PROPOSED PILOT EVALUATION DESIGN
Community-based Conditional Cash Transfer Pilot
Tanzania Social Action Fund (TASAF)

1. Description of CCT Pilot

The objectives of this pilot are to test how a conditional cash transfer (CCT) program could be implemented through a social fund using a community-driven development (CDD) approach, seeking to mitigate some of the principal impacts of the HIV/AIDS crisis on children and the elderly. This CCT program, similar to other CCT programs, will provide grants to poor and vulnerable households contingent upon specific household actions: keeping children enrolled in and attending school and taking them to health centers on a regular basis. This CCT also stipulates that elderly persons visit health centers regularly, albeit less frequently than the young children. Recipients will receive between US$12 and $36 every other month, depending on the number of children and elderly in the household. These amounts were arrived at in consultation with Tanzania Social Action Fund (TASAF) representatives and are designed to make up 100% of the most recently available per capita food poverty line for adults (and 50% for children, presuming that children consume less than adults).[1]

This CCT pilot distinguishes itself in leveraging the central management capabilities of TASAF as well as the capacities of community organizations to deliver a CCT program. The Government of Tanzania (GoT) identified TASAF I-supported communities as the best places to pilot a community-based CCT program: these communities have previously received financial management training, they have successfully managed TASAF-funded sub-projects in their communities, and they have experience in monitoring and managing contractors. Community Management Committees (CMCs) in these communities will play several roles usually played by a centralized administration in CCTs: they will identify the recipient households, communicate the project conditionalities, monitor compliance, and manage the cash transfers.[2]

The pilot aims to focus on the poorest and most vulnerable districts, villages, and households of Tanzania. This is achieved by confining the pilot to districts and villages that received a TASAF I intervention. Ranking of regions was undertaken during TASAF I to determine the number of districts that would be assigned to participate within each region. Regions were selected using various indicators of poverty (e.g., poverty level, food insecurity, primary school gross enrollment ratio). Within the regions, districts were prioritized using an index of relative poverty and deprivation constructed using data from the 1992 Income and Expenditure Survey. TASAF I this way targeted vulnerable districts, and this program builds on that by focusing on a collection of villages identified by TASAF I administrators as being among the poorest in the program.

[1] Project dates for TASAF I are from Nov 2000 – June 2005; for TASAF II, from Nov 2005 – June 2010.
[2] Conditionality is "soft": households receive two warnings for non-compliance over eight months before a proportion of their benefits are withheld. At least one *un*conditional cash transfer program has showed significant impacts on physical and cognitive development: see Paxson and Schady 2007

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 household 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 providing 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.

The GoT is interested in scaling up this program, and the training and experience received by TASAF I communities are being expanded from 40 districts and 2 islands in TASAF I to all of Tanzania's 123 districts and 2 islands in TASAF II. Thus, the lessons from this pilot will directly inform the potential scale-up. In addition, we will use data from the nationally representative Tanzania household budget survey (last administered in 2001) to identify how program households and villages compare with national averages to further inform scaling considerations.

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 CDD 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.

Lessons from an impact evaluation of this pilot will have direct relevance for the portfolio of 13 social fund programs in the Africa region, totaling US$1 billion. This pilot will also inform any country which is considering a CCT program but where centralized administrative capacity is limited. It complements other efforts to test the effectiveness of cash transfer programs in Africa, such as the proposed evaluations of an unconditional cash transfer project in Zambia and a mixed conditional/unconditional project in Burkina Faso; but this project offers unique insights on using communities to identify target households and to monitor compliance with conditions. The quantitative impact evaluation is tied to a qualitative examination of how the program and the role of the community therein affect community dynamics and a process evaluation to illuminate the mechanisms by which the program has its impacts. As the first combined CDD-CCT effort, a high quality impact evaluation is needed for this pilot to inform future efforts not only in Tanzania, but also the future cash transfer programs globally.

2. Objective of the Evaluation and General Evaluation Approach

The primary objective of this evaluation is to test the combined effectiveness of (a) a CCT program in Tanzania and (b) the CDD model of administering a CCT program. If either of these parts fails, then the CCT will be ineffective in improving outcomes for

vulnerable households.[3] In order to assess how effective the program is in accomplishing improved conditions for vulnerable households, the impact evaluation will seek to answer the following research questions in this novel context with limited central administration capacity (as is the case in much of Sub-Saharan Africa):

- What is the impact of CCTs on health for vulnerable children and the elderly?
- What is their impact on education for vulnerable children?
- What is their impact on consumption for vulnerable children and the elderly?
- What is their impact on pre-existing informal solidarity systems for vulnerable households?
- What is the impact of a community managed version of the CCT program on community dynamics?

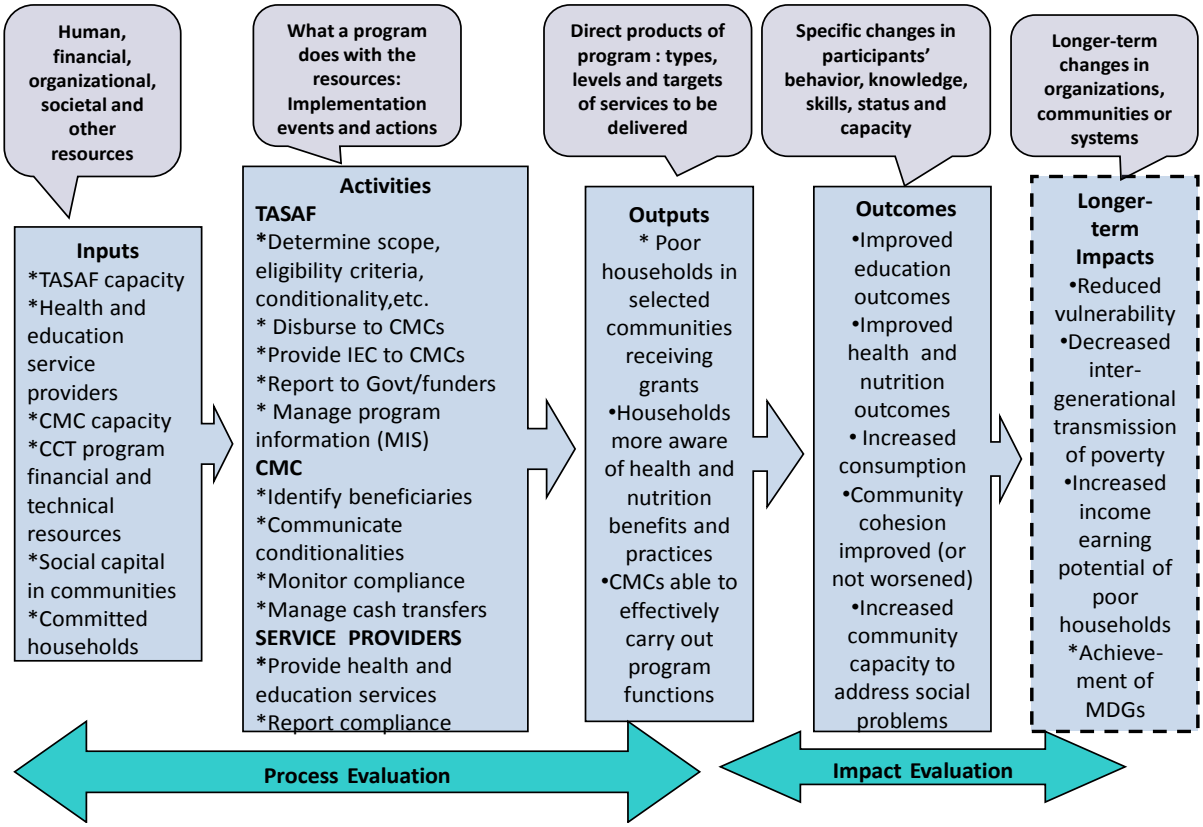
The question underlying most of the questions above is *whether this community-based model of conditional cash transfers is effective at achieving health, education, and consumption gains as has been the case of more centrally administered models used elsewhere.* These research questions are derived from the CCT program's logic model, a schema of which is presented in Box A. In this model, a set of inputs are translated through program implementation into the delivery of conditional grants to a specific number of Tanzanian households. These outputs may then affect participant's behavior in terms of health and education outcomes, increased consumption, changes in attitudes toward education and health services, and beyond the household, to a strengthening of community social capital, and other broader effects. If successful the program would contribute over the longer-term towards societal goals like the reduction of vulnerability, achievement of the MDGs, and a reduction in the intergenerational transmission of poverty, though these longer term effects are beyond the timeframe of this evaluation.

Given the importance of the program as a potential flagship for other social protection programs in Africa, the evaluation would focus on three main areas:

- **Household-level outcomes**, including program impacts on health and education of household members and related impacts in the areas of employment and time use, consumption, transfers and savings, and household-level decision-making, attitudes and preferences;
- **Community dynamics,** including program effects on social capital and potential conflicts, traditional solidarity systems, quality and utilization of services and perceptions of service providers, and other community-wide impacts; and
- **Program processes,** including the effectiveness and efficiency of its operations, activities, use of resources, and so forth. This would be particularly important in identifying any implementation issues to be addressed at program scale-up.

[3] Ideally, we would test the effectiveness of each of these separately: however, due to the lack of a strong central administration to manage a CCT program in Tanzania, all participating communities will use the CDD model.

Box A: Tanzania CCT Basic Logic Model



3. Evaluation Methodologies

Quantitative Impact Evaluation

The project uses randomized assignment of the program at the village level, ultimately relying on comparing the changes in outcomes of beneficiary households in 40 randomly selected treatment villages over time to those of households that *would be* beneficiaries in 40 control villages. Impact evaluation communities will be drawn from Bagamoyo, Chamwino, and Kibaha districts. There are 80 villages within those three districts that have managed at least one TASAF-supported project and – in that context - have training and experience in financial management, monitoring, and implementation of small-scale infrastructure. We have met with representatives of the GoT and they have approved this plan; they will not be rolling out programs in the next two years that will specifically target the control villages. (In the case of some unforeseen contamination, an alternative strategy is to take advantage of the community ranking of vulnerable households and use a regression discontinuity approach to evaluating the impact of the cash transfers.)

In each community participating in the impact evaluation, we will hold meetings to ensure understanding among participant households and community leaders about the purposes of the impact evaluation (i.e., to increase knowledge and inform future

planning) and the reasons that the treatment cannot be universal (the program does not have resources to benefit all villages). Discussions with TASAF leaders suggest that even villages not benefiting from the cash transfers have received significant benefits from TASAF in the past and so are likely to participate in the data collection exercises.

The selection of treatment and control households will follow the following process:

Phase 1: Selection of program villages. In this phase, the team will compile village-level information on the size of villages, the existence of the infrastructure necessary to accommodate the increase in demand (for example, in school enrollment or health clinic usage) that a CCT will induce, and the experience and quality of CMCs, as will be necessary to stratify the sample and to ensure that the villages are suited to the requirements of the CCT and to the enforcement of the program conditions. The sample of villages must have enough geographic heterogeneity to ensure that treatment and comparison villages will not be adjacent after random assignment. This is important to avoid extensive migration or other confounding of the treatment and control villages. If some of the 80 villages do not satisfy these conditions, we will draw on available villages from adjacent districts to fill the sample without expanding operational costs.

Phase 2: Identifying eligible households. In this phase, the potential beneficiaries in all program villages (not yet divided into control and treatment communities) will be identified. CMCs and village councils will prepare ranked lists of households based on the criteria for vulnerable households which have been determined in discussions with TASAF communities *before* the villages are assigned as treatment and comparison villages. These lists will inform the selection of recipient households in treatment villages and of households for data collection in control villages. Extensive discussions with TASAF officials suggest that clear communication from the start that not all villages can participate will help to manage expectations to minimize tension that could arise if hypothetical beneficiaries never become actual beneficiaries.

Phase 3: Selecting the treatment and control villages. Once eligible households have been identified in all 80 program villages, 40 villages will be selected at random. Random selection will be stratified on known village characteristics (such as sub-district and village size) to ensure comparability between treatment and comparison villages.

Phase 4: Selecting the treatment and control households. The design team will use the total share of the eligible population across all selected communities to ensure proper coverage among all treatment communities. CMCs will receive a cap of how many households in the community can participate in the program based on a combination of village population and poverty map projections.

Phase 5: Data collection. Once all communities are assigned into the treatment or comparison groups, sampling for data collection can begin. Through power calculations, we have identified the need to interview an average of 25 households per village.[4] In

[4] With a total of 80 participating villages (40 treatment and 40 control) and an effect size of 0.20, we expect to need to interview 20 households per village in order to achieve 80% power. We recommend

cases where participating households (i.e., households that *would* receive treatment, whether in a treatment or control community) do not exceed that number, the team will interview the full sample of target households. Alternatively, in communities with more participating households, the team will collect data on a random sample of households to achieve the program-wide average of 20 households per village. We will supplement this household survey with administrative data on child school attendance gathered from local schools and on health care from local clinics.

Household indicators will be supplemented with a short module of community indicators. We will gather information on the education and employment of community leaders as well as their effectiveness in mobilizing the community (e.g., by measuring the number of community meetings and the number of projects carried out by the community). This information will both indicate how the program affects community leadership and demonstrate how pre-existing community capacity (at baseline) affects program impacts. Further details on household and community survey content are provided in Section 4-6 below.

Qualitative Fieldwork

This evaluation also calls for the use of qualitative evaluation methodologies, making it a mixed-method evaluation. The qualitative and quantitative approaches are complementary, and their integration is an important characteristic of the evaluation design. This follows international best practice for CCT programs specifically and program evaluation more generally. Qualitative research offers a number of strengths for evaluating conditional cash transfer programs that survey methods do not. Qualitative methods are used to understand program impacts that are harder to measure through a quantitative survey: for example, changes in social relations and community dynamics resulting from a program intervention, intra-household and gender issues, how people view and interact with local program agents, and why and how participants respond to the program design, incentives, training, or other implementation aspects.

For purposes of the CCT pilot, the methodology proposed is one of a series of focus group interviews in a small number of treatment communities.[5] Focus group interview

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interviewing 25 households per village since not every household will have vulnerable children: some few households may only have vulnerable elderly. This assumes 95% confidence levels for statistical significance and an intra-cluster correlation of 0.05. Evaluations of conditional cash transfer programs elsewhere have found effects of this size. For effects of this magnitude on health and education outcomes in a Nicaraguan CCT, see Rawlings & Rubio, "Evaluating the Impact of Conditional Cash Transfer Programs," *World Bank Research Observer*, 20(1):29-55, 2005, Table 6. For Mexico's PROGRESA program, see effect sizes on child height in Behrman and Hoddinott, "An Evaluation of the Impact of PROGRESA on Preschool Child Height," Food Consumption and Nutrition Division Discussion Paper, IFPRI, March 2001. See effect sizes on longer-term schooling outcomes in Behrman, Sengupta, and Todd, "Progressing through PROGRESA: An Impact Assessment of a School Subsidy Experiment in Rural Mexico," *Economic Development and Cultural Change*, 54: 237-275, 2005.

[5] If resources become available, other CCT programs have used ethnographic approaches, where researchers are embedded in a small number of communities to observe key program implementation events and interact with a small number of beneficiary households to more closely observe program dynamics within a village and within households (see Adato2007).

methods are particularly well-suited for understanding how people think or feel about a program, getting reactions to pilots before large amounts of money are spent in implementation and evaluating how well programs or projects are working and how they might be improved (Casey et. al. 2001).

About 6 focus group villages would be selected from the same sample frame as the household survey treatment communities, with purposeful selection of villages by general characteristics (e.g. rural/urban, ethnic group, geographical location, successful/less successful at program implementation, etc.), looking for variation of experience rather than statistical representativeness. Rather than have one community-wide focus group, where there would be power and incentive differentials among participants that might preclude effectively eliciting in-depth information, in each focus group village, there would be several separate focus group interviews carried out representing similar groups of key stakeholders: (a) beneficiary families, (b) non-beneficiary families (c) health and education service providers, and (d) CMC members. This will also allow for triangulation of viewpoints between the groups.

Following best practice on focus group interviews, these groups would be comprised of 6-8 people that are generally representative of the particular segment of the community.[6] Interview guides would steer the process and, to the extent possible, focus groups perceptions of quality and program performance would be expressed through quantifiable ranking exercises, where appropriate. The researchers would develop a systematic approach to recording and analyzing data. Issues and questions to be addressed using these qualitative methodologies are further discussed in Sections 4-6 below.

This research proposal calls for two rounds to focus group interviews, corresponding to the two rounds of the household survey. Gathering beneficiary perceptions and insights on community dynamics after the first year of operation will provide an important input into any needed program adjustments during the pilot phase. The second round ideally would be carried out after preliminary results are available from the household survey to allow for a richer discussion and the explicit linking of focus group topics to areas that may require more in-depth explanations. It would also allow for feedback to the community and local program implementers of the preliminary evaluation findings and development of pertinent recommendations.

Administrative Data

Basic administrative data will be collected both from TASAF through its Management Information System as well as from CMCs and health and education service providers in the sampled communities using the standard reporting formats to be developed for the program. Data areas include program and component costs, timeliness of transfers,

[6] TASAF is currently implementing Community Score Cards as a monitoring and accountability tool. A CSC tool could also be adapted for the CCT program and is under discussion with program managers. If the CSC tool is adopted for the CCT program, the focus group interviews of service providers and beneficiaries could be dovetailed into this process.

implementation of information, education and communication activities, community and household profiles available ex-ante, and activity records of CMCs. Much of this data will be used to inform the process evaluation which is discussed in further detail in Section 6.

4. Household-Level Impact – Issues and Indicators

In order to measure changes in the areas covered by the impact questions, relevant indicators will be measured for education, health, consumption, and transfers (see indicative set of outcome indicators in Annex 1). For education, each child's current school enrollment, a measure of frequency of attendance, their current standard and their standard the previous year (to measure grade progression), and end-of-year test scores will be measured. If enough households have children ages 5 to 8, we will estimate the impact on age at school entry, which can be relatively late in Tanzania. In health, information on clinic visits, recent episodes of disease or illnesses and the steps taken to treat them, the ability to perform daily activities (for the elderly, it can be very indicative of their health to ask if they can, for example, use the bathroom by themselves, walk a certain distance by themselves, and so on) will be gathered. For children, we will also gather information on height and weight to check for malnutrition: short-term malnutrition leads to reduced weight (for a given height), called "wasting," and longer-term malnutrition leads to reduced height (for a given age), called "stunting." (Over the time period in this study, we expect clearer impacts on weight than on height.) Several questions will be included to quantify household perceptions of the importance of education and health activities and the quality of local service providers.

For consumption, we will measure of the number of meals consumed as well as how much and what kinds of foods individuals consume each day, as the transfers are likely to directly affect household food consumption. Cash transfers are also likely to affect whatever systems already exist to transfer assistance to the poor. We will gather data on cash and in-kind transfers received by beneficiary households in the month previous to the baseline and then later to examine how the magnitude and nature of those transfers may have shifted in response to this external program. We will also ask about vulnerable households' savings to see whether the transfers allow the households to build a buffer against adverse shocks.

In addition to the quantitative data from the household survey, the focus group interviews will be used to collect complementary information on program impacts at the household level. Issues to be explored include: beneficiary views on program effectiveness and impact, perceptions of timeliness and amount of transfer, use of time use trade-offs for children, possible effects on intrahousehold transfers, empowerment effects (e.g. confidence, awareness, changes in household decision-making processes, etc.), motivational factors (besides cash, what might influence the decision of parents to send children to school, or the elderly to make regular health care visits), issues around benefits and compliance directed to orphans, the elderly and other potentially vulnerable household members, work incentives, time demands on women, and changes in attitudes toward the education of girls and women.

5. Evaluation of Community Dynamics – Issues and Indicators

Impacts at the community level will also be queried using both quantitative and qualitative techniques, covering two main areas: (a) general community characteristics and dynamics, and (b) impacts on health and education services. In terms of general community dynamics, the household and community survey modules will measure social capital effects in terms of social cohesion and membership in social and community groups, as well frequency and attendance at meetings, forms of local decision-making, perceptions of trust and number of disputes and crime. The focus group discussions will further probe community dynamics in terms of the relationship of the CCT program to traditional solidarity systems, any changes in social relations within the community resulting from the program, community capacity effect, comparisons of community dynamics between the CCT program and TASAF's community development grant-making experience, as well as community-wide gender and empowerment issues.

In addition to these general community dynamics, the evaluation will explore changes in perception and quality of local education and health services as a result of the program. The household survey will ask about service quality and availability. The qualitative methods will query issues involving provider-user interaction (involvement of CCT beneficiaries and non-beneficiaries in decision making regarding school management/health care provision, perception of discrimination, treatment attitudes, etc. Annex 2 provides full Terms of Reference of the Community Dynamics Evaluation, including a list of sample indicators).

6. Process Evaluation – Issues and Indicators

The previous sections have principally dealt with the impact evaluation, examining the impacts of the program on various quantitative and qualitative outcome measures of child, household, and community well-being. In addition, a process evaluation is an important element in any impact evaluation and will gather output and process indicators to help understand the causal chain between the program design and measured impacts. A program may have positive impacts, but understanding the mechanisms by which those impacts come about depends on a number of intermediate steps. This evaluation will examine whether the CCT program can be effectively administered by CDD mechanisms through various elements of process evaluation. The main issues to be explored include:

- *Quality of targeting*. Fairness, accuracy, and efficiency in the selection of program beneficiaries will be assessed.
- *Information, education and communication (IEC) effectiveness*. The process evaluation will assess the level and accuracy of information that citizens in beneficiary communities have about the program, including understanding and perceptions of program rules and compliance requirements.

- *Transparency and accountability*. The process evaluation will query the effectiveness of the program's fiduciary management as well as community and beneficiary perceptions on procedures for complaints and sanctions.
- *Community management of the program*. The process evaluation will assess performance of the Community Management Committees (CMC) as local program implementation agents.
- *Health and education service availability and effectiveness*. The process evaluation will assess the availability of necessary services to fulfill the CCT conditions (e.g., availability of places in school for students to attend and health personnel to carry out health monitoring) and their perceived overall quality.
- *Cost efficiency*. The process evaluation will include a detailed cost accounting, both in terms of program costs as well as additional costs borne by participants in terms of time, travel and foregone family support from children.
- *Operational issues.* The evaluation will look at the timeliness of transfers as well as reporting.

Annex 3 provides full Terms of Reference of the Process Evaluation, including a list of sample performance indicators.

7. Integration, Synergies and Phasing

Integration of Different Methodologies and Instruments

To achieve maximum effect, the different areas of research focus (household impacts, community dynamics and process evaluation) will be integrated into the different methodological instruments rather than being treated as separate evaluations. In this way both the quantitative and the qualitative methods and instruments can be applied to each research area. This will increase the potential value-added of the mixed method approach through triangulation and complementarity. As the same time, foreseeing the administrative data needs of the evaluation at this early point in time will provide TASAF officials with guidance on key indicators and information to be generated through its internal reporting and MIS system. An illustration of this integration is presented in Box B below.

Box B: Integrated Evaluation - Mapping Evaluation Synergies

Methodologies and Information Sources

	Quantitative Data Source: Household Survey	**Qualitative Information** Source: Focus groups Communith Score Cards	**Administrative Data** Source: MIS Program information Facilities records
Household Impact Evaluation	• Education outcomes • Health outcomes • Nutrition measures • Consumption • Savings/transfers • Employment effects • Household perceptions • Trust in local organizations	• Beneficiary perceptions • Time use and trade offs • Work incentives • Empowerment effects • Intrahousehold effects • Changes in attitudes	• Beneficiary registry • Beneficiary compliance records • Transfer amounts
Community Dynamics	• Membership in community groups • Participation in community activities • Perception of service quality	• Effect on traditional solidarity mechanisms • Sharing of benefits • Gender issues • Social tensions/conflicts • Changes in or impacts on CMCs • Community capacity • Perception of service quality/availability	• CMC membership • Service utilization data from schools and health centers
Process Evaluation	• Household poverty levels (targeting) • Regularity and amount of payments • Private costs • Perceptions of CMC performance • Knowledge of program rules	• Perception of targeting fairness • Role and performance of CMC • Perception of program by health and education providers • Complaint and sanction procedures • Service availability	• Program costs • IEC activity registry • Payment processing • Beneficiary compliance, suspension/exit • Operational reporting

Phasing

We plan to gather data on target households in both treatment and control villages at baseline and then again after one year and after two years. Administrative data will be gathered at regular intervals in the course of the two years. Qualitative data will be collected in parallel data rounds, from a sample of the target households as well as key community members (e.g., members of the CMCs) in the same villages as the quantitative data sample. Finally, each round of the household survey will be supplemented with the community module, administered to a community leader.

Proposed Timeline for Impact Evaluation [TO BE UDPATED]

References

Adato, M. 2007. "Combining Survey and Ethnographic Methods to Evaluate Conditional Cash Transfer Programs" International Food Policy Research Institute (IFPRI), Washington, D.C. Q-Squared Working Paper No. 40 November 2007

Adato, M. and T. Roopnaraine. 2004. A social analysis of the *Red de Protección Social*. Report submitted to the *Red de Protección Social*. IFPRI, Washington, D.C

Behrman and Hoddinott, 2001. "An Evaluation of the Impact of PROGRESA on Preschool Child Height," Food Consumption and Nutrition Division Discussion Paper, IFPRI.

Behrman, Sengupta, and Todd, 2005. "Progressing through PROGRESA: An Impact Assessment of a School Subsidy Experiment in Rural Mexico," *Economic Development and Cultural Change*, 54: 237-275, 2005.

Caldés, N., and J. A. Maluccio. 2005. The cost of conditional cash transfers. *Journal of International Development* 17(2): 151–168.

Casey, M.A, J. Donner, S. Kirsch, R. Krueger, and J. Maack, 2001. "Social Analysis: Selected Tools and Techniques". Social Development Papers No. 36, World Bank.

Coady, D., and S. Parker. 2004. Cost-effectiveness of analysis of demand- and supply-side education interventions: The case of PROGRESA in Mexico. *Review of Development Economics* 8(3): 440–451.

Greene, J. Caracelli V. and Graham W, 1989. "Toward a Conceptual Framework for Mixed-Method Evaluation Designs **"***Educational Evaluation and Policy Analysis*, Vol. 11, No. 3 (Autumn, 1989), pp**.** 255-274

IFPRI. 2001a. *Evaluation Design for the Pilot Phase of the Nicaraguan* Red de Protección Social. Report submitted to the *Red de Protección Social.* IFPRI. Washington, D.C.

———. 2001b. *Evaluation System for the Pilot Phase of Nicaraguan* Red de Protección Social: *Baseline 2000.* Report to the *Red de Protección Social.* IFPRI. Washington, D.C.

Paxson, C. and Schady, . "Does Money Matter? The Effects of Cash Transfers on Child Health and Development in Rural Ecuador," World Bank Policy Research Working Paper 4226, May 2007

Rawlings & Rubio, "Evaluating the Impact of Conditional Cash Transfer Programs," *World Bank Research Observer*, 20(1):29-55, 2005

Skoufias, E. 2005. *PROGRESA and Its Impacts on the Human Capital and Welfare of Households in Rural Mexico: A Synthesis of the Results of an Evaluation by IFPRI.* Research Report 139. IFPRI. Washington, D.C.

Annex 1: Baseline survey: outline of questions

1. Household survey

    1.1. Education
        1.1.1. Current school enrollment
        1.1.2. Frequency of school attendance
        1.1.3. Current standard / grade
        1.1.4. Previous year's standard / grade

    1.2. Health
        1.2.1. Recent episodes of illness
        1.2.2. Steps to treat recent illness
        1.2.3. Activities of daily living (e.g., ability to carry water, walk a certain distance)
        1.2.4. Anthropometric measurements (e.g., height, weight, arm circumference)

    1.3. Consumption

    1.4. Transfers & Savings
        1.4.1. Loans to other households (money or in-kind)
        1.4.2. Gifts to other households (money or in-kind)
        1.4.3. Loans from other households (money or in-kind)
        1.4.4. Gifts from other households (money or in-kind)
        1.4.5. Savings in past month

    1.5 Social Capital and Community Capacity
        1.5.1 Frequency of Community Management Committee (CMC) meetings
        1.5.2 Attendance at CMC meetings
        1.5.3 Membership of CMC (number of members, disaggregated by sex)
        1.5.4 Forms of decision making within CMC (vote, consensus, other)
        1.5.5 Village meeting attendance (number, disaggregated by sex and age)
        1.5.6 Number of social groups in village (e.g. women's groups, youth groups)
        1.5.7 Frequency of social group meetings

    1.6 Village Tension
        1.6.1 Number of crimes committed in community in past 6 months
        1.6.2 Number of intra-household disputes (needs to be defined – may be non violent)
        1.6.3 Number of inter-household disputes (needs to be defined – may be non-violent)

    1.7 Process Indicators (to be applied only to treatment group follow-up survey)
        1.7.1 Perceived level of fairness in selection process
        1.7.2 % of beneficiaries that understand compliance requirements

1.7.3 % of beneficiaries who report participating in training activities during last XX months
1.7.4 % of beneficiaries reporting satisfaction with CMC management
1.7.5 % of beneficiaries that report that there was sufficient space to enroll their children in school
1.7.6 % of beneficiaries reporting that health post was open and personnel available the last time they went
1.7.7 Reported amount of last grant received
1.7.8 # of trips related to program compliance in the last month (to calculate private costs)
1.7.9 Time spent in the last month on program compliance (to calculate private costs)

Annex 2: Terms of Reference: Evaluation of Community Dynamics

Objective

As part of the overall evaluation of TASAF's Conditional Cash Transfer Pilot, a component evaluating community dynamics will be carried out. The key objectives are to:

- Assess program effects on social capital, social cohesion and traditional solidarity networks
- Assess any impacts on community capacity and community organizations from the CDD approach adopted; and
- Evaluate program effects on community services, particularly health and education services and service providers.

Such community-wide effects have been noted in evaluations done of other CCT programs. In particular, issues related to potential tensions between beneficiary and non-beneficiary families and added demands on health and education facility staff have been noted. It will be useful to analyze the extent to which these same issues surface, or not, in the case of a more community-managed program.

Methodology and Data Sources

The approach will use both quantitative and qualitative methods, though community-level focus group interviews will provide much of the insights into changes in community dynamics and services. The quantitative survey (household and community module) will measure social capital effects in terms of membership in social and community groups, frequency and attendance at meetings, forms of local decision-making, perceptions of trust and number of disputes and crime. The household survey will also ask about health and education service quality. (see Annex 1).

In addition, the qualitative focus group interviews will probe community dynamics among selected subsets of stakeholders, particularly beneficiaries, non-beneficiaries, community leaders, and health and education service providers. Specific issues to be queried include:

- The creation of any social tensions arising from the selection of beneficiaries
- Ways of mutual aid/existing coping strategies within the community – were these affected by the introduction of CCTs, and if so, how?
- Influence of other village actors on the decisions taken by participants
- Community group dynamics and whether being a CCT beneficiary or not affects relationships with other community group members (i.e. contribution of labor, cash and time to other community activities)
- Possible sharing of benefits with other community members
- Gender issues at the community level, including different perceptions of program effectiveness and impact

- Overall willingness to engage in community actions
- Comparisons of community dynamics between the CCT program and TASAF's community development grant-making
- Changes in or impacts on CMCs with the introduction of the CCT program, which confers household benefits, as opposed to TASAF's community-wide micro-project grants
- Service provider interactions (e.g. involvement of CCT beneficiaries and non-beneficiaries in decision making regarding school management/health care provision, perception of discrimination, treatment attitudes, etc.)

In addition, TASAF has begun implementation of Community Score Cards[7] as part of its routine monitoring procedures. Depending on how advanced TASAF is in the implementation of CSC as a monitoring and accountability tool, CSCs can provide an added source of local level information and perceptions. Specifically, if they are available in the pilot communities, the existing CSCs that monitor health and education services can provide insights into the effects the CCT program has on these services.

Administrative data provided through TASAF's MIS and standard reporting formats with CMCs and service providers will provide information on the conformation, activities and capacity of the CMCs.

Indicators

Table 1 provides potential quantitative indicators applicable to the evaluation of community dynamics, with the data sources noted. In addition to these more quantifiable indicators, the qualitative fieldwork will provide a rich level of detail and explanation around community issues.

Timeline and Resources

Analysis of community dynamics would take place in two rounds, corresponding to the two rounds of the household survey and community focus group activities. The first round would be oriented mainly internally, to provide quick feedback to program managers on the unfolding community dynamics, and the second round would provide more summative evidence of program effects on community capacity, services and social fabric.

[7] The community score card (CSC) process is a community based monitoring tool that is a hybrid of the techniques of social audit, community monitoring and citizen report cards. Like the citizen report card, the CSC process is an instrument to exact social and public *accountability* and responsiveness from service providers. However, by including an *interface meeting* between service providers and the community that allows for immediate feedback, the process is also a strong instrument for *empowerment* as well. The CSC process uses the "community" as its unit of analysis, and is focused on monitoring at the local/facility level. It can therefore facilitate the monitoring and performance evaluation of services, projects and even government administrative units (like district assemblies) by the community themselves (Singh, World Bank).

Table 1: Potential Community Dynamics Evaluation Indicators

	Proposed Indicator	Source of Information
Social capital and social Cohesion	1. Village meeting attendance (number, disaggregated by sex and age)	Household Survey
	2. Number of social groups in village (e.g. women's groups, youth groups)	Household Survey
	3. Frequency of social group meetings	Household Survey
	4. Frequency of crimes and disputes	Household Survey
	5. Level of social tensions arising from CCT program	Focus Group Interviews
Community capacity	6. Frequency of CMC meetings	Household Survey
	7. Attendance at CMC meetings	Household Survey/CMC Reports
	8. Membership of CMC (number of members, gender)	Household Survey/TASAF MIS
	9. Forms of decision making within CMC (vote, consensus, other)	Household Survey/Focus Groups/CMC Reports
	10. Satisfaction with CMC management	Focus Group Interviews
Effects on community services	<u>Education</u>	
	11. Student-teacher ratio	School data/ CSC Input Tracking
	12. Desks per student	School data/ CSC Input Tracking
	13. Textbooks per student	School data/ CSC Input Tracking
	14. Composite CSC performance assessment indicator	CSC Performance Assessment
	15. Composite CSC provider self-assessment indicator	CSC Provider Self-Assessment
	16. General perception of education quality	Focus Group Interviews
	<u>Health</u>	
	16. Average waiting times	CSC Input Tracking
	17. Availability of essential medicines	CSC Input Tracking
	18. Composite CSC performance assessment indicator	CSC Performance Assessment
	19. Composite CSC provider self-assessment indicator	CSC Provider Self-Assessment
	20. General perception of health service quality	Focus Group Interview

The analysis of community dynamics is more of a component of the final evaluation write-up than a stand-alone piece of consulting work as it draws from the household survey and the focus group interviews. The scope of work of the consultants hired for the household survey and qualitative focus group interviews should specify coverage of these issues and inclusion of community dynamics indicators.

Annex 3: Terms of Reference: Tanzania CCT Process Evaluation

Objective

As part of the overall evaluation of TASAF's Conditional Cash Transfer Pilot, a process evaluation will be carried out. The key objectives are to:

- Assess the overall efficiency of TASAF in implementing the CCT program;
- Assess the effectiveness of the community-driven development (CDD) approach in managing the program through Community Management Committees (CMCs);
- Evaluate the quality of delivery of the interventions and the level of satisfaction with and opinions about the program by key stakeholders; and
- Identify operational issues to improve program performance in the context of an eventual scale up of the program.

This process evaluation will serve as an important input into the impact evaluation, helping to explain how issues involved in program implementation may affect, either positively or negatively, observed outcomes at the household and community levels. In addition, findings on program efficiency and effectiveness can be compared with international experience in CCT programs to gauge how community-managed implementation compares with best practice.

Methodology and Data Sources

The process evaluation will assess the program's efficiency and effectiveness in translating its resources and activities into the expected program results. In general terms, efficiency is measured by the volume of output achieved for the inputs used (time, money, etc.). Effectiveness measures the degree to which the program's features and capabilities meet the participant's needs. Effectiveness is also a measure of quality in attaining program objectives.

The main issues to be explored in the process evaluation include:

- *Quality of targeting*. Fairness, accuracy, and efficiency in the selection of program beneficiaries will be assessed. Household level data will permit evaluating errors of inclusion (households who receive benefits but should not) and errors of exclusion (eligible households who do not receive benefits). In addition, community perceptions will be queried of targeting effectiveness and perceived fairness as well as the level of influence the CMC has over targeting, versus influence of other actors (e.g. village chief, village council).
- *Information, education and communication (IEC) effectiveness*. The process evaluation will assess the level and accuracy of information that citizens in beneficiary communities have about the program, including understanding and perceptions of program rules and compliance requirements.
- *Transparency and accountability*. The process evaluation will query the effectiveness of the program's fiduciary management as well as community and beneficiary perceptions on procedures for complaints and sanctions. TASAF and

CMC transparency and accountability will be queried in focus group interviews as will issues involved in the complaint process and enforcing sanctioning requirements. The household survey will inquire about the amounts that households received to learn whether they actually received the amount intended.

- *Community management of the program*. The process evaluation will assess performance of the CMCs as local program implementation agents. Qualitative evaluation will explore whether and how the CMC interacts with traditional decision-making structures within the community.
- *Health and education service availability*. The process evaluation will assess the availability of necessary services to fulfill the CCT conditions (e.g., availability of places in school for students to attend and health personnel to carry out health monitoring) and gather service provider perspectives on program implementation.
- *Cost efficiency*. The process evaluation will include a detailed cost accounting, both in terms of program costs as well as additional costs borne by participants in terms of time, travel and foregone family support from children. The evaluation will use internationally-accepted norms and accounting methods for assessing CCT costs (Coady 2000, Caldés and Maluccio 2005). The *total costs* of a CCT program can be categorized as *program costs* and *private costs. Program costs* capture all the costs associated with the delivery of cash transfers to households including (1) targeting costs; (2) conditioning costs associated with ensuring that households meet their responsibilities by ensuring attendance of children at school and household members at scheduled regular preventative check-ups; and (3) operation costs associated with the actual operation of the program. *Private costs* are the costs that households incur in order to receive cash transfers, for example the time and financial costs of traveling to schools and health clinics as well as to collect the transfers. The household survey data will provide data to develop private costs and the TASAF MIS will provide program expenditure data. Qualitative methods will query the perception of private costs and how they are borne by household members. Using a standard CCT cost analysis methodology with allow for comparison across countries.
- *Processing efficiency*. The evaluation will look at the timeliness of transfers as well as reporting. Experience from other CCT program show common difficulties with timely payments particularly during the pilot start-up, which could affect perceptions, program compliance and, ultimately, impacts.

The process evaluation will use both quantitative and qualitative methods. Information will be drawn from three main sources:

(a) A small module added to the **impact evaluation household survey**. The household survey provides an opportunity to include several questions that can elicit quantitative data on various implementation aspects. For example, the household survey may provide a useful compliment of information about how participants heard of the program, whether they understand its conditionality and whether they participated in any training events.

(b) A group of discussion questions integrated into the **qualitative focus group interviews**. The qualitative focus group interviews will allow for the generation

of insights and deeper probing about implementation dynamics and the roles of the various actors in the process; and

(c) **Administrative data** provided through TASAF's MIS and standard reporting formats with CMCs and service providers.

Indicators

Table 1: Potential Process Evaluation Indicators

	Proposed Indicator	**Source of Information**
Quality of targeting	1. % of eligible HH in community that do not receive benefits	Household survey
	2. % of ineligible households in community that receive benefits	Household survey
	3. Perceived level of fairness in selection process	Household survey/Focus Groups
	4. % of households reporting perceived social tensions	Household survey/Focus Groups
Information, education and communication (IEC)	5. % of beneficiaries that understand compliance requirements	Household survey/Focus Groups
	6. % of beneficiaries who report participating in training activities during last XX months	Household survey
Transparency and accountability	7. % of beneficiaries in compliance during preceding month/year	TASAF MIS
	8. Unqualified financial audits	TASAF
	9. Participant knowledge and utilization of complaint mechanisms	Focus Groups/CMC Rpts/TASAF MIS
	10. % of beneficiaries suspended from the program in the last year	TASAF MIS
	11. % of beneficiaries voluntarily leaving program in last 12 months	TASAF MIS
Community management of the program	12. % of beneficiaries reporting satisfaction with CMC management	Household Survey
	13. % of CMCs receiving training (or # of training hours)	TASAF MIS
	14. Frequency and attendance at community meetings	CMC Reports
	15. % of CMCs providing timely financial reports	TASAF MIS
Service availability and provider perspectives	<u>Education</u>	
	16. % of beneficiaries that report that there was sufficient space to enroll their children in school	Household survey
	17. Level of education staff and administrator satisfaction with the program	Focus Group interviews
	<u>Health</u>	
	18. Level of education staff/administrator satisfaction with the program	Focus Group interviews
	19. % of beneficiaries reporting that health post was open and personnel available the last time they went	Household Survey
Cost efficiency	20. Administrative costs as a share of total program costs	TASAF MIS
	21. Administration costs(excluding fixed costs) per one-unit transfer to a beneficiary	TASAF MIS
	22. Annual private costs per beneficiary	Household Survey
	23. Total cost transfer/ratio	TASAF MIS/Household Survey
	24. Average monetary transfer as % of annual household consumption	Household Survey
Processing efficiency	25. % of beneficiaries receiving delayed payments	Household Survey/MIS
	26. # of days of average payment delays	MIS/CMC Reports

Table 1 above provides potential quantitative indicators applicable to the process evaluation, with the data source. Several of these indicators have been used in other CCT evaluations, so some international comparisons will be available. It will be important as the pilot is further designed and before implementation to ensure that any needed process indicators are included in both the standard reporting formats and TAAF MIS as well as within the household and community survey questionnaires once implementation is underway.

Timeline and Resources

The process evaluation will be carried out in two parts, corresponding to the two rounds of qualitative fieldwork proposed. While it would be premature to launch a process evaluation before the project is operational, it will be important that the data needs of the process evaluation are planned for in the design of the CCT program MIS and reporting and the impact evaluation household survey. The first round of qualitative focus group interviews at the end of the first year will allow for quick feedback to program managers on implementation issues as they arise. However, the full process evaluation will be carried out at the end of the pilot phase, incorporating data from the surveys, focus group and TASAF's MIS for a more complete picture of process and implementation issues. It should be completed prior to program scale-up to inform any design or operational changes necessary.

The process evaluation will be carried out by external consultants to ensure objectivity, but the evaluators will work closely with TASAF. In terms of level of effort and cost, some of this depends on whether the qualitative focus group/community dynamics work can be bundled with the process evaluation. A stand-alone process evaluation where the data is already available from the household survey and community focus groups would imply no additional fieldwork and the costs would be relatively low. With interview of program managers and other key stakeholders and data analysis, especially of program costs, the process evaluation would take somewhere in the neighborhood of two months with one or two consultants.