reported that their number of sick days dropped by half a day per month, while the poorest children in the group reduced their number of sick days by a full day per month.

The program also had a positive effect on education, particularly for girls and the community's most vulnerable children.

Overall, the program led to an increase in the number of children completing primary school and going on to higher education. Children aged 7-14 whose families were in the program were 6 percentage points more likely to have at least finished four years of primary school— an increase to 42 percent from 36 percent before the program began. Children aged 15-18 were 13 percentage points more likely to have completed the last three years of primary school (grades 5-7). The figure for girls is even higher. They were 24 percentage points more likely to have completed primary school (grade 7).

The program also had a big effect on children who weren't in school when the program was launched. Almost three years into the program, these children were more likely to have at-

tended some school, be in school, and be literate. In community focus groups and in-depth interviews, teachers said that beneficiaries were better able to focus in school because they were eating more. Participants also reported an increase in morale as a result of the program, especially among those who could not afford school uniforms or school supplies before the program began. Nevertheless, absenteeism rates remained unchanged and the program had no impact on the likelihood that children overall would be literate.



Participants in the program used the money to invest in health insurance, livestock and shoes...

Treatment households purchased five times more medical health insurance than the control group. Many program participants also used the money to purchase livestock such as chickens or goats that allowed them to create a small business. Thanks to the cash transfers, households—particularly the poorest of the poor—were more likely to buy shoes for their children. In addition to health benefits, owning shoes helped the children's education: In focus groups and in-depth interviews with researchers, teachers emphasized that children need shoes—in addition to notebooks and a uniform—to attend school.

...but the program had little impact on overall consumption, bank savings or credit decisions.

Beneficiaries were no more likely to have a bank account, have other savings or have taken out a loan. Overall, participants said that the cash helped cover key expenses, but not more: there was no surplus to save. The one exception was among the poorest beneficiaries, who saw a fivefold increase in the rate of non-bank savings.

The program also had positive effects on communal cohesion: recipients had greater trust in their leaders as well as each other.

Overall, the program had positive effects on the community structure, especially in Kibaha district. The treatment group was more likely to attend village council meetings and female recipients were more likely to have volunteered their time and labor to a community development project. The poorest recipients were also more likely to give high scores to their school and health facilities as a result of the program. In focus groups, beneficiaries told researchers they felt like their leaders cared about them.



Conclusion

Community-based conditional cash transfers have proven to be an effective tool for alleviating poverty and improving health and education outcomes for the poor. These are important lessons for development experts and should provide much-needed evidence for policy makers looking to expand social safety net programs in low income countries. As this

evaluation shows, governments don't necessarily need strong central bureaucracies to administer cash transfer programs. Community groups, provided they are given proper training and adequate support, can handle the logistics of the cash transfers, and in doing so, help improve the lives of their poorest neighbors.

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THE WORLD BANK, HUMAN DEVELOPMENT NETWORK
1818 H STREET, NW WASHINGTON, DC 20433