TANZANIA COMMUNITY-BASED CONDITIONAL CASH TRANSFER PILOT[1]

1. Background

The children of Tanzania have been hard hit by the AIDS crisis. 6.2% of Tanzanian adults are estimated to be infected with HIV.[2] Twelve percent of Tanzanian children have been orphaned, and the total number of orphaned children is expected to continue rising.[3] The impact of the crisis on children's outcomes has been significant, and those effects have been shown to endure. Recent work on the impacts of orphanhood in Tanzania shows significant long-term reductions in educational attainment and height, the latter suggesting persistent consumption deficits throughout childhood.[4] This pilot seeks to directly mitigate these challenges by providing cash transfers to poor households conditional on their keeping their children in school and seeking regular health care for them. The experience of similar cash transfer programs elsewhere suggests that most of the resources are directed toward improving consumption.

An area of the HIV/AIDS crisis on which there has been less of a spotlight is the vulnerable elderly. Many older persons who would traditionally have relied on their prime-age children for support have been left to seek alternative livelihood mechanisms, and for the poorest households there are few options. This project will also target these elderly-headed households, particularly those left with the responsibility of caring for orphaned children.

2. Pilot Objective and Description

The overall objective of the pilot is to test how a conditional cash transfer (CCT) program could be implemented through a social fund[5] using a community-driven development approach, and what systems may need to be in place to achieve positive results in mitigating the effects of the AIDS crisis. This is both the first time that a social fund agency is being used to implement a CCT program in Africa and the first time that a CCT program is being delivered using a community-driven approach. Specific objectives of the pilot are to (a) Develop operational modalities for the community-driven delivery of a CCT program through a social fund operation; and (b) Test the effectiveness of the community-based CCT model and ensure that lessons from the pilot inform government policy on support to vulnerable families. The pilot will also test – in a few villages – a new transfer mechanism to reduce the burden on communities and ensure that funds reach the intended beneficiaries.

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[1] This Concept Note was prepared by Samantha de Silva (HDNSP, World Bank) with input from Myrtle Diachock (SDV, World Bank) and David Evans (AFTRL, World Bank).

[2] See TACAIDS (Tanzania Commission for AIDS), *UNGASS Country Progress Report: Tanzania Mainland*, 30 June 2008.

[3] From 2.4 million in 2005 to 2.5 million in 2010 (UNICEF & UNAIDS 2006).

[4] See Beegle, Kathleen, Joachim De Weerdt, and Stefan Dercon, "Orphanhood and the long-run impact on children," working paper, September 2005.

[5] Social funds are multi-sectoral programs that provide financing (usually grants) for small-scale public investments targeted at meeting the needs of the poor and vulnerable communities, and at contributing to social capital and development at the local level (Social Funds Website, www.worldbank.org/socialfunds)

Conditional cash transfer programs provide grants to poor and vulnerable families contingent upon specific family actions, usually investments in human capital such as keeping children in school or taking them to health centers on a regular basis. There is clear evidence that successful CCT programs increase enrollment rates, improve preventive health care, and raise household consumption of beneficiaries (World Bank Safety Nets Primer 2005).

The community-driven development approach, which gives control to community groups and local governments over planning resources and investment decisions, has been shown to improve the effectiveness and efficiency of service delivery, and many social funds rely on and build community capacity for delivery of a range of social and economic services.

As observed in CCT programs in Latin America and South Asia, considerable central level capacity is required to administer a system of cash transfers to millions of poor households (and to ensure that funds are utilized properly). Since central level capacity is limited in Tanzania, the pilot aims to leverage the management capabilities of the Tanzania Social Action Fund (TASAF) to oversee the program and the capacities of community organizations strengthened during the first phase of TASAF to implement the cash transfer system. Communities supported under phase I of TASAF have already successfully managed sub-projects (e.g. construction/rehabilitation of basic health-care facilities, schools and other small-scale infrastructure), giving them experience in managing funds, employing contractors and labor, reporting, and monitoring. It is envisaged that lessons from the pilot will potentially have broad operational implications both for low capacity countries and for the Bank supported social fund portfolio.

In the community-based CCT pilot, the community organizations will be expected to handle much of the activities related to implementation of the cash transfer system (activities usually assumed by a centralized administration in other CCT programs), including:

- Screening of potential beneficiaries
- Communicating program conditionalities to potential beneficiaries
- Transferring funds to individual beneficiaries
- Applying peer pressure for compliance with the program conditionalities

3. Poverty and Vulnerability Targeting

As noted, the CCT pilot will be implemented in the districts and villages targeted under TASAF I. TASAF 1, which began implementation in 2000, targeted the poorest and most vulnerable districts of Tanzania, using a rigorous selection process. Regions were ranked using several indicators (poverty level, food insecurity, primary school gross enrollment ratio, access to safe water, access to health facilities, AIDS case rates, and road accessibility). Districts were then prioritised within the regions using an index of relative poverty and deprivation constructed using data from the 1992 Income and Expenditure Survey. In addition, participatory assessments were conducted during project preparation to gain an understanding of the coping strategies used by the poor.

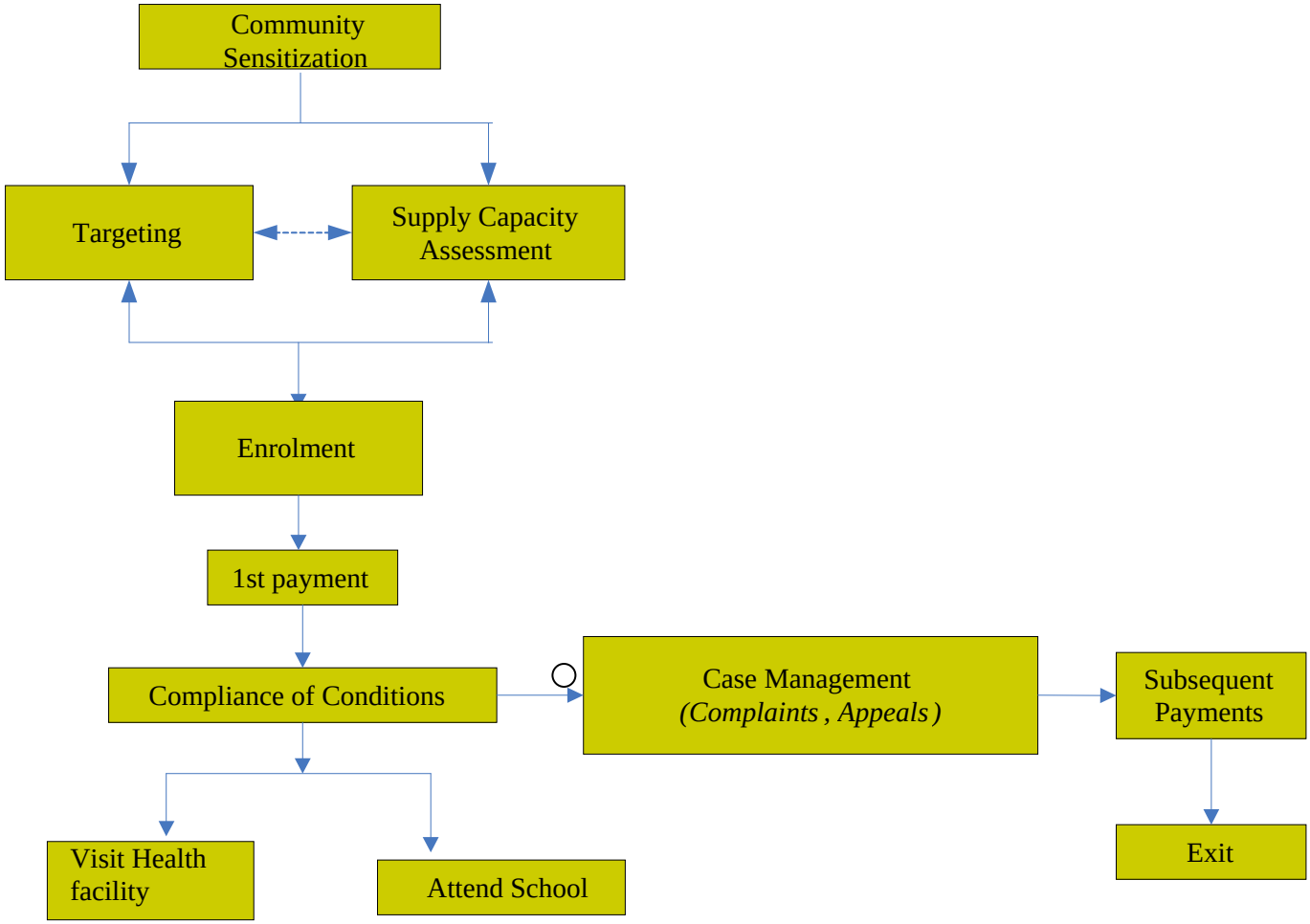
At the household level, eligibility criteria for beneficiary households are based on household characteristics of the very poor that were defined by communities themselves through focus group discussions. The criteria are that the households be: (a) very poor, (b) not receiving similar benefits in kind or cash from another program, and (c) home to an elderly person (60+) or an orphan or vulnerable child (OVC). "Very poor" was defined by stakeholders as a household meeting at least three of the following characteristics: (1) lack of a basic dwelling or shamba; (2) difficulty having two meals per day; (3) no adult member has worked in the last month; (4) children with clothes/shoes in poor condition; (5) family does not own livestock; and (6) family does not own land.

4. Coverage

The CCT pilot will operate in three districts – Bagamoyo (70 km from Dar es Salaam), Chamwino (500 km from Dar), and Kibaha (35 km from Dar). The pilot will cover 80 villages (40 treatment and 40 control) and around 2,000 households, for a total of approximately 6,000 individual beneficiaries. All 80 villages within the three districts have community management committees that received financial training from TASAF and have successfully managed at least one TASAF-supported project. The villages will be randomized into treatment and control groups, stratified on village size and district. In other words, among villages of a similar size and in the same district, each village will have an equal likelihood of becoming a treatment village (i.e., getting the cash transfers) or becoming a control village (i.e., does not receive the cash transfer). This maximizes the likelihood that treatment and control villages are similar in unobserved characteristics as well as the measured characteristics.

5. Project Cycle and Key Stages of Implementation

The community based CCT project cycle is outlined below.



Key stages of the CCT process are elaborated below.

(a) Community Sensitization and Supply Capacity Assessment: Prior to targeting of beneficiaries, an extensive communications and training program on the CCT program will be conducted by TASAF at the regional, district and community levels. Additionally, local government authorities will need to assess the capacity of primary schools and health facilities, to ensure that they can meet the expected increased demand for these services, since the CCT pilot requires beneficiaries to comply with education and health conditionalities (i.e. regular attendance at primary school by OVCs, and occasional visits to the health centers by all beneficiaries, as stipulated in the section on conditionalities below). The program is also exploring the possibility of coordinating with other donors and foundations (e.g. the Clinton Foundation, UNICEF) who could work to strengthen the capacity of health centers and primary schools in the pilot areas.

(b) Targeting - the targeting process aims at identifying, selecting and prioritizing the poorest and most vulnerable households. Rather than using a centralized system for identifying the most vulnerable on a nation- or district-wide basis, the social fund will rely on the community's knowledge to target the vulnerable at the village level.

Targeting will be done by the community management committees under the oversight of the Village Council, using screening forms designed to identify vulnerable children and elderly based on the following criteria, which were defined by the communities themselves:

Vulnerable children are defined as follows:

1. One parent or both parents deceased, or
2. Abandoned children, or
3. Having one or two chronically ill parents (e.g. HIV/AIDS), or
4. Chronically ill children despite having two parents alive.

Vulnerable elderly are defined as follows:

1. Elderly with no caregivers
2. Poor health
3. Very poor

TASAF will perform proxy means testing on a sample basis to ensure that beneficiaries targeted qualify.[6] Validation of the list of eligible households will be done by the Village Assembly. Priority ranking of households will be conducted in the event that the number of beneficiaries exceeds available resources, along the following criteria:

First priority:	Households with a child as head of the household
Second priority:	Households with an elderly person as a head of the household
Third priority:	Households with only elderly persons

Random selection of the control and treatment villages will be done after vulnerable households have been identified in all 80 villages, in order to ensure comparability between vulnerable households identified in the treatment and control groups.

(c) Enrolment of beneficiaries will be carried out in each village, with the enrolment process lasting one to three days, depending on the total number of beneficiary households in the village. The enrolment team will identify who will receive payments in a household, update family information, link children and elderly with schools and health centers, provide an orientation session on the program and provide identify cards. Data collected during enrolment will be entered into the MIS system, which will generate the lists of beneficiary households.

[6] The term "proxy means test" is used to describe a situation where information on household or individual characteristics correlated with welfare levels is used in a formal algorithm to proxy household income, welfare or need – World Bank LSMS Working Paper 118, 1995

(d) Payments and Flow of Funds – Payments to beneficiary households will be made bimonthly (every two months), ranging from $12 minimum to $36 maximum depending on the number of people in the household. These figures are based on the food poverty line[7], and calculated as follows:

US$ 3 per month for orphans and vulnerable children (50% of food poverty line)
US$ 6 per month for elderly (100% of food poverty line)

Funds will be routed to the communities either through the local government authorities or directly to the community, depending on the capacity of the local government. The governance picture in Tanzania varies widely, with some local governments having sophisticated planning and budgeting processes, while others with low capacity having inadequate planning and budgeting capabilities. In districts where the local government is LGDCG-compliant[8], payments will be disbursed by TASAF to a bank account managed by the local government authority, who will disburse the funds directly to the community-managed accounts. If the local government is not qualified to receive capital development grants, TASAF will disburse the funds directly to the community-managed accounts. The community management committees will then be responsible for making payments to individual beneficiary households.

The project is also planning to leverage the emergence of cash transfers through mobile phones, most popularly established in Tanzania through Vodacom's M-PESA program. M-PESA could be used either to transfer funds directly to communities, who would then transfer the cash to households, or to transfer funds to the households themselves. The advantage of transferring funds directly to the households is that the risk of theft is significantly reduced; the disadvantage is the requirement of a degree of technological literacy. We are working with the project development department at M-PESA to see how this technology could potentially be applied in the program, in which case it would be piloted in a few villages. If successful, this technology could represent a significant improvement in getting benefits directly to households.

(e) Conditionalities and Monitoring Requirements - The role of conditionalities is to ensure that children go to primary school, and that both the elderly and children visit health facilities, fostering long-term improvement of their education and health indicators. Conditionality and monitoring requirements are shown in the matrix below.

[7] The food poverty line in Tanzania, based on minimum caloric requirement for 28 days is T.Sh. 6,631 or approx. US$6 (2006 figures). Source: "Cash Benefits in Low-income Countries: Simulating the effects on poverty reduction for Senegal and Tanzania". Franziska Gassmann and Christina Behrendt. International Labour Office. May 2006.

[8] Tanzania's Local Government Development Capital Grant (LGDCG) system provides financing to local governments for local capital improvements, conditioned on LGAs meeting minimum requirements which ensure that the funds transferred to them are properly used (allowing them to be certified as LGDCG-compliant).

Sector	Beneficiary	Conditionality	Frequency of Required Compliance	Frequency of Compliance Monitoring
Education	All beneficiary children 7 -15[9] years	Admission in primary school	Once a year	Once a year after the enrolment period ends, by filling out compliance form
	All beneficiary children 7 -15 years	Individual attendance	80% attendance of total school days	At the end of each trimester (3 times a year) by filling out compliance form
Health	Children 0 - 5 years	Visit to health facility to monitor growth	Three times a year	At the end of each visit (3 times a year) by filling out compliance form
	Children 0 - 2 years	Vaccination and growth monitoring		
	Elderly (60+ years)	Visit to health facility for basic check and orientation	Once a year	At the end of annual visit by filling out compliance form

Monitoring of conditionalities will begin after the first payment is disbursed to beneficiaries, and will be done for a period of four months. The monitoring process is conducted by TASAF and the community management committees, with support from the schools, health centers, and district staff. Monitoring forms will be completed by the schools and health centers, collected by the communities, and delivered to TASAF (through the district authorities) where monitoring data will be entered into the MIS system, and the payment list generated.

If beneficiaries fail to comply with the conditions, a warning will be issued to them by the community management committees. This, however, will not affect their second payment, which will be paid in full. If after the next period of monitoring (8 months after the first payment), beneficiaries still fail to comply with the conditions, payment will be reduced by 25% and a second warning will be sent. After two warnings are issued, beneficiaries that fail

[9] In Tanzania, school registration is required by law, and children can register to enter primary school until they are 12 years of age, after which they continue to progress through each grade.

to comply will be suspended indefinitely, but allowed to return to the program after review and approval by the communities and TASAF.

The community management committees play a key role in monitoring conditionalities as they are responsible for collecting the monitoring forms from the schools and health clinics, and will need to conduct awareness sessions for the beneficiaries on a regular basis. They will also need to make regular home visits to stay abreast of developments in beneficiary households in order to update the records as changes occur in the households, and deliver warnings when conditionalities are not being met.

(f) Case Management covers the range of appeals, complaints, and other issues arising during the course of the program. Households that believe they meet the beneficiary criteria and were unfairly excluded from the pilot can appeal to the local government authorities or TASAF. Beneficiaries can submit complaints to TASAF and the local government authorities on issues relating to payments, quality of education and health care services, and management of the program by community members, local government or TASAF staff. Other social welfare issues that come to light through the program (for example, violence or abuse in the households) will be referred by the community communities to the relevant government ministry representation at the district level using existing procedures for dealing with such issues.

(g) Exit policy for Beneficiaries - Households will be in the program for the duration of the pilot provided that they comply with the conditions. They can also leave/or may be asked to leave the program for the following reasons:

- If they decide to opt out and inform the community management committee
- If the household no longer has an elderly person or a child at least under 15 years old in primary school
- If household members fail to comply with conditions after a warning has been issued three consecutive times for children, and two consecutive times for the elderly
- If they move permanently to another village where the program is not operating
- If the household representative has presented false information related to eligibility and/or committed fraud against the program.

6. Pilot Monitoring and Evaluation

Routine monitoring and reporting activities will be carried out as part of implementation by TASAF and local government authorities, with input from communities, to ensure that activities are being carried out as planned, proper targeting has taken place and funds are properly disbursed. As mentioned earlier, random ex-post audits will be conducted in the villages on a sample basis to ensure that the beneficiaries who have been targeted qualify for the program. TASAF will submit quarterly financial management reports, and will conduct semi-annual audits of community accounts. TASAF is subject to independent financial audits led by the Auditor General, and also undertakes systematic process and technical audits (all of which have been highly satisfactory to date). Monitoring of conditionality information provided by the community management committees will be randomly cross-checked against submissions from the schools and health facilities.

Community Score Cards: A new and innovative module on Community Score Cards (CSCs) will be used as part of the intervention itself so as to enhance the accountability and process monitoring of the CCT roll out. CSCs are simple community monitoring tools that blend different participatory monitoring approaches and social accountability techniques (such as social audits and citizen report card surveys) together. They have proven to be powerful instruments to exact accountability and promote transparency in rural contexts[10]. The CSC process consists of four elements:

(a) *Input tracking* **–** in which a mini social audit is undertaken at the community level that attempts to match project/program inputs with actual outputs and disbursement. In the context of the CCT pilot it would mean tracking disbursements and timing of CCTs to stated beneficiaries and cross-checking targeting efficiency. For the schools and health centers themselves, it would track key infrastructure and materials that are available (e.g. classrooms, medicines, medical equipment, etc.);

(b) *Community performance scorecard* **–** in which different focus groups (e.g. CCT beneficiaries, non-beneficiaries, youth, elders, men, women, etc.) in each community all rate the performance of different elements of a program (in this case the CMC management, CCT system or the school and health facilities participating) on different performance criteria (this could include criteria such as transparency, fairness, timeliness, adequacy, etc.), as well as the services being provided (are there teachers, health personnel, supplies, medicines, etc.);

(c) *Self-evaluation scorecard* - the community management committee that is administering the CCT and the schools and health centers participating in the program themselves give a self-assessment of how they see the system to be performing (these could end up being similar to the criteria above, but normally one always finds that providers rate themselves differently compared to beneficiaries); and

(d) *The interface meeting* - providers (CMC, health staff, school teachers, etc.), and the community are finally brought together to share their results, discuss the findings, and come up with some joint planning on how to make the process work better. This action plan can then feed back to TASAF management and perhaps help modify the operation of the pilot in subsequent rounds.

The use of CSCs in the context of the CB-CCT pilot is warranted for several reasons. Firstly, given that the administration of the CCTs will be community-based, it is also important to have a monitoring and accountability mechanism at the community level that can help to ensure transparency and oversight on the process. Secondly, as this is a pilot that is testing the CB-CCT model for the first time, there will be a need to have a regular feedback mechanism on the process from the grassroots level. Thirdly, the CSCs will provide a simple evaluation of the quality of health and school facilities that can supplement the supply side capacity assessment. Finally, the CSCs will also provide information relevant to both the

[10] See for instance Bjorkman, M. and Svensson, J.: *Power to the People – Evidence from a Randomized Field Experiment of a Community Based Monitoring Project in Uganda*, World Bank Policy Research Paper 4268, June 2007.

impact and process evaluations, and will, in and of themselves, provide a means for empowering vulnerable households besides the cash transfers.

Since CSCs have already been used by TASAF in the context of monitoring for their sub-projects, the same model will be applied in the context of the CB-CCT pilot. The facilitation will be managed by the Local Government Authorities in partnership with TASAF and will cover all treatment communities.

Impact and Process Evaluation – Given that this is the first time that a social fund agency is being used to implement a CCT program in Africa, and the first time that a CCT program is being delivered using a CDD approach, a thorough and rigorous impact and process evaluation will be conducted. A quantitative impact evaluation will be coupled with a qualitative examination of how the program and the role of the community therein affect community dynamics.

The primary objective of the impact evaluation is to test the combined effectiveness of a CCT program in Tanzania, and the use of the CDD model to administer the program.[11] The impact evaluation will examine the effectiveness of the pilot in improving health, educational and nutritional outcomes and assess the impact on community well-being. A baseline survey will be conducted in 40 treatment and 40 control villages, to be followed by two rounds of surveys as implementation progresses. The qualitative assessment will shed additional light on the mechanisms and the social dynamics behind the changes in outcomes.

The process evaluation will examine the use of a CDD model in administering the CCT program by looking at the quality of community-based targeting and fund management. It will also serve to assess the availability of health and education services, and evaluate the cost effectiveness of the program. The processes used in the pilot will be documented as it proceeds, identifying necessary changes needed for scale-up and replication.

Lessons from the impact and process evaluation will have direct relevance for a portfolio of thirteen social fund programs in the Africa region totaling US$1 billion, and will also influence the Bank's Social Funds and CDD operations across all regions as they consider how to improve the effective use of critical public services. This pilot will also inform any country which is considering a CCT program but where centralized administrative capacity is limited

[11] Note on Proposed Community-Based CCT Pilot Evaluation Design, David Evans, June-wei Sum, October 2007.

7. Implementation Plan

Timing	Activity
November 2007 – September 2008	Program Design (completion of Operational Manual, set up of MIS, preparation of guidelines, forms and materials for training activities)
September - November 2008	Sensitization at regional, district, ward and community levels
October - November 2008	Targeting activities (field data collection, data entry and community validation of beneficiaries)
October - November 2008	Training on targeting of district officers and community management committees
September 2008 – February 2009	Development of impact evaluation survey samples and baseline questionnaire; field data collection
February - March 2009	Pilot Launch – enrolment of beneficiaries (program to run 2.5 years, till end-December 2010)
May 2009	First payments made to beneficiary households
December 2009	Impact evaluation (1st questionnaire, one year after baseline)
December 2010	Impact evaluation (2nd questionnaire)
December 2011	Completion of pilot

8. Sustainability

Sustainability of the pilot can be assessed at two levels: (a) beneficiary level – will beneficiary well-being improve as a result of the program? (b) program level – will the community-based CCT model be sustainable in Tanzania in the long run? It is assumed that access to educational and health services will improve human capital at the individual level in the long run. Additionally, the pilot will test several mechanisms for improving the skill levels of individuals who have been in the program for a given period of time and training in literacy and vocational skills will be provided to the beneficiaries as complementary activities. Building the capacity of existing community institutions (community committees, village councils, and village assemblies) should also have a lasting impact on the communities.

Support to Livelihoods: As a way of promoting long-term sustainability, the project will develop a savings and loan component that enables people living in the pilot villages to join small savings groups. Those receiving CCTs may use all, or a portion, of their transfers for their contributions to the group's savings. Group members may use their savings to make loans to members, and some of those loans may be for the development of small economic activities. In this way, group members will gain experience with money management as well as with the development of their livelihoods. As the groups gain experience with managing their own financial resources, they may become attractive to (and attracted to) financial institutions operating in the project area. Efforts will be made by the community leadership to introduce households within this program to the variety of financial institutions in the area (e.g. Savings and Credit Cooperatives, Financial NGOs, Banks, etc.) and to link households to the institution of their choice. Such linkage would provide the groups with access to more financial products, which in turn could be of benefit to their livelihoods.

At the program level, TASAF has expressed strong interest in promoting CCTs as a way of targeting the most vulnerable, and if the pilot is successful TASAF is committed to scaling up the model to cover all the villages in which it works. The government of Tanzania is interested in learning from this model and using it in its efforts for broader poverty reduction.